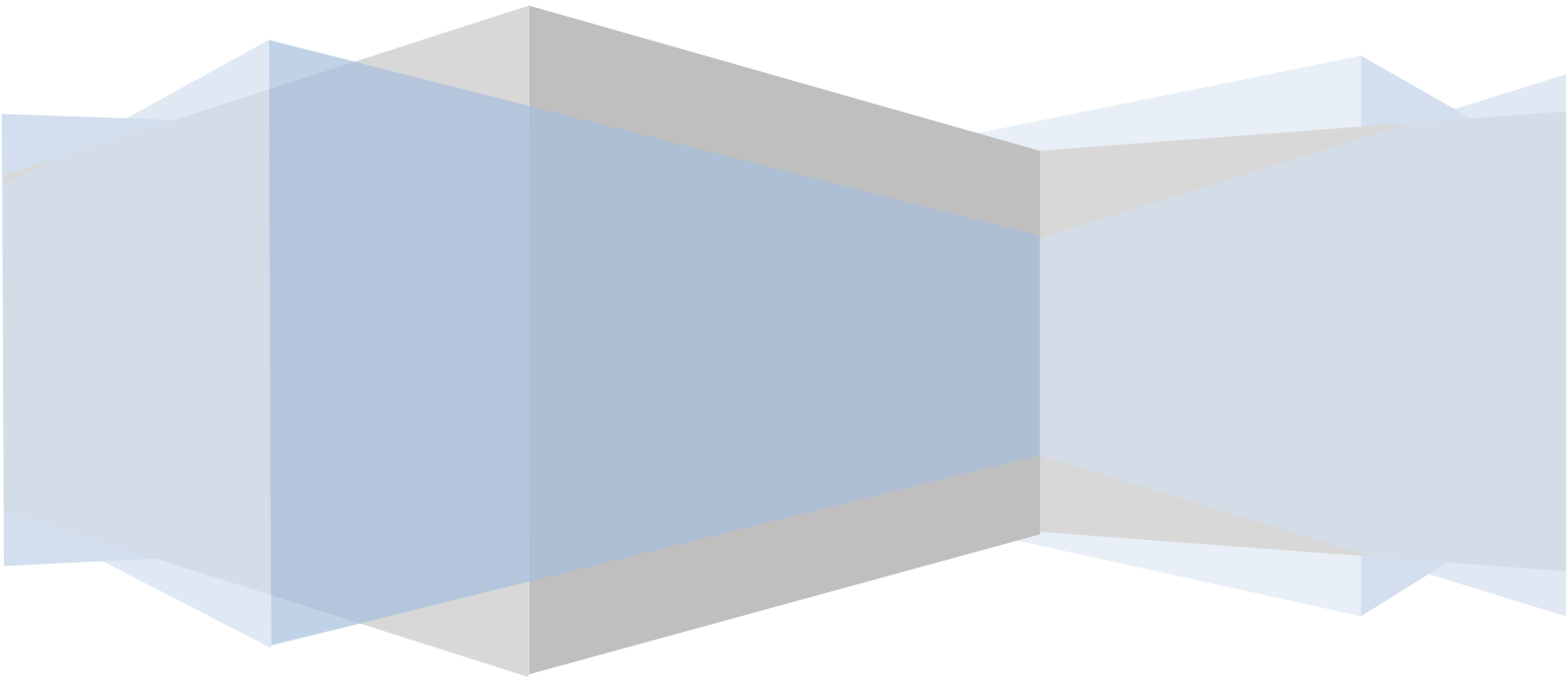
Health and Social Care Board

Public Health Agency

Commissioning Plan 2013/14

16 April 2013



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Foreword

This Commissioning Plan describes the actions that will be taken across health and social care during 2013/14 to ensure continued improvement in the health and wellbeing of the people of Northern Ireland. The Plan, developed in partnership by the Health and Social Care Board and the Public Health Agency, responds the Commissioning Plan Direction published by the Minister for Health, Social Services and Public Safety on the 28 of January 2013. In doing so, it outlines a range of actions that have been developed in partnership with patients and the public which are driven by need, clear goals and budgetary transparency.

Over recent years, Northern Ireland's health and social care service has made improvements in the quality of care for our population and people are living longer than ever before. However, the service faces considerable challenges going forward. Not only is our population increasing, but it is getting older. Elderly people are more likely to live with a long-term condition and have increased needs for health services and a greater reliance on hospital-based care. All of this signals a continued increase in demand for care. Despite the projected increase in demand, the current economic climate means that Northern Ireland's health and social care will receive a real cut in its budget by 2014/15 of around 2.7%.

The inevitable outcome is if that we want to have a sustainable service, we need to create one that looks and feels very different from the one we have today. We are committed to placing the patient, carer and community at the heart of that transformation and believe that by continuing to focus aggressively on quality, safety and the patient experience and by thinking more innovatively about our ways of working, we can improve outcomes whilst taking the necessary actions to build a sustainable health and social care service for the people of Northern Ireland. *Transforming Your Care* (TYC) outlined such a vision and it is that vision that underpins many of the actions within the plan.

TYC highlights the need to redesign and refocus services in order to:

- Enhance primary prevention to improve the way we live and look after our health;
- Improve the management of people with long term needs and complex conditions so that they are less likely to become unwell and less likely to require hospital care in the event that they do become unwell;
- Supporting people to live independently for as long as possible;
- Providing more care closer to home – home as hub of care;
- Recognising and valuing carers;
- Focussing spend on the most clinically and cost effective interventions; and
- Providing better quality acute care, which may require concentration of some services to ensure minimum clinical critical mass and maximum efficiency.

During 2013/14 we intend to demonstrate this commitment in a number of ways including:

- Increasing how much we spend on prevention;
- Establishing a number of Integrated Care Partnerships which will bring together a range of primary, secondary, community, voluntary and independent sector providers to look at how we can provide more seamless care, closer to home, reducing reliance on hospital-based care for the frail elderly and people of all ages with respiratory conditions, diabetes or stroke;
- Asking providers to develop their community services to support older people to live independently for longer;
- Working with providers to develop a range of quality assured self-management programmes for people with a long-term condition; and
- Having a stronger focus on carer support.

We commit to supporting the delivery of the actions outlined in the Plan by:

- Listening to what patients, carers and the public tell us about their needs and experiences;
- Supporting our staff through training and development;

- Working with clinicians to ensure delivery of best practice;
- Working in partnership with providers, including the private and voluntary sector to support greater choice and innovation;
- Embracing innovation and technology (e.g., Connected Health);
- Developing our information, communication technologies (e.g., to support electronic referral and the implementation of the NI Single Assessment Tool); and
- Through a continued focus on reducing health inequalities.

The structure of the plan is outlined below.

Section	Title	Content
1	Introduction	Outlines the purpose of the plan and provides information on the commissioning structures and processes which oversee its development and delivery.
2	Strategic Context & Key Drivers	Outlines the assessed needs of the population of NI and outlines how these, together with a range of key policies and strategies, drive the actions outlined in the plan
3	Ensuring Financial Stability & Effective Use of Resources	Outlines how we intend to spend the health & social care budget for 2013/14 in order to ensure best value and achievement of financial balance.
4	Regional Commissioning Priorities 2013-14	Outlines our detailed commissioning intentions across a number of different service areas
5	Opportunities & Enablers	Looks at some of the key ways we can support achievement of the actions outlined in the plan.

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Chair
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1.0 Introduction

1.1 The Purpose of the Plan

This Commissioning Plan is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Service and Public Safety for 2013/14. The Plan identifies the key strategic priorities, including NI Executive, Ministerial and Departmental priorities, that will influence the commissioning of health and social care services over the next 3 to 5 years and provides direction for the development of those services for the population of Northern Ireland. Specifically, it makes explicit those areas of service development and delivery that providers will be expected to respond to in their development plans for 2013/14 and against which they will be monitored. The document does not attempt to encompass all of the many strands of work that HSCB and PHA will continue to progress with providers during 2013/14. Rather it provides focus on a discrete number of key strategic and service priorities which we feel will have the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level, and those which represent a step change in how we deliver our services. The Plan encompasses all of the Transforming Your Care (TYC) recommendations and will provide the means through which TYC is planned and implemented.

The objectives within the Commissioning Plan have been identified through regional and local needs assessment and with reference to evidence-based or agreed best practice. In particular, they aim to respond to the six strategic priorities and statutory obligations identified by the Minister in the Commissioning Plan Direction (see Appendix 1 for further detail):

- To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion, anticipation and earlier intervention;
- To improve the quality of services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services;
- To improve the management of long term conditions in the community, with a view to improving the quality of care provided and reducing the

incidence of acute hospital admissions for patients with one or more long term conditions;

- To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector;
- To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities; and
- To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services;

In responding to these priorities the document seeks to outline how the stated objectives align with, and support the implementation of, a range of Government and Departmental strategies and standards including:

- Achievement of Ministerial standards / targets 2013/14 (see Appendix 2)
- *The Executive's Programme for Government, Economic strategy and Investment Strategy*
- *Transforming Your Care* (TYC)
- *Quality 2020*
- *Public Health Strategic Framework: Fit and Well Changing Lives 2012-22.*

The document also outlines how we will meet our Equality duties under the Northern Ireland Act 1998(b) and how we have sought to embed Personal and Public Involvement (PPI) in our commissioning processes.

1.2 Commissioning Structures and Processes

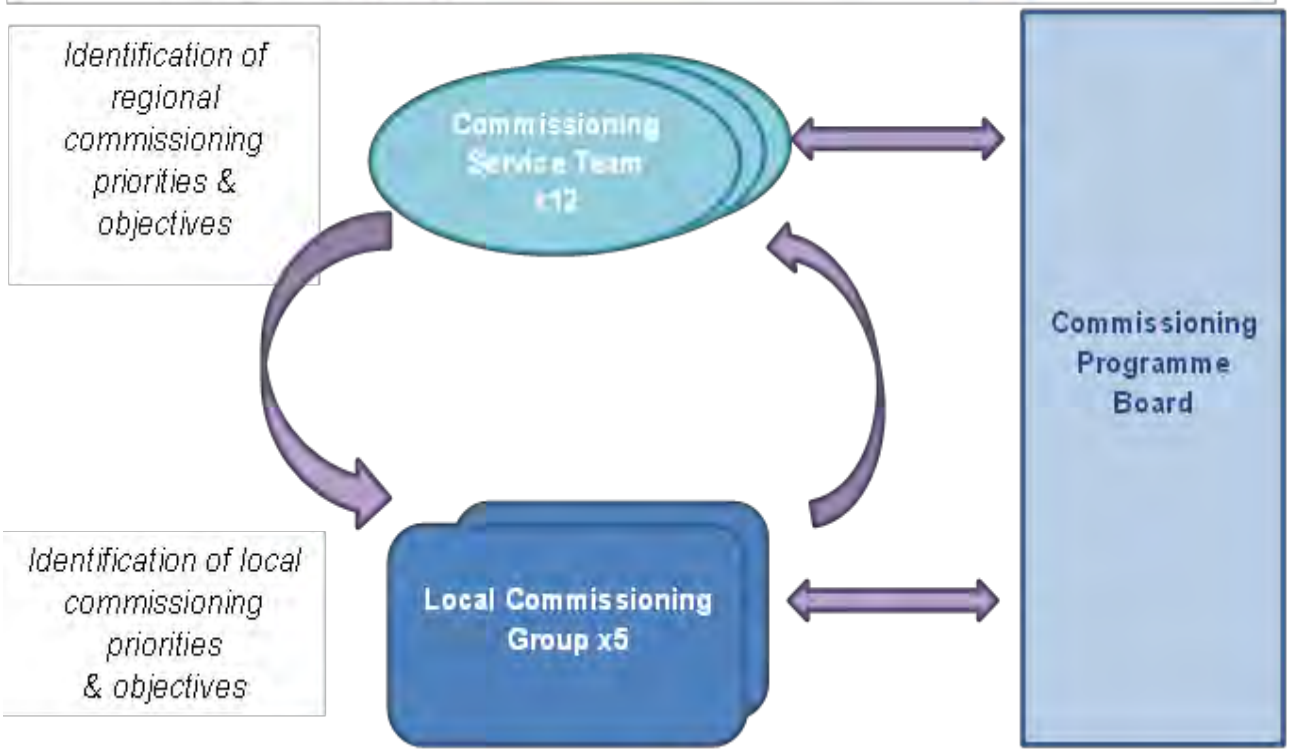
Commissioning objectives are determined at both a regional and local level. The process for identifying commissioning priorities is two-way, with local commissioning informing regional priorities and regional priorities providing a frame of reference for local commissioners to work from (see Figure 1). The process is outlined in greater detail overleaf.

1.21 Regional Commissioning Structures & Processes

At a regional level, commissioning takes place via a number of commissioning service teams (see Appendix 3). Each Commissioning Service Team is

multidisciplinary and includes public health, nursing and AHP staff from the PHA. Each team also includes input from: local commissioning; primary care; social care; pharmacy; finance; and information. Service teams are responsible for defining a service model or service specification for their service area which is both needs-led and evidence-based and which is developed with appropriate input from clinicians, service managers and service users. The teams consider the whole patient pathway from prevention through treatment, to rehabilitation, self-care and end of life. They also consider a range of key cross-cutting issues such as life stage, settings of care and strategic workforce needs.

Figure 1. Process for identification of regional and local commissioning priorities & objectives



The service specifications are live documents, which are reviewed on an ongoing basis as the needs of the population and the evidence base evolve. The service specification sets out the commissioning intention in relation to that service area, ensuring that, as funding is made available, it is aligned to and supports the service developments required to implement the service model. Commissioning Service Teams are report to a Commissioning Programme Board which is Chaired by the HSCB's Director of Commissioning.

Each Commissioning Service Team takes into account a range of planning considerations and information when developing the service specification for their service area (see Table 1 overleaf). In addition to the assessed needs of the population, a key component of this process is the review of performance management information, which indicates how well we are delivering on the strategic priorities set out by the Minister. All of these issues are considered within the context of the financial allocation and underpinned by our commitment to PPI and equality, diversity and human rights. Not only do teams look at the current position in relation to their service area, but they seek to horizon scan with a view to ensuring that our services are future-proofed. They also seek to take account of opportunities for and the benefits of partnership working with other Departments and agencies whose policy, strategy and service provision impinges on health and social care. The key strategic priorities (see Section 2) and service area objectives (see Section 4) presented in this report are the outworkings of this process.

Table 1. Commissioning Service Team Planning Considerations

	Section	Key Questions	Key information sources
Current View	**Need**	▪ What do we know about the level of need in this service area? ▪ Where are needs addressed poorly? ▪ Where do we appear to have an imbalance between supply and needs/outcomes?	▪ Needs assessment & health inequalities data ▪ Demand and capacity information ▪ Evidence of unmet/poorly met need through PPI
	Outcomes	▪ Where are outcomes significantly below or above targets/benchmarks?	▪ Health inequalities data ▪ Comparative peer benchmarking
	Service Quality, Safety & Performance	▪ Where is service performance (e.g., quality, waiting times, patient experience etc.) above or below targets/expectations? ▪ Are there any known safety issues ▪ What variation do we see in service quality and performance?	▪ Performance management information ▪ PPI (undertaken as part of planning process or drawing on existing sources e.g., Patient and Client Council reports) ▪ Benchmarking, peer review & audit ▪ Patient complaints and SAIs ▪ Deanery reports, Trust QI Plns, RQIA Reports ▪ NICE, Service Framework documents
	Health inequalities & Service	▪ Where do we have significant health inequalities and variation in service performance, by	▪ Health inequalities data ▪ LCG needs assessment, performance data and PPI initiatives

	variation	locality or client group?	▪ Managed Clinical Networks
	Policies, strategies& guidelines	▪ What policies, strategies and guidelines do we need to consider?	▪ Ministerial Priorities and Programme for Government, ▪ Quality 2020, Fit and Well Changing Lives, ▪ *Transforming Your Care* Strategic Implementation Plan &Population plans ▪ Other relevant DHSSPS strategies ▪ NICE, SCIE, Service Framework documents ▪ Strategic service reviews (e.g. Bamford, Maternity Services)
Future View	**Opportunities**	▪ Where could we re-scope our service offer and make significant cost savings with limited impact on outcomes? ▪ Where could we achieve the greatest savings in healthcare through investment, for example in prevention?	▪ Financial data (e.g. prescribing data and spend) ▪ Best practice examples (i.e. awareness and early detection, self management) ▪ Service improvement initiatives (i.e. preventable admissions)
	Projected need & Demand	▪ How will our population and need/demand change over the coming years? ▪ What policy drivers will we have to meet (e.g. NICE, Service	▪ Population projections ▪ Emerging strategies, policies and guidelines

		Frameworks etc.)? ▪ How could changing need/demand and other external factors (e.g. funding levels, technology, economic situation etc.) combine to impact us in future? ▪ How would the impact be felt?	
	Technology & Innovation	▪ Which currently available or emerging technologies and innovations could have the greatest potential to improve outcomes, service performance and efficiency? ▪ What's on the horizon that may have significant impact on demand and/or resource allocation?	▪ Horizon scanning (ongoing and undertaken as part of process, or, drawing on existing fora such as NICaN Drugs & Therapeutics Committee)

1.22 Local Commissioning Structures and Processes

The HSCB and PHA are committed to ensuring that commissioning priorities are focused upon need, are locally responsive and reflect the aspirations of local communities and their representatives. There are five Local Commissioning Groups (LCGs) and each is a committee of the HSCB: Belfast; Northern; South Eastern; Southern; and Western. LCGs are responsible for assessing local health and social care needs; planning health and social care to meet current and emerging needs; and supporting the HSCB to secure the delivery of health and social care to meet assessed needs.

The objectives of the regional Commissioning Service Teams provide a framework for local commissioners to use in the identification of their local commissioning priorities. However, these regional priorities and objectives may be amended by an LCG to reflect the local context or added to by an LCG to address a locally identified need. LCGs also have an opportunity to feed the outcome of their local needs assessment into the identification of the regional objectives; each LCG has a Commissioning Lead representative sitting on the Commissioning Programme Board and a member of their local team feeding into the regional Commissioning Service Teams.

The commissioning objectives of the five LCGs are presented in Appendix 7 - 11. These, together with the Ministerial targets, will provide the frameworks within which Trusts prepare their Trust Delivery Plans (TDPs).

1.23 Monitoring Performance

The priorities and targets detailed in the *Commissioning Plan Direction* are complemented by a number of indicators of performance indicated in a separate *Indicators of Performance Direction* for 2013/14 (see Appendix 4). The *Indicators of Performance Direction* has been produced to ensure that the Health and Social Care sector has a core set of indicators in place, on common definitions across the sector, which enable us to track trends and performance. The HSCB, PHA and Trusts monitor the trends in indicators, taking early and appropriate action to

address any variations in unit costs or performance or deteriorating trends in order to ensure achievement of the Ministerial targets.

2.0 Strategic Context & Drivers

This section outlines the key strategic drivers that have shaped our commissioning priorities for 2013/14 and beyond.

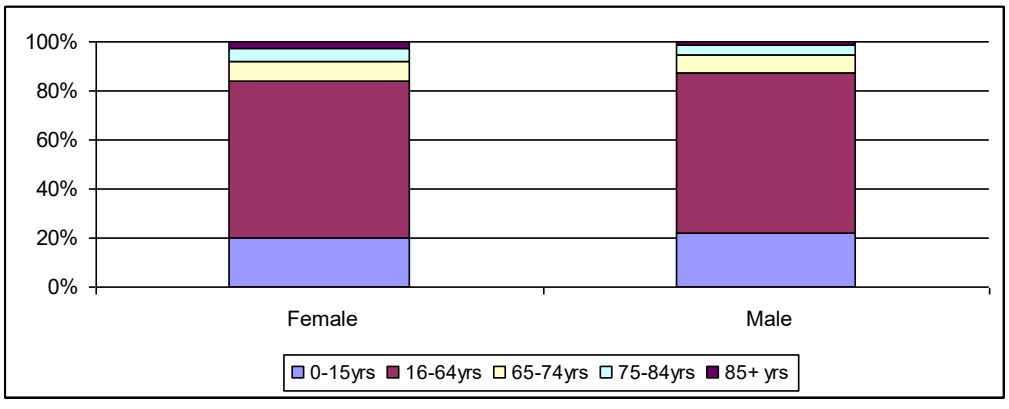
2.1 Demographic Changes & Health Inequalities

The paragraphs below provide a high level overview of demographic changes within NI. They also provide information on health status and lifestyle and behaviour, highlighting known inequalities. The focus is on regional trends; local area data explored in detail within the relevant LCG Plans (see Appendices 7-11). Demographic changes and health inequalities are a key driver of the regional and local priorities identified within this plan.

2.11 Demography

On Census day 2011 the population of Northern Ireland was at an all-time high of just over 1.81 million persons, representing an increase of 7.5% (almost 126,000 persons) since the 2001 Census. The gender split is 51% female and 49% male, which has not changed since the previous Census in 2001. Approximately one fifth (20%) of the population is aged under 16, almost two thirds (64%) are aged 16-64 years and 15% are aged 65 years and above (see Figure 2).

Figure 2. Age breakdown by gender for Northern Ireland (% of Total)



Source: Census 2011, NISRA 2012.

As people grow old the likelihood of illness increases and therefore also does the reliance on health and social care services. As noted above, in NI 15 % of the population are older people (65 and over) equating to some 264,000 persons. The most recent projections (based on the 2010 population) indicate that the overall population of Northern Ireland is to increase by 6% by 2020. This increase will include a marked rise in the size of the older population. Estimates indicate that the number of persons aged 65 and over will rise by more than 25% by 2020. In percentage terms the most significant projected increase is within the 85+ age category which will experience an increase of 51% by 2020. By 2041 it is expected that 24% of the population will be aged over 65 years and approximately 1 in 5 of this total is expected to be aged 85 years and over. Table 2 provides an overview of population projections for Northern Ireland for 2012-18.[1]

Table 2. Short term Population Projections for N Ireland and LCGs, 2012- 2018

Age Group	2012	2013	2014	2015	2016	2017	2018
Total	**1,827,000**	**1,839,000**	**1,851,000**	**1,862,000**	**1,874,000**	**1,885,000**	**1,896,000**
0-15	384,000	384,000	385,000	386,000	388,000	391,000	393,000
16-49	855,000	854,000	852,000	849,000	845,000	842,000	838,000
50-64	314,000	320,000	326,000	332,000	338,000	344,000	349,000
65+	274,000	282,000	288,000	295,000	302,000	309,000	316,000
75+	124,000	127,000	131,000	134,000	137,000	142,000	147,000
85+	33,000	35,000	36,000	37,000	39,000	41,000	42,000

Source: NISRA (published 2010).

Births

In 2011 there were 25,273 live births registered in NI. The number of births in Northern Ireland has remained relatively stable since 2008 following an increasing trend from a record low in 2002 when there were 21,385 births.

[1] Note these projections are based population figures published by NISRA in 2008, and are presented as rounded to the nearest thousand.

In 2011, there were 1,170 births to teenage mothers in Northern Ireland which is the lowest recorded in 35 years.

Deaths

Deaths were at the lowest recorded level in 2011 (total 14,204). Long term, the overall trend has been of a falling death rate, despite populations increasing and people living longer. The main causes of death in 2011 were cancer (4,059 deaths; 29%), diseases of the circulatory system (3,951, 28%) and diseases of the respiratory system (1,923 deaths 14%).

Each year in NI around half of all deaths take place in hospital. In recent years through the implementation of the Palliative Care Strategy, this situation has shown improvement with proportion of deaths taking place in hospital falling. Figures for 2011 indicate that 49% of Northern Ireland deaths took place in hospitals compared to 51% during 2009.

2.12 Health Status

It is well know that many factors impact on the health status of individuals and populations. These include age, gender and genetic makeup, lifestyle and behaviour, social and environmental factors. Health status of a population may be monitored through a combination of measures for example mortality, life expectancy, morbidity and perceived health status.

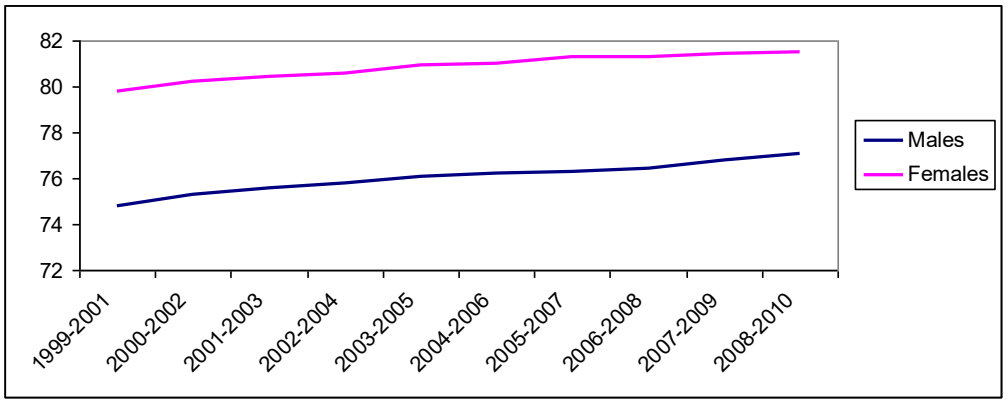
Life Expectancy

Life expectancy is used internationally as a measure of population health. For the period 2008-2010, life expectancy in NI was lower than in the rest of the UK, with the exception of Scotland. Males and females in NI could expect to live 1.4 and 1.0 years less respectively on average than their counterparts in England (Source: ONS, 2012).

In Northern Ireland, life expectancy has increased between1999-2001 and 2008-2010 from 74.8 years to 77.1 years for men, and from 79.8 years to 81.5 years for

women (see Figure 3). In spite of improvements across the population as a whole, it is also true that persistent patterns of inequality remain and mirror wider inequalities in society.

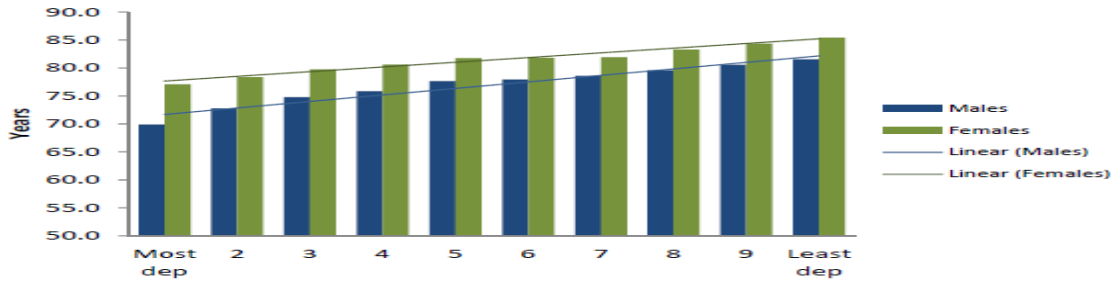
Figure 3. Life expectancy by Gender in Northern Ireland, 1999-2001 to 2008-2010.



Source: NISRA, 2012

The influence of social conditions is evident when we compare life expectancy and other health outcomes across geographical areas and population groups. For example, males living in the 10% least deprived areas in NI could expect on average to live almost 12 years longer than their counterparts living in the 10% most deprived areas. For females, the gap is more than 8 years. Figure 4 below shows life expectancy at birth by deprivation decile. For females the scope of inequalities in life expectancy across the population is lower than for males, which is evidenced by the steeper gradient across the deciles for males.

Figure 4. Life expectancy by Deprivation decile 2008-10



Source: IAD, DHSSPS, 2012.

Similarly, life expectancy for male Travellers is estimated at some 15 years less and Traveller women at some 10 years less than the adult population as a whole.

Perceived health status

The 2011 Northern Ireland Census asked respondents how they perceived their health. Approximately one fifth of the Northern Ireland population stated that they had a long term limiting illness. Almost 80% felt they were in good health. When asked about the type of long term condition suffered just under 7% of the Northern Ireland population stated they had a chronic illness and 10% suffered long term pain or discomfort.

Qualities & Outcomes Framework Disease Registers

The Prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation (PHA, 2011).Across Northern Ireland the most prevalent LTCs are hypertension (127 per 1000 patients), asthma (60 per 1000 patients) and diabetes (40 per 1000 patients).

In February 2010, the Institute of Public Health in Ireland published a report "Making Chronic Conditions Count". The report contains forecasts of the population prevalence of a number of chronic (long term) conditions, namely Hypertension, Coronary Heart Disease, Stroke and Diabetes. It predicts that between 2007 and 2020 the prevalence of these long term conditions amongst adults in Northern Ireland is expected to increase by 30%.

Emergency Admissions to hospital for LTC

During 2011/12 long term conditions such as asthma, COPD, diabetes, heart failure and stroke accounted for a total of 11,483 emergency admissions to hospital (where relevant ICD-10 codes were coded as a primary diagnosis or main condition treated on the admission episode) out of a total 128,169. Of the 11,483 admissions, COPD accounted for just under 40%, at a rate of 329 admissions per 100,000 population (aged 18+; see Table 3).

Table 3. Total number of emergency admissions and Rate per 100,000 population (aged 18+) to hospitals in Northern Ireland for selected long term conditions 2011/12.

Northern Ireland	Asthma	COPD	Diabetes	Heart Failure	Stroke
Number of Emergency Admissions	812	4,522	996	2,385	2,768
Rate per 100,000 popn.	59	329	72	174	201

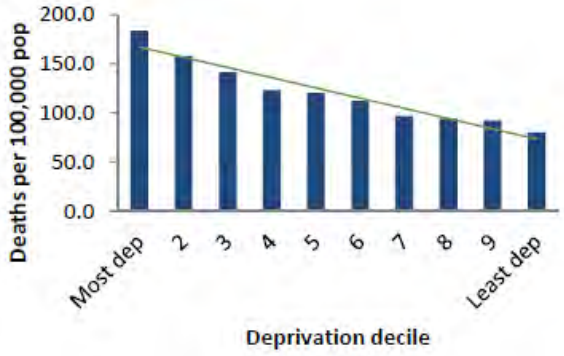
Source: Hospital Inpatient System, DHSSPS

Cancer

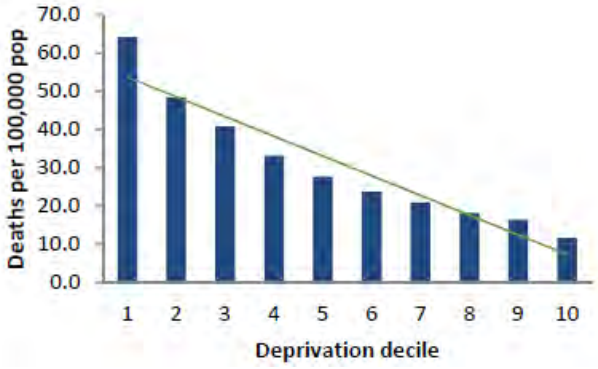
Cancer now accounts for the largest number of deaths attributable to a single cause in NI (4,059 deaths or 29% of all deaths in 2011). In 2011, the most common cancer sites for males and females was the trachea, bronchus or lung which accounted for 26% of cancer deaths in males and 19% of female cancer deaths. Breast cancer accounted for 18% of female cancer deaths in 2011, and prostate cancer for 11% in males.

Cancer death rates are linked to deprivation. The graphs in Figure 5 illustrate the social gradient in relation to the death rate under 75 years due to (i) cancer (all sites) and (ii) lung cancer. Cancer-related mortality in the most deprived decile was more than twice that in the least deprived and one and a half times that in NI as a whole. Lung cancer related mortality in the most deprived decile was five and a half times that in the least deprived.

Figure 5. Standardised death rate (SDR) for cancer (all sites) and lung cancer for the aged under 75yrs, by deprivation decile, 2005-2009



All sites



Lung

Source: IAD, DHSSPS

Cancer incidence rates measure how much more or less an individual is likely to develop cancer in a specific geographic area compared with the Northern Ireland average, having taken in to account the age and gender profiler for that area. Data shown in Table 4 below show a substantial decrease in the risk of cancer for Belfast LCG residents relative to other LCG areas from 15% above the average to now being at the average. Reductions in smoking are the most likely explanation for this.

Table 4. Cancer Incidence rates 1993-99 to 2003-09 by LCG of Residence

LCG Area of Residence	1993-99	2003-09
Belfast	115	100
Northern	94	99
S-Eastern	94	99
Southern	98	103
Western	99	99
N. Ireland	**100**	**100**

Source: IAD, DHSSPS 2012 & NI Cancer Registry, 2012.

2.13 Lifestyle and behaviour

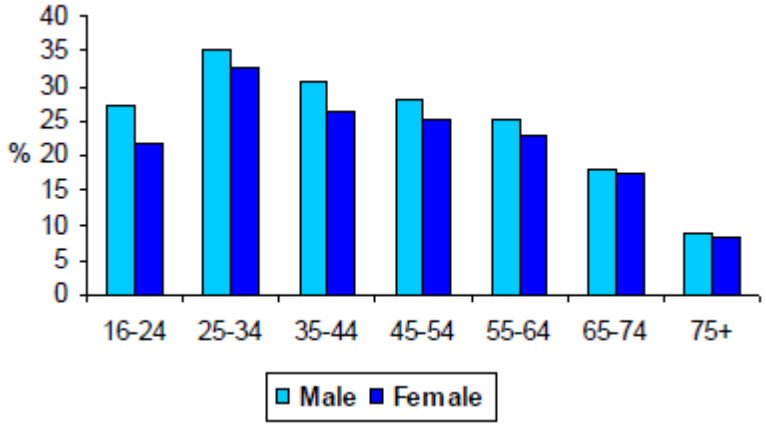
Smoking

Smoking rates are highest among people who earn the least and are lowest amongst those on higher incomes, for example while smoking prevalence amongst the general population is now 24%, amongst manual workers it remains high at 31%.

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in NI, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 48 individuals every week (PHA, 2012). Smoking related deaths have decreased across NI over the last number of years, by 9%.

Results published from the Health Survey NI (2011/12) reveal that a quarter of respondents indicated that they currently smoke, 27% of males and 23% of females (DHSSPSNI, 2012). Smoking prevalence was higher within the 25-34 age group at 33% and lowest amongst the over 75s (Figure 6).

Figure 6. Smoking prevalence by age and gender 2011/12



Source: Health Survey Northern Ireland DHSSPSNI, 2012.

The survey also revealed that just over three quarters (76%) of smokers had tried to quit smoking at some stage.

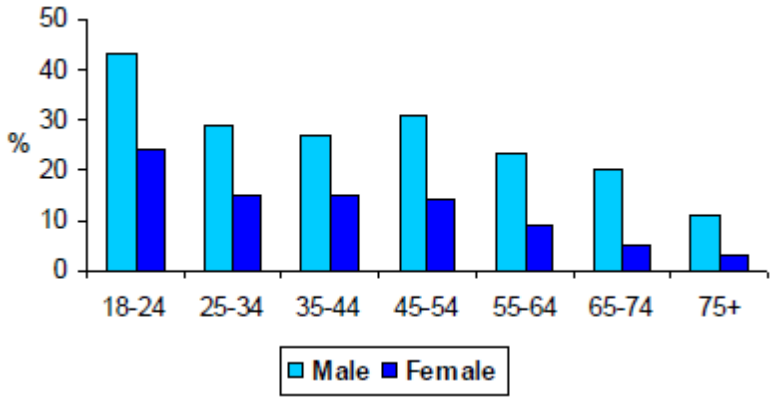
Alcohol

The number of alcohol-related deaths in NI has been increasing over the past decade. Since 2001, there have been a total of 2,785 alcohol-related deaths in Northern Ireland, 68% of which have been deaths to males.

Alcohol-related admission rates have also been on the increase in Northern Ireland over the past decade with an average increase of 21% (from 528 standardised admissions in 2000/01-2002/03 to 641 in 2008/9-2010/11). Alcohol related standardised admission rates and death rates for Belfast LCG residents are significantly higher than other LCGs with Belfast accounting for 31% of alcohol related deaths since 2001.

Findings reported from the Northern Ireland Health survey show that three quarters (75%) of respondents aged 18 and over indicated that they currently drink alcohol, 81% of males and 72% of females. In general the proportion of respondents indicating that they drink alcohol decreased with age, from between 85% - 88% of 18-34 year olds to 44% of those aged 75 and over. Almost one fifth of all respondents aged 18 and over reported drinking in excess of the weekly drinking limits (see Figure 7).

Figure 7. Respondents drinking above weekly limits by age and gender, 2011/12



Source: Health Survey Northern Ireland DHSSPSNI, 2012.

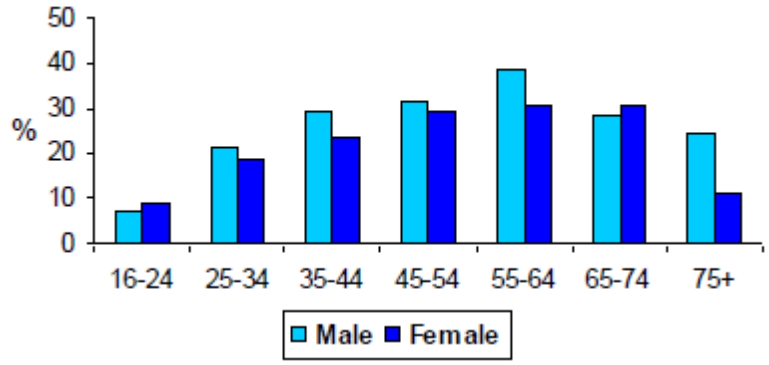
It is well known that health outcomes are generally worse in the most deprived areas, with alcohol related mortality in the 10% most deprived areas of Northern Ireland being almost 9 times that in the least deprived areas (PHA, 2012).

Obesity

Obesity is one of the most important public health challenges in NI today, and indeed the prevalence of obesity has been rising over the past number of decades. Projections suggest that half of the UK will be obese by 2030 – a rise of 73%. Research has shown that obesity can reduce life expectancy by up to 9 years as well as increasing the risk of coronary heart disease, cancer, type II diabetes as well as affecting mental health and self-esteem and quality of life (CMO, 2010).

Recently published findings of the Health survey Northern Ireland shown in figure 25 indicate that 10% of 2-5 year olds were assessed as being obese. Overall, 61% of adults measured were either overweight (37%) or obese (23%), with a higher prevalence in males (34%) than females (25%; see Figure 8).

Figure 8. Obesity levels by age and gender



Source: Health Survey Northern Ireland DHSSPSNI, 2012.

Smoking, obesity and misuse of drugs and alcohol are disproportionally concentrated amongst particular deprived groups (Source: PHA, 2012), as are the social determination which increase the likelihood of less healthy lifestyles – poverty, poor mental health, crime, poor physical environment.

Rurality

Generally health outcomes in rural areas tend to be better than in NI overall. However evidence suggests that health inequalities can be significant for people living in rural communities. Challenges faced by many people living in rural areas include:

- Deprivation and fuel poverty;
- Social isolation and social exclusion - small, sparsely distributed populations;
- A growing ageing population and changing population patterns; and
- Adequate access to services.

Pressures felt by wider society as a result of the economic climate are often exacerbated in rural areas resulting in increasing numbers of rural people finding themselves in positions of poverty and exclusion. These challenges are compounded with many needs and issues hidden as a result of isolation in the rural setting. Rural poverty manifests itself differently from poverty in urban areas; it is not spatially concentrated and is therefore more difficult to identify. Rural poverty is clearly associated with the remote rural regions although obviously not confined to them.

The *New Policy Institute* found, for example, that disadvantage was more prevalent in western districts of Northern Ireland. Broader research carried out across rural areas in the UK indicates that most rural areas are affluent, with rural poverty scattered and hidden amongst general affluence. People in rural communities are less likely to identify they are in poverty and there is a culture of making do. This is evidenced in part by the lower than average take-up of benefits in rural areas (*see Bramley et al 2000)*. In 2007 – 2008 in Northern Ireland, of those who earned 50 per cent below the UK Mean Income before Housing Costs, almost half (46 per cent of individuals) lived in rural areas (PHA, 2012).

2.2 Tackling Inequalities & Preventing Ill Health

Approximately 4000 people die prematurely each year in Northern Ireland due to preventable ill health. While Northern Ireland has seen reductions in inequalities

gaps (for example, in relation to infant mortality, cancer incidence rates, teenage births), gaps still exist and the improvements have not been seen in all groups at the same rate. Programme for Government has prioritised the need for increased investment in preventative and other public health programmes and this is very welcome. The HSCB and PHA also look forward to the new Public Health Strategic Framework "Fit and Well – Changing Lives" which provides an essential framework for transforming this pattern over time.

The strategy sets the direction for Government, agencies and communities in the challenge of improving health and wellbeing outcomes. It makes clear the need for strong cross-departmental action to address the wider socio economic determinants of health through shared priorities and coordinated action and use of resources.

The new strategy is built on the life course approach, which focuses on the social influences on health at every stage of development throughout life from early years. The framework is underpinned by two themes, engaging and promoting supportive and sustainable communities and building healthy public policy.

The PHA approach with the HSCB to reducing inequalities and improving health and wellbeing will reflect the Public Health Strategic Framework, once finalised, and is currently based on 4 building blocks:

1. <u>Give every child the best start</u>
   Evidence suggests that effective intervention in early child development will bring significant benefits long into adult life in terms of educational attainment and economic status. The PHA and HSCB will advance investment in and extend evidence based initiatives such as the Family Nurse Partnerships, parenting support and infant mental health programmes. HSCB is investing in Family Support Hubs.

2. Ensure a decent standard of living
   The current economic climate presents a challenge, both in terms of available government resource and as a direct influence on health and wellbeing. For example, there is clear evidence of the link between unemployment and poor health with every 1% increase in unemployment met with 0.8% increase in suicide. The PHA and HSCB will work with government and across sectors to ensure a decent standard of living, in particular working to address poverty.

3. Build substantive communities
   It is recognised that some groups experience increased inequality and marginalisation which contributes significantly to poorer outcomes. The PHA and HSCB will coordinate action to address the needs of vulnerable people and communities including those living in disadvantaged areas and population groups who require additional or more specific support such as Travellers, migrants, Lesbian, Gay, Bisexual and Transgender (LGBT), Looked After Children, those with Disability, and Homeless people. Action will focus on partnership models which include the active engagement of those most affected alongside other agencies that can influence the determinants of health.

4. Make healthy choices easier
   This work will include action on alcohol and drug misuse, tobacco, mental health and suicide prevention and sexual health and wellbeing. It will also, in line with Programme for Government, focus on halting the rise in obesity. The PHA will take a lead role in implementing the Fitter Futures strategy.

The PHA will also address active ageing as a key priority, working with HSCB and other partners, including local communities, to promote the inclusion and full engagement of older people in improving their health and wellbeing.

2.3 Programme for Government

The Programme for Government (PFG), launched March 2012, sets the strategic context for the Budget, Investment Strategy and Economic Strategy for Northern Ireland. It identifies the actions the Executive will take to deliver its number one priority – a vibrant economy which can transform our society while dealing with the deprivation and poverty which has affected some of our communities for generations.

PFG identifies a number of key priorities to be delivered over a three year planning cycle across all Government departments. The commitments that relate specifically to health and social care are as follows:

- Commitment 22: Allocate an increasing percentage of the overall health budget to public health
- Commitment 44: Enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic condition management programme
- Commitment 45: Invest £7.2 million in programmes to tackle obesity
- Commitment 61: Introduce a package of measures aimed at improving safeguarding outcomes for children and vulnerable adults across Northern Ireland
- Commitment 79: Improve Patient and Client outcomes and access to new treatments and services
- Commitment 80: Reconfigure, Reform and modernise the delivery of Health and Social care services to improve the quality of patient care.

The HSCB and PHA have committed to the achievement of a number of related targets across the three year plan to support the delivery of the Executive's priorities. Specifically, the HSCB and PHA have committed to achievement of the following targets during 2013/14:

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

- Invest £2.4 million in tackling obesity
- Open new Sexual Assault Referral Centre at Antrim Area Hospital
- Improve quality of life for the children of teenage mothers from disadvantaged backgrounds by rolling out the Family Nurse Partnership Programme
- By 2013/14 reduce the number of days patients stay in acute hospitals unnecessarily (excess bed days) by 10% compared with 2011/12
- Work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively, alongside full application of the Remote Telemonitoring contract.

All of these targets are included in the HSCB's Commissioning Priorities 2013/14 (see Section 4).

In line with the PFG commitment 22, an additional £7m (from the 2011/12 baseline) is to be invested in public health during 2013/14. PHA has responsibility for investing this funding in a range of programmes that will help to reduce health inequalities and improve health and well-being outcomes. In 2012/13, the first tranche of the funding was invested in a number of new areas including:

- The provision of additional services to help support people affected by suicide and mental health issues;
- Establishment of a regional Self Harm Registry
- new initiatives to support vulnerable young children and their families, including the establishment of 2 additional Family Nurse Partnerships;
- development of new programmes to help older people to continue to live independently;
- additional investment to support research focused on improving health and well-being and addressing health inequalities
- establishment of a new digital mammography breast screening service;
- new initiatives to help tackle obesity, including the development of a new public information campaign; support for breast feeding services, GP physical activity referral schemes and outdoor gyms; and

- development of new services to support vulnerable groups such as LGBT '; homeless and migrants.

Discussions are on-going with DHSSPS colleagues to agree the areas of new investment that will be supported in 2013/14.

2.4 *Transforming Your Care*: Providing care closer to home & improving choice

The recent review of the provision of health and social care with Northern Ireland, '*Transforming Your Care*' (published in December 2011) contained a total of 99 recommendations resulting from comprehensive engagement and consultation with a wide range of stakeholders and analysis of the current provision of care. As outlined in 2.1, Northern Ireland has a growing and ageing population and an increased prevalence in long term conditions which is contributing to increasing demand and over reliance on hospital beds. This is coupled with need for HSC services to continue to provide value for money and greater productivity.

TYC proposes a new model for health and social care, designed with the person at the centre and with health and social care services built around the individual, supporting them to make good health decisions.

The main aims of the "shift left" approach outlined in TYC are to reduce unnecessary hospital admissions, provide care closer to home, personalise care through empowering patients and service users and support the movement of service upstream towards the prevention of ill health. All of this will be underpinned by: a continued focus on quality, safety and sustainability; by a commitment to utilising all available resources to maximum benefit; by maximising the use of technology; and by supporting our workforce.

Some of the key recommendations from the TYC review focus on providing care as close to home as practical; providing greater personalisation of care and

more direct control, including financial control, over care for patients and carers; and greater choice of service provision, particularly non-institutional services, using the independent sector, with consequent major changes in the residential sector.

A key commissioning priority for 2013/14 and beyond is the development of a range of innovative and accessible services in the community to support people to live as independently as possible. Individuals will be supported to maintain good health and wellbeing, preventing the onset of illness and avoiding deterioration with any existing conditions. Primary care and community-based services will be enhanced, avoiding the need for people to attend hospital and ensuring that, when hospital care is necessary, they are able to be discharged from hospital as soon as they are fit to do so.

Key to the delivery of the new model of care outlined in TYC is a more integrated approach to service planning and delivery. Integrated Care Partnerships will play a central role in the reform and modernisation of health and social care, particularly in the "shift left" of services out of the hospital sector and into the primary and community sector.

TYC recommends the establishment of 17 Integrated Care Partnerships (ICPs) which would join together the full range of health and social care services in each area. These collaborative networks will include GPs, health and social care providers, hospital specialists and representatives from the independent, voluntary and community sector. It is proposed that ICPs will be established around natural communities (approximately 100,000 people). The introduction and establishment of ICPs will be on a phased approach across the LCG areas. ICPs will work in partnership with emerging Community Planning structures.

ICPs will identify how the blockages and barriers to the integration of services might be overcome, creating opportunities to integrate and streamline care, through a range of mechanisms including: strategic level activity - such as local application of full integrated, Commissioner-approved care pathways; risk

stratification of a defined population of service users; and patient level activity - including anonymised case work and improvement in control and prevention of inappropriate acute admission.

It is anticipated that the initial the focus of ICPs will be on the frail elderly and aspects of long term conditions for all ages, namely diabetes, stroke care and respiratory conditions. This may include Palliative & End of Life Care in respect of these agreed areas. This could potentially involve service developments such as: GPs with enhanced services; enhanced roles for community pharmacy; 24/7 Urgent Care including GP; provision of outpatient care; access to a greater range of diagnostics and links to Voluntary and community organisations to support care. Service specifications will identify new care pathways that will substantially change the management of patients' conditions. There will be an emphasis on what can be done to manage a patient's condition by promoting prevention and earlier intervention in order to prevent it exacerbating or escalating to the stage of requiring hospitalisation. For example GPs will be expected to identify and risk stratify those patients who may be most at risk of a fall and to work with occupational therapists to prescribe aids and adaptations to prevent a serious fall from occurring which may result in a hospital stay to treat a broken hip being avoided. A diabetic patient may be targeted to ensure that they are encouraged to give up smoking thereby reducing additional complications resulting from circulation problems. For patients with several conditions, these will be managed by an integrated approach which will aim to ensure that the co-morbidity of conditions is addressed and early intervention with one condition prevents exacerbation of another, thus avoiding a future hospital stay.

Subject to these initial work areas being appropriately addressed, subsequent work areas may be proposed by the Department, the HSCB/LCGs and/or the ICPs.

2.5 Improving Quality & Safety – Quality 2020 and Service Frameworks

The Francis Report highlights that the fundamental responsibility of the NHS is to provide safe, compassionate care and treatment. It reasserted the importance of commissioning in defining safety and quality specifications and supporting and managing the performance of providers to ensure these standards are met.

Statistics, benchmarks and action plans are tools not ends in themselves and should not come before patients and their experiences. The DHSSPS Quality 2020 (Q2020) strategic framework ensures that patients and their experiences remain at the heart of service design and delivery by defining quality under three headings:

1. Safety – avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.
2. Effectiveness – the degree to which each patient and client receives the right care (according to scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.
3. Patient and Client Focus – all patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The document comprises 5 strategic goals which when achieved will reflect positive change. These are:-

i Transforming the Culture
ii Strengthening the Workforce
iii Measuring the Improvement
iv Raising Standards
v Integrating Care

The PHA chairs the Q2020 Implementation Team for 2013/14, DHSSPS and other key stakeholders have prioritised 7 projects for implementation. These projects reflect the 5 strategic goals and are:

i The Management of Safety Alerts;

ii Development of Annual Quality Reports;
iii Development of a policy framework to review existing standards within the HSC;
iv Development of a multi-professional leadership programme;
v Development of an E-Learning platform supporting access to E-Learning modules;
vi Completing ward level reviews of Patient Experience and the Quality of Clinical Care,
vii Completing a literature review on Changing Cultures.

Each Project has designated leads responsible for delivering on the project objectives. In addition, a communication strategy and evaluation plan will be developed.

Service Frameworks for Cardiovascular Disease, Respiratory Conditions, Cancer and recently, Mental Health will continue to be implemented through engagement with clinicians and other practitioners, charities and voluntary groups, people with these conditions and service managers. Specific priorities include expansion of end of life care at home, patient education programmes, timely GP access to diagnostics and increased provision of insulin pumps for children.

Commissioning Teams will also take close account of NICE Clinical Guidelines and Quality Standards in identifying service developments / redesign and investments, and will commission NICE Technology Appraisal recommendations throughout the year.

The PHA and HSCB have worked to develop a rigorous health and social care Quality and Safety Assurance Framework linked to the DHSSPS Quality 2020 Strategy. The Framework addresses the three components of Quality: Safety, Effectiveness and Patient and Client Focus as set out in Quality 2020 (see Appendix 3) and comprises a number of components including:

- Production of Quality Improvement Plans (QIPs) by Trusts

- Implementation of the DHSS&PS's Patient and Client Experience Standards
- Provider Support in relation to patient safety across a range of initiatives from emergency medicine to falls prevention.
- Progression of a Regional Adverse Incident Learning System (RAIL)
- Introduction of Key Performance Indicators for Nursing and Midwifery Care
- Workforce planning within Nursing and Midwifery Services.

Work is also ongoing to respond to the recommendations of a number of best practice reviews including the Maternity Services Review and the Review of Paediatric Congenital Heart Services (see Section 4), and RQIA Reports including on Pseudomonas and on Under 18s in Adult Wards.

Table 5. The People's Priorities for Health and Social Care

	The Peoples' Top Ten Priorities 2011	Young Peoples' Top Ten Priorities 2012
1	Access to and Quality of Hospital Care	**Accident and emergency services.** When people go to hospitals for emergency treatment, they should not have to wait an unreasonable time and should be seen by fully trained professional staff every time.
2	Care of the Elderly (including Care in the Community)	**Staffing levels.** More trained staff are needed to give proper care and treatment in hospitals, GP surgeries, nursing homes and other places where people are cared for, including their own homes.
3	Waiting Times (Hospital Care and Treatment)	**Waiting times.** Waiting times for appointments must be cut down, not just your GP but also time to see a consultant. You should not be kept waiting to be seen when you do keep an appointment.
4	Cancer Services	**Quality of care.** Doctors and others should treat people with courtesy; be fully trained; have the necessary modern equipment for quality care; and communicate in a way people understand that.
5	Mental Health and Learning Disability Services	**Health promotion.** People need to be educated to live healthier lifestyles so that they do not need treatment for conditions caused by obesity, smoking, drinking alcohol and drug abuse.
6	Health and Social Care Staffing Levels	**Mental health and learning disability services.** They want to see action to remove the stigma associated with mental ill health. Also better counselling and treatment for depression, anxiety, self-harm, eating disorders and suicide prevention. More day opportunities for people with a learning disability are needed.
7	Access to GPs and Primary Care	**Care of elderly people.** More support for elderly people in nursing and residential homes and to help them to stay in their own homes. They also need day centres and such places to avoid loneliness – giving them and their carers a break.
8	Children's Services	**Funding.** More spent on research, cancer drugs, mental ill health staffing, equipment, community care and support services, including help for young carers.
9	Reducing the costs of Administration and Management	**Cancer care and research.** As well as the need to spend more money on research and care for people with cancer, more screening for cancer and more cancer drugs are needed.
10	Quality Assurance of Health and Social Care Services	**Equipment, including beds.** Up to date equipment should be provided, including the latest beds and enough of them to meet demand.

Underpinning this commitment to engage with patients and the public is our PPI strategy which is core to the effective and efficient commissioning, design and delivery of Health and Social Care services and we have many good examples of how PPI is shaping how we commission.

One example is the *Transforming Cancer Follow Up* project. The impetus behind the project came from a workshop for patient and carers back in 2009, at which they gave feedback that "aftercare is an afterthought". Since then the HSCB, PHA and the NI Cancer Network (NICaN) have worked in partnership with Macmillan Cancer Support to begin to transform how cancer follow up is undertaken. A PPI representative sits on the project steering group, and the NICaN PPI forum provides a sounding board against which to test the direction of travel. PPI representatives have been involved in the development of patient information relating to self-directed follow up, and NICaN PPI Readers Panel quality assure the information (in terms of readability) before its production.

In breast care follow-up services, the thrust is on supporting patients to be self-managing, by providing them with appropriate information and support, and by signposting them to services provided by many cancer charities in their local community. To help develop a shared vision for this, NICaN has facilitated a number of cancer charities collaborative working meetings to identify how best to work together to achieve better spread of support services across NI. There has been much enthusiasm and a coming together of the cancer charities to achieve this aim of enabling recovery and promoting cancer rehabilitation. As a result of this work 30% of breast care patients are now on a self-directed aftercare pathway – avoiding the need for unnecessary follow-up appointments.

The Long Term Conditions Service Team used a qualitative research technique, called Sensemaker, to capture the experiences of people with heart failure. A half-day workshop for patients, family, carers, health care professional, commissioners and relevant voluntary organizations, such as the British Heart Foundation and NI Chest Heart and Stroke Association, was held to develop the SenseMaker experience survey. This was piloted with the cardiac network and

with some heart failure patients. The aim the survey was to identify ways in which patients and their carers can be equipped to better manage the condition.

The final version of the survey was distributed to patients on the primary care heart failure register via their GP and to patients attending secondary care, via their heart failure specialist nurse. It was also made available on the websites of the voluntary organizations involved and the Public Health Agency. In total of 183 questionnaires were returned. The results were presented to representatives of primary and secondary care, heart failure nurses, and the voluntary organisations at an analysis workshop. Attendees interpreted the findings and developed a number of recommendations. These recommendations will inform future commissioning and quality improvement work in relation to heart failure.

Following the review of the Paediatric Congenital Cardiac Service (PCCS) in Belfast Trust, the Minister requested that the HSCB working with the PHA establish a Working Group to take forward the development of a consultation document on the future commissioning of Paediatric Cardiac Surgery and Interventional Cardiology for the population of Northern Ireland. Parents and parent representatives have been involved at a number of levels. Firstly, parents and parent groups form a core component of the working group, with four "parent" members. As well as formal representation, there has been an open invitation for parents, service users or other members of the public to attend the Working Group meeting. At each of the meetings, there have been two to four parents / service users in attendance. Finally, during the consultation period, the HSCB and PHA have held five public meetings and four focus groups meetings across NI. A total of 176 people attended the public meetings and 28 parents and service users attended the focus group meetings. Their feedback, along with the formal consultation responses, will inform recommendations on the future of commissioning of PCCS for the population of NI.

In taking forward an agreed pathway to prevent unnecessary emergency admissions from nursing homes due to dehydration, Western LCG engaged with

independent homes across the Western area as part of the introduction of an agreed care pathway. The LCG needed to ensure that nursing homes had the capability and commitment to administer sub-cutaneous fluids prescribed by a GP. The LCG liaised with the Western Trust's Rapid Response Nursing service which had been working with independent nursing homes to improve nursing capability through a training and support programme. The LCG had also brokered support from all Western GP practices that where sub-cutaneous fluids were an option in the case of dehydration of a patient in a nursing home, that the GP would work with the nursing home to administer these, as is best practice.

The LCG arranged three workshops across the area, which were attended by representatives of most of the independent nursing as well as leads for Rapid Response Nursing. Discussion highlighted some of the practical barriers for nursing homes to providing sub-cutaneous fluids but emphasised a strong commitment among the providers to work to deliver the pathway. The LCG addressed some of the practical issues, such as providing an initial stock of fluids and drip-stands, where required. Discussions with community pharmacists also took place to ensure re-ordering of fluids would be straightforward. The pathway was initiated in May 2012 and has been running successfully since then. Western LCG plans to undertake evaluation during 2013.

Section 5.2 provides further detail on progress made in relation to PPI during 2012/13 and plans to expand PPI during 2013/14.

3.0 Ensuring Financial Stability & Effective Use of Resources

3.1 Introduction

Maintaining financial stability across the HSC is one of the core responsibilities of the Health and Social Care Board. This can only be achieved through effective financial planning and robust accountability arrangements. This section sets out:

- A summary of the key principles underpinning and approach to the development and implementation of the financial plan;
- An overview of the Financial Plans for 2013/14 and 2014/15;
- An overview of the planned investment of Health and Social Care Board and Public Health Agency resources;
- A summary of the approach to improving productivity and maximising use of resources;
- An overview of the values and volumes of activity commissioned and how this relates to changes in the assessed needs of the population; and
- An overview of how resources will shift from the acute to primary / community settings as a result of "shift-left".

3.2 Producing the Financial Plan 2013/14 – 2014/15

The following paragraphs outline the principles, approach and outcome of the financial planning process for 2013/14 – 2014/15.

3.21 Financial Framework HSCB - Key Principles

Resource management will be led by the HSCB with all key organisations represented. Local Commissioning Groups, which are sub-Committees of the HSCB, have a fundamental role in the financial planning of the investment of resources and the implementation of cash and productivity targets.

Only specific inescapable pressures will be reflected in financial plans, sufficient to enable the maintenance of existing activity levels, address Ministerial targets, fund agreed service developments and meet residual demand.

The HSCB will set overall cash and productivity targets for individual HSC Trusts for each of the remaining years in the Spending Review period in light of the allocation received by the DHSSPS. These targets will take account of the relative efficiency levels and the relative incidence of pressures within each Trust. Agreed cash and productivity targets will be attributed to the organisation incurring the pressures.

The financial plan will take account, where possible, of funding inequities across Local Commissioning Groups.

All organisations will continue to be held to account for the delivery of cash savings and productivity improvements through an agreed monitoring and accountability process.

These principles have been applied in producing the Financial Plans set out in section 3.24.

3.22 Financial Plan - The Approach

This section sets out the approach of the HSCB in respect of producing the Financial Plan, allocating resources, monitoring and delivering financial stability across the Spending Review period.

Financial Plans for 2013/14 and 2014/15 have been developed in an overall HSC context. This involved:

- An assessment of available income;
- An assessment of the emerging inescapable pressures;
- A review of additional solutions to meet resource requirements;
- Identification of cash and productivity targets for all organisations.

The HSCB has a central role monitoring progress in respect of the financial plan and will hold Trusts to account on the full delivery of their element of the overall

HSC Financial Plan and on their individual requirement to break-even in-year and on a recurrent basis.

A minimum dataset of financial and non- financial performance measures will be issued to all relevant organisations.

3.23 Review of 2012/13

The Commissioning Plan 2012/13 identified £273m pressures. At the time of the Commissioning Plan funding solutions to these pressures were identified together with an unresolved deficit as per Table 6.

Table 6 2012/13 Funding solutions

2012/13	£m
Total Pressures	(273)
Less DHSSPS funding	58
Projected deficit	**(215)**
Sources:	
In year easements	30
Trust Cash and Productivity Targets	107
FHS Targets	42
HSCB Over- commitment	15
Deficit	21
Total resource requirement	**215**

Additional in-year financial controls were adopted to fully address the deficit and it is anticipated that in 2012/13 the HSC will deliver financial breakeven in line with its key financial target. However, £51m of theses sources are not recurrently available and therefore contribute to an opening deficit in 2013/14.

3.24 The Financial Plan Overview

This section provides an overview of the financial plan 2013/14 – 2014/15. Table 7 summarises the income and resource requirements projections and identifies the gap to be addressed each year.

Table 7. Summary of Financial Plan 2013/14 – 2014/15

	13/14	14/15
	£m	£m
Total Income	4,150	4,246
Total Resource Requirement	4,298	4,372
Funding Gap	(149)	(126)
Total solutions incl Cash and Productivity Targets	149	126

Table 8 below summarises the overall budgetary requirements for the HSCB/PHA for the next two years. The financial plan for 2013/14 assumes an opening recurrent allocation of £3,995m from DHSSPS, additional funds of £124m and a non-recurrent allocation of £28m for TYC. The HSCB/PHA are currently liaising with the DHSSPS to confirm these assumptions.

The funding for TYC £28m is not confirmed but will be subject to in-year monitoring bids, following final approval of the full business case by DFP. In the event the £28m funding is not secured for TYC in 2013/14, this would result in a financial deficit for the HSCB.

Table 8 shows that there is insufficient income to meet identified financial pressures and if the HSC is to breakeven additional cash and productivity targets will be required.

Table 8. Budgetary requirements 2013/14 – 2014/15

	13/14	14/15
	£m	£m
DHSSPS Allocation - Opening	3,995	4,119
DHSSPS Additional Cash	124	84
DHSSPS Additional Cash Transitional TYC	28	38
Additional Non DHSSPS Income	3	5
Total Income	**4,150**	**4,246**
Total Resource Requirements	**4,298**	**4,372**
Funding Gap	**(149)**	**(126)**

Table 9 summarises the identified funding solutions/sources to address the funding gap set out in Table 7.

Table 9. Summary of projected deficit and funding solutions for 2013/14

	13/14	14/15
	£m	£m
Solutions:		
Cash & Productivity Targets Trust	93	70
Cash & Productivity Targets Board	25	23
Other sources (in year easements)	31	34
Total solutions	**149**	**126**

Total pressures across the two years are detailed in Table 10. In arriving at these forecasts the approach has been both conservative and realistic, seeking to minimise pressures and identify only those which are likely to be viewed as inescapable.

Table 10. Detailed Budgetary requirements 2013/14 – 2014/15

Summary	2013/14 £m	2014/15 £m
Pressures:		
Pay inflation	28	22
Non Pay inflation	35	35
Service Developments	0	10
Demography - General	25	25
Demography - Acute Elective > 55yrs	4	4
Demography - Acute Non Elective > 55yrs	6	6
Specialist Hospital Services	13	4
NICE Drugs	13	10
Rates		
RCCE	7	5
MH resettlements	5	4
LD resettlements	7	6
Residual Demand Other	16	10
General Pharmacy Services	30	30
General Dental Services	3	3
General Medical Services	6	6
General Ophthalmic Services	1	1
Elective Care Recurrent	24	0
Extra Contractual Referrals	0	0
PHA	1	0
Total pressures	**224**	**181**
Add Costs of TYC Reforms *	**35**	**57**
Less reduction to Demography & elective care pressures above which will be used to part fund TYC Reforms	**-7**	**-12**
Adjusted pressures	**252**	**227**

** section 3.25 (xiii) provides further detail*

3.25 Inescapable Funding Areas

(i) Pay

The pay pressure £28m 2013/14 (£22m 2014/15) is based on a financial model which identifies pay expenditure and uplifts the cost by the nationally planned increase of 1% in both years. It also includes additional amount for incremental advancement in 2013/14.

(ii) Non-Pay

This pressure of £35m 2013/14 (£35m 2014/15) is to cover inflationary increases for goods and services. The pressure is based on a financial model which identifies non-pay expenditure (based on 2011/12 HSCB, PHA and Trust Annual Accounts) and uplifts the cost by an average uplift factor of 3.1% in 2013/14 (and 3.0% in 2014/15). This average uplift factor is drawn from a review of Health Service Cost Index in 2012 and adjusting for known variations in Northern Ireland (e.g. Electricity and Gas).

(iii) Service Developments

The plan recognises that despite the tight financial restraints it is important to reflect a level of investment of new service developments in the final year of the Spending Review period and therefore £10m has been included for 2014/15.

(iv) Demography

The demography pressures identified in the plan take account of projected additional costs for each programme of care resulting from increases in population projections (see Table 11). This includes £3.1m pressures of reablement covered in *Transforming Your Care*.

Table 11. Demography by POC

	Demography - Elective	Demography - Non-Elective	Demography - General
	13/14 £m	13/14 £m	13/14 £m
POC 1	4.3	5.7	
POC 2			0.4
POC 3			0.4
POC 4			18.6
POC 5			2.6
POC 6			1.1
POC 7			0.8
POC 8			0.7
POC 9			0.4
TOTAL	4.3	5.7	25.0

(v) Specialist Hospital Services

This funding has been identified to recognise the need for Specialist Hospital Services. Pressures in this area include neurosurgery, catheterisation laboratories and paediatric intensive care beds and associated transport services.

Table 12. Specialist Hospital Services – Detail

Specialist Hospital Services	13/14 £m
Neurosurgery	2.20
Regional Intestinal Failure Service	0.30
Paediatric cardiac surgery Review	1.00
Paediatric Transport Service(4 PICU beds)	2.00
Paediatric Transport Service(Transport)	0.50
Paediatric Pathology	0.15
Paediatric orthopaedics	0.15
Specialist paediatric	0.30
Heptology	0.15
Renal access NHSCT	0.00
Maxio Facial	0.20
Rare diseases	0.10
Clicky hips	0.03
TB	0.08
RBHSC MRI	0.06
Other	0.50
Cath Labs 13/14 profile spend	5.32
Total	**13.04**

(vi) NICE Approved Drugs

This funding has been identified to enable the implementation of relevant NICE approved treatments in NI.

(vii) RCCE

The RCCE pressure is to address those revenue costs arising from capital projects committed to, and planned to be committed to, over the Spending Review period including radiotherapy provision in the Belfast City and Altnagelvin hospitals, and the additional revenue costs associated with the new South West Hospital.

(viii) Mental Health Resettlements

This funding will be used for the resettlement of mental health patients from hospital to a community setting. Further work is ongoing with Trusts to validate total client numbers over the Spending Review period.

(ix) Learning Disability Resettlements

This funding will be used for the resettlement of learning disability patients from hospital to a community setting. HSCB has instigated a community integration programme to oversee the resettlement process, comprising representatives from DHSSPS, HSCB, Trusts and other stakeholders.

(x) Residual Demand

This funding will be used to address the growing demand for services caused by new drugs and technologies, changes in disease profile and other factors which increase demand for care, other than demographics. Areas earmarked include pseudomonas, long-term conditions, children with disability and the implementation of the physical disability strategy.

Table 13. Residual Demand Detail

Residual Demand	Pressure Area	13/14 £m
Social Care:		
	Addiction Services	0.3
	Prison Health	0.2
	ED Psychiatric Assessment	0.4
	Autism Act Implementation for Adults	0.3
	Carers support	0.3
	Adult Safeguarding	0.5
	Children disability	1.0
	Children with complex needs	0.8
	Looked after children therapeutic services	0.3
	Carer support(Children with disability)	0.8
	ADHD(NHSCT)	0.1
	Physical Disability strategy	1.0
	Dementia Strategy	1.0
Long Term Conditions		
	Paediatric Asthma & Anaphylaxis service	0.4
	Huntington Disease Service Provision	0.1
	Database for FH(Familial Hypercholesterolemia)	0.1
	Palliative Care Co-ordinators	0.2
	24/7 Nursing Support Marie Curie	0.3
	Diabetes and Pregnancy	0.5
Non Shift Recommendations in pop plans £1m		1.0
Maternity		0.2
Pseudomonis		3.5
Carbon Reduction		2.0
Chemo Nursing		0.2
Acute Oncology		0.3
Haematology		0.1
Insulin Pumps		0.3
Total		**16**

(xi) Family Health Services (FHS)

The pressures identified for FHS are primarily to cover anticipated increased costs in Prescribing, Dental, General Medical and Ophthalmic Services including demography, residual demand and non-pay inflation.

(xii) Elective Care

This funding has been identified to assist in meeting elective care waiting time targets. This includes £3.6m of pressures relating to PCI/Cardiac catheterisation.

(xiii) *Transforming Your Care* (TYC) Gross Costs

The original TYC report estimated that the required funding of reforms would be c. £70m. This is still the case, as HSCB has assessed an estimated £70m is needed to deliver the reforms proposed by the TYC report.

Following discussion between HSCB and DHSSPS, the financing of the TYC and QICR programmes have been brought together under one single programme. As a result, the costs of the VR/VER elements of QICR have been estimated to be £15m and have been included in the TYC business case prepared by HSCB for DFP/DHSSPS approval. This business case therefore now requests approval of £85m funding, £70m for TYC reforms and £15m for the QICR programme. This is detailed in Table 14a below.

The business case however is required in addition to show the cost of reforms which are being funded from other sources. As some £26m of funded pressures had been identified in previous commissioning plans, this has also been included in the business case. This brings the total cost of the business case to £111m. This is detailed in Table 14b below.

The £70m funding for TYC reforms will be used to fund the implementation of TYC initiatives in areas such as Integrated Care Partnerships, Stroke, Voluntary Early Retirement / Voluntary Redundancy. This funding is not recurrent.

Table 14a. Funding Required

Year	2012/13	2013/14	2014/15	TOTAL
	£m	£m	£m	£m
TYC Programme Funding	14	23	33	70
QICR Programme Funding	5	5	5	15
TOTAL	19	28	38	85

Table 14b. TYC Reforms

Reform Area	12/13 - 14/15 Net £m	12/13 - 14/15 Gross £m	13/14 Gross £m	14/15 Gross £m
ICPs	14	22	5	14
Service Change: Stroke	11	11	4	6
Service Change: pPCI	2	9	4	4
Service Change: Reablement	3	14	4	7
TYC Implementation	8	8	3	2
Telecare	1	1	0	0
Prevention	0	0	-	0
Carers Respite	1	1	0	1
Bamford	2	2	1	2
Child Development	0	0	-	0
111 Urgent Care	1	1	1	1
NIAS See Treat Leave	2	2	0	1
Self Directed Support	1	3	1	1
Workforce Reskilling	2	2	1	1
TYC VER/VR	22	22	7	12
TYC REFORMS ONLY	**70**	**96**	**30**	**53**
QICR VR/VER	15	15	5	5
TOTAL TYC COSTS	85	**111**	**35**	**57**
Less Funded by HSCB				
PPCI from Elective			4	4
Reablement from Demography			3	7
Self Directed Support from Demography				1
TYC Benefits Realised from 12/13 & 13/14				7
TOTAL DHSSPS FUNDING SOUGHT 13/14			**28**	**38**

3.26 Planned Investment 2013/14

The Health and Social Care Board and Public Health Agency will receive some £4.1bn for commissioning health and social care on behalf of Northern Ireland 1.8m resident population for 2013/14 (see Table 15).

Table 15. Total Allocation 2013/14

	2013/14 £m
HSCB	4,035
HSCB TYC	28
PHA	84
Non DHSSPS Income	3
TOTAL	**4,150**

Of the total received, approximately £3bn is allocated to the six provider Trusts and other providers of care such as Family Health Services and voluntary organisations. Figure 9 illustrates this for both the HSCB and PHA.

Figure 9

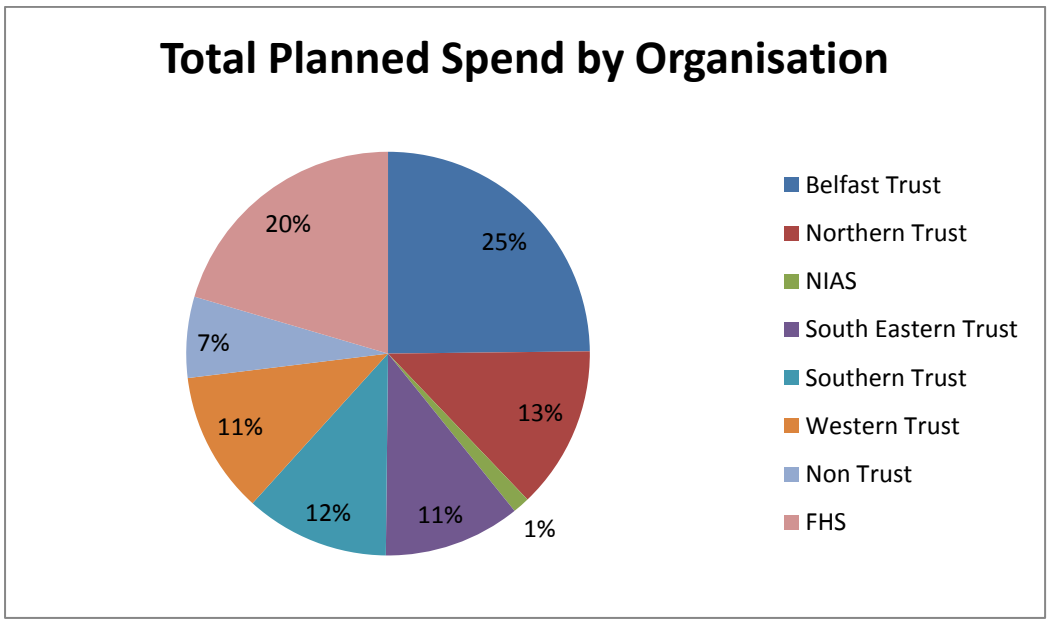


Table 16 sets out how the total resources are planned to be allocated across the Programmes of Care and Family Health Services. The planned expenditure set out in the table reflects the transitional costs for TYC. However, it is anticipated that the TYC programme will also result in a shift of resources on an in-year basis from acute to other Programmes of Care. The HSCB is currently working with Trusts to quantify this and its impact on individual service areas.

Planned expenditure by Programme of Care is currently subject to a comprehensive rebasing exercise. This will help facilitate a comparison of planned spend with actual Trust expenditure reports. Updated figures will be reflected in the Strategic Resources Framework analysis.

Table 16. Planned Expenditure by Programme of Care

Programme of Care	PHA		HSCB		TOTAL	
	£m	%	£m	%	£m	%
Acute Services	0	0.00%	1,420	45.06%	1,420	44.12%
Maternal & Child Health	0	0.00%	132	4.19%	132	4.10%
Family & Child care	0	0.00%	202	6.42%	202	6.28%
Older People	0	0.00%	657	20.85%	657	20.41%
Mental Health	2	2.31%	246	7.81%	248	7.70%
Learning Disability	0	0.00%	237	7.51%	237	7.36%
Physical & Sensory Disability	0	0.00%	98	3.11%	98	3.05%
Health Promotion	65	97.54%	49	1.54%	114	3.54%
Primary Health & Adult Community	0	0.15%	110	3.50%	111	3.44%
Sub Total	67	*100%*	3,151	*100%*	*3,218*	*100%*
FHS	0		848		848	
Not allocated to PoC*	17		67		84	
Total	**84**		**4,066**		**4,150**	

* BSO, DIS, Management & Admin

Ensuring resources are fairly distributed across local populations is a core objective in the Commissioning process. The HSCB commissions by Local Commissioning Group population.

Figure 10 shows how the HSCB resources are planned to be spent across localities. This reflects the different population sizes and need profiles within each locality (e.g. the Northern LCG crude resident population is the largest with 25.58% and the Western LCG the smallest with 16.26%). Family Health Services

(FHS) are not assigned to LCG in the graph as these are managed on a different population base, as stated above. A&E and Prisons have not been assigned to LCG as these are regional services.

Planned expenditure by Local Commissioning Group is currently subject to a comprehensive rebasing exercise. Updated figures will be reflected in the Strategic Resources Framework analysis. It is anticipated that the analysis across Local Commissioning Groups will substantially change.

Figure 10

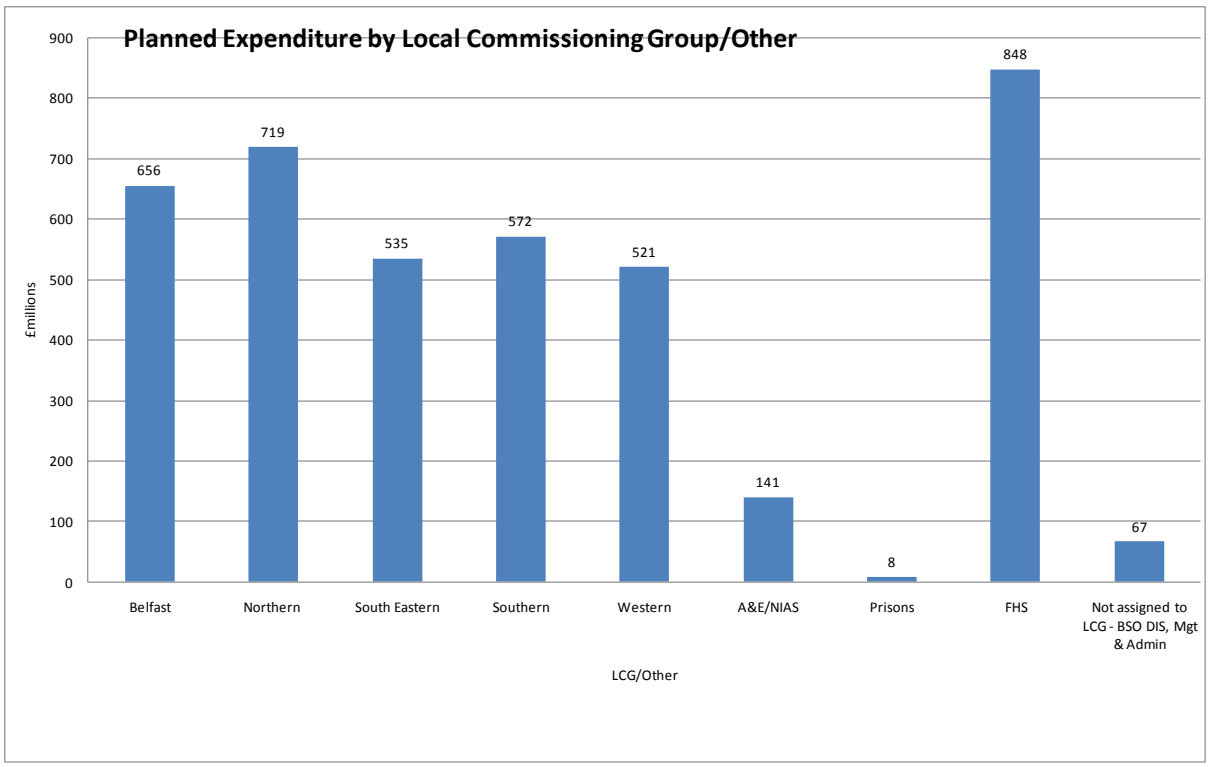


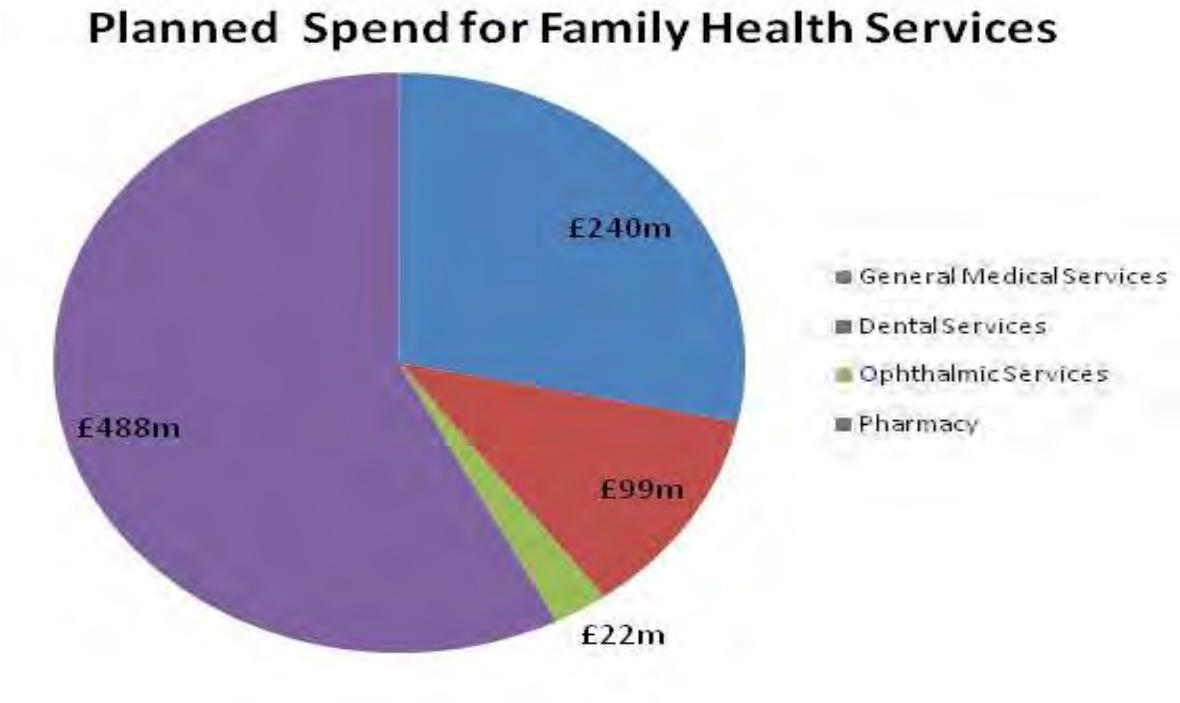
Table 17 demonstrates how each Local Commissioning Group plans to allocate its resources to providers of Health and Social Care.

Table 17. Resources by LCG

HSCB / Trust	Local Commissioning Group								
	A&E/ NIAS £m	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Prisons £m	FHS £m	Total £m
BHSCT	22	575	154	141	81	49	0	0	1,022
NHSCT	14	3	516	2	2	2	0	0	539
NIAS	57	0	0	0	0	0	0	0	58
SEHSCT	21	45	7	365	10	3	7	0	458
SHSCT	17	1	5	1	453	2	0	0	479
WHSCT	10	1	9	1	5	443	0	0	468
Non Trust - Vols, Extra Contractual Referrals	0	48	44	36	33	34	0	848	1,042
Sub Total	**141**	**672**	**735**	**546**	**583**	**533**	**8**	**848**	**4,066**
Not Assigned to LCG*									84
TOTAL									**4,150**

The Board commissions services from a range of Family Health Services. Figure 11 below shows the breakdown of planned spend across these services.

Figure 11



3.27 Locality Equity

Achieving equity in commissioning health and social care for its local population is a key objective of the Commissioning Plan. In order to support the delivery of this objective, the Health and Social Care Board's strategic direction will continue towards ensuring all local populations have fair and equal:

- access to services - dependent upon need;
- allocation of resources - dependent upon availability of funds;
- levels of high quality, safe and effective care - subject to agreed standards and recommended best practice.

In order to inform its strategy the HSCB has initiated a comprehensive equity review which will be completed before the end of the 2012/13 financial year and will be used to inform future financial plans. In addition the following table demonstrates how the additional pressures identified in the 2013/14 financial plan are to be allocated across Local Commissioning Group areas.

A key measure which informs the HSCB in assessing whether resources have been allocated fairly to local populations is the capitation formula. This is a statistical formula which measures the relative need for available resources across local populations. The formula takes account of the factors which most differentiate one areas need for resources from another. The primary factor is the total number of people living within a locality. A second key factor is the age of the population, as the very elderly and the very young are the greatest users of health and social care resources. Other factors include the different socio economic profile of local populations, as areas of higher deprivation have a higher than average need for health and social care resources. The additional planned investment net of planned cash and productivity efficiencies has been compared to the fair share capitation formula (see Table 18).

Table 18. Impact of 2013/14 Plan Compared to Capitation Share

LCG	Belfast £m	North £m	South East £m	South £m	West £m
Share of Funding above capitation share	-2.4	0.2	0.3	1.0	0.9
Productivity/Savings requirement less than capitation share	0.6	-0.8	-0.7	1.5	-0.6
Impact on Equity	-1.8	-0.6	-0.4	2.5	0.3

3.3 Improving Productivity & Maximising Use of Resources

The Commissioning Plan acts as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. This involves balancing the need to live within a significantly constrained financial envelope whilst addressing local populations increasing need for health and social care.

Central to this is Improving productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities.

This will be supported through targeting areas where efficiency improvements can be made, implementing learning from relevant benchmarking studies and sharing and promoting best practice.

It is anticipated that additional expenditure requirements will significantly exceed total available additional income in the current expenditure period and comprehensive savings and productivity plans are required if we are to continue to live within the resources available.

The efficiencies of £149m to be delivered in 2013/14 means that there will be a significant challenge for the HSC to breakeven and at the same time maintain the integrity of the service and drive forward the transition necessary to implement the long terms reforms planned in *Transforming Your Care*.

Given the scale of the challenge the HSCB will continue to implement a process across the HSC whereby the productivity and financial challenges can be managed in a streamlined way and in the longer term context of *Transforming Your Care*. The approach will ensure that there is a clear plan to allow the system to breakeven and that this is delivered through maximising productivity and minimising the impact on patient and client outcomes.

The HSCB's planning involves both top down and bottom up planning processes, with a regional approach for those areas impacting on major strategy and policy areas, supported by planning process taken forward at local level by LCGs working with Trusts and other providers. To date this has included:

- Providing an indicative high level assessment of potential opportunity areas across the HSC for the next three years covering the following areas: acute productivity, staff productivity, social care and other areas including Prescribing
- Setting all organisations an annual total cash and efficiency improvement targets and in 2012/13 which should enable the HSC to breakeven in this financial year

In 2013/14 the HSCB will:

- Set clear targets across the HSC to allocate the requirements between cash, savings requirements and productivity as summarised in the Table 19.
- Continue to implement robust monitoring and accountability arrangements in respect of these targets.

Table 19. Productivity improvement targets 2013/14 by Trust

	Cash	Productivity	TOTAL
	£m	£m	£m
Belfast HSC Trust	26	6	**32**
Northern HSC Trust	12	5	**17**
South Eastern HSC Trust	10	4	**14**
Southern HSC Trust	9	5	**14**
Western HSC Trust	11	4	**15**
NI Ambulance Service	1	-	**1**
Family Health Services		25	**25**
OTHER	31	-	**31**
TOTAL	**100**	**49**	**149**

In developing the Financial Plan it has been assumed that all Programmes of Care will contribute towards the cash efficiency savings on the basis of current investment share. The HSCB will continue to work with Trust to ensure appropriate areas are targeted. Trusts and Commissioners will work together to establish local plans to summarise how the cash release element of the target will be achieved. These plans reflect the overarching reform programme for the HSC established in *Transforming Your Care*. They include a wide range of initiatives under the following headings:

(i) Acute Productivity

- Focus on reducing excess bed days and increased patient management within an Outpatient (e.g., achieve target new to review ratios, reduce DNAs) & Day Case setting
- Day Surgery Reform – both in terms of achieving Day Case rates and consolidation of Day Surgery Services
- Reducing excess bed days in line with best practice
- Reducing readmission rates

(ii) Social Care Reform

- Planning and implementation of Re-ablement initiative

- Price negotiations with independent domiciliary care providers
- Savings in management / administration of Older People Homes to reflect lower occupancy levels
- Improved management of Community Care and increased usage of Independent sector

(iii) Staff Productivity

- Workforce cost reduction through sickness absence control, reduction on agency reliance and vacancy control
- Unit cost management through management of skill mix, overtime and additional hours
- Electronic data management , E-Rostering of hospital wards
- Expand E-Rostering outside Nursing, and capital invest to save schemes
- Implementation of scrutiny of permanent and temporary vacancies resulting in posts being held for an agreed period of time

(iv) Miscellaneous Productivity

- Targeting management administrative and clerical costs managed through Voluntary Redundancy / Voluntary Early Retirement (VR/VER),reducing backfill and non-replacement of vacant posts
- Lean processes to be introduced harnessing new technology methodologies
- Targeting discretionary expenditure items including Travel, Training etc.
- Various procurement initiatives
- Variety of estates schemes e.g. energy, standardising car park charges, review/rationalise maintenance contracts

(v) Prescribing Efficiency

The HSCB, in conjunction with LCGs, will continue to deliver prescribing efficiencies through a range of initiatives including:

- Maximising generic dispensing
- Product standardisation
- Cost effective switching and effective systems management of prescribing

- Development of effective prescribing guidelines for primary and secondary care
- Development of a Northern Ireland formulary

3.31 Benchmarking

The delivery of more efficient, effective and patient focused care is paramount in delivering a modern health service. The current financial constraints require that all organisations transform their services, embedding a culture of efficiency to meet the ever increasing service demands and expectations of patients.

Service users have a growing expectation that the services we design and manage will result in the maximum health gain for the resources that we deploy. Reducing waste, increasing throughput and streamlining patient pathways are all actions which contribute to improved quality of care and delivering a more efficient and productive health service. To support the ongoing drive for efficiency, Commissioners have developed a range of indicators to measure and assess performance:

- *New to review ratios*
- *Outpatient Do Not Attends (DNAs)*
- *Day surgery*
- *Day of admission surgery*
- *Theatre utilization*
- *Reduced length of stay*

In order to help the HSCB in this area a range of benchmarking information sources are available from recent reviews such as Charlesworth, PEDU and McKinsey's. These will be accessed, as appropriate, to help identify further efficiencies and to demonstrate that best practice is being achieved. Trust Delivery Plans need to demonstrate how these benchmarks have been used to drive further efficiencies.

Benchmarking within community and social care is more challenging due to the problematic nature of the existing information systems. However, work is

ongoing to improve those systems and over time, we will seek to develop appropriate measures of productivity (e.g. staffing numbers per population number).

3.4 Values & Volumes of Services and Assessed Need

Table 20 provides an overview of the volumes of activity commissioned by Programme of Care (PoC) during 2012/13. The activity figures cover various contract currencies depending on the PoC. A contract currency is a term used to briefly describe or define the activity. Examples include inpatient episodes, births, domiciliary care hours and face-to-face contacts. The activity data presented does not attempt to account for all of the spend for a given PoC, rather it selects anywhere between two and six "activities" or "currencies" which account for the large majority of the total spend for that PoC.[2] The Board will seek to update with providers the commissioned volumes for 2013/14 – consistent with changes in assessed need and other factors – in the first half of the financial year. In addition, the HSCB will share with the Department by the end of June 2013, indicative value and volume uplifts by activity on the basis of broad central assumptions.

[2]The remaining proportion of the spend may be made up of in excess of 20 other currencies which are not easily grouped.

Table 20. Overview of Activity Commissioned by PoC during 2012/13

Programme of Care	Service Description	Currency	NI Regional Service Volume
Acute	Elective	Inpatients	68,000
		Daycases	164,000
		New Outpatients	1,357,000
		Review Outpatients	888,000
	Dignostics	MRI	50,000
		CT	111,000
		Ultrasound	156,000
		Plain film X-RAY	960,000
		ECHOs	50,000
		Endoscopy	49,000
		Diagnostics	642,000
	Unscheduled	Inpatients	203,000
		ED Attendances	600,000
		Non-Elective Admissions	138,000
		NIAS Journeys	180,000
Maternity & Child Health	Obstetrics	Births	25,000
	Comm Midwives	Contacts	164,000
	Health Visiting	Contacts	124,000
	Speech & Lang Therapy	Contacts	113,000
Family & Child Care	Social Work	caseload	21,000
	Residential Homes	Occupied beddays	64,000
Older People	Geriatric Hospital Services	Occupied Beddays	226,000
	Day Care	Attendances	368,000
	Domiciliary Care	Hours	11,214,000
	Residential & Nursing	Occupied Beddays	3,742,000
	Community Nursing &	Face to face	2,163,000
	Social Work	Caseload	41,000
Mental Health	Hospital	Occupied Beddays	256,000
	CPN	Contacts	180,000
	Res & Nur Homes + Supported Housing	Places	327,000
	Day Care	Attendances	206,000
	Dom Care	Hours	401,000
Learning Disability	Hospital Services	Occupied Beddays	109,000
	Day Care	Attendances	666,000
	Domiciliary Care	Hours	850,000
	Residential & Nursing	Occupied Beddays	466,000
	Community Nursing and AHPs	Face to face contacts	157,000
	Social Work	Active Caseload	9,000

The following tables present activity data for each PoC together with information on the value of services commissioned during 2012/13 and the proposed additional investment for 2013/14. Each table is accompanied by text which

outlines the key commissioning intentions for 2013/14 for that PoC, detailing how these relate to the assessed needs of the population and ensuring that we make best use of available resources in order to realise the service improvements required to ensure achievement of the Ministerial targets.

Acute Programme of Care

(1) Elective Care

Table 21 summarises the volume of elective care capacity purchased from HSC Trusts in 2012/13. In addition, significant additional capacity was purchased from Independent Sector (IS) providers to address recurrent capacity shortfalls (as per the Boards demand/capacity models) and/or reduce maximum waiting times for patients.

Table 21. Acute Programme of Care – Values & Volumes of Activity Commissioned in 2012/13

Activity commissioned 2012/13

Elective

- Inpatient (finished consultant episodes) – 69,000
- New Outpatient Appointments - 1,375,000
- Review Outpatient appointments – 889,000
- Day Case Procedures -164,355

Unscheduled

- Inpatient (finished consultant episodes) – 203,000
- NIAS journeys - Emergency (144,000), Urgent (36,000)
- ED Attendances - New & Unplanned Re-attenders (572,000); Planned Review Attenders (28,000)
- Non-Elective Admissions Via ED – 138,000

Diagnostics

MRI – 50,000 CT – 111,000 Ultrasound – 156,000	Plain film x-ray – 960,000 Echos – 50,000 Endoscopy – 49,000
Total investment 2012/13	£1,350m
Additional investment 2013/14	*£69m*[3]
Total investment 2013/14	£1,420m

Looking ahead into 2013/14, it is assumed that demand for elective care services will increase in general terms in line with NI demography. In addition, the Minister's waiting time targets for 2013/14 are more challenging with backstops of 15 weeks for outpatients (previously 18 weeks) and 26 weeks for inpatients/day cases (previously 30 weeks).

In order to ensure achievement of elective waiting times the HSCB's commissioning strategy for elective care in 2013/14 will be as follows:

- To continue to maximise existing capacity from HSC Trusts, to include an uplift of capacity expectation from existing resources.
- To make targeted recurrent investments in a range of specialties and Trusts to reduce or eliminate any gaps between demand and capacity.
- To continue to utilise the IS to address known gaps in capacity.
- To develop further existing demand management models in primary care.

[3] Note: "Additional investment" for 2013/14 reflects total pressures (i.e., before productivity is netted off). It includes non-pay and pay costs.

(2) Unscheduled Care

Table 21 shows the values and volumes of unscheduled care services commissioned from HSC Trusts in 2012/13, including unscheduled activity by ambulance services.

The last three years have seen a consistent growth in demand for unscheduled care across acute hospitals with the exception of a small fall (0.6% between 2009/12) in the number of attendances at Emergency Departments (ED). Achievement of ED waiting time targets continues to be challenging. Non-elective admissions through an ED or assessment unit rose by 5.1% between 2009/12.

In the context of the above patterns of demand, together with continued performance difficulties against the 4-hour and 12-hour standards, the Board's commissioning strategy for unscheduled care for 2013/14 will be as follows:

- The HSCB will agree robust capacity volumes with each Trust in relation to both ED attendances and emergency admissions.
- The HSCB will introduce population zoning to ensure an equitable spread of population demand for urgent and emergency services, linked to individual site and Trust capacity.
- The HSCB will further develop arrangements to prevent unnecessary attendance and ED's and admission to hospital beds through investment in improved management of long term conditions in primary care, an extended ambulance paramedic role to treat patients at the scene without the need for transport to hospital, and greater acute care at home.
- Patients will spend the optimum time necessary to receive hospital treatment and will be discharged with support to return to a high degree of independence with appropriate wrap-around support.

(3) Diagnostics

Table 21 provides an overview of the volumes of activity provided within HSC. Significant additional capacity was also provided via a combination of leasing additional mobile scanners and directly purchased from the IS sector.

It is anticipated that demand for diagnostic areas will incur major growth, with changes in clinical practice, demography, emergency technologies and government policies e.g. development of screening programmes. In particular and based on experience from the rest of the UK this could potentially amount to a year on year increase of 10% in MRI and CT.

In response to this the HSCB is currently evaluating a number of Strategic Outline Business Cases with Diagnostics which if fully supported would increase the regional capacity by approximately 50%. The Boards strategy will be to establish 7 day a week access to key imaging modalities across all Trusts and continue to maximise the current capacity.

During 2011/12, demand for endoscopy rose on average by 5%, including screening for Bowel Cancer. It is expected that this rate of increase will continue each year in line with demographic changes and with the planned extension of Bowel Cancer Screening to the age of 74 in April 2014. In response to this change the Board will continue to maximise existing capacity by improving productivity in year, concurrent with a review of demand for symptomatic services, linked to an analysis of the predicted demand for Bowel Cancer Screening.

The Board has reviewed current predicted demand for ECHO based on a range of modelling exercises carried out in GB and it is expected that further expansion of a minimum of 5% each year will be required over the next 5 years to meet need. In 2013/14 the Board will agree capacity expectations with Trusts that maximise the use of existing resources and consider how the predicted growth in demand may be met.

Family & Child Care Programme of Care

Table 22 outlines in broad terms the value and volumes of children and families services purchased from HSC Trusts in 2012/13.

Table 22. Family & Child Care – Values & Volumes of Activity Commissioned 2012/13

Activity commissioned 2012/13 Social Work (active caseload) – 21,000 Residential Homes (Occupied beddays) – 64,000	
Total investment 2012/13	£198m
Additional investment in year	*£4.0m*
Total investment 2013/14	£202m

Looking ahead to 2013/14 there has been a small but consistent rise in the numbers of children with a learning disability and challenging behaviour which has created significant pressures both for families and services available within the looked after system. The HSCB has recently assisted with costs for out of country placements. The HSCB intends, subject to an ongoing demand/capacity analysis, to invest in additional intensive support packages to enable these children to be cared for within NI.

Advances in medical technology and increased expertise mean that children with complex healthcare needs and life limiting illness are living longer. These children require high resource intensive support which in some instances necessitates 24 hour care. The HSCB/ PHA intends to commission additional services to support children with complex needs, allowing families to care for their children within the family home if this is at all possible. For the very small number of children who may not be able to be looked after at home there is a need to ensure that appropriate provision is in place.

There has been a growth in the number of children becoming looked after; there were 1607 looked after children in 2008/09 compared to 1946 in 2011/12. This is consistent with the national trend. Children entering the care system are also coming with more complex and challenging behaviours. In line with the strategic direction as outlined in TYC the HSCB intends to commission services that will promote the need for children to experience a positive family life experience. Where this cannot be provided by birth parents there is a need to move to permanent care arrangements which are consistent with promoting the child's best interests. It is clear that some children need additional supports to help them recover from previous trauma and the HSCB will enhance existing services to continue to address this need.

The NHSCT has seen significant growth in the number of children with ADHD which has impacted on the Trusts capacity to meet this demand. The HSCB is seeking to make investment to allow the Trust to respond in a timely manner to referrals of children with ADHD.

Maternity and Child Health Programme of Care

Table 23 summarises the values and volumes of maternity and child health care purchased from HSC Trusts in 2012/13.

Table 23. Maternity & Child Health – Values & Volumes of Activity Commissioned 2012/13

Activity commissioned 2012/13 Obstetrics (Births) – 25,125 Community Midwives (Contacts) – 164,000 Health Visiting (Contacts) – 124,000 Speech and Language Therapy (Contacts) -113,000	
Total investment 2012/13	£128m
Additional investment in year	*£4.0m*
Total investment 2013/14	£132m

The birth rate is currently quite static (around 25,150 births per annum since 2008) following a period of sustained growth. However, we now have more births with to older mothers, more multiple births and more births to women who are significantly overweight or who have a chronic condition all of which increase the risk of complications. Babies born prematurely or with severe congenital abnormalities now survive the initial neonatal period and require long term, if not lifelong support.

The relatively stable birth rate means that the commissioned activity outlined for 2012/13 will not alter significantly in 2013/14. Rather, in line with the recently published Maternity Strategy and the anticipated Paediatric Review, the HSCB is re-focusing attention on ensuring that safe, sustainable and high quality maternity and child health services are commissioned and provided across the region. The related commissioning intentions are outlined in detail Section 4 (10) but just two examples include: allowing women with straightforward pregnancies to be receive midwifery-led care closer to home while ensuring that women with risk factors or who develop complications are offered consultant-led care and ensuring that children admitted to inpatient paediatric units will be seen in a timely fashion by the appropriate level of staff.

Learning Disability Programme of Care

Table 24 provides an overview of the values and volumes of learning disability services commissioned in 2012/13.

Table 24. Learning Disability – Values & Volumes of Activity Commissioned 2012/13

Activity commissioned 2012/13
Hospital Services (Occupied Beddays) - 110,000
Day Care (Attendances)- 666,000
Domiciliary Care (Hours) - 850,000
Residential & Nursing Homes (Occupied Beddays) - 466,000
Community Nursing and AHPs (Face to face contacts)- 157,000

Social Work (Active Caseload) – 9,000	
Total investment 2012/13	£226m
Additional investment in year	*£11m*
Total investment 2013/14	£237m

Looking ahead to 2013/14, one of the key priorities of the HSCB, will be to commission additional community accommodation with support to ensure achievement of the Ministerial targets for resettlement and complex discharge.

People with a learning disability are living longer. Over time their families are getting older and carer support needs are increasing. In accordance with Bamford recommendations, the Commissioning Plan will also ensure enhanced carer support through the delivery of additional short break services and the delivery of improved community based day services in line with HSCB specifications/models.

The HSCB will also seek to provide additional services for adults with ASD, in line with the Autism Act (NI) 2011. This will ensure the provision of adult clinical time in each Trust area to facilitate more effective care and support of adults with ASD.

Mental Health Programme of Care

Table 25 provides an overview of the value and volumes of mental health services commissioned during 2012/13.

Table 25. Mental Health – Values & Volumes of Activity Commissioned 2012/13

Activity commissioned 2012/13	
Hospital (Occupied Bed Days) – 256,000 CPN (Contacts) – 180,000 Res & Nursing Homes + Supported Housing (Places) – 327,000 Day Care (Attendances) – 206,000 Dom Care (Hours) – 401,000	
Total investment 2012/13	£237.3m
Additional investment in year	*£10.5m*
Total investment 2013/14	£247.8m

Looking ahead to 2013/14, one of the HSCB's key priorities will be to commission additional community accommodation with support in order to ensure achievement of Ministerial targets for Mental Health Resettlement and Complex Discharges.

Waiting times for child and adolescent mental health services (CAMHS) improved during 2012/13 with most patients waiting less than nine weeks in the second half of the year. In order to ensure achievement of waiting time targets in 2013/14 the HSCB will work with Trusts and primary care to increase capacity. Key to this will be the establishment of integrated care arrangements for the care and treatment of common mental health needs to include arrangements for the provision of a primary care psychological therapy service beginning with the appointment of primary care coordinators and training in CBT and / or counselling for a minimum of five staff in each Trust.

Currently available data indicates that there may be higher rates of self-harm in NI than in other parts of the UK and Ireland. Individuals who undertake self-harm are at increased risk of suicide in the future. The HSCB and PHA is therefore undertaking work to improve assessment and enhance response times in Emergency Departments to people presenting with self-harm or suicidal ideation.

In line with the HSCB/PHA Commissioning Framework for Substance Abuse and Addiction additional Tier 3 services will be commissioned.

Community Care and Older People's Programme of Care

Table 26 provides an overview of Statutory Residential Provision provided during 2012/13.

Table 26. Community Care and Older People's Services – Values & Volumes of Activity Commissioned 2012/13

Activity commissioned 2012/13 Geriatric Hospital Services (Occupied Beddays) -226,000 Day Care (Attendances) – 368,000 Domiciliary Care (Hours) – 11,214,000 Residential & Nursing Homes (Occupied Beddays) – 3,742,000 Community Nursing & AHPs (Face to face contacts) – 2,163,000 Social Work (Caseloads) – 41,000	
Total investment 2012/13	£634m
Additional investment in year	*£23m*
Total investment 2013/14	£657m

During 2013/14, in line with TYC recommendations, the HSCB is seeking to reduce reliance on statutory provision and to promote investment in more innovative

models of accommodation, respite and home based support. It will contribute to market rationalisation and a shift in the model of care.

As our older population increases, the number of carers also increases. In response to the increase in demand for respite, the HSCB intends to audit and rationalise existing respite options in order to develop a more focussed and cost effective approach to support for individuals and their carers.

As our population ages, the number of people with dementia increases. During 2013/14 the HSCB intends to identify and develop an agreed best practice model for Memory Services, which clearly outlines the relationship between regional and local services, is based on agreed care pathways and promotes equity of access across Northern Ireland.

Our ageing population means that the number of people living with chronic diseases is increasing, and with it, the burden on secondary care. During 2013/14 the HSCB has identified two priorities which intend to reduce premature reliance on health and social care services. Firstly, the HSCB intends to commission a number of specific initiatives ranging from prevention of admissions to hospital/institutional care to promoting independent functioning by improving the health and wellbeing of older people. The priority areas relate to falls prevention, improved nutrition, reducing isolation and delivering a co-ordinated range of targeted physical activity and health programmes. Secondly, the HSCB intends to continue to develop reablement services, within the parameters of the agreed regional model. This will require a greater emphasis on community, voluntary and domiciliary based care instead of more costly forms of institutional care.

Physical Disability and Sensory Impairment Programme of Care

Table 27 provides an overview of the activity commissioned within physical disability and sensory impairment services within 2012/13.

Table 27. Physical and Sensory Disability – Values & Volumes of Services Commissioned 2012/13

Activity commissioned 2012/13	
Hospital Services (Occupied Beddays) - 40,000 Day Care (Attendances) - 154,000 Domiciliary Care (Hours) - 1,427,000 Residential & Nursing Homes (Occupied Beddays) - 149,000 Community Nursing and AHPs (Face to face contacts) - 165,000 Social Work (Active Caseload) - 13,000	
Total investment 2012/13	£94m
Additional investment in year	*£4.0m*
Total investment 2013/14	£98m

The population is relatively stable moving into 2013/14. The activity commissioned in 2012/13 is unlikely to change significantly in 2013/14. Rather, looking ahead to 2013/14, the focus is on reviewing traditional models of service provision in order to meet the changing expectations of disabled people.

The recent RQIA Inspection of Service for People with Sensory Impairment recommended that a survey the needs of the Deafblind community should be undertaken. During 2013/14 the HSCB will undertake a detailed needs analysis of this group of service users in order to assist in the re-organisation and more appropriate targeting of services for those with a dual impairment.

The HSCB plans to evaluate the effectiveness of current communication services for people with a sensory impairment to promote equitable access and the most effective use of resources.

Transforming Your Care emphasises the need to promote independence and choice through the promotion of personalised budgets and self-directed support.

During 2013/14 the HSCB intends to build on progress made in relation to the uptake of Direct Payments.

During 2013/14 the HSCB intends to capitalise on the re-evaluation of the role and function of residential and day care to examine the potential for more innovative or personalised options for disabled people to avail of respite opportunities. This will be done in conjunction with service users and their carers.

The HSCB intends to respond constructively to the recent regional audit of support for carers and the RQIA inspection of carer involvement in assessing needs and the provision of support services. The intention is to further prioritise significant actions/proposals to progress the carers' agenda.

3.5 Shifting Financial Resources through Transforming Your Care ('TYC')

A key financial objective with the TYC reforms is to ensure that financial resources appropriately reflect the proposed new service models across all areas of care. This was described in TYC as a *Shift Left.* The TYC report highlights the intention to shift approximately 5% (£83m) of recurrent funding in real terms out of the projected cost of hospital based care in 2014/15 and into a primary/community based setting by March 2015. As a consequence, spend is anticipated to increase in Personal and Social Services, Family Health Services, Primary Care Services and Community Services.

3.51 Effecting the shift

In order to effect this shift of care and funding out of hospital services and into the primary / community setting, the HSCB will commission services to be delivered in a different way. There will be a number of strands to this work including:

(1) *Integrated Care Partnerships (ICPs)* - As outlined in Section 2.4, it is anticipated that the initial focus of ICPs will be on the Minister's priorities

of frail elderly and aspects of long term conditions for all ages, namely diabetes, stroke care and respiratory conditions. This may include Palliative & End of Life Care in respect of these agreed areas. Commissioner-approved care pathways and more active anonymised casework, information sharing and improvement in control and prevention of inappropriate acute admission, these collaborative networks will shift £8m during 2013/14 and a further £19m during 14/15.

(2) *Acute care* - It is envisaged that a number of reform initiatives will be undertaken specifically within acute care, which ultimately will shift care out of hospital settings. In the first instance the shift left initiatives in acute care in 2013/14 will be delivered through:

- Service changes in stroke services to ensure that the majority of patients are admitted to an acute stroke unit, with hyper acute care post thrombolysis. This has been shown to reduced mortality and morbidity. It also results in reduced lengths of stay for stroke patients which frees up resources within acute services, allowing them to be shifted into community based models to resource Early Supported Discharge Schemes. It is anticipated that by 2015/16, the number of beddays will be reduced by c.17000 per annum. The 2013/14 target will be to shift resources by £1.5m (6000 beddays).

- Movement of some elective consultations and / or procedures into the primary /community setting. This will involve a number of elective specialties, such as ENT, Dermatology, Orthopaedics, Opthalmology, and will involve new pathways for elective patients to be seen and treated closer to home and where appropriate, by a GP. It is expected that waiting times for first appointment will improve together with new : review ratios. Proposals to shift secondary care activity into primary care will be commissioned as follows during 2013/14 to have a full year financial effect in 2014/15 :
    - Dermatology 9250 procedures costing £0.65m

- Orthopaedics 3000 assessments and follow ups costing : £0.6m
- Opthalmology : Glaucoma procedures costing £1m
- ENT 12000 procedures costing £0.825m

(3) *Learning disability & mental health resettlement programmes* - Resettlement programmes will see a significant amount of resource shift from acute care provision to the community in order to strengthen community services and prevent people from being readmitted to hospital.

For the Learning Disability programme, an estimated 179 people will move from a hospital to a community setting over the 3 year period 2012/13 to 2014/15, with 64 patients planned to be resettled in 2013/14.

For the Mental Health programme, an estimated 220 people will move from a hospital to a community setting over the 3 year 2012/13 to 2014/15, with 81 patients planned to be resettled in 2013/14.

Following an initial assessment, it is anticipated that £76m (at 2014/15 prices) of financial resources will be shifted left through these service changes as outlined in Table 28.

Table 28: Overview of financial resources to be shifted into primary / community setting

	2012/13 £m FYE	**2013/14 £m FYE**	**2014/15 £m FYE**	**Total £m FYE**
ICPs		8	19	27
Acute Care		4	7	11
MH Resettlement	4	8	6	18
LD Resettlement	7	7	6	20
	11	**27**	**38**	**76**

Table 28 reflects the financial resources to be shifted left during 2013/14 which will have a full year effect of £27m in 2014/15. HSCB priority will be given to commissioning transformational change which delivers the required shift in financial resources on a FYE basis.

Through the existing governance arrangements, HSCB will monitor both the CYE and FYE of each transformation proposal across all programmes of care, once detailed proposals have been agreed.

More robust and detailed planning of the new integrated clinical service models is required in order to determine the precise financial impacts on the primary care, community and personal social services sectors of the resources that shift out of hospital settings.

3.52 Further shift left considerations

In addition to moving care outside of the hospital setting, a shift left of services can also be considered when moving service provision along a continuum of care. This includes shifting care, in terms of both numbers and intensity of care packages, along the continuum of care from institutional residential and nursing home care through to domiciliary care by implementing re-ablement models, which promote more independent living away from hospital/ institutional residence.

Therefore, in addition to the hospital based initiatives noted above, the HSCB plans to shift some £16m of financial resources at 2014/15 prices by implementing re-ablement models by March 2015, £9m of which will be delivered in 2013/14.

The HSCB will continue to investigate all opportunities to commission services in a different way to ensure that more services are provided either outside a hospital setting or moved along the care continuum. In that context, the shift left plan will continue to be refined and updated throughout the year.

3.53 Monitoring the Delivery of Financial Shift Left

The delivery of this shift in resources will be monitored and measured on a monthly basis by the HSCB and reported through the TYC Transformation Programme Board. It is anticipated that this will be demonstrated both through a review of key activity levels/metrics as well as an analysis of the associated financial resources.

4.0 Regional Commissioning Priorities 2013/14 – Summaries by Service Area

This section details the regional commissioning intentions for 2013/14 and beyond.

Whilst services are funded along groups called Programmes of Care the HSCB/PHA has organised its commissioning teams to reflect key service areas. Commissioning intentions are outlined in relation to each of the following service areas.

1. Cancer Care
2. Children and Families
3. Community Care & Older People
4. Diagnostics
5. Elective Care
6. Health and Social Wellbeing Improvement
7. Health Protection
8. Learning Disability
9. Long Term Conditions
10. Maternity and Child Health
11. Medicines Management
12. Mental Health
13. Palliative and End of Life Care
14. Physical Disability & Sensory Impairment
15. Prisoner Health
16. Screening Services
17. Specialist Services
18. Unscheduled Care

The following paragraphs outline for each service area:

- A brief overview of the service area
- Key successes from 2012/13
- The key challenges for 2013/14 and beyond
- Ministerial targets for that service area
- The key commissioning objectives for 2013/14.

As stated in Section 1, the objectives identified here do not encompass all of the service improvements that the service teams will be working with local commissioners, providers and service users to secure during 2013/14. Rather, they reflect those areas of work which:

- are likely to have the greatest impact on patient outcomes and experience (based on the evidence base and / or patient and service user feedback); and/or
- require significant investment of resources; and/or
- represent a step-change in how we provide services; and/ or
- reflect an Executive or Departmental priority or target, including the relevant TYC recommendations.

Appropriate progress with implementation of all NI endorsed NICE guidance and service framework standards is assumed. Objectives will specifically reference implementation of NICE guidance or service framework standards only where they represent a step change in service or require significant investment.

The key commissioning objectives are presented in tabular form. The columns to the left hand-side identify the strategic driver or need that contributed to the prioritisation of the objective for inclusion in the Commissioning Plan. *This section should be read in conjunction with Appendix 2 which outlines our intentions in relation to each individual Ministerial target.*

Commissioning service teams will work up detailed operational plans which outline how the objectives will be met. They will be held to account for the delivery of the plans through the Commissioning Programme Board which is chaired by the Director of Commissioning, or for public health, through the programmes structures in PHA.

Detailed equality screening and impact assessments may be required in relation to a number of the objectives identified and these will be completed, as appropriate, in advance of any service changes being taken forward.

1. Cancer Care

Cancer affects all of us. Over 10,000 people in Northern Ireland are diagnosed with cancer every year and 3,885 people die annually from the disease. It is estimated around 56,000 people in Northern Ireland are currently living with a diagnosis of cancer. Prevalence is increasing by 3.2% per annum which has major implications for the delivery of health and social care.

Cancer patients have a complex series of planned journeys through screening, diagnostics, treatment (surgery / systemic anti-cancer therapies / radiotherapy) and follow up. In addition, patients may develop complications of the disease or its treatment which require access to unscheduled care.

Headline successes from 2012/13

Much has been done to standardise cancer care across NI, in line with evidence based guidelines. Achievements include:

- 98% of cancer patients consistently receive first definitive treatment within 31 days of decision to treat as at December 2012.
- Self-directed aftercare pathways for newly diagnosed patient with breast cancer have been developed and Trusts are close to achieving the target of 30% of patients being on a self-directed care pathway. There has been extensive engagement with cancer charities and councils to ensure create opportunities to address health and well-being issues and patients themselves have been involved in developing the new pathways and the patient information that underpins them.
- Development of a cancer survivorship website http://survivorship.cancerni.net
- Agreement to roll out the Transforming Cancer Follow Up Programme during 2013 and successful appointment of an external evaluator for the programme.
- Proposal for public awareness campaign for early signs and symptoms of cancer has been developed incorporating findings from the International Cancer Benchmarking Partnership.

- Major PHA/HSCB Cancer Awareness Conference has been arranged for February 2013.
- Working with the cancer network a process for internal peer review of cancer MDTs has been developed and the schedule for roll out to MDTs over the next 3 years has been agreed.
- Lung, Colorectal and Ovarian clinical management guidelines have been amended to ensure compliance with NICE 2012 published guidelines.
- Analysis of the 2010 Lucada Lung data at regional level along with the identification of targeted service improvement activity to address pathway delays.
- Regional protocol for the management of cancer referrals has been rolled out to Trusts and Primary Care.
- Significant work has been completed on the Outline Business Case for the Regional Information System for Oncology and Haematology.
- Configuration for Haematology Multidisciplinary Teams has been agreed along with draft principles for recording of virtual clinic activity - to be implemented and monitored during 2013/14.

Key Challenges for 2013/14 and beyond

- More people are living with cancer as a chronic illness. New models of follow up are needed to address the needs of cancer survivors.
- While cancer survival rates have increased significantly over the past 10-15 years, international benchmarking projects show that the NI survival rates for colorectal, lung, and ovarian behind the best performing countries. In addition, people who live in the 20% most deprived areas of NI have cancer rates that are 2-3 times higher than those who live in the 20% most affluent areas; later diagnosis and poorer survival rates are also seen.
- The National Audit Office reported that almost one in four cancers are detected only when a patient is admitted to hospital as an emergency. More needs to be done to raise patient awareness of early signs and symptoms to encourage them to seek help earlier. We also need to

provide sufficient diagnostic and service capacity to assess all potential cases in a timely way in order to detect patients who have cancer as early as possible.

- To secure further improvements in cancer survival rates there is a need to reduce smoking rates, ensure high uptake of screening programmes in all areas, enable early diagnosis of cancer and provide high quality care and support to all.
- There is a requirement to improve cancer data intelligence to inform effective commissioning, support practice change and enable monitoring of outcomes.
- While progress has been made in the latter half of 2012/13, achievement of 62day waiting time target continues to be challenging.

Specific Ministerial target to be achieved for cancer services in 2013/14

- From April 2013, ensure that 95% of cancers patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

Cancer Care

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Key Deliverables	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
During 2013/14 all Trusts will continue to address longest waits and improve the headline percentage to ensure that 95% of patients receive their first definitive treatment within 62 days to include: maintaining mechanisms for patient tracking; breach analysis; and action planning and follow up with HSCB personnel In addition, Belfast Trust will progress developments to include: improved access to Brachytherapy; provision of enhanced thoracic surgical capacity and the centralisation of upper GI surgery in order to address pathway issues which contribute to delays.	● ●			✓ Targets 14		

Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery. • Minimum of 30% of Breast Cancer Patients on self-directed aftercare pathway by Jan 2013- rising to 40% from Jan 2014 • All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services • All Trusts should develop clear project plans and begin to introduce a risk stratified model	●	●			Rec 21, 24, 26, 27, 75 & 77	Cancer Service Framework Standard 46 Improving Outcomes 2,3,4 & 5[4]
	●					
	●	●	●			

[4]National Cancer Improving Outcomes; 1- Survival, 2 – Patient Experience, 3 – Safety & Quality, 4 – Productivity, 5 – Quality of Life

of follow up across all other cancer groupings, which will clear and prevent review backlog • Findings of external evaluation to be incorporated into Trust Transforming Follow Up action plans		●				
All Trusts should work with HSCB to implement the recommendations of the 2010 NI Chemotherapy Service Review. This should include: • Establishment of an Acute Oncology Service (activity to be monitored as agreed with the HSCB). • All Trusts to work with HSCB to agree regional model that provides appropriate oncology presence across centre and units • All Trusts to monitor compliance with NICE guidance on neutropenic sepsis and to report	● ●	● ●	●		Rec 77	Chemotherapy Service Review Improving Outcomes 1,2,3,4&5

to the HSCB on a monthly basis via the performance management information returns • All Trusts to work closely with HSCB to modernise oncology services including staff levels and skills mix. • All Trusts to implement C-PORT • All Trusts to continue to ensure involvement of relevant personnel / stakeholders in the development of RISOH	●	● ● ●	●		Rec 79 & 95	
Effective Multidisciplinary Teams All Trusts should ensure that cancer MDTs undertake the NICaN Peer Review process and develop action improvement plans which will be shared with HSCB. • All Trusts should participate in						Cancer Services Framework Standard 20 Improving Outcomes

peer review of, Lung, Gynae, Colorectal, Urology and Haematology	●					1,2,3,4&5
• All Trusts will participate in peer review of Skin, Head and Neck, Upper GI/HPB and Breast ,MDTs		●				
• BHSCT to participate in peer review of Sarcoma, Brain& CNS MDT			●			
• All Trusts to participate in national Lung, e.g Bowel, UGI and Head and Neck audits	●	●				
• All Trusts to share with HSCB on an annual basis findings from national and other relevant audits (including M&M Meetings) and subsequent action plans.	●	●	●			
• All Trusts will audit the Protocol						

for Amending the Status of a Red Flag Referral including the implementation of the NICE Guidance for Suspected Cancer	●					
All Trusts will work with the Regional NICaN TYA postholder to scope out current practice (including pathways and referral patterns) and will encourage staff involvement in education and training on the needs of this cohort of patients. • All Trusts to participate actively in the development of streamlined pathways for teenagers and young adults with cancer • Trusts to participate in multiprofessional multidisciplinary working e.g virtual MDMs	●	●			Rec 27	Cancer Service Framework Standard 32 Improving Outcomes 1,2,3,4&5

Haematology Services • All Trusts should formally establish & implement virtual clinic arrangements and support the agreed MDM configuration as determined by the HSCB regional working Group. • Trusts working with HSCB should ensure recommendations from NICR Haematological Malignancy Audits are implemented • All Trusts should ensure maximisation of skills mix initiatives as determined by the HSCB working group • All Trusts should ensure that clinical teams commence work on implementing a risk stratified model of follow up for patients with a haematological cancer	●					Cancer Service Framework Standard 39 &40 Improving Outcomes 1,2,3,4&5
	●					
	●	●				
		●				

• All Trusts should apply the agreed regional commissioning planning assumptions for Haematology and ensure the delivery of the core volumes in the Haematology SBA, including the agreed Clinical Nurse Specialist Job Planning		●				
Ovarian Cancer Trusts should link with Primary Care to raise awareness of the signs and symptoms of cancer, working with GPs within their area to provide Training and Awareness events. An initial focus will be on the introduction of specific referral and diagnostic pathways for suspected ovarian cancer in line with NICE Clinical Guidance.	●					Improving Outcomes 1,2,3,4&5 NICE Quality Standard for Ovarian Cancer Cancer Service Framework

2. Children and Families

This service area relates primarily to duties and responsibilities as outlined in legislation and works along a continuum of interventions ranging from universal family support through to permanent care arrangements for children as well as services for care leavers.

The HSCB has issued a Commissioning Specification for Children and Families Services which sets out the standards and expectations to be realised for each of the given areas of statutory responsibility.

This reinforces the importance of families being offered support at an early stage. If statutory intervention is required, this should be focused and needs led with the promotion of stability and permanence for children as the multidisciplinary assessment and planning indicates.

The service area also encompasses the multidisciplinary aspects of children with a disability where a range of skills and professional backgrounds are essential to meet the diverse needs of the children and young people.

Headline successes in 2012/13

- There has been major recognition of the requirements for and benefits of integrated planning and commissioning through the Children and Young Peoples Strategic Partnership which includes senior officers from disciplines and agencies at the highest level.
- The GEM scheme (Going the Extra Mile) where care leavers can remain with their foster carers post 18 years of age is now available to over 70% of all eligible care leavers and affords much needed stability and support.
- By March 2013 each Trust will have a single point of entry for referral into Children's Social Services (Gateway) to provide greater consistency of response.

Key Challenges for 2013/14 and beyond

- The rising demands in terms of number of referrals and increasing numbers of children entering the looked after systems are significant.
- Thankfully, with increased technology and medical expertise some children with life limiting illness are living longer. This however requires the availability of intensive high cost support packages.
- There are a growing number of adolescents with learning disability and challenging behaviour where sustaining a family placement is increasingly difficult.
- There is an ageing foster care population and the need to replenish where there is turnover is a challenge.
- The HSCB and Trusts will continue to work with other agencies to provide risk assessments and supports as appropriate to separated /unaccompanied children, some of whom may be trafficked, arriving in Northern Ireland.
- Children entering the looked after children systems are coming with a multiplicity of highly complex needs.
- The percentage of women who receive an antenatal visit by a Health Visitor is variable across Trusts but can be as low as 5%. Trusts should aim to increase this percentage rapidly over the next three years as the antenatal visit is an important opportunity to identify risk factors. There should be incremental progress to achieve full coverage in the next three years (50% - 75% -100%).[5]

[5] This sits alongside a broader Departmental Commissioning Indicator which will measure the baseline for the uptake of developmental reviews offered by Health Visitors as part of the universal child health promotion programme

Specific Ministerial targets to be achieved for children and families services in 2013/14 are:

- From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%.
- From April 2013, ensure a 3 year timeframe for 90% of all children to be adopted from care.
- By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%.

Children and Families

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts should ensure that a child becomes looked after where that child's long term outcomes will be improved or there is a need for the child to be removed as a safety measure. Trusts should ensure that there is an adequate range of placements available to meet the assessed needs of Looked after Children / Care Leavers.	●	●	●	✓ Targets 24 & 25	Recs 48, 49, 50, 56 & 57	
Working within the Children and Young Peoples Strategic Partnership the Trust led Outcomes Group will progress the development of local integrated delivery arrangements with the establishment of more Family Support Hubs. This should ensure that interventions are needs led and strive for the minimum	●	●	●		Rec 47	OFMDFM, Delivering Social Change.

intervention required. The HSCB / PHA will progress Family Support and Parenting Programmes to address TYC recommendation 46. It is assumed SureStart Projects, reporting to the Childcare Partnership will provide support in those localities and the focus for greater co-ordination and development will be in those areas which do not have Surestart provision.	●	●	●			
All Trusts should ensure that a robust needs assessment and a localised service is provided for children with complex healthcare needs and for children with a learning disability and challenging behaviour.	●	●	●		Rec 50	Learning Disability Service Framework
All Trusts to engage in the Review of AHP support for Children with Special Needs within Special Schools and Mainstream Education	●	●				Review of AHP services for children

	Phase 1[6]	Phase 2[7]				with special needs within Special Schools and mainstream education Learning Disability Service Framework

[6]This phase will begin in 2013 and end in March 2014. It will involve a scoping exercise of current AHP provision and support and will establish current models of practice. It will end with the agreement of recommendations for further action

[7]This phase will begin in April 2014 and end in March 2015. It will involve the agreement and implementation of a regional model, based on the recommendations for further action at the end of phase 1.

All Trusts to increase the percentage of women who receive the recommended antenatal visit by a Health Visitor, to reach 100% by March 2016	● 50%	● 75%	● 100%			Healthy Child Healthily Future
All Trusts should fully implement the recommendations of the RQIA CAMHS Review and implement the DHSSPS Stepped Care Model.	●	●	●		Rec 51 & 52	

3. Community Care & Older People

The needs of our ageing population arguably pose the most significant challenge to the responsiveness of Health and Social Care services.
A variety of flexible and innovative responses will be required ranging from an increased emphasis on promoting healthy ageing, providing tailored support for those who wish to remain at home, developing diversionary services to maintain independence and targeted intensive support for more dependent individuals requiring specialist care.

Headline Successes 2012-13

- Approval of the e-NISAT business case to commence roll-out of an ICT solution to support professional assessment.
- Joint HSCB/Carer 'Carers' Strategy Implementation Group' (CSIG) established with additional funding allocated for carer support services.
- Safeguarding activity monitoring format agreed and standardised.
- Establishment of Dementia Strategy Implementation Group to oversee the development of Action Plan.

Key challenges for 2013/14 and beyond

- Working with newly established ICPs to streamline and improve the care of the frail elderly.
- Delivery of key actions in the regional Dementia Strategy within the agreed timeframes.
- Reduced reliance on statutory service provision through an increasing emphasis upon prevention, self-care, appropriate housing provision and greater use of the community and voluntary sector.

- Improved support for carers through increased access to carer assessments and respite options.
- To further roll-out and embed NISAT as the regionally approved assessment tool within older people's services.
- Continued roll-out of targeted Public Health Agency (PHA) preventative health and well-being improvement programmes.
- Strengthening of regional Safeguarding arrangements.
- Developing Social Care procurement arrangements that support a stable and competitive marketplace, ensuring equity between all providers.
- Development of the Re-ablement model to achieve quantifiable reduction in unnecessary dependence on statutory services and associated service efficiencies.
- Developing and promoting more diverse approaches to the provision of individualised budgets to provide greater choice and diversity of service provision.

Specific Ministerial target to be achieved for older people's services in 2013/14

- From April 2013, people with continuing care needs wait no longer than 5 weeks for assessment to be complete, and have the main components of their care needs met within a further 8 weeks.
- By March 2014, deliver 720,000 telecare monitored patient days (equivalent to approximately 2,100 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI Contract.

Community Care & Older People's Services

Timescale for achievement				*Strategic Driver/Needs Assessment*		
Key Deliverables	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
In line with improved availability of community based support for older people, and reducing demand for residential care, Trusts are required to review existing statutory residential care provision and develop specific proposals for a phased reduction in capacity consulting on these proposals where required. This process will include consideration of restricting new admissions where plans indicate closure of facilities within a defined timeframe.	●			✓ Target 17	Recs 9 & 10	
Trusts and HSCB will work with independent sector providers to identify practice, training and contractual implications of	●				Rec 12	

preventing unnecessary admissions to acute care from nursing homes.						
Trusts will review current respite care provision to identify the potential for increased support for carers through service remodelling/re-investment in the independent sector.	●			**Target 28**	Rec 13 & 19	Service Framework for Older People
Trusts will work collaboratively with HSCB/PHA/LCGs/ICPs to scope and develop a regional network for Memory Services.	●				Rec 9	Dementia Strategy
Trusts and ICPs will progress a comprehensive range of targeted health and wellbeing programmes in all localities to address the changing health and well-being needs of older people. They should ensure that arrangements are in place:- • To improve provision of advice information and signposting	●				Rec 14	Service Framework for Older People

on all aspects of health and wellbeing improvement • Deliver a co-ordinated, multi-faceted falls prevention service • To fully implement the "Promoting Good Nutrition Guidelines for Older people across all settings • Develop and co-ordinate a shared service model to reduce the risk of social isolation and poor mental well-being amongst vulnerable older people • With relevant partners to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people. • Deliver a co-ordinated range of targeted Physical Activity and Health programmes to address the CMO Guidelines for						

Physical Activity						
Trusts will implement eNISAT, the ICT for the Northern Ireland Single Assessment Tool within older people's services in line with agreed Project Structures, processes and deadlines.	●			**Target 28**	Rec 16	Service Framework for Older People
Trusts and ICPs will establish single point of entry arrangements; enhance the role of the community and voluntary sector and develop a Re-ablement service which maximises the independence of the service user.	●			**Target 28**	Rec 11	Service Framework for Older People
Trusts will develop a Gateway Model and single point of referral for the receipt and screening of all referrals to adult safeguarding	●				Rec 17	Service Framework for Older People PfG commitment 61

4. Diagnostics

A diagnostic service provides an examination, test or procedure used to identify a person's disease or condition and allows a medical diagnosis to be made. The diagnostic waiting time relates to all tests with a diagnostic element. Included are tests that are part diagnostic and subsequently part therapeutic.

Headline Successes from 2012/13

- In the majority of areas the 9 week waiting times for diagnostics was maintained, with the exception of a small number of specialist investigations, including routine PET and Neurophysiology.
- Ensured endoscopy waiting times of 13 weeks for (colonoscopy, ERCP, gastroscopy and flexible sigmoidoscopy).
- Audiology Quality Standards introduced in Northern Ireland to bring a regional focus on measurable improvements to the service, including best practice documentation for use in interactions with patients and improved pathways for access and continuing care
- Survey of patient experience post fitting of hearing aid carried out with Action on Hearing Loss that will inform the design of services to access and continue care
- Pilot direct access pathways have been developed in local commissioning areas including access to adult audiology, x-ray and colonoscopy in NHSCT, access to Ultrasound for diagnosis of DVT in South East Trust and chest x-ray in SHSCT. The aim of these pathways will be the streamlining of referrals so that the most appropriate professional sees the right patient at the right time
- Commissioning of second MRI in South West Area Hospital and replacement of MRI scanner at Ulster Hospital

- Development of testing for H Pylori prior to referral for gastroscopy in WHSCT to ensure appropriateness of referral and in line with NICE Guidance. This has reduced referrals for gastroscopy by approximately 10%.
- The HSCB has completed a demand and capacity exercise for radiology resulting in a Service and Budget Agreements for the first time in MRI, non-obstetric ultrasound, CT and plain-film X-Ray. Further work will be required to refine these SBAs in 2013/14.
- Development of a Strategic Implementation Plan for the NI Pathology Network that takes into account the recommendations of the NI Pathology Review (DHSSPS 2007), technological advances and emerging priorities since then, and which is aligned with the objectives of Transforming Your Care.

Key challenges for 2013/14 and beyond

- There is an increasing demand for access to a range of diagnostics.
- The increasing demands for diagnostic investigations will require additional capital investment in both the replacement of existing radiological equipment and the provision of additional diagnostic equipment.
- Ensuring the delivery of timely and appropriate diagnostics and the timely reporting of the test outcomes.
- Providing diagnostic testing as early as possible in the patient journey and where possible in a primary care setting or through direct access secondary care services or in one-stop clinics.
- Ensuring patients are provided with information about what to expect to allow them to participate fully and expedite their treatment and care.
- Ensuring an appropriately skilled workforce which is equipped and competent to deliver the service in a variety of settings.

- Improving clinical and administration processes to improve productivity and utilisation of available resources.
- Development of 7 day working for key diagnostic services.
- Delivery of the NI Pathology Network Strategic Implementation Plan, including: a whole service analysis of demand and capacity; agreeing and delivering the future regional requirement for pathology service provision and in particular for molecular diagnostics; the development of a commissioning platform for pathology; incorporating technological advances across all disciplines; and ensuring an effective, integrated and auditable ICT solution is in place to support the pathway from requesting any pathology test through to receipt of the result with clinical interpretation.

Specific Ministerial target to be achieved for diagnostic services in 2013/14:
From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.

Diagnostics

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts should ensure that RQIA radiology recommendations are fully implemented during 2013/14.[8] As a minimum this requires all Trusts to: • Put in place written escalation procedures to reduce the risk of delays in plain X-ray reporting during 2013/14. • Ensure that all images are accounted for on the PACs system	●					RQIA Independent Review of Reporting Arrangements for Radiological Investigations

[8] During 2013, the HSCB will establish a Radiology Clinical Network. The Network will be the vehicle to ensure full implementation of the RIQA phase 1 and 2 recommendations for service improvement and planning from 2013.

from March 2013 and they have processes in place to ensure that all images are reported on within the required target times from March 2014						
All Trusts should provide Ultrasound as part of the neonatal hip screening programme from 2013/14.	●					
All Trusts should ensure that the requirements for 7 day access to the MRI imaging requirements for Stroke and MSSC are delivered by March 2014. Going forward, all Trusts should ensure that, where additional imaging capacity is commissioned, that this will in the first instance be achieved through a longer working day to improve patient access.		●				
All Trusts should implement NICE CG on Management of Dyspepsia, supported by pre-referral testing as indicated by the Guidance		●			Rec 77	NICE CG 17

All Trusts should have implemented a direct access pathway for ECHO for patients considered for left ventricular failure (LVF) *as defined by NICE Guidance CG for chronic heart failure,* by September 2013 with the aim to have reduced referrals to cardiology outpatients by 10 % by March 2014.	●	●				NICE CG 108

5. Elective Care

Since 2009/10, the demand for outpatient services has increased by some 2% with approximately 620,000 patients being referred to hospital for specialist assessment in 2011/12.

While routine referrals have experienced a 3.6% drop in demand, over the same time period, there has been a significant increase in the number of red flag referrals (for suspect cancer) with the region experiencing a 72% increase from 2009/10 to 2011/12. Overall for all referrals (including GP, Other and ICATS) there has also been an increase in the number of patients classified as urgent. This change in referral priority has put significant increasing pressure on the ability to treat routine patients within agreed waiting time targets.

The increase in referrals to secondary care has had a direct impact on elective admissions with the demand for inpatient and day surgery procedures increasing by 4% since 2009/10 (n=10,342 procedures).

Headline successes from 2012/13

- Improvements in waiting times across outpatient appointments, inpatient or day case treatments, diagnostics (including endoscopy), and Allied Health Professionals.
- Following a regionally agreed position on the capacity and demand gap for across both assessments and elective treatments for the main surgical specialties, targeted investments have been made to increase elective capacity to support demand and improve waiting times.
- The HSCB has made a number of targeted recurrent investments in areas to deal with the current levels of predicted demand and provide additional elective capacity to maintain and improve waiting times. This has included those regional services where there is no readily available Independent Sector solution.
- Significant progress has been made in 2012/13 to refine the Theatre Management System (TMS) reports. This will provide improved data on theatre utilisation, thereby supporting more informed commissioning.

- The DHSSPS have been working with Trusts to ensure that action plans are produced and self-assessments undertaken against the recommended NCEPOD standards. All Trusts will be asked for updated action plans early in 2013 and these plans can be considered in the light of DHSSPS paediatric review consultation paper.
- Following requests from Trusts and the orthopaedic community in Northern Ireland, the HSCB agreed that from 1st April 2013, all joint replacements carried out in Northern Ireland should now be registered on the National Joint Register (NJR).
- Following the successful pilot of the paediatric orthopaedic triage clinic which helped to reduce the demand and waiting times for paediatric orthopaedic assessments by 15% it has been agreed that the pilot will be extended for a further 12 months.
- The Clinical Communications Gateway (NICCG) is now available in all GP practices and Trusts and provides a standardised referral process from Primary to Secondary care. It will also provide a mechanism to develop decision support, thereby supporting more appropriate referral.

Key Challenges for 2013/14

As set out above, significant progress has been made during 2012/13 in relation to improving waiting times for elective care services. It is the HSCB's expectation that further progress will be made in 2013/14, although there are particular risks and challenges in this regard:

- The delivery by Trusts of agreed core volumes of activity
- The availability of capacity from alternative providers when Trust capacity is insufficient to respond to demand
- The availability of adequate funding
- The need to deliver improved productivity given demand increases and wider resource pressures.

In relation to the delivery of core capacity, in general Trusts have delivered to, or sometimes above, expected levels. However, there have been significant difficulties in some specialty areas which have necessitated the provision by

the HSCB of additional resources, and/or longer waiting times for patients than would otherwise have been the case.

For these specialties, the HSCB has signalled to relevant Trusts that funding will be withheld in the first part of 2013/14, pending demonstration by the Trusts that specialties are delivering in full the required volumes of activity. The HSCB will apply a similar approach in other specialties where performance difficulties arise during the course of 2013/14.

In relation to the availability of capacity from alternative providers, the HSCB and its LCGs have relied heavily on such providers in 2012/13 to both respond to ongoing gaps between capacity and demand and to clear waiting list backlogs. The HSCB expects there to be a continued but reduced requirement to utilise capacity from alternative providers in 2013/14; a number of investments were made during the last 12 months to increase (local) HSC Trust capacity. Nonetheless, in some specialties, there will continue to be a need to utilise alternative providers. This is particularly true of orthopaedics, where the increased demand for the service means that each year the numbers of patients referred (c29,000) exceeds the capacity of the service (20,000) by some 45%.To expand Trust capacity to meet this gap will take several years. The HSCB is working with local providers to quantify the orthopaedic capacity gap across both staffing and theatre requirements. This work is not only reviewing the current capacity gap but is also horizon scanning to assess how capacity will be affected by increasing subspecialisation and future consultant retirements. Therefore, it is the HSCB's intention, during this time, to put in place a medium term arrangement for the provision of this service with one or more alternative providers. Arrangements in this regard will be taken forward through the appropriate processes in early 2013/14.

Finally, in relation to the need to demonstrate improved productivity, the HSCB will seek to uplift existing core capacity requirements of Trusts, consistent with reasonable expectations and drawing on experiences of Trust delivery over the last 12-18 months.

Other key challenges in 2013/14 and beyond include:

- Attracting and retaining clinical staff with the necessary skills to ensure that services can be sustained locally is becoming increasingly problematic, particularly in areas of sub specialisation.
- The future reconfiguration of acute services coupled with the need to retain appropriate services in local acute units due to the dependencies between specialties will prove a particular challenge and possibly restrict the type of cases which can be done in elective units outside core acute sites. This will have a direct impact on the level and type of day surgery undertaken in peripheral sites.
- Secondary care pathways need to be redesigned, in partnership with ICPs, to ensure that procedures of higher clinical value are prioritised. Alongside this we will need to work to create both the will and capacity within primary care to undertake some of the lower value procedures (e.g. removal of skin lesions, vasectomy).
- The withdrawal of joint appointment teaching posts creating a loss of capacity in some services e.g. medicine, respiratory and dentistry, requiring a much more planned process to be agreed between the HSCB, QUB and DHSSPS.
- Working with ICPs to ensure that we develop and retain staff with the necessary skills in primary and community care in order to facilitate new care pathways and reduce demand on secondary care.
- The full utilisation of the electronic referral system by GP practices to assist Trusts with care pathways and effective triage of patients.
- Implementing new services models (e.g. podiatric surgery).

Specific Ministerial target/s to be achieved for elective services in 2013/14 are:

- From April 2013 at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014 and no patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014.

- From April 2013, at least 70% of inpatients and day cases are treated within 13 weeks, increasing to 80% by March 2014, and no patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014.
- By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.
- From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Elective Care

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts should ensure they have robust and effective booking, scheduling, POA processes to ensure the full utilisation of available elective capacity The HSCB will expect the following and will monitor these indicators to ensure this objective is achieved: • All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more that 8% by March 2014 Trusts should demonstrate a measurable improvement in shift of procedures from day surgery to outpatients with procedure (OPP) by April 2014. (this will be based on the day surgery	●	●		✓ Target 3, 4,7, 8 & 9	Rec 77	

rates at April 2012) • All Trusts should reduce Theatre DNA/Cancellation rates to 5% by 31 March 2014. • All Trusts should ensure theatre utilisation rates of 83% (as a minimum and in line with Audit Commission recommendations) from March 2014. • All Trusts should work to sustain and improve endoscopy throughput per session from an average of 6.2 patients per session in 2012/13 to 6.5 patients per session by December 2013, 6.7 by March 2014 and 7.1 by March 2015. • Trusts will ensure that they are delivering the recommended day surgery rates for the trolley of procedures identified by The British Association of Day Surgery from March 2015/16.	●	● ● ●	● ●		Rec 77 Rec 77 Rec 77	

• As a minimum Trusts should ensure that they are delivering the day surgery rate for the basket of 24 procedures identified by the Audit Commission (excluding Termination of Pregnancy). In addition, the Trusts should utilise the electronic referral system, to support effective patient pathways and triage processes from March 2013. For example in the use of photo images to support dermatology referrals and other means which will support the implementation of the EUR policy		●				
All Trusts should implement an enhanced recovery model across an agreed range of surgical specialties to improve outcomes, reduce lengths of stay and increase productivity by 2014/15. The initial focus should be on the best practice pathways. This may include the pathways associated with		●	●	✓ Target 21	Rec 77	Enhanced Recovery Partnership: A better journey for patients and a better deal for the NHS'.

the following 8 procedures: colectomy; excision of rectum; prostectomy; cystectomy; hysterectomy (vaginal and abdominal); and hip and knee replacement.						
Once established as a regional service, all Trusts will utilise the podiatric surgery service for foot and ankle surgery from 2014/15		●			Rec 77	
One Trust to undertake a pilot service of self-referral for Musculoskeletal Physiotherapy. Pilot to be evaluated for local learning moving towards implementation in 2014/15	● Pilot	● Implement				
In line with the NICE guidance for Glaucoma, Trusts will work with primary care in the referral refinement programme for glaucoma during 2013/14. This will reduce the false positives and ensure only those patients who require evaluation, monitoring and		●			Rec 77	

treatment are referred to secondary care.						
All Trusts should provide an ultrasound service for infants at risk of or with suspected developmental dysplasia of the hip in line with the standards and guidance of the UK National Screening Committee, the Royal College of Radiologists and the College of Radiographers	●					
All Trusts will work towards the development of pathways to support. • All Trusts will achieve 90% of vasectomy procedures provided within primary care or as a minimum all moved off main acute hospital sites from April 2014. • All Trusts will move all low risk skin lesions off main acute sites from April 2013 and from April 2014 90% of low risk skin lesions are moved to		● ●			Rec 77 Rec 77	

a primary care setting. • All Trusts to work towards the introduction of a regional pathway for varicose veins which is in line with NICE guidance (CG the diagnosis and management of varicose veins) and includes the provision of minimally invasive surgery for 90% of varicose veins from April 2014. • All Trusts should support the implementation of an MSK / Pain pathway. This service will support the delivery of a primary/community care facing service, with MDT pathways developed to include lower back, knee, shoulder etc., by the end of March 2014. All service models should include self-management/education at the core of service design.	●	●			Rec 77	NICE Guidance

All Trust will support improved outcomes measurements to support service improvement and evidence based commissioning • All Trusts should participate in the national hip fracture database during 2013/14 and ensure 100% compliance from 2014/15. • All Trusts providing elective orthopaedic procedures will participate and provide data into the National Joint register from 2013. • All Trusts providing vascular services should ensure the full participation in the National Vascular Database from 2013/14. • Support the Patient reported outcome measures (PROMS) pilot for varicose veins		● ● ● ●				

6. Health and Social Wellbeing Improvement

Health and wellbeing improvement refers to any activity which aims to prevent ill health and improve the health and wellbeing of the population. Programmes aim o take into account greatest need, including rural issues. The primary focus is to reduce health inequalities with emphasis placed on services commissioned within health and social care, as well as the development of effective partnership with other sectors, including communities, in order to influence the wider determinants of health. Service areas are described under the following headings:

1. Give Every Child and Young Person the Best Start in Life
2. Work with Others to Ensure a Decent standard of Living
3. Build Sustainable Communities
4. Make Healthier Choices Easier

Headline Successes from 2012/13

- Family Nurse Partnership programme extended to two further HSCT areas.
- Roots of Empathy programme expanded to include over 50 schools across Northern Ireland serving the most disadvantaged areas with early research findings from RCT due January 2013.
- Mount Vernon locality planning delivering a service redesign model using social enterprise and building social capital locally.
- Regional Travellers Forum operating to share good practice and drive change across region to take forward the findings of the All Ireland Travellers Health Study.
- An LGB&T staff Forum established and e-learning module developed for use across all health and social care organisations, acting as an exemplar for other public and private sector organisations.
- A New Entrant Health Service and a new Migrant Health and Social Wellbeing Collaborative Network established to help meet the needs of disadvantaged groups.

- The second phase of the Maximising Access in Rural Areas (MARA) programme has been successfully implemented, realising an average of £9 benefit for each £1 of investment alongside other benefits, including a reduction in social isolation and serving as a model of good practice for wider government welfare programmes.
- Increase of 47% in the uptake of stop smoking services with the quit rate remaining steady at approximately 50% at 4 weeks (much higher than other parts of the UK).
- Significant developments in joint working arrangements with local government and impacts on the environment to increase physical activity (e.g. 8 outdoor gyms in disadvantaged areas of Belfast, Active Travel maps in the western area, and local 'Give it a Go' campaign in the southern area with incentivised participation in physical activity).
- Roll out of the Deliberate Self Harm Registry to all HSC Trusts.
- Development and analysis of 24/7 Lifeline service.

Key challenges for 2013/14 and beyond

- There is an increasing pressure on acute services. Prevention has a key role to play in keeping people healthy and reducing demand for HSC services.
- Structural barriers in society which have a profound influence on inequalities e.g. poverty
- Economic climate and the impact on unemployment (e.g. a 1% increase in unemployment is associated with a 0.8% increase in suicide).
- Proportion of the population who are overweight or obese (61%) with impacts across a wide range of health conditions. A range of actions are required to encourage people to make healthy choices consistently.
- Proportion of the population who smoke (24%) with impact on a wide range of health conditions. Sustained public information campaigns, and stop smoking services are two ways the HSC can reduce smoking rates.
- Levels of alcohol consumption with an estimated 23% of the adult population consuming more than the recommended weekly limits with impacts noted across the health and social care system (alcohol estimated to be a significant factor in 40% of all hospital admissions).

Brief intervention training, alcohol liaison services, and specialist addiction services are the most effective ways to reduce alcohol harm. Increased pricing and reduced availability are effective preventative measures.

- Relatively Low levels of breastfeeding with impacts on maternal and child health and levels of obesity. Maternity support workers, peer support and public acceptance of breastfeeding are effective ways to increase breastfeeding rates.
- Increasing life expectancy and the need to maintain independent and active ageing for as long as possible. Social isolation is a key issue for some older people.
- The need to promote mental health and emotional wellbeing in the adult population (estimated 25% have experienced a mental health problem). Better recognition, early access to talking therapies are two ways the HSC can improve mental health.
- Concentration of disadvantage and marginalisation in some population groupings with adverse impact on health (e.g. migrant groups, LGB&T community).

Specific Ministerial target to be achieved in 2013/14

- By March 2014, improve long term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further site.

Health and Wellbeing Improvement

Timescale for achievement				*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts are expected to deliver on the implementation of 'Fitter Futures for All' framework including: • Pilot pregnancy programmes; • Achieving UNICEF Baby Friendly Standards and peer support initiatives to support breast feeding; • Pilot weight loss programmes for adults and children; • Provision of healthy food choices in all HSC facilities.	●				Rec 1	'Fit and Well', DHSSPS 'Fitter Futures for All' framework, DHSSPS Breastfeeding Strategy, DHSSPS PfG commitment 45
All Trusts will ensure delivery of a range of evidence based early years				✓ Target 2	Rec 1	'Fit and Well', DHSSPS

intervention programmes including: • Roots of Empathy • Family Nurse Partnership • Infant Mental Health Training • Parenting support.	●					CYP Strategy, HSCB Hidden Harm, DHSSPS
All Trusts will ensure that they support the implementation of key public health strategies including: • tobacco cessation services and BIT in particular for pregnant women and other vulnerable groups; • work toward smoke free campuses; • services within hospital and custodial settings (including emergency departments) which can respond to alcohol and drug misuse, self harm and associated mental health issues; • continue to collect data for the Deliberate Self Harm Registry on	●				Rec 1	'Fit and Well', DHSSPS Ten Year Tobacco Control Strategy, DHSSPS New Strategic Direction on Alcohol and Drugs, DHSSPS Protect Life, DHSSPS Bamford Review, DHSSPS

attendances at ED that are related to self-harm, report on trends and emerging issues and influence the maintenance and/or re-design of appropriate services.						
All Trusts should provide timely access to specialist sexual health services.	●					'Fit and Well', DHSSPS Sexual Health Promotion Strategy and Action Plan
All Trusts should ensure that existing service provision is tailored to meet the needs of vulnerable groups including: • Looked After Children; • Homeless people • LGBT	●					'Fit and Well', DHSSPS All Ireland Traveller Health Study, DHSSPS

• Travellers • Migrant groups						European Convention on Human Rights, EU CYPS, HSCB 'Including the Homelessness', DSD
All Trusts should support social economy businesses and community skills development through public procurement, expanding capacity incrementally over the following 3 years.	●	●	●		Rec 5	'Fit and Well', DHSSPS

7. Health Protection

The PHA's Health Protection Service has a front line role in protecting the Northern Ireland population from infectious diseases and environmental hazards through a range of functions such as surveillance and monitoring, operational support and advice, response to health protection incidents, education, training and research. Working closely with partner organisations in the UK and through international networks such as those of the Health Protection Agency (HPA), World Health Organisation (WHO) and the European Centre for Disease Prevention and Control (ECDC), the overall objective is to have the best quality health protection service possible for Northern Ireland.

The Health Protection Service works closely with colleagues responsible for infection control in the local Trusts and healthcare providers to further reduce and prevent avoidable Healthcare Associated Infections (HCAI) occurring in Acute, Primary and Community Care settings in Northern Ireland.

Key Challenges for 2013/14

There are two new issues requiring additional input from healthcare workers across HSC during 2013/14:

- the introduction of two new vaccination programmes for children: rotavirus and influenza
- the healthcare associated consequences of three major events taking place in Northern Ireland during 2013 which will require all Trusts to review their emergency preparedness plans.

Specific Ministerial target to be achieved in 2013/14

- By March 2014, secure a further reduction of x% in MRSA and Clostridium difficile infections compared to 2012/13.

Health Protection

Timescale for achievement				*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts should test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption potentially associated with specific major events including the G8 Summit; the World Police & Fire Games 2013 and the All Ireland Fleadh in August as part of the City of Culture.	●	●	●			
All Trusts will ensure that they support the implementation of key health protection initiatives including maintaining Northern Ireland's excellent vaccination rates in respect of	●	●	●			Introduction of two new vaccination programmes(Flu &Rotavirus)

influenza and childhood immunisations and the introduction of two new childhood vaccination programmes (Flu and Rotavirus)						
All Trusts will continue to monitor and review the occurrence of Health care Associated Infectionsand implement appropriate and agreed infection control measures with particular reference to Ministerial targets on Clostridium difficile and MRSA.	●	●	●	✓ Target 10		
The South Eastern Health and Social Care Trust will ensure that agreed procedures are in place in respect of infection control in the prison population including protocols for control of an outbreak of a communicable disease in a prison setting and access of prisoners to appropriate vaccinations.	●					Agreement between Prison Healthcare Commissioning Team and Health Protection Service

8. Learning Disability

Learning Disability is a lifelong condition which is generally recognised before adulthood and which is characterised by significant intellectual impairment alongside social functioning difficulties. While the term learning disability is a single definition it encompasses a wide range of ability and a range of accompanying health and support needs across the full age spectrum which requires diverse service responses to meet individual's needs.

The key aims of services are to promote independence for people with a learning disability in inclusive activities in the community which promote their health and wellbeing and to support families who in care for the majority of children and adults with a learning disability. These aims should increasingly be met through partnership working with other statutory agencies and with voluntary and community providers.

Headline successes from 2012/13

- Development of a Regional Day Opportunities Model.
- Roll out across all Trust areas of the Directed Enhanced Service for Learning Disability and the completion of an evaluation of the service.
- Implementation of the Guidance for Commissioners on Advocacy (DHSSPS).
- Further reduction in the long stay population in learning disability hospitals.
- Enhancement of community infrastructure through investment in services to reduce unnecessary hospital admissions and promote timely discharges from learning disability hospitals.
- Development of a Forensic Learning Disability Model.
- Parents/carers of people with a learning disability have joined the HSCB/PHA Learning Disability Service Team.

Key challenges for 2013/14 and beyond

- Improving post transition from school services to meet the full range of assessed needs for day time opportunities.

- Increasing the range and volume of short break/respite services for adults with a learning disability which meet their needs and the needs of their families/carers.
- Improving multidisciplinary community services to respond to the full range of needs across the 7 day week which reduces the number of hospital admissions and permits timely discharge.
- Completing the resettlement of the remaining long stay patients from Northern Ireland learning disability hospitals.
- Further developing Direct Payments and other forms of individual budgets to make a reality of self-directed support for people with a learning disability and their families.
- Addressing the existing health inequalities experienced by people with a learning disability to further improve lifespan and improve the mental and physical health of people during these additional years.
- Developing services which meet the particular needs of the growing population of older people with a learning disability and their families.
- Further developing with NIHE a range of housing options with care and support which allow for people with a learning disability to move from their family home in a planned way.
- Implementing the Learning Disability Service Framework year 1 target to baseline each of the 33 required standards during 2013/14.
- Implementing the Bamford Action Plan 2012-2015 DHSSPS targets.
- Improving co-operation and co-working with other statutory and voluntary/community providers.

Specific Ministerial targets to be achieved for learning disability services in 2013/14 are:

- From April 2013, ensure that 99% of all learning disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hour; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital taking place within 6 hours.

- By March 2014, resettle 75 of the remaining long-stay patients in learning disability hospitals to appropriate places in the community, with completion of the resettlement programme by March 2015.

Learning Disability

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
Trusts should ensure the resettlement of the long stay population as identified over the next 3 years.	● BHSCT (25) NHSCT (12) SEHSCT (5) SHSCT (33) WHSCT (0)	● BHSCT (24) NHSCT (12) SEHSCT (13) SHSCT (0) WHSCT (1)		✓ Target 23	Rec 71	Bamford Action Plan 2012-15 DHSSPS

All Trusts should start to deliver Day Services in line with the Regional Model 2013 currently being developed.	●	●			Rec 67	Bamford Action Plan 2012-15 DHSSPS
All Trusts should develop their specialist community services to respond to the needs of people whose behaviours challenge services and those with offending behaviours including a 24 hour response 7 days per week and high support beds in the community.	●	●		✓ Target 21		Bamford Action Plan 2012-15 DHSSPS
All Trusts should deliver additional support for Carers through enhanced short break and respite services.	●	●			Rec 67	Bamford Action Plan 2012-15 DHSSPS
All Trusts should work with primary care to further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation.	●				Rec 64	Evaluation of existing Directed Enhanced Service

All Trusts should deliver the targets of the Learning Disability Bamford Action Plan 2012-2015 DHSSPS.	Yr 1 targets	Yr 2 targets			Rec 66, 69 & 70	Bamford Action Plan 2012-15, DHSSPS
All Trusts should develop action plans to promote the health of people with a learning disability, in line with the priorities identified in the Public Health Strategic Framework: Fit and Well Changing Lives 2012-22	●					

9. Long Term Conditions

Long-term conditions (LTCs) refer to any condition that cannot, at present, be cured but can be controlled by medication and/or therapy. Our focus is on diabetes, cardiovascular, respiratory and neurological conditions. Our overall aim is to reduce the impact of long term conditions on individuals, families and the population. Care including clinical care, should be provided close to home; with patients and their families being active participants in their care. Primary care needs to be supported by responsive secondary care services to deal with exacerbations or complications that cannot be managed at home.

Headline successes from 2012/13

- Expansion in the numbers of children and adults with Type 1 diabetes using insulin pumps.
- Successful completion of the Sensemaker project on heart failure where the views of service users informed service improvement in heart failure services.
- The development of a new Oxygen contract which will allow access to up to date equipment for those who require long term oxygen therapy (more than 15 hours per day, affecting 2,500 people) or ambulatory oxygen.
- Completion of an audit of self-management programs for LTCs provided by statutory and voluntary sectors.
- Completion of first substantive review of the cardiovascular service framework.
- Update of hospital diabetes information system (to Diamond.net).
- Increased use of telemedicine in diabetes, heart failure and renal failure.
- The establishment of the Neurological Conditions User / Carer Group will ensure that the views and experiences of service users and carers are central to shaping future commissioning priorities for services for people with neurological conditions.

Key challenges for 2013/14 and beyond

- To work with the newly established Integrated Care Partnerships to coordinate the full integration and local application of Commissioner-approved care pathways in relation to aspects of long term conditions for all ages, namely diabetes, stroke care and respiratory conditions, in order to improve the outcomes and experiences of those patients.
- Rising levels of obesity in the population which is associated with an increased risk of developing a LTC and poorer outcomes if you have a LTC.
- Continued increase in the number of people with long term conditions, particularly Type 2 diabetes.
- Higher levels of risk factors (e.g., smoking, high blood pressure and obesity) for heart, stroke, vascular and respiratory diseases in more disadvantaged communities.
- Higher death rates from conditions such as coronary heart disease, stroke, vascular and respiratory diseases in more disadvantaged communities.
- Increasing public awareness that many LTCs can be prevented by avoiding obesity, not smoking or stopping smoking, regular exercise and eating a healthy diet.
- Ensure services are “joined up” between Trusts, primary care and the voluntary and community sectors. A “joined up” approach is also needed for prevention (primary and secondary) and treatment services through to palliative care.
- Improve access to self-management and patient education programmes for LTCs.
- Further develop seven day community services so that more people with LTCs can be managed at home when they become unwell or allow people to be discharged earlier from hospital.
- Ensure successful implementation of cardiovascular and respiratory frameworks.
- Ensure better co-ordination of services to treat multimorbidity (more than one LTC) in individual patients.

- To take forward the HSCB/PHA Action Plan in response to the recommendations of the "Speak Out for Change" engagement exercise for people living with neurological conditions and their carers.
- Ensure vulnerable groups who develop LTCs (e.g., adults with Learning Disability), receive high quality care.

Specific Ministerial targets to be achieved for long term conditions in 2013/14 are:

- By March 2014, ensure that at least 10% of the proportion of patients with confirmed ischaemic stroke receive thrombolysis.
- By March 2014, deliver 500,000 telehealth monitored patient days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI Contract.
- By March 2014, develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively.
- By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.[9]

[9] Achievement of this target will require work across a number of service areas and Directorates including: community care; unscheduled care and integrated care.

Long Term Conditions

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions through: • Community teams that are available to meet patient needs including provision of a named nurse for patients on disease registers (with clear arrangements for dealing with multi-morbidity and complex medication regimes) and access to specialist medical or nursing advice • Development of admissions/escalation protocols between community teams and	●			✓ Target 6 & 18	Rec 23 & 26	

secondary care						
Respiratory • Northern & Western Trusts should ensure that arrangements are in place for all TB patients to be managed by a specialist TB Service (Clinician who is a respiratory physician or appropriately trained infectious disease physician/paediatrician and specialist TB nurse) • All Trusts should have in place integrated paediatric respiratory and allergy and anaphylaxis teams, which can outreach to other parts of the hospital including A&E, outpatients and ambulatory care, and to the community, in cases of difficult asthma. • All Trusts should fully implement the COPD integrated Care Pathway.	● Service in place ● ●	● Service in place			Rec 77 Rec 77 Rec 22	Regional TB Action Plan NICE Guidance Respiratory Service Framework Standards NICE COPD Quality Standards

• All Trusts should fully develop Home Oxygen Services Assessment and Review • All Trusts to participate in a six monthly audit of all COPD patient admissions	● ●					
Stroke • Thrombolysis ➢ All Trusts to achieve a door to needle time of 60 minutes on a 24/7 basis ➢ Trusts to achieve a minimum 10% thrombolysis rate for acute ischaemic strokes. • Urgent assessment of high risk TIAs ($ABCD^2$>4) must be available on a 7 day basis • All Trusts should support early supported discharge (ESD) following	● 70% 10% ● Service in place	● 80% 11%	● 90% 12%	✓ Target 13	Rec 77	NICE Guidance &NICE Quality Standards for Stroke

an acute stroke. This should support shorter LOS and "shift left" where resources will be freed from hospital beds to develop services in the community.	● Progress report				Rec 22	
Diabetes • All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes	**Adults** 141 **Paeds** 76	**Adults** 162 **Paeds** 104	**Adults** 138 **Paeds** 86		Rec 22	NICE Diabetes in Adults Quality Standard
• Subject to satisfactory pilot evaluation, all Trusts should	●				Rec 21	

mainstream the CAWT pre pregnancy care and structured patient education program (CHOICE) for children from January 2014 onwards. [10] • All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14.		●				

[10] Requires further discussion between the Commissioner and provider(s) and /or DHSS&PS with regard to funding.

Cardiac • Implement a Familial Hypercholesterolaemia cascade testing service in N. Ireland • Commission a model for Emergency Life Support (ELS) training in the community together with an audit process to monitor agreed outcomes.[11]	● ●	●			Rec 77	Cardiovascular Service Framework
Prevention • All Trusts should ensure that smoking cessation services are available in all locations where patients with LTCs are seen including hospitals, primary	●					

[11] Further work will be undertaken during 2013/14 to finalise any funding requirements associated with this development and to identify the source of any necessary funding (HSCB/PHA/DHSSPS)

care and community pharmacy • All Trusts should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively • By March 2014, all Trusts should deliver 500,000 telehealth monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract. • Belfast Trust to undertake pilot of the Triple Aim in North Belfast • Increase the uptake of direct payments by people with neurological conditions	● ● ● ● Progress Report			✓ Target 18 ✓ Targets 16 & 19	Rec 21 Rec 27	PfG commitment 44 Connected Health

10. Maternity, Child Health and Sub-fertility Services

In 2011, there were almost 25,300 births to NI residents, and in addition around 500 women from the Republic of Ireland deliver in NI maternity units each year. While the number of births has increased from around 21,500 in 2002, there are signs that they may now be stabilising. There have been significant changes in the maternity population in NI with a trend towards women delaying childbearing to later in life; and an increase in births to mothers from other countries who have migrated to NI. Obesity in pregnant women is becoming much more prevalent, with only half of mothers at booking having a body mass index (BMI) within the normal range. Smoking and other lifestyle risk factors such as drugs and alcohol continue to be problems that are strongly associated with poorer pregnancy outcomes.

All children have access to the 'Healthy Child Healthy Future' programme of universal services with additional support provided when additional needs/risks are identified by universal services (e.g. low birth weight babies, looked after children).

Health Visitors and their teams will also work proactively in partnership with other members of the primary care team, meeting on a regular planned basis to ensure the promotion and uptake of immunisation programmes. All Trusts will ensure that they continue to support immunisation programmes and maintain Northern Ireland's excellent immunisation rates.

Hospital admission of a child only happens when community services are unable to care for the child. When children require hospital admission, either to local or regional centres, it is important that services are provided in a safe, effective and sustainable way.

Primary care staff need timely access to expert paediatric opinion through the development of short stay paediatric assessment units (SSPAUs) on all acute hospital sites.

Headline successes from 2012/13

- All HSC Trusts have developed action plans to normalise birth and reduce caesarean section rates. The HSC Safety Forum is facilitating a "Normalising Birth" perinatal collaborative to enable Trusts to take this work forward and share regional learning.
- Trusts have established Maternity Services Liaison Committees (MSLCs) in response to Chief Nursing Officer and Midwifery letters to ensure the views and experience of women are reflected in the delivery of maternity services
- Work has been undertaken by the Maternity and Child Health Service Team to examine areas of potential inequalities in both maternal health and early access to maternity services.
- A scoping exercise of Trusts' current maternity services and a parallel survey of GP practices have been carried out to provide a baseline for the implementation of the maternity strategy.
- Both of the freestanding midwife-led units in Northern Ireland are working to increase the number of women who give birth there. The maternity unit in the Mater Hospital is due to become a freestanding midwife-led unit in the coming months.
- The Public Health Agency funded the Maternity Services Liaison Committees from all Trusts to attend a training day provided by the National Childbirth Trust in order to help service users make an effective contribution to the committees.
- A pilot regional maternity obesity intervention programme for pregnant women with a BMI over 40 will commence in all Trust's early in 2013.
- The Family Nurse Partnership has been rolled out from the Western Trust to the Belfast and Southern Trusts.
- An integrated regional perinatal mental health care pathway has been developed by a Perinatal Sub-Group of the Bamford Task Group in conjunction with HSC Trusts, Service Users, and Primary Care. The pathway was launched in December 2012

- A regional care pathway for fertility services has been developed and will be further refined to take account of the role of Area hospitals in the management of subfertility; the introduction of Frozen Embryo Transfer to all new referrals to Regional Fertility Centre from the 1st April 2012.
- The cross-border 'Cooperating and Working Together' (CAWT) pilot project on pre-pregnancy care for women with diabetes is now running in all 5 HSC Trusts.
- The CAWT pilot project on structured patient education for children with diabetes is being implemented in the 5 Trusts.

Key challenges for 2013/14 and beyond

- Implementation of 'A Strategy for Maternity Care in Northern Ireland 2012-2018' will require a radical shift in how maternity care is provided, with more antenatal care provided closer to home in the community; and for women with straightforward pregnancies care will be provided primarily by the midwife with greater continuity of care and the option of giving birth in a midwife-led unit.
- Women with risk factors or who develop pregnancy complications will be offered consultant-led care. Consultant obstetric units must be adequately staffed to provide a safe level of care for these higher risk women and their babies. While perinatal mortality rates in NI are comparable with the rest of the UK, the reduction in such deaths has slowed, and there needs to be a renewed focus on reducing avoidable perinatal deaths.
- Obstetric intervention rates such as caesarean section rates are higher in NI than in the rest of the UK and the Republic of Ireland, and there is unexplained variation between units. While interventions can be life-saving, the unexplained higher rate in some obstetric units needs to be addressed.
- It will be important to continue to implement the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units and also to implement guidance on the prevention of neonatal Group B

Streptococcal infection, and the management of early onset neonatal infection.

- It is imperative that the preventive work outlined in the Health and Wellbeing section above continues to focus on women in the childbearing age group to ensure that women are as healthy as possible before and during pregnancy.
- Further development of subfertility services is required to take account of technological advances such as egg storage and a blastocyst service.
- Implementation of 'Healthy Child Healthy Future' has highlighted shortfalls in the provision of universal services e.g. the antenatal visit by health visitors which needs to be addressed.
- The Department is leading a regional review of Paediatric Services that is due to report in late 2013. This will set the future strategic direction for Paediatric Services in NI. The RQIA report on under 18s in adult wards will also be implemented.

Maternity

Timescale for achievement				*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts should ensure that the level of resident medical cover for consultant-led obstetric units meets the minimum standard recommended in the DHSSPS Maternity Strategy (ST3 or equivalent for obstetrics, paediatrics, anaesthetics). Those units that do not currently meet this standard must ensure in the interim that the risk profile of women booked to deliver in the unit is clinically appropriate to the level of staffing available.	●				Rec 36	DHSSPS Maternity Strategy
All Trusts should ensure implementation of Normalising Birth Action Plans including: • Keeping first pregnancy and birth normal	●				Rec 37	DHSSPS Maternity Strategy

• Increasing vaginal births after previous caesarean section (VBAC) • Benchmarking against comparable units in NI, rest of the UK and ROI • Implementation of NICE CG 132						NICE CG 132 Caesarean Section
All Trusts should ensure that where a consultant-led obstetric unit is provided a midwife-led unit will be available on the same site.			●		Rec 33	DHSSPS Maternity Strategy
All Trusts should ensure that all women are provided with balanced information on the available options for place of birth and benefits and risks, including midwife and consultant led units and home births.	●				Rec 34	DHSSPS Maternity Strategy
All Trusts should ensure that antenatal booking clinics will be provided in the community by midwives which will offer: • Direct access for women to their community midwife	●					DHSSPS Maternity Strategy

• Confirmation of pregnancy scan • Access to NIMATS • Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.						
All Trusts should ensure that for women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community and give greater continuity of care	●				Rec 36, 37 & 38	DHSSPS Maternity Strategy
All Trusts should bring forward 3 year plans to develop skill mix in the community midwifery service to include a phased increase in the number of maternity support workers in the community to assist with breastfeeding and early interventions commencing from 2013/14	●					DHSSPS Maternity Strategy

All Trusts should implement the Royal College of Obstetricians & Gynaecologists green top guideline No. 36 "The Prevention of Early-onset Neonatal Group B Streptococcal Disease"	●					CMO/CNO letter HSS(MD)37/ 2012 re RCOG Guideline No 36

Child Health:

Timescale for achievement				*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts to ensure that all children and young people admitted to an in-patient paediatric unit are seen by an appropriate level of medical staff within 4 hours and a consultant paediatrician within 24 hours of admission.	●				Rec 43	Child Health Specification
All Trusts to achieve 16 years as the upper limit for acute paediatric and		●	●			Child Health

surgical care. Age appropriate care must be provided in all in-patient and out-patient settings.		15 years	16 years			Specification
All units with in-patient paediatric services must have a short stay paediatric assessment unit SSPAU on site	● SSPAU 10am-6pm	● SSPAU 10am-8pm	● SSPAU 10am-10pm			Child Health Specification
All Trusts should ensure that all parents with a child with a Long Term Condition are given a named contact worker they can liaise with directly to discuss management of their child's condition and who will liaise with education services if required.	●				Rec 23	Child Health Specification
All Trusts to ensure that all children receiving palliative care have an emergency plan agreed with their GP, care team and secondary care services	●				Rec 80, 82 & 85	Child Health Specification

All Trusts to ensure that diagnostic imaging services are available on a 7/7 basis to diagnose and manage the acutely ill child including the assessment of acute surgical conditions of childhood.	●					
All Trusts to implement the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units and NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection	●					RQIA Independent Review of Pseudomonas in neonatal units; NICE CG 149

Sub-Fertility:

Commissioning Objectives	2013/14	2014/15	2015/16	Ministerial target	TYC	Other
Belfast Trust should introduce oocyte cryopreservation (egg freezing and storage), and a blastocyst service.	●					NICE Guidance

11. Medicines Management

Medicines are the most frequently used healthcare intervention with challenges from a quality and efficiency perspective in that in Northern Ireland there is:

- A need to ensure a high and consistent level of quality in the prescribing, dispensing and administration of over 35 million prescriptions
- An investment of over £500m per year on medicines across primary and secondary care

Effective use of medicines relates to ensuring that patients receive appropriate treatment, for the time they need it, at the correct dose and in the appropriate format.

Effectiveness is reduced by over or under prescribing, poor patient adherence, using treatments that are not effective, or using formulations that are not appropriate. Effectiveness is improved through adherence to NICE recommendations and guidance on topics not covered by NICE, adherence to formularies like the proposed NI Formulary, electronic prescribing systems, education and systems to improve patient adherence, and peer review of prescribing practice, particularly if associated with opportunities to redirect a proportion of savings into local service priorities.

Headline successes from 2012/13

- Development of the first version of the NI Formulary covering over 85% of prescribing choices in primary care. This has led to improved consistency in the approach to prescribing with improved application of NICE and other evidence based guidance in prescribing.
- Development of a managed entry process to improve accessibility to effective medicines for patients with improved consistency in decision making across the HSC and ultimately improved equity across NI in the use of medicines.

Key challenges for 2013/14 and beyond

- While the NI Formulary has been developed there will be a requirement for significant clinical and patient engagement to implement and further develop the formulary. Monitoring will be a key component and work is underway to enhance IT both to facilitate reporting and enable prescribing in line with the formulary.
- The process for managed entry and exit of medicines will need to be further refined and developed building on the solid foundation that has been established.
- Linked to both the formulary and the managed entry processes, there will be an ongoing requirement to develop our ability to monitor and audit medicines use across primary and secondary care to inform commissioning decisions.
- Medicines safety is a key focus and the original work on a regional Kardex will be updated and implemented as a common system throughout Trusts. Medicines safety will be further augmented through the establishment of a project to commission an e-prescribing system in secondary care. IT developments to aid medicines safety in primary care will also be taken forward including use of barcode technology and further scoping of electronic transmission of prescription information.
- While there has been a focus on the selection and management of medicines within health systems, it is recognised that further work is required such that patients adhere to medicines that have been prescribed. During 13/14, pilot work will test methodologies to support better patient adherence and inform future commissioning arrangements.

Specific Ministerial target to be achieved for medicines management in 2013/14

- From April 2013, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care.

Medicines Management

	Timescale for achievement			*Strategic Driver*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts to ensure the formulary is embedded within prescribing practice through active dissemination within electronic prescribing platforms	●	●	●	✓ Target 14	Rec 91	
All Trusts will work with the Health & Social Care Board in 2013/2014 to establish the baseline position with ICPs ensuring 70% compliance by end 13/14 and Trusts attaining target delivery in 2014/2015.	●	●		✓ Target 14	Rec 86	
All Trusts should put in place arrangements to manage regional monthly managed entry recommendations including monitoring, reporting and disinvestment arrangements	●	●				DHSSPS requirement for managed entry arrangements

All Trusts to ensure 100% compliance with local delivery against the Regional Pharmaceutical Clinical Effectiveness Programmes such that all targets are met	●	●	●			Efficiency programme
All Trusts should support development of e-prescribing in hospitals through identification of clinical champions and leads and co-ordination of local Trust implementation teams	●	●	●		Rec 91	Medicines Safety
All Trusts should ensure that all patients with highest risks (complexity; high risk medicines) have their medicines reconciled on admission and at discharge in line with NICE guidance (http://guidance.nice.org.uk/PSG001) – baseline in 13/14; delivery 14/15	●	●			Rec 77	Medicines Safety; NICE Guidance

12. Mental Health

Mental Health services aim to promote wellbeing and recovery and also provide care and support to those in distress or suffering ill health. Population based initiatives, i.e. mental health promotion, aim to enhance awareness of good mental health and enable people to better deal with day-to-day life stresses; targeted initiatives aim to promote resilience and prevent illness among at risk population groups, self-harm and/or substance misuse. The provision of mental health care and support includes direct care provided within primary care, community mental health, prisons and in-patient care settings. A key aim is to promote independence and recovery and the provision of such care within the usual primary/community care setting where possible.

Headline successes from 2012/13

- Securing agreement across Trusts to develop Recovery based care through a regionally coordinated development process using evidence based methodologies.
- Completion of a regional audit of over six hundred service user's and carer's experience of mental health services using the Sensemaker tool (GAIN audit).
- Continuing to promote good mental health and self-harm/suicide prevention regionally. A wide range of initiatives were delivered on a regional basis including commencement of the Sudden Death Notification process in partnership with PSNI, bereavement support, suicide surveillance and Community Response Plans.
- Developing a future vision for child and adolescent mental health services regionally through the completion of major regional review.
- Investment was secured to further develop the capacity to provide Psychological Therapies; funding is being used to establish additional therapists and improve training opportunities to provide such care.
- Further progress was made to resettle people from long stay mental health hospitals.
- A substance misuse services commissioning framework was developed and associated work was progressed to consolidate the provision of Tier

4 service provision models. Screening and Brief Interventions were progress through the new LES within primary care (for hazardous/harmful drinking).

- Experts by Experience i.e. people who use mental health services have joined the HSCB/PHA Mental Health Service Team.
- Development of a forensic multiagency training needs analysis

Key challenges for 2013/14 and beyond

- Promoting mental health across the wider population and supporting initiatives to address self-harm and suicide.
- Embed Recovery based care approaches and service outcomes through coordinated approaches within Trusts (and which are led by senior Trust management/personnel).
- Address substance misuse, including measures to address hazardous and harmful alcohol consumption and also drug misuse. There is a need to expand alcohol liaison services given the impact upon Emergency Departments and inpatient services, integrated with people who self-harm.
- Reduce the need for admission to hospital through the further development of community based services, including crisis response and home treatment teams.
- Reducing waiting times for Psychological Therapies across the range of Mental Health service settings and primary care (and help to reduce reliance upon prescribed medication based approaches).
- Improving the capacity of mental health services to care for children/adolescents, in particular those with preventative/early intervention functions.
- Develop additional capacity within specialist mental health services (including services for people with Eating Disorders, Forensic Mental Health, Personality Disorders and adults with Autism). This will help to reduce reliance upon Extra Contractual Referrals.

- Progress and complete the resettlement of people currently living in long stay mental health facilities.
- Continue to implement the Mental Health Service Framework, NICE guidance and associated development/implementation of Integrated Care Pathways.

Specific Ministerial targets to be achieved for mental health services in 2013/14 are:

- From April 2013, ensure that 99% of all learning disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hour; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital taking place within 6 hours.
- By March 2014, 23 of the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.
- From April 2013, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; and 13 weeks to access psychological therapies (any age).

Mental Health

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Key Deliverables	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts are required to fully implement the refreshed "Protect Life" strategy. This should include: • contributing to the development of an improved model of support for those who self-harm. • specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. • supporting the ongoing delivery of the Lifeline Service and implement the regionally	●	●	●		Rec 53 & 57	Bamford Action Plan 2012-15 DHSSPS

agreed Memorandum of Understanding.						
All Trusts should ensure the resettlement of the long stay population as follows:	BHSCT (10) NHSCT (5) SEHSCT (0) SHSCT (0) WHSCT (8)	BHSCT (11) NHSCT (7) SEHSCT (8) SHSCT (7) WHSCT (6)		✓ Target 23	Rec 62	Bamford Action Plan 2012-15 DHSSPS
All Trusts should establish integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of a Primary Care Psychological Therapy Service beginning with the	● Training completed and co-ordination posts recruited	● Roll out of the model		✓ Target 27		Psychological Therapies Strategy 2010 – DHSSPS. Bamford Action Plan 2012-15 DHSSPS

appointment of Primary Care Coordinators and training in CBT and/or counselling for a minimum of 5 staff in each Trust.						
All Trusts should begin to implement Recovery Approaches and related Integrated Care Pathways by December 2013.	●	●		✓ Targets 22 & 27	Rec 56&57	Bamford Action Plan 2012-15, DHSSPS
All Trusts should implement Crisis Response and Home treatment services for CAMHs with associated primary care teams/services including full implementation of the DHSSPSNI strategy for CAMHs.	●	●		✓ Targets 22 & 27	Rec 57 & 58	Regional CAMHS Model, DHSSPS 2012
All Trusts should further develop Specialist Community Services to include: • Autism Spectrum Disorder (ASD) services for Adult Services • access to dedicated eating	● ●			✓ Targets 22 & 27		Autism Act Action Plan 2013 Identified need

disorder beds in mental health and/or general hospitals (All Trusts should reduce eating disorder extra contractual referrals expenditure by 50% (based on the 01/04/2011 baseline))	●					to reduce the number of people who have to leave NI to access Eating Disorder Services
• a range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual Referrals based on the 1/4/2012 baseline).	●	●				Personality Disorder Strategy 2010
• the implementation of the regional Tier 4 Substance Misuse Model including the development of agreed supporting community services and enhanced alcohol liaison services within Emergency Departments	●					New Strategic Direction for Drugs and Alcohol DHSSPS

• the implementation of services to identify, assess and treat first episode psychosis (age 16+)						
Northern Trust to provide the regional Sexual Assault Referral Centre (SARC) at the Antrim Area Hospital site	●					Programme For Government
All Trusts should achieve the targets of the Mental Health Bamford Action Plan 2012-2015 DHSSPS.	Yr 1 targets	Yr 2 targets			Rec 39, 53, 58 & 60	Bamford Action Plan 2012-15, DHSSPS

13. Palliative Care & End of Life Care

Palliative care will enhance quality of life for those who are in the last year of life, although it is also applicable earlier in the course of an illness, in conjunction with other therapies which are intended to prolong life. Palliative care and acute care can both be provided together for those with cancer and non-cancer conditions. It provides relief from pain and other distressing symptoms as well as providing social, emotional and spiritual support. Of the 14,200 deaths in N Ireland in 2011 it is estimated that approximately 10,000 would have benefited from palliative care.

Palliative care can be provided by generalist staff, that is people's usual health and social care staff; and by specialist palliative care staff where there are more complex issues. Many specialist palliative care services are provided by the voluntary sector.

Headline successes from 2012/13

- A model of service provision has been agreed which will allow more people to have their palliative care needs identified. This has been based on the work of respiratory services who are leading the way in ensuring that people with respiratory diseases get the same level of palliative care as those with cancer; and is now being implemented in other areas.
- Large numbers of staff have had enhanced training in palliative care and communication skills to support them to provide better care.
- Contributing along with RQIA to the development of the GAIN guideline on Palliative care in nursing homes.
- People in nursing and residential homes are being offered the opportunity to develop advance care plans so that they can say how they would wish to be cared for.
- A business case is being developed for a Key Information System between general practice, A&E and OoHs which will address co-ordination issues.

Service Improvement Leads are working in all LCG areas to drive implementation of the Living Matter, Dying Matters Strategy.

Key Challenges for 2013/14 and beyond

- The need to work with ICPs to improve palliative and end of life care in respect of the agreed ICP priority areas, namely, frail elderly, diabetes, stroke care and respiratory conditions.[12]
- Historically palliative care services have been mainly available for those with a cancer diagnosis (approximately 25% of all deaths). The Palliative and End of Life Care Strategy, Living Matters, Dying Matters, wants palliative care to be available to all people who need it.
- The quality of life for non-cancer patients in the last year of life is significantly worse than for cancer patients.
- Most people would prefer to die in their own home or nursing home, but in 2011/12 there were nearly 6,000 deaths in acute hospitals.
- Palliative care needs are not identified early enough to allow planning for people to be cared for in their preferred place of care.
- There is a need for improved co-ordination of care around the individual (key worker function) and around service provision.

[12] Please note, any references to ICPs within the Commissioning Objectives for palliative care relate only to the agreed priority areas for ICPs, namely frail elderly, diabetes, stroke care and respiratory conditions.

Palliative Care

	Timescale for achievement			*Strategic Driver/ Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts should ensure that effective arrangements are in place to engage and promote awareness with the general population and professionals regarding issues around palliative care, dying and service delivery around death.	●	●	●			Regional Palliative & End of Life Strategy, Living Matters, Dying Matters (2010-15)
All Trusts should provide evidence that they are working to increase the quality of life for people in the last year of life by ensuring that palliative care measures run alongside acute intervention for people with cancer, cardiovascular and respiratory disease, dementia, frail elderly and those with a physical disability who are at the end of	●	●	●		Rec 80, 82 & 83	Regional Palliative & End of Life Strategy, Living Matters, Dying Matters (2010-15)

life. This should include: • implementation of the end of life operational systems model • identification, holistic assessment and referral for carers assessment • offering people the opportunity to have an advance care plan developed within 3 months of admission to a nursing home, in the last year of life and for those who have an anticipated deterioration in their condition (e.g. on diagnosis dementia) • people are supported to die in their preferred place of care • use coordinated care planning in the last few months, weeks and days of life						

Trusts and ICPs should have processes in place to ensure that care for individuals identified as being on the possible last year of life is coordinated around the patient and across services and organisational boundaries. This should be supported through continuation of the palliative care coordination posts and should include: • Implementation of the regionally agreed key worker function • The use of multidisciplinary records in the home • Effective out of hours hand over arrangements	●	●	●		Rec 82. 83 & 86	Regional Palliative & End of Life Strategy, Living Matters, Dying Matters (2010-15)
Trusts and ICPs should provide evidence of how they are working with the independent and voluntary sector to ensure that there is an increased provision of *general palliative care* services in the community, supporting patients within their own home and	●	●	●			Regional Palliative & End of Life Strategy, Living Matters, Dying Matters (2010-15)

nursing homes where that is their choice. This should include: • Access to 24 hour care and support • Equipment • Arrangements to support timely hospital discharge • Support to nursing homes to meet the standards being developed in conjunction with RQIA						
Trusts and ICPs should provide evidence of how they are working with the voluntary sector to ensure that there is an increased provision of *specialist palliative care* services in the community, supporting patients dying within their own home and nursing homes where that is their choice. This should include: • Support to generalist palliative care services • Education and training	●	●	●		Rec 81	Regional Palliative & End of Life Strategy, Living Matters, Dying Matters (2010-15)

• Development of community multidisciplinary palliative care teams • Development of new models of palliative care day hospice and outpatient services • Access to face to face specialist advice 7 days a week 9am to 5pm • Trusts & ICPs to work with the commissioners to develop access to telephone advice to professionals 7 days per week until 11pm						
All Trusts and ICPs should provide education and training in communication and end of life care for all staff (e.g. GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers etc)	●	●	●			Regional Palliative & End of Life Strategy, Living Matters, Dying Matters (2010-15)

14. Physical Disability & Sensory Impairment

The changing expectations of people with Physical and Sensory Disabilities will require a fundamental review of traditional models of institutional and day care services and an increased emphasis on giving people more influence and control over their support needs through the promotion of personalised budgets and advocacy.

These objectives can only be achieved in conjunction with increased support options for carers.

Headline Successes 2012/13

- Establishing the structures and work streams for the Physical and Sensory Disability strategy in partnership with the Community and Voluntary sector and users.
- Funding secured to promote both strategies.
- Approval of the e-NISAT business case to commence roll-out of an ICT solution to support professional assessment.
- Joint HSCB/Carer 'Carers' Strategy Implementation Group' (CSIG) established with additional funding allocated for carer support services.
- New Advocacy working group established.
- Safeguarding activity monitoring format agreed and standardised.

Key Challenges 2013/14 and beyond

- Delivery of key actions in the Physical and Sensory Disability and Dementia Strategies within the agreed timeframes.
- Ensuring greater personalisation, choice and improved outcomes through the increased use of Direct Payments, Self-Directed Support.
- Improving support for carers through increased access to carer assessments and respite options.
- Further roll-out of NISAT as the regionally approved assessment tool.
- Strengthening of regional Safeguarding arrangements.
- Improvements in Advocacy services and PPI.

Physical and Sensory Disability

Timescale for achievement				*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
Trusts and HSCB will collaborate in producing a needs analysis of people who are Deafblind to improve assessment and access to services.	●				Rec 28	Disability Strategy
Trusts will participate in a Regional Review of Communication Services in order to improve service access and consistency.	●					
Trusts will pilot at least one programme specific Self Directed Support scheme in order to develop a common approach to the use of personalised budgets and promote learning on a cross programme basis.	●					

Trusts will review their respite capacity by identifying opportunities to reduce reliance on current residential and domiciliary models and developing community-based services offering short break support.	●				Rec 33	Dementia Strategy Physical Disability and Sensory Impairment Strategy
Trusts will work with the Carers Strategy Implementation Group to address the recommendations of the 2012 Self-Audit Update and RQIA Inspection of NISAT Carers Assessments.	●				Rec 31 & 33	Dementia Strategy Physical Disability and Sensory Impairment Strategy

15. Prisoner Health Services

Prisoner Health Services are delivered within three prison establishments and are managed by the South Eastern Health and Social Care Trust. These are;

- HMP Maghaberry, which is a high security prison for adult males (both remand and sentenced).
- HMP YOC Hydebank Wood which provides accommodation for young male offenders. Women prisoners are also accommodated (in Ash House).
- HMP Magilligan which is a medium to low secure prison for sentenced adult males.

There are just over 5,000 committals annually and approximately 1,700 prisoners throughout the prison estate at any time. Prisoners receive a full range of healthcare services. The majority of services provided within the prison are primary care services, complemented by dedicated services for a number of mental health and addiction needs. Access to secondary care services are usually provided in acute hospitals through normal referral processes.

Headline successes from 2012/13

- Completion of an initial healthcare needs assessment across all three prisons.
- Development of personality disorder services.
- The introduction of primary care systems analogous to those delivered in the community.
- The final roll out of EMIS systems across the three prisons.
- Identification of funding for improvements in mental health to children and young people.
- Production of a Health Improvement Strategy.
- The introduction of access for prison healthcare staff to the Northern Ireland Emergency Care System.

Key Challenges for 2013/14 and beyond:

- To further improve health care information, particularly in relation to mental health and learning disability, by repeating the health care needs assessment in late 2013/14.
- Prison populations are rising, placing increasing pressure on health care resources.
- Meeting the healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities.
- Offender's rates of mental ill health are higher than the general population with the offender population having a much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses.
- Prison healthcare systems need to be reviewed and revised to allow for greater integration with community and secondary care services on committal and discharge.
- There is a need to ensure that prisoners' healthcare needs at committal are identified to allow for appropriate action.
- There are issues associated with the misuse of prescribed medicines and the supply of illicit drugs.
- There is a need for improved cooperation between the criminal justice system and Health and Social Care.

Prisoner Health

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
SET to develop staff profiles for each of the main staffing groups including: • Primary Care • Mental Health • Addictions • Women and Young Persons	●	●	●			Prison Ombudsman Reports Owers Review
SET should further develop information systems to help facilitate a whole systems approach to prisoner healthcare to include full and appropriately use of EMIS by all healthcare staff, demonstrating that patient diagnoses are being appropriately coded.	●					Prison Ombudsman Reports Owers Review

SET should continue to progress the development of medical services and chronic disease management in line with the principle of equivalence. This should include: • Production of an annual profile of prisoners by chronic disease category as per Quality and Outcomes Framework (QOF). • Development of registers for individuals with: ➢ Cancer ➢ Obesity ➢ Smoking addiction ➢ Neuroses	●	●	●			Prison Ombudsman Reports Owers Review
	●					
SET should develop care pathways in and out of prison, for prisoners with complex needs including: • Improved information at committal relating to: ➢ Medication needs ➢ Substance abuse ➢ Mental Health	●	●	●			Prison Ombudsman Reports Owers Review

• Discharge plans are in place prior to prisoner release.						
SET should produce annual implementation plans directed toward the full implementation of the Health & Social Well-being Strategy. To include production of evidence based plans for: • Tobacco • Healthy eating and nutrition • Health lifestyles including sexual health • Active living • Drug and other substance misuse	●	●	●			Prison Ombudsman Reports Owers Review
SET should ensure the recruitment of CAMHS and Psychological Therapies posts following additional investment from HSCB in line with IPTs	●					Prison Ombudsman Reports Owers Review
SET should develop Mental Health services for the prison population in accordance with delivering the Bamford	●					

Vision for People with Mental Health and Learning Disability. This should include the introduction of a recovery approach for mental health service provision.						
SET should ensure that prescribing and medicine administration processes comply with national and Local standards to include : • Monitoring and assurance that GP prescribing is in line with accepted regional standards in the community; • A quarterly report of all instances (including reasons) when patients did not get their medications as prescribed and actions taken to improve administration.	● ●					Medicines Formulary Medicines safety
SET should ensure that people with a Learning Disability are identified and their care managed in accordance with	●					

"Equal Lives" to include: • Introduction of Learning Disability Screening tool baseline audit. • Development of an appropriate care pathway.						

16. Screening

Screening is an important public health function that involves inviting members of the public, who have no symptoms of a particular disease, to be tested to see if they might have the disease, or are at risk of getting it. Population screening allows certain diseases and conditions to be identified at an early stage when they are more amenable to treatment. The PHA is the lead organisation for commissioning and for quality assuring population screening programmes.

Headline successes from 2012/13

- Age extension of Bowel Cancer Screening Programme from age 60 – 69 years to include age 70 and 71 from April 2012.
- Abdominal Aortic Aneurysm Screening Programme established from June 2012. This is a screening test for males aged 65 and over.
- Implemented HPV testing within the Cervical Screening Programme from January 2013.
- Established QA structures and monitoring processes for the Newborn Hearing Screening Programme and the Diabetic Retinopathy Screening Programme.

Key challenges for 2013/14 and beyond

- Ensuring screening programmes continue to meet required standards (national and local).
- Maximising the uptake of all screening programmes by improving informed choice and accessibility to screening.
- Reducing inequalities of access to screening by targeting groups that are known to have low uptake e.g. BME, LGBT, travellers etc.
- Updating patient and professional information in accordance with changes to service and the outcomes of national and local reviews.

- Ensuring service capacity to meet screening demand.
- Obtaining approval for capital funding requirements for modernisation of Breast Screening mammography equipment.

Specific Ministerial target to be achieved for screening services in 2013/14

- The HSC will extend the bowel cancer screening programme to invite in 2013/14 50% of all eligible men and women aged 60-71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014.

Screening

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
From April 2014, all Trusts should work with the PHA and the HSCB to increase screening colonoscopy capacity across the region by 25% to facilitate age extension of the bowel cancer screening programme up to 74 years. This should include the provision of at least one more endoscopy unit of JAG standard in Northern Ireland by the end of March 2015 and a further unit by 2015/16.	●	● ●	 ●	✓ Target 1	Rec 3	Programme for Government Bowel Cancer Screening Programme Project Board

All Trusts should deliver a bowel screening service in 2014/15 for the eligible population aged from 60 to 74.	●	●		✓ Target 1		Programme for Government
All Trusts should develop and implement action plans to enhance informed choice for the eligible population for bowel, breast and cervical screening. Work to focus particularly on hard to reach groups to reduce inequalities of access and uptake of cancer screening programmes.	●					PHA Corporate Plan – variation in uptake rates.
PHA, HSCB, Primary Care and BHSCT should work together to ensure robust processes are in place to maintain the screening interval for diabetic retinopathy and to ensure that ICT systems are in place so direct referral of appropriate patients from screening to ophthalmology occurs and the outcome of screening is	●					PHA Corporate Plan

shared with GPs and Diabetologists.						
Trusts who deliver the Breast Screening Programme to implement local action plans, for the replacement of analogue breast imaging equipment with digital equipment to ensure the images taken are stored on NIPACS.	●	●				PHA Corporate Plan
All Trusts to identify all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer. From April 2013, an identified Trust to provide an imaging service for ladies at high risk (x 8) of developing breast cancer in accordance with NHSBSP guidelines	● ●					Target from CMO, DHSSPS & PHA Corporate Plan

17. Specialist Services

Specialist services for acute care include specialist tertiary services delivered through a single provider in Northern Ireland or in Great Britain. High cost specialist drugs also fall within the remit of this branch of commissioning. Due to our small population the more specialist services are becoming increasingly difficult to sustain. Opportunities to link our clinical teams to larger centres in Great Britain and the Republic of Ireland in a network arrangement are essential to supporting the long term sustainability. Services which fall within this branch of commissioning include rare diseases, renal services, genetics, specialised services for children, specialist ophthalmology services; specialist neurology services and cardiac surgery. There are some 30-40 sub specialist or small specialist areas within specialist services. As some of these services evolve they will move to multicentre provision, for example renal dialysis and biologic therapies.

Headline Successes from 2012/13

- Agreed implementation process to expand catheterisation laboratory capacity and establish primary Percutaneous Cardiac Intervention (pPCI) service for Northern Ireland.
- Reduction of maximum waiting times for patients to commence NICE approved specialist therapies for the treatment of severe arthritis.
- Involvement of a range of user / carer groups in the planning and delivery of specialist services such as renal services, rare diseases and irritable bowel disease.
- Investment in a range of specialist services such as neurosurgery, neurophysiology and paediatric rheumatology to ensure that waiting times are in line with agreed standards.
- Recruitment of senior clinical staff to consolidate the live donor transplant service.
- Provision of a bi-lateral cochlear implant service.
- Established a robust process for the receipt and approval of extra contractual referrals (ECRs) and individual funding requests (IFRs).

- Agreed investment to support infectious disease services.

Key Challenges for 2013/14 and beyond

Specialist Paediatrics

Following the publication of the Review of Paediatric Congenital Cardiac Services provided by the Belfast Trust, in August 2012, the DHSSPSNI wrote to the HSCB asking that a Paediatric Congenital Cardiac Services (PCCS) Working Group be established to:

- Develop a detailed service specification for commissioning Paediatric Cardiac Surgery and Interventional Cardiology;
- Establish clear criteria (with agreed rational for inclusion and weighting and scoring) against which the service for children from Northern Ireland should be assessed
- Set out the implications of the criteria on potential service model options including an all-Ireland model.

A consultation document incorporating each of the above strands was agreed and approved by the Minister on 25 September 2012, for a 12 week period of consultation. This concluded on 21 December 2012

The Working Group will consider the responses to consultation and agree the final post consultation document for submission to the HSCB and the Minister in February 2013.

Separately, but in parallel with the PCCS process, the DHSSPSNI also asked HSCB to undertake a robust analysis of current transport arrangements for children particularly in emergency situations. Subject to approval by the HSCB, it is anticipated that current emergency transport arrangements for children will be enhanced during 2013/14.

Other challenges within specialist paediatrics include:

- Implementing clinical network arrangements for specialist paediatric services within Northern Ireland and between Northern Ireland and Great Britain / Republic of Ireland.
- Establishing additional capacity for paediatric intensive care in line with projected demand.
- Putting in place arrangements to ensure the timely diagnosis of hip dysplasia.

Specialist Drug Therapies

- Maintenance of waiting times and achievement of targets for specialist drug therapies – rheumatoid arthritis, psoriatic arthritis, anklylosing spondylitis, psoriasis, IBD and multiple sclerosis.
- Ensuring timely access to new specialist drug regimes.

Renal Services

- Continuing to provide at least 50 live donor transplants per annum.
- Contribute to the Minister's proposed consultation on attitudes on an opt-out system for organ donation. Increasing the number of kidneys retrieved and transplanted in Northern Ireland that are kidneys donated after circulatory death (DCD).
- Increasing the use of peritoneal dialysis / home haemodialysis during 2013/14 and beyond.

Specialist Ophthalmology Services

- Ensuring timely access to treatment for wet age related macular degeneration and establishing services to support the introduction of new drug therapies for the treatment of retinal vein occlusion and diabetic macular oedema.

Primary Percutaneous Cardiac Intervention (pPCI)

- Securing the provision of pPCI services to meet projected demand.

Rare Diseases

- Working with the NI Rare Disease Partnership in the planning and delivery of services for people with rare diseases.

Elective Investment in Specialist Services

- Ensuring delivery of additional infrastructure and activity associated elective investments in specialist services to support the delivery of targets and ensure the effective management of emergency and elective care in line with the principles of the Confidential Enquiry into Perioperative Deaths – neurosurgery, neurophysiology, immunology, thoracic medicine, thoracic surgery, paediatric rheumatology, cochlear implants, infectious diseases.

Specific Ministerial targets to be achieved for specialist services in 2013/14 are:

- By March 2014, 30% of kidneys retrieved in Northern Ireland through DCD are transplanted in Northern Ireland.
- From April 2013, no patient should wait longer than 3 months to commence NICE approved therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis, and no patient should wait longer than 9 months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013.

Specialist Services

Timescale for achievement				*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial Targets**	**TYC**	**Other**
A 24/7 primary Percutaneous Cardiac Intervention (pPCI) services should be established (networked with NIAS and across Trusts) for Northern Ireland Scheduled cardiac catheterisation laboratory capacity should increase in NI to circa 105 per week (to include extended day and weekend working) by September 2013 to improve access to diagnostic intervention and treatment as required.	●				Rec 89	Programme for Government Clinical Engagement Activity predicted in the NI Stocktake National estimates used by DOH Demand as seen from

						Belfast pilot, uplifting activity in BHSCT residents for NI.
Belfast Trust should ensure that by March 2014, 30% of kidneys retrieved in all Trusts in Northern Ireland through Donation after Cardiac Death are transplanted in Northern Ireland; and, continue to ensure the delivery of a minimum of 50 live donor transplants	●			✓ Target 11		Clinical Engagement PPI 2008 DHSSPS Update of Renal Review DHSSPS 2011 Current Activity and Future Prediction of Need for Renal Replacement Therapy in NI

Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access specialist ophthalmology regimes, such as Wet AMD within a maximum of 9 weeks.	●					Clinical engagements Equity of access
All Trusts should pilot the regionally agreed patient journey for Duchenne Muscular Dystrophy.	● Pilot complete	● Evaluate and extend to other conditions				PPI Minister's response to the McCollum Report
Belfast Trust should: • Progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast Hospital for Sick Children Network plan. • Put in place additional capacity of 4 paediatric intensive care beds in line	●				Rec 45 & 89	Demand / capacity analysis PCCS review RQIA Pseudomonas Review DHSSPS

with projected demand expand specialist children's transport and retrieval services to support an increase in hours of cover.						Review of Paediatrics 2012
Belfast Trust will lead on the development and establishment of a specialist service model in line with the Strategic Framework for Intestinal Failure and Home Parenteral Nutritional Services for Adults.	● Model agreed	● Implemented				National strategy Clinical Engagement
All Trusts should ensure that patients commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and multiple sclerosis in line with the Commissioning Plan Direction.	●			✓ Target 12		NICE PfG commitment 79 Needs assessment based in NICE costing templates Clinical engagement

18. Unscheduled Care

In the past three years, demand for unscheduled care in acute hospitals has grown with the exception of a small fall in attendances at Emergency Departments (ED) - a reduction of 0.6% in 2011/12 compared with 2009/10. Of almost 689,000 new and unplanned review attendances, 80% were seen within 4 hours (a reduction from 84% achieved in 2009/10) and over 10,000 patients waited longer than 12 hours to be admitted or discharged – more than double the figure of 2009/10.

Non-elective admissions, through an ED or an assessment unit, rose by 5.1% in the three years. Operations due to fractures rose by 5.5% with 81% of the patients treated within 48 hours, an improvement of 5% on 2009/10.

Ambulance services have seen an overall rise in emergency calls with category A calls ('life-threatening') rising by 7.8% last year compared with 2009/10.

Headline successes from 2012/13

- The HSCB has extended the role of GPs in the management of long-term conditions. For example, the introduction of Advanced Care Plans and a review of Emergency Department attendances data to reduce unnecessary admissions..
- The HSCB is working with NIAS to introduce alternatives to hospital transfer through paramedic treatment at the scene and, in due course, will seek to refer patients to community services where attendance at an emergency department would not add value to the patient outcomes.
- The HSCB and Agency have supported improvements in EDs and inpatient flow mechanisms on acute sites which have resulted in falls in 12 hour ED breaches, particularly in BHSCT.
- Consultant staffing levels in EDs in NI have been increased to achieve extended evening and weekend on-site availability of senior decision-makers.
- Medical assessment units are becoming a common feature at acute hospitals across NI, including those recently established at Belfast City

Hospital and Antrim Area Hospital. These allow GP direct access to avoid unnecessary emergency department attendances. The units are proving successful and will be promoted on other sites which do not have this service at present.

- The numbers of patients spending very long periods in hospital (over 20 days) have reduced as a result of more rapid access to approved specialist therapies. This increases bed capacity for new admissions.
- The HSCB has confirmed its intention to increase weekly cardiac catheterisation capacity from 78 to 93 sessions per week in early 2013 and to introduce a 24/7 primary percutaneous coronary intervention service for Northern Ireland by September 2013, saving lives and improving patient outcomes.
- While regionally demand for fracture services has not increased, at a local level performance against 48 hour target for hip fracture continues to be a particular challenge. Regionally during October, 90% of patients, where clinically appropriate, received inpatient treatment for hip fractures within 48 hours. To help quantify the local capacity requirements the HSCB has recently completed a regional capacity and demand exercise. This work has helped identify the mismatch of demand and capacity on a daily/weekly basis.
- In relation to the South Eastern Trust, the HSCB has agreed to support an additional theatre session at the Ulster and the Trust intends to transfer a session from the Downe Hospital to enhance performance across the week. Discussions are also ongoing in respect of the repatriation of fracture work from Belfast to the Southern Trust which may provide opportunities in the future for additional fracture capacity for the greater Belfast area. Given these actions, and delivery of the additional sessions at the Ulster at critical points in the week, an improvement in performance is anticipated.

Key challenges for 2013/14 and beyond

As outlined above, good progress has been made in 2013/14 to improve ED performance in terms of the number of 12-hour breaches. However significant challenges remain and in 2013/14 there will be a need for an increasing focus on 4-hour performance.

The HSCB's Integrated Access Group (IAG) continues to work with Trusts to better understand their systems and processes and to determine how these can be restructured to improve performance against both the 12-hour and 4-hour performance standards. Through this work it has become evident that not all patients attending/being brought to Emergency Department (ED) require this level of care, but due to the lack of ready alternatives / infrastructure, and historical protocols, they have little alternative.

The ED needs to be viewed as one component part of the Unscheduled pathway with General Practitioners including Out of Hours, NIAS, Community Teams and Minor injury Units playing a more active role. Utilisation and reform of these services will assist the HSCB to build necessary infrastructure to facilitate TYC and help avoid hospital or ED attendance in the first instance. Accessibility, including time of day and days of week for such services will need to be redesigned to ensure that there are viable alternatives to attending Emergency Departments, not only for the public themselves but also for Northern Ireland Ambulance Service.

During 2013/14 and beyond the HSCB will work with Trusts to implement a series of actions which will better align HSC capacity with patient needs for urgent and emergency care. Specifically, the following action will be taken:

- The HSCB will agree robust capacity volumes with each Trust in relation to both ED attendances and emergency admissions.
- The HSCB will introduce population zoning to ensure an equitable spread of population demand for urgent and emergency services, linked to individual site and Trust capacity.

- The HSCB will further develop arrangements to prevent unnecessary attendance and ED's and admission to hospital beds through improved management of long term conditions in primary care, an extended ambulance paramedic role to treat patients at the scene without the need for transport to hospital, and greater acute care at home.
- Patients will spend the optimum time necessary to receive hospital treatment and will be discharged with support to return to a high degree of independence with appropriate wrap-around support.

Specific Ministerial targets to be achieved for unscheduled care services in 2013/14 are:

- From April 2013, 95% of patients attending any Type 1, 2 or 3 A&E Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department, and no patients attending any emergency department should wait longer than 12 hours.
- By March 2014, secure a 10% reduction in the number of emergency readmissions within 30 days.[13]

[13] Achievement of this target will require input from a range of Directorates, service areas and teams including Long term Conditions and Integrated Care.

Unscheduled Care

	Timescale for achievement			*Strategic Driver/Needs Assessment*		
Commissioning Objectives	**2013/14**	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
By September 2013, the Ambulance Service will, in collaboration with primary and secondary care clinicians, develop and implement agreed protocols to enable paramedics to assess and treat patients at the scene (including home) without transporting them to hospital, where appropriate.	●	.			Rec 74 &93	

By December 2013, Trusts will agree clear protocols on the management of major trauma patients and further develop collaboratively these as necessary towards establishing a Trauma Managed Clinical Network[14].	●				Rec 72 & 74	
By December 2013, Trusts, working in partnership with ICPs, will ensure that effective arrangements are in place to prevent unnecessary attendances at Emergency Departments including: • Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage;	●			✓ Target 5	Rec 74 & 93	

[14] Further discussion required between Commissioner and DHSS&PS with regard to funding for a Network.

• GP direct access to appropriate diagnostics to enhance management of conditions in Primary Care; and • rapid outpatient assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion between GP and senior hospital doctor and agreed decision on steps to take in patient management.						
During 2013/14, all Trusts to confirm that the necessary components are in place to deliver 7-day working on acute sites including access to radiology, pharmacy, and senior medical decision-makers with closer liaison with district/community nursing, AHPs and social care in order to prevent an unnecessary emergency admission through appropriate patient handover and earlier discharge.	●					

By June 2013, all Trusts and LCGs will have jointly, identified, quantified and agreed the necessary community services required to ensure that Length of Stay (LOS) within hospitals, acute care at home and post-acute care are optimised. Integral to this will be the development, collaboratively among Trusts (including NIAS), by March 2014, of a directory of community services to support timely discharge of patients as well as prevent emergency attendances/admissions.	●					
From April 2013, all HSC Trusts, including the Ambulance Service, will maximise emergency ambulance capacity through minimising ambulance turnaround times (15 minutes for ED handover and 15 minutes ambulance turn around unless deep clean of vehicle required) .	●					

19. Integrated Care

Introduction

The Directorate of Integrated Care oversees family practitioner services to include: GP practice services, dental services (hospital and community), pharmacy services and optometry services. The Directorate of Integrated Care also oversees the development of the primary care infrastructure. The information below outlines the commissioning intentions for 2013/14 across each of these areas.

(1) General Practice

The key development within general practice in 2013/14 will be the development of the Integrated Care Partnership.

The nature and purpose of ICP's and their role within shift left is outlined in greater detail in section 2.4.

(2) Dental

New Dental Contracts

The oral surgery pilot will commence on 1st April 2013 and will take place in the Southern LCG area. Following a successful tender exercise, the HSCB has secured the services of a Referral Management Centre (RMC) for the pilot. Referring practitioners will submit a pro forma for each patient they wish to refer to specialist oral surgery services along with radiographs. HSCB has put in place arrangements to allow these referrals to be sent electronically as well as by hard copy. The RMC will then use the information provided to determine whether the patient is most appropriately treated in primary or secondary care. The pilot will run for a 6 month period and will be accompanied by an extensive evaluation exercise.

A different approach is being adopted for the new orthodontic contract; it is being implemented through a series of incremental changes to the current contract. The most significant of these is the introduction of an orthodontic needs

index which sets the threshold for entitlement to Health Service orthodontic care. Bringing in a needs index requires regulatory change and so DHSSPS are required to undertake a consultation exercise. The Department intend to have this completed so that the needs index can be introduced from 1st April 2013.

Hospital Dental Services

The completion of the demand-capacity project for all hospital dental specialisms has allowed HSCB to identify gaps in Trust dental service provision. The greatest concerns remain to be in the areas of oral medicine and oral surgery. The HSCB is finalising referral criteria and referral pathways for oral medicine and oral surgery with the hope of having these fully implemented by 1st April 2013. These criteria will make optimum use of the high street oral surgery specialists within the limits of the current contractual arrangements. Additionally, they will allow HSCB to channel patients requiring Trust based oral surgery services to providers such that numbers of referrals are matched to Trust capacity as closely as possible.

(3) Pharmacy

Pharmaceutical services are delivered across the HSC by a range of providers, the biggest group of which is community pharmacy with over 530 pharmacies across NI. The vision for community pharmacy services is to integrate and apply clinically focussed activity further which utilises the skills of community pharmacists to improve outcomes for patients. Over the past few years, pharmacy has been recognised as being important in providing tremendous access for the public to health improvement activities e.g. community pharmacy is now the biggest provider of specialist smoking cessation within the HSC.

Throughout 12/13, there has been ongoing negotiation to build additional services through community pharmacy and in 13/14, it is anticipated a number of developments will be realised. These will be commissioned to deliver against the need for safe, effective and efficient use of medicines as well as utilising the access and community capital inherent through the community pharmacy network through health improvement activities. New services will build on

developments such as the Pharmacy Intervention Service and additional therapy areas within the Minor Ailments Service.

Specifically, targeted Medicines Use Reviews for two areas - Respiratory and New Medicines - will be commissioned across all pharmacies which will improve outcomes for patients. There will also be co-ordination of health improvement activities through the introduction of a Health Promoting Pharmacy service.

(4) Optometry

Within the context of TYC, new commissioning objectives for Optometry services will be set to secure integration between primary and secondary care, and within an overall regional Ophthalmology Plan. The publication of "*Developing Eyecare Partnerships (DEP): Improving the Commissioning and Provision of Eyecare Services in Northern Ireland* (DHSSPS 2012) offers a platform around which such commissioning will be delivered.

Glaucoma Demand Management

A new model of delivery for glaucoma services will improve the quality of the service, streamline the patient journey and make best use of the available skills mix. High street optometrists will be commissioned to undertake referral refinement for glaucoma and ocular hypertension, in line with NICE guidelines. This will reduce false positives and refer only those patients who require evaluation, monitoring and treatment.

Diagnosis and Management of Acute Eye Conditions

In line with Objective 9 of *DEP,* a regional Primary Eyecare Acute Referral Scheme (PEARS) will be commissioned, subject to successful piloting. Non-sight-threatening conditions which may be safely managed in primary care (by optometrist, GP or pharmacist) have been identified, with each professional group assessing their competencies as to which conditions they might treat. In 2013/14, the HSCB will seek to promote optometrist independent prescribing (Objective 10, *DEP).*

Cataract

In addition to glaucoma, other major eye conditions will be evaluated for suitability for regional care pathway management (Objective 6, *DEP)*. Cataract-only referral protocols will be introduced, ensuring that patients present only when a cataract has a detrimental effect on quality of life or patient safety, and when the patient is willing to undergo surgical intervention.

(5) Primary Care Infrastructure Development

The Primary Care Infrastructure Development (PCID) Programme was established in October 2011 to facilitate investment in the primary and community care infrastructure. It is part of a strategy for improving the overall health and well-being of the community and for improving the delivery of integrated primary, community and secondary care services.

Analysis of existing primary care infrastructure has shown the need for significant investment in facilities, many of which are no longer fit for purpose. Investment in the primary care infrastructure will support the direction of travel as set out in the "*Transforming Your Care*" report of December 2011, which proposes the delivery of services closer to people's homes and in the community, where appropriate.

A service model has been agreed for the PCID Programme, based upon a hub and spoke approach, with a number of hubs providing core services for its range of spokes. Each spoke will have a defined level of services and will draw on the services of the hub as required. This hub and spoke approach will be implemented across Northern Ireland.

The service model will incorporate the co-location of GP and Trust-led primary care services, the availability of diagnostics (x-ray, ultrasound and point-of-care testing), public health and disease prevention services, and complementary community care services. The service model is intended to provide a basis for Trusts and Local Commissioning Groups (LCGs) to structure the local delivery of

services to reflect the requirements of each area's hubs/spokes and which best meet the needs of the population. The details of the model will vary in each area, depending on how the existing infrastructure and service model can be augmented.

Two 'Pathfinder' hub developments will be fast-tracked in Lisburn and Newry. Outline Business Cases for both of these schemes have been drafted for consideration. It is anticipated that the developments will commence in 2013/14. The learning from these Pathfinders will be considered during the implementation of the PCID Programme across the region.

5.0 Opportunities & Enablers

There are a range of areas and issues which create opportunities for us to improve how we deliver services to the benefit of service users and carers.

5.1 Cross-Sector Collaboration

The pressures and evolving nature of our HSC system mean that we must seek to continually challenge and improve our ways of working. Effective partnership working has always been a critical part of effective commissioning, but never more so than now, as we plan and implement the recommendations arising from *Transforming Your Care.* The development of more responsive and innovative models of care, closer to people's homes requires effective collaboration across statutory, independent and voluntary and community practitioners and organisations. ICPs provide a valuable mechanism for this cross sector and cross care settings collaboration and innovation to take place. The HSCB and PHA are committed to reflecting this same approach in relation to the commissioning of services.

5.2 Patient & Public Involvement

The HSCB and PHA recognise that Personal and Public Involvement (PPI) is core to the effective and efficient commissioning, design, delivery and evaluation of Health and Social Care services. PPI 'means discussing with those who use our services and the public: their ideas, your plans; their experiences, your experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services (Valuing People, Valuing their Participation, Circular HSC (SQSD) 29/07).

The legislative requirements for Health and Social Care organisations in regard to PPI are outlined within the HSC (Reform) NI Act 2009. Departmental Guidance issued in 2007 and further updated in 2012, details the value and benefits to be accrued from effective PPI, and outlines roles and responsibilities of Health and Social Care organisations in this regard. The concept of Involvement is also regarded as a Ministerial Priority.

As Commissioners, we are committed to embedding PPI into our culture and practice. To this end, all commissioning service teams and Local Commissioning Groups actively consider PPI in all aspects of their work, from ensuring that feedback from service users and carers underpins the identification of their commissioning priorities, to involving patients in the development of service models and service planning, and in the evaluation and monitoring of service changes or improvements. There are many examples of good practice:-

- Involvement of service users to discuss public consultation documents on the Strategic Direction of GP Out of Hours services;
- Completion of a regional audit of over six hundred service user's and carer's experience of mental health services using the Sensemaker tool;
- Patient engagement undertaken in relation to the provision of general medical services to patients of a rural practice;
- Engagement with parents/carers/service users in respect of the Regional Acquired Brain Injury project work;
- Engagement with service users and carers regarding the modernisation of Glaucoma Services;
- Type 2 Diabetes pathfinder – gaining users perspectives of diabetic services from 'at risk' communities;

However, we also acknowledge that there are still areas where we can strengthen what we do. In this context the PHA and HSCB are currently implementing a joint PPI Strategy (produced in 2012). Complementary action plans have been developed and are being finalised and put into practice, with opportunities for joint working between the two organisations being identified and taken forward.

<u>Increasing our capacity to engage with patients and the public</u>

The PHA and HSCB have funded a number of PPI based training initiatives for staff and service users in 2012/13 on a pilot basis. In addition, service users and carers were proactively involved in developing a specification for the design and development of a generic PPI training programme for the wider HSC. The PHA will take the lead in commissioning this programme moving forward with the active involvement of services users and carers.

Funding of over £100,000 has been committed in the last year to pilot projects to advance and promote PPI across the HSC. After evaluation, best practice will be identified and shared across the HSC, with a view to embedding it into normal culture and practice.

The planned development of guidance for staff on service user involvement and participation will further strengthen the HSCB's and PHA's capacity to effectively and meaningfully engage with service users, carers and key stakeholders.

Involving service users and carers in monitoring and evaluation

The PHA and HSCB are working collaboratively to enhance PPI specifically in relation to monitoring and evaluation of our services. In addition, mechanisms are being developed to capture outcomes from PPI including what difference has been made by engaging directly with service users, carers and key stakeholders, and to learn from these experiences and examples.

We will also continue to work with service users and carers in the development and operation of performance management arrangements which look at how well we are discharging our responsibilities in relation to PPI.

We will continue to work collectively across related areas such as patient experience, safety, advocacy, complaints and community development and in partnership with other HSC organisations including the PCC, to share learning and insights, to improve processes and systems including monitoring, evaluation and most importantly to improve outcomes for service users and carers.

5.3 Clinical Engagement

The ability to influence, manage and drive change in health care to achieve improved health outcomes is central to the transformational change envisaged in TYC. Change is a constant in today's unpredictable and dynamic health care work environment and the barriers to implementation of health service change can at times seem too great to overcome.

Many clinicians have shown innovation and a desire to make a difference to take up the challenge. Some, however, have often felt isolated in this endeavour indicating that motivating others to join them can be a lonely journey. HSCB would envisage the development of clinical networking through ICPs as a real opportunity for these inspirational leaders to grow and support each other. ICPs, through the united goal of improving health outcomes through evidence informed approaches to care delivery will facilitate and nurture this engagement. The ICP focus on Inclusive opportunities for leadership will provide corresponding opportunities for exploring different approaches to evidence utilisation at the point-of-care and promoting and fostering leadership skills in all settings.

5.4 Information & Communication Technologies

Information and Communication Technology is now a key enabler in most modern businesses. The Health and Social Care organisations in N. Ireland have made considerable progress over the past few years in harnessing the power and benefits of modern ICT but there is still much more scope for using ICT to enable more effective and more efficient ways of delivering and managing the services that the HSC provides.

The 'shift left' required for the successful implementation of the recommendations contained in the Transforming Your Care report depend heavily on the availability of relevant ICT systems and services in order to improve the sharing of records and to provide new and faster means of communication.

ICT is already deployed or deployment is in progress in many of the areas that are changing in line with the TYC recommendations.

In 2013/2014 the approach will continue to be pragmatic, building on what exists where this is possible and sensible, and strengthening the focus on adopting common solutions across the HSC where new systems or services need to be procured. Maintaining existing systems will continue to have a high priority and will continue to consume the lion's share of the revenue budgets.

As the details of the additional requirements for TYC clarify, these requirements will be prioritised within the ICT Programme Implementation plan.

Electronic Care Record

Over the next year the Electronic Care Record will be implemented in all Trusts and clinical staff will be encouraged to use this new system to streamline and improve their care processes. The ECR will allow all authorised health and social care staff convenient access to a common patient record including details of the patient's conditions, their medication, tests results and treatments. This will mean that any patient will be able to attend any facility across Northern Ireland and the health records and information will be accessible. This will make it quicker for health professionals to get important information to the HSC staff treating patients, including in an emergency. When the first phase of the ECR is rolled out, the ECR Clinical Content Group will prioritise data from other systems, including summary Community Information System data, for inclusion in the ECR. The improved flow of clinical information across the health system will support improved safety and timeliness of care. The ECR will also be available to clinicians working in the newly formed Integrated Care Partnerships.

New technologies will be funded to improve Bed Management and Patient flow in Trusts. Improved patient flow will help reduce the pressures on Trust Emergency Departments. ICT initiatives will also be progressed in Cardiology, Northern Ireland Single Assessment Tool (NISAT), Out of Hours and End of Life care. Work is also ongoing to reduce paper with the introduction of Electronic Document Management solutions and the use of portable handheld computing.

As part of the regional Medicines Management initiative, a new project will be launched to introduce ICT support for electronic prescribing and drugs administration in hospitals, and work will commence on providing new technology to improve the effectiveness of prescribing in General Practice. The RISOH project is progressing a business case to procure and implement a HSC wide Oncology and Haematology system encompassing electronic prescribing for

cancer services. In addition, the N. Ireland formulary will be made available on an internet website. All of this will support safer and more effective prescribing.

A robust community information system is required to support the increase in care to be delivered in the community, supporting the ability of staff to work as an effective, integrated, multidisciplinary team. The implementation of Community Information Systems (CIS) will continue with BHSCT implementing PARIS, the SHSCT also implementing PARIS, and the WHSCT progressing their CIS business case through DHSSPS and Department of Finance and Personnel. The implementation of these systems is rapidly bringing to the fore the issue of 'fit for purpose' mobile access to patient/client information and work is in progress to review the ICT Security policy and to agree common mobile ICT platforms. The review of the ICT Security policy will also take into account the need to enable secure access to internet services e.g. Skype, Dropbox, Social Media, and Cloud based services. Mobile working by community staff will be important in delivering the "shift left" agenda and will allow better use of staff resources.

Electronic Care Communications

HSCB, PHA and PCC will work with Trusts and primary care to develop an HSC and Web Portal to provide an HSC-equivalent of the NHS Choices website for England. The Web Portal will provide comprehensive information on symptoms, possible diagnoses, investigations, treatment and services. It will enable people to self-treat minor conditions and manage long term conditions more effectively.

The HSCB and BSO will continue to work with GP practices and other practitioners to increase the use the electronic referrals system and will develop the capability of this system to support electronic requests for advice. Electronic referrals will allow more rapid referral, while use of referral templates which embed best practice guidelines will support more appropriate referrals.

The Primary Care ICT network will be replaced by a higher bandwidth network that will enable the use of technologies such as video conferencing. Several pathfinder projects are planned over the next year to explore the potential of this

technology in improving processes and providing enhanced services to patients, moving care closer to the patient. There is also a requirement to provide secure access to the HSC Network for Community Pharmacists. Over the next year, work will commence on a business case for this development and funding will be sought to fund the recurring revenue requirements of this development.

The DQiP project is addressing the issues around access to data held in GP systems and the HSCB/PHA has recently appointed a Clinical Informatics Specialist who will help set the agenda for improvements in Health Informatics. The Data Warehouse will continue to be developed in line with the priorities set by the Regional Information Group (RIG).

A number of new procurement projects are already in progress addressing the replacement of the Health+Care Number index, the replacement of the GP network, and the replacement of the Technology Partner Agreement. Trusts are represented on the project boards for all of these projects.

5.5 Innovation & Connected Health

As part of the patient centred vision for the transformation of the HSC system as outlined in Transforming Your Care there is an increased focus on Integrated Care supported not only by an innovative ECR but also by the further application of connected health. Policy includes the promotion and securing of community alternatives to hospital referral and admission, the introduction of innovative approaches to better manage demand and better use of ICT, combined with reform of the care delivery system.

Innovation and Connected Health have an integral part to play in this that is wider than the Telemonitoring NI service and reaches across all of Health and Social Care. They also have a key part to play a wider economic agenda ,the Regional Economic Strategy also includes a key focus on healthcare innovation as stated by the Memorandum of Understanding between DHSSPS and DETI.

The development of a connected health & social care strategy

The PHA, HSCB DHSSPS will work to develop a connected health & social care strategy which will set out a vision for the development of connected health and social care services, suggest priorities for development, and outline the issues which will need to be addressed to enable the implementation of a strategic approach towards the adoption of technological advancements. Its purpose will be to prompt debate on the strategic direction for the development of connected health and social care services.

Progressing the Implementation Plan arising from the Memorandum of Understanding agreed between DHSSPS & DETI

The Connected Health MoU has four key priority areas:

- Priority Area 1 - Targeted Connected Health R&D and innovation funding, including optimising assets across the various organisations;
- Priority Area 2 – The development of the NI Connected Health Eco System, along with international linkages
- Priority Area 3 - Collaboration with international regions, particularly within Europe and North America, for mutual gain
- Priority Area 4 – Promoting the Connected Health agenda internationally, particularly within Europe and North America

The HSCB and the PHA will work with the DHSSPS and DETI to progress the implementation plan of the Memorandum of Understanding.

European Innovation Partnership for Active & Healthy Ageing

The EIP AHA's aim is to tackle innovation barriers for major societal challenges by encouraging European collaboration in and across the fields of research/innovation, health and ICT. It aims to identify and remove persistent barriers to innovation across the health and care delivery chain. The target is to increase the average number of healthy life years by 2 and reinforce sustainability and efficiency within healthcare systems across Europe. Northern Ireland is inputting to the EIP in a number of ways:

- DHSS&PS Reference Site application
- Commitment to specific actions
  - Medicines Adherence Programme (HSCB)
  - Therapy through video-conferencing (PHA)
  - Connecting nutrition research evidence to older people's meals (DHSSPS)
  - Piloting integrated care services for the elderly (HSCB)
  - Telemonitoring NI (PHA)
  - Telecare and use of assistive technology (PHA)
- Membership of Action Groups

The HSCB and the PHA will work with the DHSSPS to take forward Northern Ireland's input to the EIP.

The development of Telemonitoring NI

Work is underway on a road mapping exercise for Telemonitoring NI service with all stakeholders. This is to identify areas for improvement and expansion of the service in the foreseeable future. There is scope for the service to broaden out from the four long-term conditions (COPD, CHF, Diabetes and post-stroke) that are currently supported. The service has the potential to be used to monitor other conditions such as hypertension, for weight management and for renal patients and work is ongoing to increase this flexibility. Work is underway to enable integration of Telemonitoring NI with the ECR to improve information flows for clinicians, leading to better patient care.

The service will be used to provide and support Telecare across all Trusts from 2013-14 in support of a new Commissioning Plan target, seeking to offer the service to learning and physical disability, sensory impairment, frail elderly, dementia and mental health clients.

Initiatives arising from the Implementing Transnational Telemedicine at Scale (ITTS) programme being pursued by CCHSC

The ITTS project is working to implement transnational telemedicine solutions, at scale, across the Northern Periphery region of the EU. Partners are Scottish Centre for Rural Health, Norwegian Centre for Integrated Care and Telemedicine, County Council of Vasterbotten (Sweden), Oulu Arc Subregion (Finland), National University of Ireland (Galway) and NI Centre for Connected Health and Social Care (PHA).

The aim of the project is to improve accessibility, situating services in local communities or in patients' homes, normalise the use of technology into everyday practice and foster transnational knowledge exchange. The partners are working on, and sharing, innovative health service solutions on the themes of video-consultation, mobile self-management & home-based health services. This is an opportunity for partners to implement services that have been tried successfully elsewhere, accessing expertise and sharing knowledge. Elements such as mobile health and video-conferencing have the capacity to enable the shift left agenda towards integrated care and care closer to home as envisaged in Transforming Your Care.

5.6 Finance and workforce planning

The *Transforming Your Care* (TYC) programme proposes that finance and workforce planning enabler work streams be established to promote and support the transformational change necessary to implement TYC.

There is an acknowledgement that in order to deliver the planned changes outlined in TYC, resources will be required to pump prime the reforms and allow a system of dual running to operate for a short period of time (1-2 years). In the current Budget 10 period (2012-15) a total of £111m is required as follows:

- 2012/13 £19m
- 2013/14 £35m
- 2014/15 £57m

Should additional funding be secured in 2013/14 it will be necessary to ensure the approvals to spend are secured in a timely manner and the spending plans will need to be in place before the start of 2013/14. This will be dependent on the proposals being sufficiently developed by the start of 2013/14 to allow front line changes to commence.

The implications of the HSC not securing additional funding to support the delivery of the TYC objectives, but still proceeding with the reforms is that it may take longer to implement them, they may not all be able to be taken forward and/or existing financial plans/services may have to be scaled back in order to divert funds to afford the TYC reforms.

The HSC has a highly skilled and dedicated workforce. A change in the model of care delivered by hospitals and the need to deliver more services in the community and at home, will impact on the type of workforce that we will require to deliver the service. Effective workforce planning and development is a critical building block in ensuring that staff are appropriately trained and confident in their new and evolving roles.

The workforce enabler workstream seeks to ensure that we do just that. The first strand provides external support to produce work force capacity and planning data to determine how many staff are required in the hospital, community, personal social services or primary care sectors in the future. Additionally it will deliver an analysis of what the skills mix should be in the future and information on the phasing of the transfers. HSCB will work with Trusts to undertake detailed planning and modelling around current and future service models and workforce to ensure that information is fed into workforce planning. Moving forward workforce both in terms of capacity and capability will be critical to delivery of TYC recommendations and will be taken account of when planning any service changes.

The second strand will also aim to re-skill employees who will transfer from a hospital setting to work in a community or primary care based one, with work commencing in 2013/14.

The third strand of the workforce enabler is the provision of financial support to facilitate staff exiting the service, where this is appropriate, under the Voluntary Redundancy/Voluntary Early Retirement schemes.

Finally, DHSSPS advise there are constraints on the level of capital funding available over the Investment Strategy Northern Ireland period (ISNI) to 2011/21. The implications of this are that prioritization of certain capital schemes may be required. The degree to which revenue based solutions (e.g. Public Private Partnerships and Third Party Developments) will be available to supplement capital funding is, at this stage, unknown. Further work is required to understand the implications of this on the delivery of TYC.

5.7 Equality, Good Relations and Human Rights

Promoting equality and equity are at the heart of the HSCB's and PHA's values – ensuring that both organisations exercise fairness in all that they do and that no community or group is left behind in the improvements that will be made to health outcomes across Northern Ireland.

We recognise that to deliver equality we need to understand diversity and that diversity exists even within and between equality groups. We believe that it is important that decisions are informed by human rights standards and principles with attention to those areas of commissioning that have a higher risk of raising human rights issues such as older people, mental health and children.

To support this work the HSCB/PHA has published our Equality Scheme and our Audit of Inequalities Action Plan, both of which are intended to promote and disseminate an understanding of what we need to do corporately and as a commissioning organisation to better address inequalities in outcomes and access to services.

One of the key priorities identified within our action plan is the need to improve the information that we collect on service use and outcomes. Information on service need and outcomes, together with demographic information, underpins the identification of our commissioning priorities. Unfortunately, information is

not routinely collected in relation to a number of the equality groups (for example, information about sexual orientation, political views and religion are rarely collected in a health setting) so it can be difficult to establish the needs of these groups through quantitative information sources.

As an organisation the HSCB is currently undertaking an audit of any information systems that include patient information to ascertain what information is recorded in relation to the 9 equality groups. The second phase of the audit, to be completed in 2013/14, will involve us looking across these information systems with a view to improving recording where equality fields exist, but are not currently being completed, and by seeking to include additional equality information fields where we feel it is likely to inform commissioning.

One of the other ways we can seek to enhance the impact of our commissioning on vulnerable people and communities, including those living in disadvantaged areas and population groups who require additional or more specific support such as Travellers, migrants, Lesbian, Gay, Bisexual and Transgender (LGBT), Looked After Children, those with Disability, and Homeless people, is by engaging and promoting supportive and sustainable communities. The health promotion and prevention approach utilised by the PHA is underpinned partnership models which include the active engagement of those most affected alongside other agencies that can influence the determinants of health. Similarly, LCGs, seek to engage directly with communities in the identification of their health needs, working in partnership with the community to address them.

We have also embedded equality and diversity and human rights into the mainstream commissioning cycle to include screening undertaken by each service team in relation to their commissioning priorities and operational plans. This is to ensure that, in the developmental stage, commissioning decisions are informed by an explicit consideration of the needs, experiences of, and impacts on, those across the 9 categories protected by the equality duties.

An equality screening template detailing the overarching screening outcomes and the screening outcomes from each service team area accompanies this Commissioning Plan (see Appendix 5 [DN to be inserted]). It is also published as part of the HSCB's screening outcome report as is required as part of the equality duties.

The HSCB and PHA will continue to work internally, and in partnership with colleagues within the DHSS&PS, to ensure that advancing equality and diversity is central to how we conduct our business as an organisation.

Appendix 1: Responding to Ministerial Priorities

In November 2012, the DHSSPS issued the Commissioning Plan Direction for 2013/14. The Direction outlines six broad themes or Ministerial priorities each of which has a number of associated targets. This Appendix sets out our commitment to deliver improvements across the six priority areas and details in which sections of the Plan the relevant information is referred to. Appendix 2 provides further detail in relation to how we intend to ensure achievement of the individual targets.

Ministerial Priority 1: *To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion, anticipation and early intervention*

Improving health and wellbeing and reducing inequalities has always been, and continues to be, a key priority for the PHA and HSCB. We know that in general health has been improving. Unfortunately, the rate of improvement has not been the same for everyone. Health outcomes are generally worse in the most deprived areas in Northern Ireland when compared with the region generally.

Information in relation to commissioning priorities related to this Ministerial Priority are included in Sections 2.2, 2.3 and 4 (6).

Ministerial Priority 2: *To improve the quality of services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services*.

This Ministerial objective underpinned the 2011 review of health and social care, *Transforming Your Care* (TYC). The strategic review assessed the present quality and accessibility of services and the extent to which they meet the needs of individuals, families and communities now and into the future and brought forward proposals for the future shape of services together with an

implementation plan. The proposals, based on a review of evidence, aim to improve outcomes for patients and put individuals, families and communities at the heart of how things are done. The key themes from TYC underpin the Plan and many of the detailed commissioning objectives outlined in aim to ensure the planned delivery of TYC objectives.

The PHA is leading a programme of work looking at the implementation of Quality 2020 and a robust Quality Assurance Programme is in place across the HSC. Work is also ongoing to respond to a number of best practice reviews including the Maternity Services Review and the Review of Paediatric Congenital Heart Surgery.

Information relating to this Ministerial Priority can be found in Sections 2.4, 2.5, 2.6, and 4.

Ministerial Priority 3: *To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long-term condition*

The HSCB and PHA acknowledge that in order to develop safe and sustainable services that meet the future needs of the population, we must think differently about how we deliver care. TYC identifies the need to "shift left" care from hospitals, closer to home, providing more community based services. ICPs will play a critical role in this, creating opportunities for GPs, health and social care providers, hospital specialists and representatives from the independent, voluntary and community sector to come together to identify opportunities to create more innovative and responsive services which better meet the needs of their local population. A central focus of this work will be on the frail elderly, many of whom have multiple comorbidities, and on patients of all ages with respiratory conditions, stroke or diabetes.

Information relating to this Ministerial Priority can be found in Sections 2.4, 4 & 5.

Ministerial Priority 4: *To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the independent sector*

The HSCB and PHA are committed to placing the patient at the heart of services and continue to involve patients and the public in all aspects of commissioning, with many examples of effective PPI during 2012/13. However, there is an acknowledgement that we can do more in this area and work is ongoing to increase our capacity to engage, with a specific focus on involving patients and the public more in the monitoring and evaluation of services.

Information relating to this Ministerial Priority can be found in Sections 2.6 and 5.2.

Ministerial Priority 5: *To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities*

An increasing and ageing population means we will experience increasing demands on our services over time. Therefore there is an ongoing duty on the service to make best use of available resources through efficient allocation and utilisation of all resources. Key to this is the need to improve productivity in line with levels reported elsewhere in the United Kingdom.

Information relating to this Ministerial Priority can be found in Sections 3 and 5.6.

Ministerial Priority 6: *To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services*

The HSCB works closely with Trusts and other partner agencies to ensure that there are robust arrangements in place to support the most vulnerable people in our society. Outcomes are measured through the Delegated Statutory Functions monitoring reports. HSCB has established structures in the form of the Children's Services Improvement Board and the Northern Ireland Adult Safeguarding Partnership, in addition to our normal commissioning arrangements to provide a dedicated focus on this work

Information relating to this Ministerial Priority can be found in Sections 4 (2).

Appendix 2. Overview of Ministerial Targets

This Appendix provides a brief overview of performance against the Ministerial targets set out for 2012/13. It also outlines the proposed approach to the delivery of each of the Ministerial targets set out in the Minister's Commissioning Plan Direction 2013.

Areas of progress 2012/13

During 2012/13, the HSCB continued to closely monitor Trusts' progress against the standards and targets set out in the Minister's Commissioning Plan Direction 2012 and take action as necessary.

Overall, Trusts made progress across a range of the 2012/13 standards and targets including the following:

- elective care waiting times have reduced considerably overall compared to 2011/12, including no patients waiting longer than 13 weeks for endoscopy
- an expectation that only a handful of patients will be waiting longer than 9 weeks for endoscopy by the end of 2012/13
- there has been a significant reduction in the number of patients attending A&E Departments who waited more than 12 hours to be admitted or discharged home compared to 2011/12
- the 2012/13 Commissioning Plan requirement for 98% of patients with cancer to commence treatment within 31 days and 100% of urgent breast cancer referrals to be seen within 14 days has been substantially achieved
- an expectation that the target to deliver a minimum of 50 live donor transplants by March 2013 will be achieved
- no patient waiting more than nine months (three months from September 2012) to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis
- achievement of the standard for 62% of care leavers aged 19 to be in education, training or employment.

There have also been a number of performance challenges on which the HSCB will continue to work with Trusts during 2013/14 to secure further improvements, including:

- A&E (4 hour)
- Cancer (62 day)
- Mental Health Services (9 weeks)
- Mental Health Services (13 weeks – psychological therapies)

Further details of how the HSCB and PHA intend to address these performance challenges, together with the other targets for 2013/14, are outlined below.

Response to Ministerial Targets 2013/14

MINISTERIAL PRIORITY:		**To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion and earlier intervention.**
	Area	
1	Bowel Cancer Screening	The HSC will extend the bowel cancer screening programme to invite in 2013/14 50% of all eligible men and women aged 60-71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014.

The Bowel Cancer Screening Programme (BCSP) was extended from April 2012 to invite all eligible men and women aged 60-71 to participate in screening.

The programme operates on a 2-year screening round: this means that approximately 50% of the total eligible population is invited to participate in any one year. The service is on track to slightly exceed the target of inviting 50% of the eligible population in 2012/13 and will therefore invite the balance during 2013/14. While this may not be exactly 50% of the target population during

2013/14, the programme does expect to have invited 100% of the eligible population over the 2-year screening round from 1 April 2012 – 31 March 2014.

A public information campaign to raise awareness of the programme was launched on 3 February 2012 and ran during February and March. For those who received their invitations or a reminder letter during the 3-month period associated with the campaign (January – March 2012) the uptake rate at six months increased to 52%. A rerun of the campaign commenced in November 2012 and the impact on uptake will be monitored.

The PHA aims to continue to raise awareness of the screening programme so that the eligible population can make an informed choice as to whether they wish to complete the screening test.

The PHA and HSCB will be working with all Trusts during 2013/14 to model the expected impact of further age extension on the demand for screening colonoscopy services and to put in place all arrangements to facilitate age extension from April 2014.

MINISTERIAL PRIORITY:		**To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention**
	Area	
2	Family Nurse Partnership	By March 2014, improve long-term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site.

Around 2,600 children are born each year to first-time mothers in more vulnerable circumstances. Family Nurse Partnership (FNP) is a voluntary preventive programme for teenage mothers, which offers intensive and

structured home visiting, delivered by specially trained 'family nurses', from early pregnancy until the child is two years of age.

The aim of FNP is to improve the health and wellbeing of our most disadvantaged families and children, and to prevent social exclusion.

FNP is being tested across England and Scotland and is now placed on two sites in Northern Ireland, within WHSCT and SHSCT. With a further site planned in BHSCT, we will have three sites up and running in 2013/14.

MINISTERIAL PRIORITY:		**To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services**
	Area	
3	Hip Fractures	From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures

While regionally demand for fracture services has not increased, at a local level performance against 48-hour target for hip fracture continues to be a particular challenge in one Trust (South Eastern). Regionally during quarter end December 2012, 89% of patients, where clinically appropriate, received inpatient treatment for hip fractures within 48 hours (57 % in South Eastern Trust). To help quantify the local capacity requirements the HSCB has recently completed a regional capacity and demand exercise. This work has helped identify the mismatch of demand and capacity on a daily/weekly basis.

In relation to the South Eastern Trust, the HSCB has agreed to support an additional theatre session at the Ulster and the Trust intends to transfer a session from the Downe Hospital to enhance performance across the week. Discussions are also ongoing in respect of the repatriation of fracture work from Belfast to the Southern Trust which may provide opportunities in the future for additional

fracture capacity for the greater Belfast area. Given these actions, and delivery of the additional sessions at the Ulster at critical points in the week, an improvement in performance is anticipated in 2013/14.

The HSCB will continue to work with all Trusts to support delivery of the hip fractures waiting time standard.

MINISTERIAL PRIORITY:		**To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services**
	Area	
4	Cancer Care Services	From April 2013, ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days.

HSCB will work with Trusts during 2013/14 to support delivery of the cancer waiting time standard. The HSCB will build on work undertaken during 2012/13 whereby significant progress was made to address longest waits alongside progress to increase the headline percentage of patients who receive their first definitive treatment within 62 days. Mechanisms for ensuring appropriate tracking, breach analysis and follow up with Trusts will continue in 2013/14.

During 2013/14 the HSCB will undertake a number of actions to address pathway issues which have previously led to delays and subsequent breaches of the target. These include:

1. Support earlier diagnostic access to some key investigations including cytoscopy, MRI, EUS and PET.
2. Focus on the brachytherapy service.
3. Move to enhance thoracic surgical capacity.
4. Centralisation of upper GI surgery.

The pattern of increased numbers of urgent 'red flag' referrals for suspected cancer will continue for the foreseeable future and represents a challenge in ensuring appropriate and timely outpatient and diagnostic capacity for suspected cancer patients. The Board has however developed revised 'red flag' guidance in conjunction with NICaN with the aim of ensuring that such referrals are appropriate. The supporting protocols and activity associated with these guidelines will be closely monitored during 2013/14. The Board is also considering how the electronic referral system in primary care can be used most effectively to support the implementation of the suspect cancer referral guidelines.

MINISTERIAL PRIORITY:		**To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services**
	Area	
5	Unscheduled Care	From April 2013, 95% of patients attending any Type 1, 2 or 3 A&E Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.

Waiting times for A&E services in Northern Ireland continue to fall well short of the Ministerial standards for 2013/14. During 2013/14 the HSCB will continue to work with Trusts to support delivery of the unscheduled waiting time standard.

There has been significant improvement in performance against the 12-hour standard in comparison to 2011/12, however, there continue to be substantial challenges at two Trusts (South Eastern and Northern) on this important issue. In addition, progress is required in relation to the percentage of patients treated and discharged home or admitted within 4 hours of arrival at A&E. The HSCB, in conjunction with the PHA, established an Emergency Department Improvement Action Group (EDIAG) to work with all Trusts to bring about a step change in A&E performance.

The HSCB/PHA will continue to work with Trusts through the EDIAG to ensure the issue of A&E performance is given the highest priority.

The HSCB provided additional financial support to Trusts in order to support service pressures during the winter period. This was focussed on four areas: admission avoidance; improving flow; improving discharge; and enhancing community services. The EDIAG has worked with Trusts to identify where specifically this support would be most beneficial.

During 2013/14 and beyond the HSCB will work with Trusts to implement a series of actions which will better align HSC capacity with patient needs for urgent and emergency care. Specifically, the following action will be taken:

- The HSCB will agree robust capacity volumes with each Trust in relation to both ED attendances and emergency admissions.
- The HSCB will introduce population zoning to ensure an equitable spread of population demand for urgent and emergency services, linked to individual site and Trust capacity.
- The HSCB will further develop arrangements to prevent unnecessary attendance and ED's and admission to hospital beds by investing in improved management of long term conditions in primary care, an extended ambulance paramedic role to treat patients at the scene without the need for transport to hospital, and greater acute care at home.
- Patients will spend the optimum time necessary to receive hospital treatment and will be discharged with support to return to a high degree of independence with appropriate wrap-around support.

Transforming Your Care means that alternatives to attendances at Emergency Departments will be promoted. In particular, ambulance services will, in collaboration with primary and secondary care clinicians, develop and implement agreed protocols to enable paramedics to assess and treat patients at the scene (including home) without transporting them to hospital, where appropriate. Patients requiring urgent care will have greater access to clinical advice and

information, particularly with the introduction of the urgent care '111' service, including increased access to GP services in and out of hours.

MINISTERIAL PRIORITY:		**To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services**
	Area	
6	Hospital readmissions	By March 2014, secure a 10% reduction in the number of emergency readmissions within 30 days.

This target will be achieved through greater focus on those conditions which make up the greatest proportion of emergency readmissions and will include management of long term conditions.

Effective communication between primary and secondary care is essential in preventing readmissions through prioritisation of review of those patients recently discharged following an emergency admission.

The HSCB/PHA will also continue to work with Trusts and Primary Care to extend current schemes such as remote telemonitoring and one-to-one education and self-management programmes.

MINISTERIAL PRIORITY:		**To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services**
	Area	
7	Elective Care Outpatients	From April 2013, at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014 and no patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014.

8	Elective Care Diagnostics	From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.
9	Elective Care Inpatients	From April 2013, at least 70% of inpatients and daycases are treated within 13 weeks, increasing to 80% by March 2014, and no patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014.

The HSCB/PHA has continued to work with Trusts to secure improvements in elective care waiting times during 2012/13. During 2013/14 the HSCB will work with the Trusts to ensure this are continues to be prioritised, to maintain the current momentum and continue to support delivery of the elective waiting time standards.

As soon as possible in 2013/14, the HSCB will seek to improve the percentage of patients seen within 9 weeks and 13 weeks for outpatients and inpatients/daycases respectively, consistent with the standard for the year. The HSCB will continue to ensure this area is prioritised in 2013/14, seeking as far as possible within available resources to maintain the current momentum and secure further reductions in maximum waiting times for patient assessment and treatment.

Further improvements in performance will be secured through a combination of ensuring Trusts deliver agreed levels of core capacity for 2013/14, together with investment in additional in-house or Independent Sector activity where this is required.

During 2013/14 the HSCB/PHA will seek to ensure that targeted recurrent investments made in 2012/13 in specialties where there was an agreed capacity gap translate into additional activity as quickly as possible.

In relation to diagnostics reporting, the HSCB/PHA will continue to work with Trusts to ensure timely reporting of urgent tests. The HSCB will work with Trusts to ensure

the effective planning and implementation of those RQIA review recommendations for which the HSCB is in the lead.

MINISTERIAL PRIORITY:		**To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services**
	Area	
10	Healthcare Acquired Infections	By March 2014, secure a further reduction of X% in MRSA and Clostridium difficile infections compared to 2012/13. [X to be available in March 2013]

The response detail will be provided upon receipt of the finalised target.

MINISTERIAL PRIORITY:		**To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services**
	Area	
11	Organ Transplants	By March 2014, 30% of kidneys retrieved in Northern Ireland through DCD are transplanted in Northern Ireland.

The Donation after Circulatory Death (DCD) programme in Northern Ireland is still relatively new. Achievement of this target will be dependent on the availability of surgical staff and infrastructure to enable transplantation in a timely fashion. This will be achieved through the planned expansion of the clinical team and supporting infrastructure in Belfast Trust to support the Live Donor Programme. It is planned to recruit two substantive consultant transplant surgeons in late 2013. If this is successful the use of DCD kidneys in Northern Ireland should be able to be maximised in the final quarter of 2013/14, allowing achievement of the target during that period.

MINISTERIAL PRIORITY:		To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services
	Area	
12	Specialist Drugs	From April 2013, no patient should wait longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing sponylitis, and no patient should wait longer than 9 months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013.

Performance in this area has been strong in 2012/13 and only a small number of patients have waited longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis since the target date to have no patients waiting longer than three months (September 2012).

Plans are in place to ensure that this maximum waiting time standard is maintained during 2013/14 and that 3-month target for rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis was achieved by the due date in 2012/13. Plans are in place to ensure that the 3-month maximum waiting time target for psoriasis will be achieved by September 2013. Progress against these targets will continue to be monitored on a monthly basis.

MINISTERIAL PRIORITY:		To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services
	Area	
13	Stroke Patients	From April 2013, ensure that at least 10% of patients with confirmed ischaemic stroke receive thrombolysis.

Performance in this area has been strong in 2012/13. 24/7 thrombolysis services are available in designated hospitals in the five Trusts in Northern Ireland. Performance monitoring arrangements are in place and the HSCB/PHA will continue to build on the progress made in 2012/13 including improving the proportion of patients receiving thrombolysis within 60minutes.

MINISTERIAL PRIORITY:		**To improve the Quality of Services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services**
	Area	
14	Medicines Formulary	From April 2013, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care

During 2012/13, there was phased publication of the major chapters of the formulary and this was completed at the end of January 2013 with over 80% of prescribing choices now being covered by the formulary. A number of smaller chapters have been identified and will be produced in 2013/14.

With the development of each chapter, monitoring arrangements have been developed and the 2012/13 70% compliance rate is expected to be achieved.

Work will be taken forward in 2013/14 to identify and research outlying prescribing practice with the aim of aligning this to the regional average. Further work on implementation of the formulary is planned for 2013/14 and 2014/15 which will see incorporation of the formulary within electronic prescribing systems.

MINISTERIAL PRIORITY:		To improve the management of long term conditions in the community with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term condition
	Area	
15	AHPs	From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.

Waiting times for AHP treatment reduced considerably in 2012/13 compared to 2011/12. A capacity and demand review of AHP services was completed across the five Trusts in 2012/13 and investment to bridge agreed capacity gaps has been allocated. The HSCB will work with the Trusts to support the delivery of the AHP waiting time standard.

MINISTERIAL PRIORITY:		To improve the management of long term conditions in the community with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term condition
	Area	
16	Telehealth	By March 2014, deliver 500,000 telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.

This will be a challenging target to achieve as it represents an increase of 66% on the projected outturn for 2012-13. Trusts have reported that in some areas there remains amongst the clinical community a lack of buy-in to the concept of remote monitoring, and that this is underpinned by a perceived lack of evidence in the area and a general lack of awareness of the benefits of telemonitoring.

Implementation of remote telemonitoring may also necessitate service change and/or change in working practice associated with embedding the service into clinical practice.

The Centre for Connected Health & Social Care is working with Trusts and the provider of the Telemonitoring NI service on actions to increase the levels of referrals. These include:

- Work to develop service models to use telemonitoring for a wider range of conditions such as renal and weight management.
- Amendments to the Telemonitoring NI service to increase flexibility to step-up and step-down care and to facilitate easier referrals for new conditions in the future.
- Work to explore the role of Telemonitoring in supporting the clinical care provided by GPs and under the development of ICPs
- The development and implementation of a communications plan, the objective of which is to increase awareness of telemonitoring, to highlight the contribution of Telemonitoring NI to the modernisation of healthcare and the HSC review agenda; and to create awareness of the value of telemonitoring to patients, carers and professionals.

The PHA will also be putting in place a comprehensive evaluation of the Telemonitoring NI service and will work with Trusts to support the delivery of the telehealth target.

MINISTERIAL PRIORITY:		To improve the management of long term conditions in the community with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term condition
	Area	
17	Telecare	By March 2014, deliver 720,000 telecare Monitored Patient Days (equivalent to approximately 2,100 patients) from the provision of remote telecare including those provided through the Telemonitoring NI contract.

This is a new target for 2013/14. For a number of years across Northern Ireland there has is a disparate pattern of development in Telecare services; where such development has occurred it has mostly been in relation to the care of older people.

There are currently 1,077 people on these 'core' services with annual monitored patient days totalling around 393,000 annually and it is anticipated that this level of provision will be maintained and further built on with an additional 327,000 monitored patient days in order to meet the target. This additional provision will provide a means by which services developed in recent times on a non-recurrent basis (e.g. through the CAWT older people's programme) may be mainstreamed. The additional provision will also enable the development of telecare across the region. It is anticipated that bringing the provision of telecare under the Telemonitoring NI contract will improve the provision of services.

The Centre for Connected Health and Social Care CCHSC will be progressing work with commissioning teams and Trusts to establish the appropriate utilisation and deployment of telecare across a range of client groups, potentially including older people, dementia, learning disability, physical and sensory disablement. This will be supported with a range of appropriate communication and engagement activities.

The PHA will work with trusts to support delivery of the Telecare target.

MINISTERIAL PRIORITY:		**To improve the management of long term conditions in the community with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term condition**
	Area	
18	LTCs	By March 2014, develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively.

An audit of current education, information and support programmes for LTCs in Northern Ireland is currently underway in the five Trusts and across the voluntary sector. Informed by the outcome of the audit, the HSCB will put in place a range of quality assured education, information and support programmes to help people manage their long term conditions effectively. It is anticipated that there will be a need for a portfolio of education programs ranging from generic programmes on living with long term conditions to disease specific programs such as DAFNE (adults) and CHOICE (children) for Type 1 diabetes where patients are taught about the conditions, how to count carbohydrates, self-adjust their insulin dose based on their blood results and calorie intake.

MINISTERIAL PRIORITY:		To improve the management of long term conditions in the community with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term condition
	Area	
19	Unplanned admissions	By March 2013, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.

Performance has been strong in this area in 2012/13 and progress is on track to achieve the target to reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions by end of March 2013.

In relation to securing a further reduction by March 2014, Integrated Care Partnerships will be central in ensuring integration among primary and secondary care providers to meet patient needs with clear arrangements for dealing with patients with long term conditions, multi-morbidity and complex medication regimes, and access to specialist medical or nursing advice. The HSCB/PHA will ensure the provision of one-to-one and group education programmes to support self-management that have agreed content and arrangements for patients to receive regular updates.

Moreover, the introduction of risk-stratification, provision of integrated community teams and enhancements to remote telemonitoring during 2013/14 will all contribute to a reduction in ED attendances, emergency admissions, and length of stay and/or bed days.

It is also anticipated that the drive on reablement will also have an impact on readmissions as patients are supported to re-establish their independence following a period in hospital.

MINISTERIAL PRIORITY:		To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the independent sector
	Area	
20	ICPs	During 2013/14, to implement Integrated Care Partnerships across Northern Ireland in support of *Transforming Your Care*

It is currently proposed that nine ICPs will be implemented from 1 April 2013, increasing to 17 by March 2014.

MINISTERIAL PRIORITY:		To improve productivity by ensuring effective and efficient allocation & utilisation of all available resources, in line with priorities
	Area	**Unscheduled care**
21	Unnecessary Hospital Stays	By March 2014, reduce the number of excess bed days for the acute programme of care by 10%

Through the continuing work of the EDIAG across the unscheduled care pathway, a range of initiatives are being taken forward by the HSCB at regional and local levels in line with the development of Integrated Care Partnerships towards delivering the Minister's target.

Transforming Your Care requires a shift in healthcare with the potential for more acute care to be delivered in the home and community. Each LCG and its respective HSC Trust has developed a Population Plan which will see extended community nursing services, including acute care at home and ambulatory care within primary care centres, and the introduction of reablement. This will enable early discharge and support patients to regain as much of their independence as possible.

A closer involvement with General Practices through Integrated Care Partnerships will lead to greater collaboration in the delivery of care with prevention and early intervention in the management of long-term conditions. Moreover, *Transforming Your Care* means GPs will have improved access to diagnostics and rapid outpatient assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion between GP and senior hospital doctor and agreed decision on steps to take in patient management.

MINISTERIAL PRIORITY:		**To improve productivity by ensuring effective and efficient allocation & utilisation of all available resources, in line with priorities**
	Area	
22	Patient Discharge	From April 2013, ensure that 99% of all learning disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.

During 2013/14, the HSCB/PHA will continue to work with Trusts to ensure effective care planning and timely discharge of patients across all programmes of care. The requirement that no complex discharge from an acute hospital takes longer than seven-days will not be achieved as there will always be a small number of patients with complex needs who require a longer period of planning for discharge to ensure that adequate support is in place in the community.

In order to support Trusts to meet the learning disability and mental health discharge standards, improvements in community infrastructure and community packages will be commissioned during 2013/14.

MINISTERIAL PRIORITY:		To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across our service
	Area	
23	Learning Disability / Mental Health Resettlement	By March 2014, 75 of the remaining long-stay patients in learning disability hospitals and 23 of the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.

While the target number of long stay patients was not resettled during 2012/13, Trusts have plans to ensure the resettlement of all the mental health and learning disability long stay patients by 2015, in line with the Minister's overall target.

The agreed target numbers of patients to be resettled from Mental Health and Learning Disability Hospitals during 2013/14 and 2014/15 have been notified to Trusts. Progress on the delivery of Trusts' plans will be closely monitored by the HSCB during 2013/14 and 2014/15. The HSCB has established a Steering Group co-chaired with the Housing Executive to oversee this process and to ensure that all necessary actions can be taken to achieve the required outcome.

MINISTERIAL PRIORITY:		To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across our service
	Area	
24	Children in Care	From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%.

This target reflects incremental progress from last year's target (82%) and continues to reflect the need for stability and permanency for children in the looked after system. The HSCB will work with Trusts to ensure that a range of

looked after placements which meet the assessed needs of the children are available to deliver on this target.

The focus within TYC is for children to have experience of family life, if at all possible, which may see a reduced reliance on residential child care. This is however contingent on the development of additional foster care services and adequate support services to maintain children within their placements.

MINISTERIAL PRIORITY:		**To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across our service**
	Area	
25	Children in Care	From April 2013 ensure a 3 year time-frame for 90% of all children to be adopted from care.

This standard confirms the need to expedite permanency via adoption where this is the preferred care plan for the children in question.

The HSCB will work with Trusts to review existing processes to identify any areas adding to delay and seek to resolve same. Equally, it is acknowledged that legal processes are also a contributory factor and the Family Justice Review will afford an opportunity to identify areas where court processes could be expedited.

MINISTERIAL PRIORITY:		**To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across our service**
	Area	
26	Children in Care	By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%

There is a commitment to assisting young people to achieve their potential and this target makes a contribution if we are to address the cyclical nature of

children coming into the care system and young care leavers being disproportionately represented within adult mental health, justice, acute services and further engagement when they become parents.

Undoubtedly the target will be a challenging but the consensus view is that we should provide opportunity for care leavers as any good parent would want. The Trusts through their 16+ Teams will continue to work with other agencies including DEL etc. to promote said opportunities and support the young people to become involved and stay involved. Trusts have reflected also on the wider economic situation which may impinge on the potential to reach and maintain the target but the direction of travel and the inherent benefits are recognised.

The HSCB will continue to work with Trusts to support delivery of the care leavers target.

MINISTERIAL PRIORITY:		**To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across our service**
	Area	
27	Mental Health Services	From April 2013, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; and 13 weeks to access psychological therapies (any age)

This maximum waiting time standard is in line with the overall strategic direction for CAMHS and Children with a Disability, including autism, where there is an imperative to provide the necessary assistance as soon as possible.

Waiting times for child and adolescent mental health services (CAMHS) improved during 2012/13 with most patients waiting less than nine weeks in the second half of the year.

The HSCB will work with Trusts and primary care in 2013/14 to increase capacity and ensure achievement of the target in 2013/14. Key to this will be the establishment of integrated care arrangements for the care and treatment of common mental health needs to include arrangements for the provision of a primary care psychological therapy service beginning with the appointment of primary care coordinators and training in CBT and / or counselling for a minimum of five staff in each Trust.

MINISTERIAL PRIORITY:		**To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across our service**
	Area	
28	People with Care needs	From April 2013, people with continuing care needs wait no longer than 5 weeks for assessment to be completed, and have the main components of their care needs met within a further 8 weeks.

Currently some 96% of patients have their assessment completed within five weeks and 98% have the main components of their care needs met within eight weeks. The HSCB/PHA will work with Trusts in 2013/14 to further improve performance.

The continued roll out of 'Re-ablement' regionally during 2013/14 will further support achievement of the target by ensuring that people have access to an early assessment of their needs, and that where care services are required, these are targeted, rehabilitative and goal focussed in nature. 'Re-ablement' is being delivered in partnership with the Community and Voluntary sector. This approach is delivering a range of care responses as determined by the complexity of an individual's assessed needs, and ensuring community resources are deployed for no longer than is necessary.

Improved quality of assessment will continue to be progressed via the implementation of the Northern Ireland Single Assessment Tool (NISAT).

Appendix 3: List of Commissioning Service Teams

1. Cancer Care
2. Children and Families
3. Community Care, Older People, Physical Disability & Sensory impairment
4. Elective Care& Diagnostics
5. Health and Social Wellbeing Improvement (including screening & health protection)
6. Long Term Conditions
7. Maternity, Sub-fertility& Child Health Services
8. Medicines Management
9. Mental Health& Learning Disability
10. Palliative and End of Life Care
11. Prisoner Health
12. Specialist Services
13. Unscheduled Care

Note: Some of these service areas have been further sub-divided for the purposes of presenting the detailed regional commissioning priorities outlined in Section 4.

Appendix 4: Indicators of Performance by Priority Area

Ministerial Priority 1 *- To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention*

Indicators of Performance

Life expectancy

1. Average life expectancy for women and men.
2. Life expectancy differential between Northern Ireland average and most disadvantaged areas for women and men.
3. (a) Number of deaths of men aged 65 and over from abdominal aortic aneurysm (AAA), excluding thoracic aortic aneurysm; (b) Rate of uptake of Northern Ireland wide Screening Programme for AAA.
4. Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare.
5. Healthy Life Expectancy.
6. Self-reported well-being.
7. Infant Mortality.

Standardised death rates

8. Age Standardised Death Rate (SDR) for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas.

Suicide and self-harm

9. Suicide rates across Northern Ireland and in the most deprived areas.
10. Number of A&E presentations due to deliberate self-harm.

Diabetes

11. The prevalence of diabetes.

Obesity

12. Level of overweight and obesity across the life course (2-10 year olds and 16+).
13. The proportion of adults meeting the Chief Medical Officer's recommended guidelines on physical activity.
14. The proportion of adults (aged 16+) and children (aged 0-15) consuming the recommended 5 portions of fruit and vegetables each day.

Alcohol consumption

15. Standardised rate of alcohol-related admissions to hospital.
16. The proportion of adults who report having reached or exceeded the recommended weekly limit.

Smoking

17. Proportion of adults who smoke.
18. Numbers of pregnant women, children and young people and adults from deprived areas (lower quintile) who set a quit date through cessation services.

Teenage pregnancies and sexual health

19. Rate of births to mothers under 17 years of age (with breakdown against most deprived areas).
20. Number of new episodes of selected sexually transmitted infections diagnoses made by Genito-urinary Medicine clinics.
21. New HIV diagnoses.

General health – flu

22. Uptake of seasonal flu vaccine by front-line health and social care workers.

Circulatory conditions

23. Admissions for Venous Thromboembolism.

Maternity and young children

24. Activity in maternity and Child Health Programme of Care (PoC).
25. Percentage of babies born by caesarean section and number of babies born in midwife-led units either freestanding or alongside.

26. Breastfeeding rate at discharge from hospital.
27. Establish a baseline for the uptake of developmental reviews offered by Health Visitors as part of the universal child health promotion programme.
28. Percentage reduction in intervention rates (including caesarean sections) benchmarked against comparable units in UK and Ireland.

Ministerial Priority 2 -To improve the quality of services and outcomes for patients, clients and carers through the provision of safe, resilient and sustainable services

Indicators of Performance

Cancer services

1. Percentage of patients receiving first definitive treatment within 31 days of a decision to treat.
2. The number of red flag cancer referrals.
3. Percentage of patients seen within 14 days of an urgent referral for breast cancer.

Attendances at Emergency Departments

4. Percentage of Category A (life threatening calls) responded to within eight minutes regionally, and in each LCG area.
5. Number of new and unplanned attendances at emergency departments Types 1 and 2.
6. Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to 12 hours and 12 hours or more, before being treated and discharged or admitted (for those sites for which patient-level data are readily available).
7. Patient and ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes).

Elective care

8. Rate of review outpatient appointments where the patient did not attend.

9. Rate of new outpatient appointments cancelled by the hospital.
10. Number of GP referrals to consultant-led outpatient services.
11. The number of outpatient appointments with procedures within the specialties of pain management, ophthalmology, gynaecology, general surgery, plastic surgery and dermatology.
12. The number of barium enema, computerised tomography, magnetic resonance imaging, non-obstetric ultra sound, positron emission tomography and plain film x-ray tests undertaken.

Stroke

13. Number of patients admitted with stroke.

Patient / client experience

14. Outcomes against the patient client experience standards in the settings agreed for the formal work plan.
15. Incidence of pressure ulcers occurring in hospital medical and surgical care settings between 0-300 days.
16. Falls in hospital settings.
17. Number of hearing aids fitted within 13 weeks as a percentage of completed waits.
18. Percentage of patients waiting over 13 weeks for any wheelchair (basic and specialised).
19. Percentage of patients who have lifts and ceiling track hoists installed within 16 weeks of the OT assessment and options appraisal.

Prescribing

20. Attainment of targets set out in the Regional Board pharmacy efficiency programme.

Organ transplants

21. Percentage change in overall transplants.
22. The number of live donor transplants.
23. Number of organs declined.

Cardiac catheterisation

24. Percentage increase in access to cardiac catheterisation.

Fracture

25. Percentage of patients, where clinically appropriate, waiting less than 7 days for inpatient fracture treatment.

Hospital re-admissions

26. The number of emergency admissions for acute conditions that should not usually require hospital admission.
27. The number and proportion of emergency admissions and readmissions for people aged 0-64 years and 65 years and over: (i) with and (ii) without a recorded long term condition, in which medicines were considered to have been the primary or contributing factor, by HSC Trust.

Ministerial Priority 3: *To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions*

Indicators of Performance

Pharmacy

1. The number of medicines management and public health pharmaceutical services delivered in the community reported by LCG area. The number and proportion of Health and Care Centres in each HSC Trust with: active pharmaceutical services provision, plans for active pharmaceutical services provision.
2. Proportion of people accessing the "Building the Community Pharmacy Partnership" (BCPP) projects residing in the bottom 3 quintiles of wards / Super Output Areas (SOAs) by deprivation.

Specialist drug therapies

3. Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for multiple sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.
4. Number of patients waiting longer than 9 weeks to commence specialist drug treatment for wet AMD for the first eye, and 6 weeks for the second eye.

Long term conditions

5. Number of patients benefiting from remote telemonitoring.
6. Number of patients benefiting from the provision of telecare services

Allied Health Professionals

7. Number of patients waiting longer than 9 weeks to access Occupational Therapy Services.
8. Number of patients waiting longer than 9 weeks to access Speech and Language Therapy (SLT).
9. Number of patients waiting longer than 9 weeks to access dementia services.

Ministerial Priority 4: *To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the independent sector*

Indicators of Performance

Advocacy services

1. Gaps in supply of commissioned advocacy services within each HSC Trust area categorised by model of advocacy.

Direct payments

2. Numbers of direct payment cases by Programme of Care (PoC).

Ministerial Priority 5: *To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources in line with Ministerial priorities*

Indicators of Performance

Efficiency indicators

1. Elective average pre-operative stay.
2. Elective average length of stay in acute programme of care.
3. Average length of stay for stroke patients.
4. Day surgery rate for each of a basket of 24 elective procedures.
5. Percentage of operations cancelled for non-clinical reasons.
6. Percentage of patients admitted electively who have their surgery on the same day as admission.
7. Percentage of routine diagnostic tests reported on within 2 weeks of the test being undertaken.
8. Percentage of routine diagnostic tests reported within 4 weeks of the test being undertaken.
9. (a) Initiate the use of existing normative nurse to bed staffing; (b) normative staffing ranges developed within specific community settings.
10. Ratio of new to review outpatient appointments attended by speciality and HSC Trust.

Out of hours GP attendance

11. Out of Hours GP attendance.

Expenditure

12. Balance of expenditure between community-based and hospital mental health services.
13. Percentage of funding spent on primary and community care.
14. Percentage of funding invested in Tackling Obesity.

Pharmacy

15. (a) Prescribing activity, and the level of compliance of GP practices, by LCG for each Chapter of NI Medicines Formulary; (b) prescribing activity by LCG for generic prescribing and dispensing rates.

Ministerial Priority 6: *To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services*

Indicators of performance

Children

1. Percentage of all foster care placements that are kinship care placements.
2. Number of care leavers in education, training and employment by placement type.
3. The percentage of children with an adoption best-interests decision that are notified to the Adoption Regional Information Service (ARIS) within 4 weeks of the HSC Trust approving the adoption panel's decision that adoption is in the best interest of the child.
4. The number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type.
5. Length of time for best decision to be reached in the adoption process.

Mental health services

6. Children in adult mental health wards.

Appendix 5: Quality Assurance Framework 2013/14

The HSCB and PHA have in place a comprehensive Quality Assurance Programme which encompasses the following priorities.

Quality Improvement Plans (Q.I.Ps)

In line with Commissioning requirements, Health and Social Care Trusts are required to submit for approval their Quality Improvement Plan (Q.I.P). The plan focuses on those key priority areas that will lead to improved quality services and better outcomes for patients and clients through the provision of safe, effective and sustainable services. In 2013/14, Q.I.Ps will take account of the following quality improvement indicators as required by the Commissioner. However, Trusts are expected to include additional local quality improvement priorities over and above the core commissioning priorities.

The core commissioning quality improvement plan priorities for 2013/14 are:

1. Pressure Ulcers – Trust will spread the SKIN Bundle to 80% of all adult inpatient areas / Wards ensuring 95% compliance by March 2014. Trusts will monitor and provide reports on bundle compliance and the rate of pressure ulcers per 1,000 bed days.

2. Falls – Trusts will put in place a test and spread plan to ensure 95% compliance with a Fall Bundle in identified pilot clinical areas by March 2014. Trusts will monitor and provide reports on bundle compliance and the incidents of falls per 1,000 bed days.

3. The safe management of Controlled Drugs – Trusts will, in response to the RQIA Report on 'Controlled Drugs in Hospitals 'put in place action plans and report progress on a quarterly basis with implementation of their actions.

4. WHO Surgical Checklist – Trusts will achieve at least 95% compliance with completion of the WHO Surgical Safety Checklist across all theatre and procedural areas by March 2014.

5. Preventing harm from Venous Thromboembolism (VTE) – Trusts will improve compliance with VTE risk assessment across all inpatient

units/wards to achieve 95% compliance with appropriate VTE prophylaxis prescribing in all clinical areas by March 2014.

6. Crash Call Rates – Based on 2012/13 baseline data, Trusts will maintain or reduce crash call rates by 20%.

7. Surgical Site Infection surveillance programmes – Trusts will achieve 100% compliance with device associated surveillance in I.C.U. (VAP, CLABSI and CAUTI) and at least 95% compliance with Neurosurgery, C-Section and Orthopaedic SSI Surveillance.

Patient and Client Experience: Implementing the Standards

During 2013/14 the Patient and Client Experience Steering Group will provide strategic direction for the implementation of the DHSSPS Patient and Client Experience Standards and agree the annual work plan which will include the following:

- Trusts will be required to submit quarterly monitoring reports and detailed action plans to the PHA for approval. . In the final quarter of 2013/14, i.e. January-March 2014, Trusts will be required to undertake an evaluation of improvements achieved and identify priorities for the following year. Reports on progress will be submitted to the DHSSPS and Boards of PHA/HSCB bi-annually.

- Development of an action plan to ensure adoption of NICE guidelines.

- Through 2013/14 a planned programme of work for the independent collection of patient stories will be developed. Each HSC Trust will collect 2000 patient stories using an agreed methodology. The Trusts will submit monthly update reports to the PHA.

The Patient Safety Forum

During 2013/14, the Patient Safety Forum will develop a comprehensive work plan to provide mutually agreed support to providers to include the following;

- A new regional collaborative to promote the concepts and clinical practices which underpin Normalising Childbirth in line with the 2012 Regional Maternity Strategy

- A regional approach to improving the care of the deteriorating adult patient – to include use of a physiological early warning scoring tool and arrangements for appropriate intervention and escalation as outlined in HSS(MD) 39/2012 and the NCEPOD report 'Time to Intervene'. Similar principles should be used to progress care of the deteriorating child.

- To continue the regional collaborative in Emergency Medicine, building on the agreed quality indicators and extending the work to promote improvement in other significant areas of practice.

- To continue the regional collaborative in Nursing Homes, sustaining the progress on falls prevention and spreading this across the system. Also to promote improvement in other areas of practice (e.g. promoting hydration and nutrition and preventing pressure damage)

In addition, the HSC safety Forum will support Trusts with small projects tailored for their prioritised needs. Discussions on the specifics are on-going and will be finalised in Q4 2012/13.

Regional Adverse Incident Learning System (RAIL)

During 2012/13, the PHA supported by the HSCB developed an Outline Business Case (OBC) to take forward the pilot of a RAIL system for Northern Ireland. The OBC has been submitted to the DHSSPS for approval. Pending approval, the pilot phase will commence during 2013/14. The pilot will inform the development of a full Business Case for submission to the DHSSPS at the end of the pilot period.

Key Performance Indicators for Nursing and Midwifery

During 2013/14, Trusts will commence measurement and reporting of agreed Key Performance Indicators within Nursing (KPIs). The initial Indicators to be measured will be agreed by the PHA. These Indicators will lead to improved Patient and Client Experience outcomes, and will provide evidence of the quality of Nursing and Midwifery care in Northern Ireland. The KPI's will be generated

using the best available Clinical evidence based information as well as organisational and patient experience indicators. The work will include the spread of an electronic dashboard system for monitoring compliance with the Indicators across all wards/units by March 2014.

Workforce planning within Nursing and Midwifery Services

The Minister has requested the Public Health Agency (PHA) lead on developing a suite of tools to support commissioners and providers to ensure the right number of nurses and midwives are available to provide a safe and effective service. The work will include developing workforce tools in specific areas, commencing with Medicine and Surgery and moving swiftly to cover community services, and extending to all areas over a three year period.

During 2013/14, work will continue on the implementation of Specialist Nurse Job planning. This work is aimed at delivering on Safety, Quality and Patient Experience outcomes within hospital services. Work will commence on the development of similar plans for Specialist Community Nursing Services.

Appendix 6. Equality, Good Relations & Human Rights Screening of Commissioning Plan

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Commissioning Plan 2013/14

The Plan takes full account of the financial parameters set by the Executive and DHSSPS, and is consistent with the direction and priorities set out in the Minister's Commissioning Direction and Indicators of Performance for 2013/14.

1.2 Description of policy or decision

- **What is it trying to achieve? (aims and objectives)**

The Commissioning Plan aims to provide a clear roadmap for the development of health and social care services for the population of Northern Ireland. The Plan builds upon the work in previous years and also is fully consistent with and supportive of the long-term direction set out within Transforming Your Care and in the Quality 2020 Strategy. While the primary focus of the Plan is on the 2013/14 financial year, many of the changes signalled will be implemented over a much longer timescale, up to and beyond 2015.

This Plan sets out the level of service that the population of NI can expect to receive, and the changes that are necessary to existing services to secure this.

The overall aim in commissioning is to ensure that the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. The plan outlines a direction of travel.

Many of the changes outlined within the plan will be subject to individual screening, public consultation and / or equality impact assessment prior to implementation.

- **How will this be achieved? (key elements)**

The Health and Social Care Board (HSCB) has organised its commissioning teams to reflect key service areas. Commissioning proposals are therefore presented in the following service areas:

1. Health and Social Wellbeing Improvement, Health Protection and Screening
2. Unscheduled Care
3. Elective Care (including diagnostics)
4. Cancer Care
5. Palliative and End of Life Care
6. Long Term Conditions
7. Maternity, Child Health & Sub-fertility
8. Community Care, Older People and Physical Disability
9. Children and Families
10. Mental Health and Learning Disability
11. Prison Health
12. Specialist Services
13. Medicines Management

Each service area has a dedicated team which is tasked with working with stakeholders to identify and deliver on the commissioning priorities within their service area for the year. During the course of the year, teams will work up detailed plans which outline how the priorities will be met. Detailed equality screening and impact assessments may be required in relation to a number of the priorities identified and these will be completed in advance of any service changes being taken forward.

The Board is also supported by five Local Commissioning Groups (LCGs). LCGs will be responsible for working with their local economies to support implementation of the regional commissioning objectives. Once again, equality screening and impact assessments may be required in advance of any service

changes being taken forward at a local level.

- **What are the key constraints? (for example financial, legislative or other)**

Key drivers for change are identified in the Commissioning Plan:

Demography – a older and growing population in Northern Ireland

Quality 2020 – sets the focus clearly on improving quality and making Northern Ireland a leader for excellence in health and social care

Programme for Government 2011-15 – a four year programme directing positive action on public health, vulnerable adults and children, tackling obesity and improving elective care through reform and modernisation

Health and Social Care Resources - maximising the productivity of resources already available

Transforming Your Care– guiding the recommended model of delivery of HSC

Public Health Strategic Framework: Fit and Well Changing Lives 2012-22 – provides an essential framework for reducing inequalities in health over the next 10 years.

Workforce – the need to plan the transition of staff from acute to community settings in line with reform and to ensure service quality directed by the above

Information Communication Technology – helping the service to work smarter and more efficiently.

Commissioning decisions will be explicitly stated whether these are concerned with cost reduction and / or quality improvement.

The overall direction of the Commissioning Plan is to improve quality and effectiveness. Commissioners will take decisions in an informed and sensitive manner that takes into account the potential implications for individuals and

communities. As with every year there are no neutral decisions. Unnecessary preservation of an existing pattern of service delivery will in all probability mean denial of new developments. Making choices is a reality for any commissioning system. This is vitally important to understand in the financial climate that commissioning is entering.

1.3 Main stakeholders affected (internal and external)

- The population of Northern Ireland - with a focus on patients, clients and carers and their advocates
- Assembly Health Committee
- MLAs, MPs and local councillors
- Designated political party spokespersons on health and social care
- City, Borough and District Councils
- Community and voluntary groups (including those groups representing the interests of Section 75 interest groups).
- Independent sector (GPs, pharmacists, opticians, pharmacists, residential nursing home provision)
- Trades Unions
- HSC Board (HSCB) and Public Health Agency (PHA) directors and staff
- The Minister for Health
- Department of Health, Social Services and Public Safety
- Health and Social Care Trusts and staff
- Local Commissioning Groups (LCGs) and Primary Care Partnerships (PCPs)
- Professional representative bodies
- Patient and Client Council
- The Press and Media
- Voluntary and Community Sectors
- Public organisations with an indirect impact on health e.g. housing, education

1.4 Other policies or decisions with a bearing on this policy or decision

- **What are they?**
- **Who owns them?**

A large number of policies and decisions have impacted on the Commissioning Plan, including:

- Transforming Your Care, the review of health and social care that describes a future vision for health and social care in Northern Ireland;
- Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland;
- Programme for Government 2011-15, a four year Programme published by the Office of the First Minister and Deputy First Minister;
- Public Health Strategic Framework: Fit and Well Changing Lives 2012-22;
- Healthy Child, Healthy Future – A framework for the Child Health Programme in Northern Ireland;
- Policy Guidance issued by the DHSSPS on the Service Model for Child and Adolescent Mental Health Service (CAMHS);
- The consultation on the Child and Adolescent Mental Health Service (CAMHS) Policy Guidance issued by the DHSSPS;
- Healthy Futures, 2010-2015 – The contribution of Health Visitors and School Nurses in Northern Ireland (NI);
- New Strategic Direction for Alcohol and Drugs; (Phase 2 December 2011);
- Hidden Harm Action Plan;
- Young People's Drinking Action Plan;

- A Healthier Future;
- A Fitter Future for All – Addressing and Preventing Obesity in NI (June 2011);
- Tobacco Control Strategy for NI (2012);
- Skin Cancer Prevention Strategy and Action Plan (June 2011);
- Sexual Health Promotion Strategy and Action Plan;
- Home Accident Prevention Strategy and Action Plan (Under review)
- Breastfeeding Strategy (under development);
- Protect Life Suicide Prevention Strategy 2012;
- The NI Civil Contingencies Framework (OFMDFM November 2005);
- Consultation on the new Public Health Framework for Northern Ireland 'Fit and Well';
- The National Risk Register of Civil Emergencies (Cabinet Office);
- The UK's Strategy for Countering Chemical, Biological, Radiological and Nuclear (CBRN) Terrorism (Home Office 2010);
- UK Influenza Pandemic Preparedness Strategy (November 2011);
- DHSSPS Policy Circular HSC (PHD) 01/2010 – Emergency Preparedness for HSC organisations;
- Bamford Action Plan 2009-2011 (2009);
- Tackling Sexual Violence and Abuse 2008-2013;
- Tackling Violence at Home;
- Cooperating to Safeguard Children 2003;
- Building the Community Pharmacy Partnership;
- Tobacco Action Plan;

- Best Practice Best Care – April 2001;
- Minimum care standards for:
    - Residential Homes – January 2008;
    - Nursing Homes – January 2008;
    - Domiciliary Care Agencies – July 2008;
    - Nursing Agencies – July 2008.
- Further standards for Residential Family Centres, Adult Daycare, Daycare and Childminding for Children Under 12, and Dental Care and Treatment (updated 2011;
- Safety First –March 2006;
- Cleanliness Matters (revised strategy 2011/12);
- Changing the Culture 2010 – Strategic regional action plan for the prevention and control of healthcare-associated infections in NI (Published January 2010);
- Implementation of the recommendations made by the Public Inquiry into Clostridium Difficile in Northern Trust Hospitals;
- Regional Decontamination Strategy – 27 February 2004 (HSS (SC) 3/04) – Revised 9 October 2008 (RDS/0802);
- Endorsed National Institute for Clinical Excellence (NICE) guidance, and pay due regard to best practice guidance issued by the Social Care Institute for Excellence and Global Alliance for Improved Nutrition;
- Service Framework for Cardiovascular Health and Wellbeing (Directive Letter Ref – BOARD DIR 01 2009-10). (Note: this was sent while Dr McBride was Acting Permanent Secretary, letter was sent on 12th June 2009);
- Service Framework for Respiratory Health and Wellbeing (Directive Letter ref –

AMCC 2864);

- Mental health Service Framework – due to be launched for implementation planning later in 2011;
- HSC (SAFETY, QUALITY & STANDARDS DIRECTORATE) Circulars on safety matters – A list of all circulars and letters can be found at DH1/10/107373;
- HSC (SAFETY, QUALITY & STANDARDS DIRECTORATE) Learning Letters;
- SAFETY, QUALITY & STANDARDS DIRECTORATE letters relating to Confidential Inquiry reports;
- Regulation and Quality Improvement Authority (RQIA) three-year review programme 2009-2010 (and related reports);
- Ward Sister's Charter;
- Get your Ten a Day – The Nursing Care Standards for Patient Food in Hospitals;
- Promoting Good Nutrition – A strategy to improve nutritional care for adults in all care settings;
- Developing Services to Children and Young People with Complex Healthcare Needs (July 2009);
- Improving the Patient and Client Experience – 5 Standards;
- Living Matters, Dying Matters – a Palliative and End of Life Care Strategy for Adults in NI (March 2010)
- Adoption Minimum Standards for NI – under development;
- Regional Standards for Leaving Care Services in NI – under development;2012, DHSSPS
- Five Year Commissioning Plan to Meet the Accommodation Needs of Care Leavers and Vulnerable Young People aged 16 – 21, 2011

- Revised Good Practice Guidance Between NIHE and HSC Trusts on Meeting the Accommodation Needs of Care Leavers and Homeless Young People (Draft – currently undergoing equality screening)
- Standards for Young Adults Supported Accommodation Projects in NI – under development;
- Kinship Care Standards – under development;
- Eyecare Services Strategy for NI – (consultation outcomes being considered)
- The NI Civil Contingencies Framework (OFMDFM November 2005);
- DHSSPS Controls Assurance Standard – Emergency Planning (updated and reissued 2011);
- BS25999 – British Standard for Business Continuity;
- Evaluation of Neonatal Services – 2011;
- Legal issues relevant to donation after circulatory death (non-heart-beating organ donation) in NI –March 2011;
- Regional Review of Dental Hospital Services –2011;
- Cancer Framework 2008;
- Recommendations for the Future of Pathology Services in NI –December 2007;
- Improving Stroke Services in NI –July 2008;
- Improving Services for Major Trauma –February 2009;
- Review of Adult Neurology Services 2002;
- Promoting Quality Care: guidance on risk assessment and management in mental health and learning disability services (2010);
- Reform Implementation Team Standards and Guidance 2008;

- Making it Better – published in 2004;
- Pharmaceutical Clinical Effectiveness Programme;
- NI Formulary;
- People First;
- Caring for People Beyond Tomorrow – October 2005;
- Developing Better Services – announced February 2003;
- Caring for Carers;
- Families Matter – issued March 2009;
- Care Matters –September 2009;
- Adult Safeguarding in NI;
- Aging in an Inclusive Society (cross government);
- Children and Young People's Strategy (cross government);
- Tackling Sexual Violence and Abuse 2008-2013;
- Tackling Violence at Home (2005);
- Acquired Brain Injury Action Plan (2010);
- Speech and Language Therapy Action Plan (2011);
- Challenge and Change (2005);
- Proposals for the Reform of the NI Wheelchair Service (2008);
- A Strategy for the Development of Psychological Therapy Services (2010);
- Personality Disorder: A Diagnosis for Inclusion (2010);
- Autistic Spectrum Disorder Action Plan (Regional Reference Group) (2009);
- Autism Act (NI)2011;
- Low Secure Report: A scoping paper to inform future mental health service

provision (2010);

- A range of service frameworks in Cardiovascular, Respiratory, Cancer and Mental Health Services;
- Guidelines for Maternity Services Liaison Committees (May 2009);
- Adopting the Future – issued for consultation June 2006, consultation summary published January 2007;
- The Children (NI) Order 1995 Guidance and Regulations Volumes 1-8;
- Circular CCPD 2/2009 – Delegation of decisions on Overnight Stays for Looked After Children issued July 2009;
- Circular CCPD 1/10 – Guidance on Delegated Authority to foster Carers in NI issued February 2010;
- Circular CCPD 2/10 – Guidance on Conditions to be considered on the Continued Placement of an 18 Year in Registered Children's Home issued October 2010;
- Delivering Excellence: Supporting Recovery: A Professional Framework for Mental Health Nurses in NI (2011-2016);
- Revised criteria for accessing publically funded fertility services – published March 2009;
- Making It Better – A Strategy for Pharmacy in the Community;
- A guide to implementing nurse and pharmacist independent prescribing;
- HSC (SAFETY, QUALITY & STANDARDS DIRECTORATE) 29/07 – Guidance on Strengthening Personal and Public Involvement in Health and Social Care – currently under review, and revised guidance will issue in 2011;
- Complaints in Health and Social Care – issued April 2009;

- Complaints handling in Regulation Establishments and Agencies – issued April 2009;
- NI HSC Services Strategy for Bereavement Care – published June 2009;
- Advocacy Policy – a guide for commissioners (planned for July 2011);
- Managing Public Money NI;
- HSS (F) 29/2000 and a range of other circulars;
- Workforce Learning Strategy;
- A Partnership for Care – NI Strategy for Nursing and Midwifery;
- Midwifery 2020 – Delivering Expectations;
- NI Executive: Everyone's Involved – Sustainable Development Strategy: 2010;
- NI Executive: Sustainable Development Strategy Implementation Plan: Awaiting Publication;
- The Ionising Radiation (Medical Exposure) (Amendment) Regulations (NI) 2010: SI 2010 No 29: 9 February 2010;
- Pharmaceutical Clinical Effectiveness Programme;
- NI Drug Tariff;
- Dementia Strategy;
- Physical and Sensory Disability Strategy;
- Learning Disability Service Framework;
- Living with Long Term Conditions – A Policy Framework Draft Service Framework for Older People. Review of Northern Ireland Prison Service – conditions management and oversight of all prisons. Prison Review Team. October 2011.

- Summary of a Review of Prison Healthcare
- A Strategy for Maternity Care in Northern Ireland. S L Russell March 2011
- Prison Ombudsman reports

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data Gathering

What information did you use to inform this equality screening? For example: previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

The data listed informed the screening of the Commissioning Plan and this will be scrutinised further as decisions are taken and recommendations made by commissioning teams and Local Commissioning Groups during 2013/14.

Many of the Commissioning Teams used the same data which contributed to last year's plan.

- Demographic information on the population of NI
- Information on deprivation indicators on health.
- Cancer Registry data
- Analysis of health and social care information systems
- Results of Patient and Client Council Survey *The People's Priorities* (2012)
- Local and national research studies and needs assessment
- Consultations with patients & professionals in relation to the development of the Service Framework documents
- Bamford Review of Mental Health and Learning Disability (2006)
- Through patient and public involvement at both local and regional level.
- Through engagement with Trusts and clinicians (for example, through Managed Clinical Networks and other established fora).
- Complaints
- Consultation with Unions and Professional Bodies.

Preparing for the HSC Equality Action Plans -Audit of Inequalities: Section 75 Equality Groups - Emerging Themes (October 2010)

Information sources produced for Audit of Inequalities and Action Plans (2010):

- A Sure Start to Later Life Ending Inequalities for Older People
- A Social Exclusion Unit Final Report, Office of the Deputy Prime
- Minister January 2006
- Heenan D, 2010 Rural Ageing in NI: Quality of Life Amongst Older People University of Ulster

  http://www.ofmdfmni.gov.uk/index/equality/equalityresearch/research-publications/esn-pubs/rural_ageing_in_ni___quality_of_life_amongst_older_people-2.pdf

- Population projections - pyramids from NISRA - http://www.nisra.gov.uk/demography/default.asp3.htm

- Age Gender costs http://www.dhsspsni.gov.uk/cfrg5_-_presentation_delivered_as_part_of_the_consultation__capitation_formula_review_group.pdf

And

http://www.dhsspsni.gov.uk/the-fifth-report-from-the-capitation-formula-review-group.pdf

- Projections for people aged 85+ for Northern Ireland: http://www.nisra.gov.uk/demography/default.asp134.htm

- Northern Ireland Life and Times Survey 2008 http://www.ark.ac.uk/nilt/2008/(attitudes to age issues) http://www.dhsspsni.gov.uk/ni_gpps_commentary_18_june_final_version.pdf

- GP Patient Survey in Northern Ireland Commentary Report

2009 -2010

http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_qof/gp_patient_survey.htm

Gender

- Birth proportions – NISRA
  http://www.nisra.gov.uk/demography/default.asp8.htm

- Life expectancy by gender NI-NISRA
  http://www.nisra.gov.uk/demography/default.asp130.htm

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Commissioning, by definition, involves determining local health and social well-being requirements and securing services to meet these. We acknowledge throughout the Commissioning Plan that individuals and groups have equality of opportunity to benefit from health and social care commissioned by the Health and Social Care Board and the Public Health Agency. But inequalities in health between different groups are well documented and long-standing. Evidence also suggests that health and social needs and outcomes are far from homogenous. There are different barriers to accessing services; there may be different obstacles for interventions consequently it is necessary that we understand each group's experiences.

The Commissioning Plan 2013/14 therefore impacts on service users, their carers, the public and staff. It is relevant to all nine equality strands as identified under Section 75 of the Northern Ireland Act 1998. These include: age; gender; disability, ethnicity dependents, political opinion, sexual orientation marital status, and religion. In addition the Commissioning Plan is particularly important in the context of deprivation, geography and human rights.

Tables 2.2 and 2.3 have been completed taking into account some generic demographic factors and other equality data. The tables also identify some of the more generic equality and human rights issues and barriers faced by groups covered by Section 75 Categories.

During 2013/14 commissioning teams will be asked to review these and the arrangements for ongoing screening of decisions.

For each of the 12 service teams please see the additional screening evidence that service teams will be using as the work directed by the commissioning plan is taken forward (see after Section 2.4).

The HSCB will continue, as part of its work in relation to Section 75 Equality Duties – Audit of Inequalities, to ensure that all aspects of the commissioning process improve the use of information available, ensure it is kept up to date with the most relevant sources and adhere to equality screening best practice.

The Commissioning Directorate will work with the Equality, Human Rights and Diversity Group to ensure that robust screening and reporting action is enacted by the commissioning teams during 2013/14.

2.2 QUANTITATIVE DATA

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

The following generic equality and human rights issues and barriers have been identified, some of which had been used for the previous plan. The information is still relevant. All updates provided by the commissioning teams have been included.

Category	***What is the makeup of the affected group? (%) Are there any issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	The population of N Ireland is – 1.811 million (June 2011). (Reference: Northern Ireland Statistics and Research Agency) http://www.nisra.gov.uk/demography/default.asp17.htm Female 51% Male 49% Birth proportions – NISRA http://www.nisra.gov.uk/demography/default.asp8.htm There is a higher level of disability among adult females (23%) compared to adult males (19%). Girls (4%) are less likely to be disabled than boys (8%).
Age	Compared with other UK jurisdictions, Northern Ireland had the fastest-growing and youngest population during 2001 – 2011, with an estimated increase of 7.5 %. It is projected to have the youngest population during 2011-2021. This equates to 23% or 448,000 children and young people aged less than 18 years. Source: NISRA 2010 Mid-year Population Estimates At the 31st March 2012 there were 2644 looked after children (LAC), 74% of whom were placed in Foster Care, the majority of whom are aged 12-15yrsNorthern Ireland is projected to have the highest

	fertility rate during 2011 – 2021. http://www.economist.com/node/2516900 Population projections indicate that the most significant change in age structure will occur in the older age bands. In 2008, the median age in Northern Ireland was 36.5 years and projected to be 38.8 years in 2021 and 41.9 years by 2031. There were 360,272 people sixty years and over living in Northern Ireland on Census Day 2011. This represents twenty percent of the population and this is projected to increase substantially. There were 232,300 people aged 65-84 years living in Northern Ireland on Census Day 2011, an increase of 16 per cent compared to 2001 and representing 13% of the NI population. There were 31,400 people aged 85 years and over (85+) living in Northern Ireland on Census Day 2011, an increase of 35 per cent compared to 2001. The 2010 based population projections suggest an increase by 2025 to 460,000 people sixty plus (another 130,000). By then they will represent 25% of the population. Those eighty five and over will increase sharply to fifty-five thousand by 2025. http://www.nisra.gov.uk/Census/pop_stats_bulletin_2_2011.pdf and http://www.nisra.gov.uk/demography/default.asp17.htm The number of people aged over 65 with dementia will increase by 30% from the current figure of 15,400 to almost 20,000 by 2017. Disability prevalence increases with age.

Religion	In Northern Ireland most data is recorded on Christian Faiths. Catholic 41%, Church of Ireland 14% Presbyterian 19% Methodist 3%. The Remainder are other non Christian faiths (0.8%), other Christian or Christian related denominations (5.8%) not stated or no religion (17%).http://www.nisra.gov.uk/Census/key_press_release_2011.pdf
Political Opinion	Limited data available
Marital Status	See Marriage trends – NISRA http://www.nisra.gov.uk/demography/default.asp11.htm Northern Ireland Health and Wellbeing survey 2005/6 NISRA http://www.csu.nisra.gov.uk/survey.asp5.htm
Dependant Status	Between 2001 and 2011 the number of lone parent households with dependent children (where the lone parent was aged 16-747474747474years74 years) increased by 27% from 50,500 to 63,900. 25% of all children are from one parent families, nearly half separated or divorced. The current estimated number of carers is 207,000 (one in every eight adults); 150,663 of these carers are people of working age. Any one of us has a 6% chance of becoming a carer.
Disability	The term disability covers such a wide range and combination of conditions that no standard method or single source of information is available. It is however estimated that between 17 – 21% of our population have a disability, affecting 37% of households. Twenty-one percent

	of the usually resident population at the 2011 census had a long term health problem or disability which limited their day to day activities. 21% adults and 6% children have a disability. 37% of households include at least one person with a disability and 20% of these contain more than one person. The multiple needs are explained by the fact that there is a higher prevalence of disability among adult females (23% compared with 19% adult males). Prevalence of disability also increases with age from 5% among young adults to 67% among those who are 85 plus years. (Northern Ireland Statistics and Research Agency (NISRA) 2007) A high proportion of the 1860 people receiving Direct Payments have a physical or sensory disability (32% at January 2011). In Northern Ireland there are approximately 16,500 persons with a learning disability. An indication of the extent of the disability is reflected in the sub-groupings that are traditionally used; mild, moderate, severe and profound learning disabilities (Equality Commission NI, 2006). http://www.equalityni.org/archive/tempdocs/LiteratureRev(F)l.doc Learning disability is a life-long condition. 78.9% of 0 -19 year olds with a learning disability are described as having 'moderate' disabilities while 21.1% are described as 'severe/profound' (N=8150). Children and young people (0-19 years) represent the larger grouping of all the age levels (20-34 years, 35-49 years and 50+ years). McConkey *et al* (2006) predict that the population of adult persons in NI with a learning disability will increase by 20.5% by 2021 (N=10,050). This compares to an estimated increase of 16.2% in

	England. The percentage of persons aged over 50 years in 2021 will increase to 35.7% in Northern Ireland (up from 26.8% in 2002).
Ethnicity	1.8% of the Northern Ireland population at the 2011 census belonged to a minority ethnic group. This was more than double that in 2001. English is not the main language for 3.1% (54,500) of the population at the 2011 census. The Traveller population in N Ireland is estimated at 3905. The number of births to mothers outside the UK and Ireland have increased over the past decade with 2477 births in 2011 compared with 661 in 2001 (9.8% of all registered births). The School Census 2011/12) shows that 5,150 primary school children have a language other than English. Source- http://www.deni.gov.uk/index/facts-and-figures-new/education-statistics/32_statistics_and_research-numbersofschoolsandpupils_pg/32_statistics_and_research-northernirelandsummarydata_pg.htm
Sexual Orientation	Accurate figures are not readily available but it is estimated that 5-7% of the population are from the gay and lesbian or bisexual community.

2.3 QUALITATIVE DATA

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

Category	*Needs and Experiences*
Gender	In Northern Ireland life expectancy increased between 2002-2010 from 74.5 years to 77.0 years for men and from 79.6 years to 81.4 years for women. Men die five years earlier. They are 3 times more likely to die by suicide, be killed in a road accident, die of a heart attack and twice as likely to die from lung cancer. Evidence suggests that men have higher levels of risk behaviour but are less likely to attend their GP or leave it late to attend. The impact of leaving attendance at GPs too late is that men are more likely to attend Accident and Emergency Services (Evidence collated for Audit of Inequalities 2010). Risk Behaviour and GP consultation rates – primarily NISRA Continuous Household Survey http://www.csu.nisra.gov.uk/survey.asp29.htm Women are more likely to have mental health problems and in the past were more likely to develop life limiting illness though there is evidence that the gap is reducing. Transgender individuals have higher level of mental health issues and are more likely to attempt suicide.
Age	Over the next 40 years as society ages dementia will become more common. There are differences across the genders as women live longer than men. A review by The Kings Fund across the NHS found evidence that older people may be being denied treatment offered to younger patients, and in some hospitals, the standard of hygiene and nutrition given to older people can fall below minimum standards. The Kings Fund concluded that while there are many examples of excellent care for older people, there is also much unfair treatment which was age related.

	http://www.kingsfund.org.uk/publications/old_habits_die.html Some evidence on the attendees at Accident ad Emergency Services suggests that attendees are younger 22-44 years and attend at peak times (mid night to 2pm). (Audit of Inequalities Evidence 2010) At 31 March 2012 Social Services in Northern Ireland had received 35,516 Children in Need Referrals relating to 28,496 children. This continues a steady increase observed since 2008, with the number of referrals received approximately 3,500 more than in 2007 relating to approximately 7,000 more children. At 31 March 2012, 2,127 children were listed on child protection registers in Northern Ireland, a decrease of 11% (274) from 2011 (2,401) but an increase of 18% (322) since 2007 Source : http://www.dhsspsni.gov.uk/index/stats_research/stats-cib-3/statistics_and_research-cib-pub/children_statistics/stats-cib-children_order.htm Records suggest some difficulties in the recording of religion or ethnicity (Source: HSCB Corporating Parenting Report, 1st April 2010- 30th September 2010). Data for 2011/12 shows that almost two thirds refused to declare a religious affiliation.
Religion	Once social needs are accounted for religion does not have a significant independent influence on health status. The variations by religion within age groups are a reflection of the correlation between various additional social needs and indicators. (Source: evidence collated as part of Audit of Inequalities 2010)
Political Opinion	A DHSSPS literature review into equality and human rights issues in relation to access to health and social care explained the difficulty with determining how well statutory health and social services are performing in relation to political opinion. This difficulty lies, in

	part, with the current lack of research into how political opinion impacts upon equity of access to health and social care services. http://www.dhsspsni.gov.uk/eq-literature-review
Marital Status	The DHSSPS literature review also highlights important factors that influence access such as laws around who can adopt access to fertility services, the male/female split in lone parenting (8% and 92% respectively) and the general lack of research in this area. Further information is available at the link below. http://www.dhsspsni.gov.uk/eq-literature-review
Dependent Status	Carers themselves are twice as likely to be sick or permanently disabled. People providing high levels of care are twice as likely to be permanently sick or disabled. Women are more likely to be informal carers than men. *Carer experience:* Carers indicate that they are often viewed by staff as additional competitors for scarce resources rather than as equal partners in the care of the person. They sense staff ambivalence rather than the prospect of collaboration. Trust training programmes include development sessions on this for staff, yet day-to-day practice still lags behind the aspirations of partnership. (HSCB Audit of Inequalities 2010) *Short breaks - Respite care:* There is little consistency in targeting carers in need of respite – a Trust may have several sets of criteria. Better methods of assessing the strain and stress of caring as experienced by carers are required (HSCB Audit of Inequalities 2010). Young adult carers experience the move from being supported as a young person through Children's Services to the support provided as an adult as inappropriate. (HSCB Audit of Inequalities 2010).

	There are also multiple needs experienced by parents and carers who themselves have disabilities but who are looking after their children There is a dearth of information on the needs of fathers who care for their disabled children and on the needs of minority ethnic groups and single fathers and on the needs of single fathers who are carers (See review entitled *"Emerging Themes Across Health and Social Care(2010*) http://www.hscbusiness.hscni.net/pdf/Emerging_Themes_Booklet_25_Oct_10.pdf
Disability	In Northern Ireland people experience the lowest disability free life expectancy (Age NI, 2010). Only a small proportion of the disabled population in Northern Ireland is in regular contact with HSC services, approximately 16,500 contacts are made with Trust disability services each year. 400 people are in nursing or residential care but the heaviest reliance is on community based day and domiciliary care, specialist equipment and therapeutic interventions. Source: A Physical and Sensory Disability Strategy 2011-2014 (DHSSPSNI Consultation Report 2010). A high proportion of the 1860 people receiving Direct Payments have a physical or sensory disability (approximately 32% at Jan 11). Northern Ireland's mental health needs are 25% higher than the rest of the UK and yet we spend 25% less to address them. Given the wide range and combination of conditions those with physical and sensory impairments face a range of accessibility, attitudinal and communication barriers when accessing health and social care services and information.
Ethnicity	National research suggests that there are differences within Black

	and Minority Ethnic groups generally when compared with the white population and they experience worse health outcomes. Ill health often starts at an earlier age. There are variations from one health condition to another. There are also differences across the age groups with the greatest variation in worse health amongst the older ethnic minority groups. For example minority ethnic groups have greater rates of cardiovascular disease than white people but lower rates of many cancers. Variations occur across genders and across geographical areas. Source: Parliamentary Office of Science and Technology Postnote January 2007 Number 276 www.parliament.uk/post. Travellers have a higher burden of chronic diseases. Certain groups experience additional disadvantage for example, male Travellers life expectancy is 15 years less and females 10 years less than the adult population as a whole. All Ireland Traveller Health Study Team 2010All Ireland Traveller Health Study Technical Report 1: Health Survey Findings. Dublin: UCD http://www.dhsspsni.gov.uk/technicalrep1.pdf Issues facing people of ethnic minority groups include language and communication, awareness of services and attitudes of staff.
Sexual Orientation	People who are *Gay, Lesbian and Bi Sexual and Transgender :*(LGBT) have significantly higher than average rates of anxiety, depression, self-harm and suicides alongside higher problem drug and alcohol use. LGBT people are at higher risk of suicidal behaviour, mental disorder and substance misuse and dependence than heterosexual people. The results of the meta-analyses demonstrate a two-fold excess in risk of suicide attempts in the preceding year in men and women, and a four-fold excess in risk in gay and bisexual men over

a lifetime. Similarly, depression, anxiety, alcohol and substance misuse were at least 1.5 times more common in LGB people. Findings were similar in men and women but lesbian women were at particular risk of substance dependence, while lifetime risk of suicide attempts was especially high in gay and bisexual men.

Sources

A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people – BMC Psychiatry June 2008. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2533652/

Young people who identify as LGBT are –

- At least 2.5 times more likely to self-harm.
- 5 times more likely to be medicated for depression.
- At least 3 times more likely to attempt suicide
- 20 times more likely to suffer from an eating disorder than their heterosexual counterparts.

Information taken from the "Shout Report 2003 – An examination of the needs of LGBT young people in Northern Ireland" –Youthnet and Department of Education

http://www.youthnetni.org.uk/Site/29/Documents/shout%20pdf.pdf

In addition the report by the Institute of Conflict Research on 'Health Care Issues for Transgender People in NI', July 2011, specifically highlighted emerging issues in relation to the small but growing numbers of young people under 18 years presenting with gender dysphoria and the need to develop a consistent service response.

See also Out on Your Own – An examination of the Mental Health of Young Same-Sex Attracted Men. McNamee 2006

http://www.rainbow-

project.org/assets/publications/out_on_your_own.pdf

See also our Health and Well-being Your Business Guidelines on Lesbian and Bisexual Women's Health and Social Care in Northern Ireland by Marie Query (2011).

2.4 MULTIPLE IDENTIES

Are there any potential impacts of the policy or decision on people with multiple identities for example; disabled minority ethnic people, disabled women, young protestant men and young lesbians, gay and bisexual people?

It is recognised that people are complex and the ways in which we define ourselves are complex. Our physical characteristics, histories, influences, behaviours, cultures and subcultures are all exceptionally intricate narratives that we use to identify ourselves .We are all constantly defining and redefining different aspects of ourselves.

The Commissioning Plan also acknowledges the cross cutting needs of the equality groupings. It recognises the need to take into account geographical differences and issues facing people who live in areas of high deprivations. This is important because, for example, people from minority ethnic groups, lone parents and disabled people are over represented in the areas of greatest deprivation.

The 20% of most deprived areas in Northern Ireland represent nearly 340,000 people.

Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances are:

- Lower life expectancy than the Northern Ireland average
- 33% higher rates of emergency admission to hospital

- 72% higher rates of respiratory mortality
- 59% higher rates of incidence of lung cancer
- 73% higher rates of death from lung cancer

93% higher teenage birth rates

116% more likely to be admitted to hospital for self- harm

82% more likely to die as a result of suicide

The evidence base used by each of the 12 service teams to inform commissioning priorities is outlined below:

1. Health and Social Wellbeing Improvement, Health Protection and Screening.

Evidence based research has determined the strategic direction of the organisation as well as informing the commissioning of services and programmes. Action has also been developed to address the needs of specific groups. Examples, which are highlighted through thematic action plans, have included:

- Equality and Human Rights: Access to health and social services in Northern Ireland (DHSSPS 2006): The DHSSPS commissioned a literature review in 2006 to assist with the Equality Impact Assessment Programme. The review covered each of the nine dimensions set out in Section 75 of the Northern Ireland Act 1998. In relation to ethnicity, the review identifies the barriers many Minority Ethnic groups face when accessing health and social care services. It is divided into 4 categories: identification of common barriers to accessing health and social care; a focus on the language barrier; difficulties faced by specific Minority Ethnic communities and difficulties experienced by those residing in rural areas.

- Health and Social Needs among Migrants and Minority Ethnic Communities in the Western area (Jarman, 2009): A report examining the health and social wellbeing needs of settled and migrant ethnic groups in the Western Health and Social Care Trust area. This included an analysis of the legislative framework, local demographics, a review of the literature on racism and other factors impacting on health and wellbeing as well as the findings from a survey of migrants' views and experiences and those of service providers and support groups.

- Barriers to Health: migrant health and wellbeing in Belfast. A study carried out as part of the EC Healthy and Wealthy Together project (Johnston, Belfast Health Development Unit 2010): A report exploring migrant health and wellbeing in Belfast. This included an analysis of current information on migrant demographics, legislation on immigration, work, health and social services and social security entitlements in Belfast.

- Health Needs Assessment of Romanian Roma (Long and Wright unpublished paper 2012).

- Health Needs Assessment of the Black and Minority Ethnic Group Children in Belfast (Elliot, unpublished MSc thesis QUB 2012).

- A study of issues faced by migrant, asylum seeking and refugee children in Northern Ireland (National Children's Bureau (NI) 2010)

- A Need to Belong. An Epidemiological Study of Black and Minority Ethnic Children's Perceptions of Exclusion in the Southern Area of Northern Ireland (Biggart, O'Hare and Connolly, Queen's University Belfast 2009):
  A report prepared for the Southern Area Children and Young People's Committee focussing on children's perceptions of their health, psychological and social wellbeing.

- Health Protection Issues Affecting Immigrants – A Literature Review (Veal and Johnston 2010 unpublished). A review of the literature on the detection, prevention, and treatment of infectious diseases affecting immigrants and refugees.

- *Relating to Community development* -Professor Sir Michael Marmot in Fair Society, Healthy Lives (2010), stated that tackling health inequalities requires action across all the social determinants of health. The report makes clear that there is a need for individuals and local communities to define the problems and develop community solutions through effective participatory decision-making at local level. Without such participation and a shift of power towards individuals and communities, he contends that it will be difficult to achieve the penetration of interventions needed to impact effectively on health inequalities.

- *Relating to LGB&T* – The "Through Our Eyes – Experiences of lesbian, gay and bisexual people in the workplace' report highlighted continuing difficulties for many employees working in the public and private sector. The research findings reported:
  - Almost 1 in 4 (24.5%) respondents from the public sector conceal their sexual orientation in the workplace.
  - 40% of public sector employees who responded have heard negative comments about LGB people from a colleague or colleagues in the workplace. 13.7% from the public sector have been subjected to negative comments about their sexual orientation from a colleague or colleagues outside their workplace.
  - More than 1 in 4 (26.9%) respondents across all workplace sectors have had reason to make a complaint relating to their sexual orientation or perceived sexual orientation.
  - Healthcare Issues for Transgender People Living in Northern Ireland, Institute for Conflict Research 2011 R McBride).
- *Relating to Older people* -there is a growing body of evidence and guidance related to the wider health and wellbeing needs of older people. These include the following:
  - "The Billion Dollar Question: embedding prevention in older people's services – 10 "high impact" changes – Policy Paper 8. (Health Service Management Centre, University of Birmingham, 2010).
  - National Service Framework for Older People (Department of Health, 2001);
  - National Institute of Clinical Excellence - Falls: the assessment and prevention of falls in older people (NICE, 2002);

- Falls and Fractures : effective interventions in health and social care (Department of Health, 2009);
- Promoting Well-being: Developing a Preventive Approach with Older People (Lewis, Fletcher, Hardy, Milne and Waddington (National Institute for Health, Leeds, 1999);
- Proven Strategies to Improve Older People's Health: a Eurolink Age report for the European Commission (Eurolink Age, 2000)
- Older People's Inquiry for the Joseph Rowntree Foundation – (Raynes et al, 2006).

- *Relating to Travellers* - The 2001 Census identified around 1,700 Travellers in Northern Ireland. The All Ireland Travellers Health Study (2010) carried out by University College Dublin, showed that the age profile of the Traveller community in Northern Ireland is markedly different from that of the general population with 75% of people under the age of 30. Only 1% of Travellers are over 65 years compared to over 15% of the settled population. This evidence offered huge differences in life expectancy and points to the considerable health and social wellbeing challenges that exist.

- Dying Fifteen Years Early – What Can Traveller men and relevant agencies do? Fergal O'Brien 2012, MSc Thesis University of Ulster, which has examined the specific needs of Traveller men with recommendations for coordinated action among agencies and Government.

- Although there is currently no Regional Travellers Strategy for Northern Ireland, the PHA and Health and Social Care Board (HSCB) undertook to establish a Regional Travellers Health and Wellbeing Forum. The Forum, representing the PHA, HSCB, Health and Social Care Trusts, Cooperation and Working Together (CAWT), Patient & Client Council and Traveller support organisations have agreed to commit themselves to undertake actions based on the findings and recommendations of the study.

2. Unscheduled Care

The Unscheduled Care Commissioning Team has taken account of the Patient Client Council People's Priorities document and has drawn available information on patient experience. Moreover the Team has taken account of emerging evidence on delivering unscheduled care from Britain, including models to increase access and promote appropriate unscheduled care delivered in the most appropriate setting, which is not generally an Emergency Department. The Team has a great deal to do to extend its evidence base which is an integral part of its Year One Action Plan.

The DHSSPS Commissioning Direction 2012 has set targets to ensure that 95% of patients attending any A&E Department are either treated and discharged home, or admitted within four hours of their arrival in the department, and no patient waits longer than 12 hours. Targets have also been set in relation to ambulance response times.

Performance at a number of hospital sites across Northern Ireland has been significantly below the 4 hour minimum standard set by the Department. These standards are routinely achieved in England.

In the last 5 years, the total number of attendances per annum at emergency care departments has increase by 3.1% to 731,000. This means that on average 2,000 patients attend A&E each day in Northern Ireland. Of the patients who attend A&E approximately one in four are admitted to a hospital bed. Rates of attendance and admission are both considerably higher than in England.

Northern Ireland has approximately a quarter more acute beds (per 1000 population) than England. However, these beds are less intensively used and patients tend to stay in hospital for longer periods than the equivalent patient in England.

Unscheduled care and admission to hospital for children also varies across Northern Ireland. In some cases, children are admitted via a children's A&E department but, in the majority of cases, they will be admitted via general

hospital emergency department. Some departments do on have a designated area for children. People from deprived areas are overrepresented in attendances at A&E and emergency admissions.

3. Elective Care

The commissioning priorities for elective care have been informed by the DHSSPS Commissioning Direction and in particular the need to ensure that all urgent operations are completed in a timely manner and that patients waiting for routine assessment or treatment should wait no longer that the maximum times set by the Department.

Each year nearly 600,000 people are referred to hospital for specialist assessment by their GPs or dentists. Every year around 450,000 people receive planned inpatient or day case operations.

The overriding priority for the elective care system in Northern Ireland is to ensure that all urgent operations are completed in a safe and timely manner and that patients waiting for routine assessment or treatment should wait no longer than the maximum times set by the Department. This is achieved by ensuring that:

- There is sufficient elective capacity to meet need;
- Appropriate referral pathways, including appropriate alternatives to acute assessment and treatment are agreed through work with General Practitioners and other referrers.
- Assessment and treatment protocols linked to higher value procedure pathways are developed in conjunction with consultants, GPs and other clinicians.

4. Cancer Care

Cancer was responsible for 27% of all deaths occurring in Northern Ireland in 2009, (NISRA Deaths in Northern Ireland, 2010)

In Northern Ireland one in three of the population develops a cancer by the time they reach 75 years of age. Excluding the rarely fatal non-melanoma skin cancer (NMSC) the risk for both males and females is about one in four. The risk of dying from cancer before the age of 75 is lower than that for developing cancer but varies by gender; among males the risk is one in seven while in females it is one in nine. In general men are at significantly greater risk than women from nearly all of the common cancers that occur in both genders (with the exception of breast cancer) (White 2009, Wilkins 2006, DH 2007). Even after allowing for higher risk factors in smoking and alcohol consumption it has been suggested that additional influences of symptom awareness and treatment avoidance may be impacting on this.

Rates of new cases of cancer in Northern Ireland are fairly static although the actual number of cases is increasing due to the ageing of the population. Despite this, as survival continues to improve mortality rates are decreasing in Northern Ireland along with other countries in the UK. However as the recent International Cancer Benchmarking Partnership study of four main cancers highlighted despite the improvements between 1995 and 2007 survival in Northern Ireland and other parts of the UK is lower than that in Australia, Canada, Sweden and Norway particularly in the first year after diagnosis and for patients aged 65 years and older.

Cancer can develop as a result of factors related to environment, lifestyle, and heredity. While our current understanding of the causes of cancer is incomplete, many risk factors that increase the possibility of getting cancer have been identified. These include age, history of cancer in the family, tobacco use, alcohol consumption, lack of balanced diet, lack of physical activity, obesity, exposure to ultraviolet radiation from sunshine or sun beds, exposure to certain chemicals and gases such as asbestos, benzene or radon gas, exposure to ionising radiation, infections such as human papillomavirus (HPV), treatments such as exposure to oestrogen through Hormone Replacement Therapy (HRT), late or lack of reproduction in females and lack of breast feeding in females. While most people

with a particular risk factor for cancer will not contract the disease, the possibility of developing cancer can increase as exposure to a risk factor increases.

The standardised incidence rate for all cancers has been consistently higher in the most deprived areas than the NI average however the gap between the rates has declined from being 20% higher in 1999 to 9% higher in 2006. The male gap reduced from 22% to 7% while the female gap fell from 18% to 11% over the period. Much of this reflects variation in risk factors particularly tobacco consumption which are substantially higher in more deprived areas. This is reflected in the difference in lung cancer incidence rates between deprived areas and NI as a whole. These have narrowed from being 81% higher in the most deprived areas in1999 but remained 65% higher in 2006.

The socio-economic gradient in incidence and survival varies by cancer. (NI Cancer registry 2007 report)

The proportionate decreases between 2001 and 2008 in the standardised death rates due to cancer in deprived areas and NI as a whole were broadly similar which meant that the inequality gap remained around a third higher in deprived areas than the Northern Ireland average. The gap for males was higher (35%) than that for females (28%). This is consistent with UK data which showed that unskilled workers are twice as likely to die from cancer as professionals.

Downing et al focused upon women with breast cancer and found that those living in deprived areas were:

- More likely to be diagnosed with advanced cancer
- More likely to have a mastectomy, rather than breast conserving surgery
- Less likely to receive radiotherapy
- Less likely to have surgical treatment
- Less likely to have survived five years

Cancer Research UK's 'Reduce the Risk' *survey in the UK* found that there was a socioeconomic gradient to knowledge of all the major risk factors or awareness of symptoms relating to cancer; with the wealthier more likely to have knowledge of

cancer risk factors compared to those lower down the socioeconomic scale. Twice as many people from the most deprived group could not name any cancer symptoms (20per cent) compared to those from the least deprived group (9per cent). For all the main risk factors, the wealthier an individual, the more likely they are to be aware of its link to cancer. They also identified differing levels of awareness between Black and Minority Ethnic communities and the general population.

A range of harder to reach groups have unmet need relating to information, support and cancer services. There is evidence of inequalities at each stage of the patient pathway, from information provision through to palliative care. UK data shows that in addition to a greater likelihood of being diagnosed with certain cancers, people from the most deprived communities have poorer outcomes once they have been diagnosed

UK Research suggests that one in six patient information leaflets produced by hospices and palliative care units can only be read by 40 per cent of the population and that only 30 per cent of GPs surgeries have accessible information for people with learning disabilities.

Language can be a significant barrier to accessing cancer services for many people from BME groups, particularly (but not limited to) asylum seekers and refugees. UK data in the report Focus on social inequalities found that 41 per cent of people with additional language needs had no one to help with interpreting when visiting a GP or health centre. The 2009/10 NI survey of GP patients while not dealing specifically with cancer patients highlighted issues about access and information for non ethnic white populations and elderly patients with chronic conditions.

The Social Exclusion Unit in UK found that those with low literacy were six per cent less likely to attend cervical screening than women with higher basic skills. Screening rates are low in women with learning disability although higher rates of the risk factors of obesity and overweight have been found in those with learning disabilities and mental health problems. Concerns have been raised in local

survey data and nationally re lesbian and bisexual women having higher behavioural risk factors but being less likely to be screened.

There has been some evidence in the UK of older patients receive differing care to their younger counterparts. Evidence, given in the Cancer Reform Strategy in England, found that older women were less likely to receive standard management, such as radiotherapy, for their breast cancer even after taking account of tumour type215 and that older patients with lung cancer were less likely to receive radical treatment for their disease.

A recent International Cancer Benchmarking Partnership study of four main cancers highlighted despite the improvements between 1995 and 2007 survival in Northern Ireland and other parts of the UK is lower than that in Australia, Canada, Sweden and Norway particularly in the first year after diagnosis and for patients aged 65 years and older. This report compared the international differences in survival across Colon, Lung, Breast and Ovarian, and showed the age standardised relative survival at one and five years.

This showed that for colorectal cancer, 8% of patients in Northern Ireland died between 1995 and 2007 within one month of diagnosis compared with 11% in England and Wales. One in ten women with ovarian cancer died within one month of diagnosis in Northern Ireland, while 12% died in England and 13% in Wales. The survival rates for patients with breast, lung and colorectal cancers looked at in this report have improved in Northern Ireland from 1995 to 2007. However, ovarian cancer is included as an example of a less common cancer with large variations in survival across countries. The specific variations for ovarian are shown http://eu-cancer.iarc.fr/cancer-16-ovary.html,en#block-9-27

The international survival trends showed persistence differences between countries, although the trends in cancer incidence and mortality were broadly consistent with the trends in survival. This work has provided the basis for the priorities of the Cancer Commissioning Team. A copy of the full report can be obtained from
http://www.lshtm.ac.uk/eph/ncde/cancersurvival/icbp_paper1.pdf

5. Palliative Care and End of Life Care

The commissioning priorities for the Palliative Care Service Team have been determined by the regional strategy, Living Matters Dying Matters. It is estimated that two thirds of all deaths in Northern Ireland would benefit from the palliative care approach in the last year of life but do not receive it. This approach is appropriate for those with chronic non cancer conditions such as respiratory disease, heart failure, neurological, renal and other degenerative conditions such as dementia and those elderly people who are approaching the end of their life.

The Centre for Policy on Ageing report for the Department of Health London 2009 identified that in England people under 65 had disproportionate access to palliative care and older people had unmet needs in palliative care and pain management. There was evidence that palliative care in nursing homes for older people was poorly organised and that older people were experiencing persistent pain without appropriate assessment and treatment.

Until recently the emphasis on generalist palliative care services in N Ireland has been mainly for those with cancer conditions, which account for only a quarter of all deaths. The biggest inequalities are therefore between those with cancer conditions and non-cancer conditions, regardless of all other aspects. These are often conditions which affect older people. There is therefore a marked commissioning emphasis on the identification of palliative care needs across non cancer conditions, as outlined above; and also particularly for people who live in nursing homes.

Over the last five years 51% of all deaths and 44% of all cancer deaths occurred in hospital, again showing inequality between cancer and non-cancer conditions. Surveys from the UK show that most people would prefer to die at home (including nursing home). This information is not available for N Ireland, but will shortly be measured through Service Frameworks. A key priority will be to develop pathways and services which support people to die at home when that is appropriate and their preferred place of death.

Specific studies from the UK suggest inequalities in access to specialist palliative care driven by gender, age, condition, socio-economic status, race and ethnicity. Again specialist palliative services in N Ireland are mainly provided for those with non-cancer conditions and we are focusing again on the identification of needs of those with these conditions to improve access, including again residents of nursing homes. In N Ireland there are no inequalities in access to hospices on the basis of socio-economic status.

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In terms of information provision UK Research suggests that one in six patient information leaflets produced by hospices and palliative care units can only be read by 40% of the population. There is no similar study in N Ireland, but an information group, supported by the Palliative Care Service Team, is being set up to consider what information needs are and how these can be met.

Research amongst varied BME groups in the UK generally identified different cultural practices relating to death and preparation for burial which required to be sensitively handled by service providers. Bereavement co-ordinators in each Trust are taking forward these issues and developing training for staff and information for those who are bereaved.

Many studies have shown that carer needs are key in many cancer and long term conditions as well as in those with palliative and end of life care needs. Again we have asked that carer needs are identified and that specific processes are put in place to give key information and support to families and carers, for example through the implementation of the key worker function.

6. **Long Term Conditions**

The commissioning priorities for long term conditions relate to heart disease, vascular disease, respiratory disease, neurological conditions and diabetes in adults and children. It is essential that care should be provided close to home.

The commissioning priorities for long term conditions have been informed by:

- The Service Framework for Cardiovascular Health and Wellbeing
- The Health Impact Assessment for the Cardiovascular Service Framework

- The Service Framework for Respiratory Health and Wellbeing
- The Annual Reports of the Director of Public Health
- The CAWT Hospital Diabetes Audit 2008
- The Northern Ireland Stroke Strategy 2008
- Living with Long Term Conditions – A Policy Framework 2012

7. Maternity, Paediatrics and Child Health

Maternity

The priorities for maternity services are largely based on the regional maternity strategy published in July 2012. The strategy has been informed by evidence of best practice including research evidence, NICE guidelines, Royal College recommendations, and RQIA review.

The Centre for Maternal and Child Health Enquiries (CMACE) has produced reports on maternal and perinatal mortality and on specific topics such as diabetes and obesity in pregnancy. The maternal and perinatal mortality reports have shown an association between factors such as ethnicity, deprivation, smoking and obesity and a higher risk of poorer pregnancy outcomes. NI has taken part in the work of CMACE(now MBRRACE-UK Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) CMACE and Trusts are expected to implement the recommendations of the CMACE (MBRRACE) reports Gynaecologists guidance.

In terms of maternal obesity the Centre for Maternal and Child Enquiries report on Maternal Obesity in the UK (2010) indicates the extent to which the prevalence of maternal obesity is a concern and the risks to both mother and baby. In Northern Ireland the prevalence women with a Body Mass Index ≥35 in pregnancy is 5.3% and those with a Body Mass Index ≥40 is 2%.

Using the index of multiple deprivation score this report also shows as confirmed in other studies that social deprivation is associated with a significantly increased risk of maternal obesity.

The NICE guideline 'Pregnancy and Complex Social Factors' has been endorsed by the Department as applicable for implementation (with some exceptions) in Northern Ireland and will help Trusts and others to address the many and often interacting social factors that can affect pregnant women living in difficult social circumstances.

The UK Infant Feeding Survey 2010 confirms the need for action to increase breastfeeding rates and reduce smoking in pregnancy. NI has the lowest uptake of breastfeeding in UK with 64% breastfeeding at birth compared to 81% in the UK. Those least likely to breastfeed include young mothers and women who have never worked.

The Infant Feeding Survey also identified that in Northern Ireland significantly more women smoke before and during pregnancy than the rest of the UK with 41% of women here who never worked smoking throughout pregnancy compared to 21% in the UK.

Obesity and smoking are known to be more prevalent in those living in deprived geographical areas.

8. Community Care, Older People and Physical Disability

Our population is ageing and this demographic change will have significant implications for health and social care as older people are major users of services. The number of people over 65 has increased by 16% since 1999 and will show a similar increase from the current figure of 255,000 by 2015. This will include a rise of 29% in the number aged over 85. The number of people over 65 with dementia will increase by 30% from the current figure of 15,400 to almost 20,000 by 2017.

In Northern Ireland we have a relatively high proportion of people living in care homes. This is at odds with the demand for greater independence and needs to be reduced substantially. Other significant initiatives will be the implementation of the Northern Ireland Single Assessment Tool as a way of delivering needs led services alongside the further development of regional safeguarding arrangements to protect those at risk of abuse or exploitation.

It is estimated that between 17 – 21% of our population have a disability affecting 37% of households. Recent research indicates that approximately 8,800 people have a visual impairment, 11,700 are hearing impaired and over 35,000 have a mobility problem.

Until recently the reform agenda within disability services has been focused on specific services resulting in initiatives aimed at reforming wheelchair services, prosthetics, brain injury services, sensory impairment provision and thalidomide survivors. A more strategic approach will be adopted as a result of the new Regional Disability Strategy. It will be followed by the Report of the Joint Housing Adaptions Steering Group which is designed to improve joint working between HSC and housing.

Evidence has been used from:

- Demographic trends/data sources
- Patient & Client Council Reports
- Centre for Ageing Research and Development in Ireland publications/research
- Serious Adverse Incident/Untoward events reporting
- Social Care Procurement Unit data
- Age Sector Platform – The Peoples Parliament Report
- Age (NI) Policy briefings.
- Disability e-zine

The commissioning priorities have also been informed by the DHSSPS Commissioning Direction 2013.

9. **Children and Families**

The Children and Families Programme is heavily prescribed by legislation and associated regulations and guidance which set out the parameters within which services should operate and which also require to be taken into account when services are commissioned. For the priorities identified within the Commissioning Plan this includes legislation pertaining to children looked after, care leavers,

children with a disability including autism, early years services, children with mental health concerns and those involved in Inter-country Adoption.

In addition to legislation there are also policy and procedures which stipulate the standards which require to be adhered to in engaging with service users across the various sub groupings. It is imperative that actions are premised on acting in the best interests of children and that account is taken of the principles contained within the United Nations Convention on the Rights of the Child and the European Convention on the Rights of the Child. This also allows the HSCB, PHA and Trusts to garner whether sufficient attention is being afforded to the equality and human rights issues.

The infrastructure within which children's services operates also provides the opportunity to look at commissioning and service provision in a holistic sense in that a range of partnerships are available where significant thought has been given to ensuring inclusivity and that the interests of Section 75 groups are appropriately represented and that challenge can be exercised when required. These partnerships include:

- The Children and Young People's Partnership
- The Childcare Partnerships
- The Bamford Taskforce
- The Safeguarding Board Northern Ireland (SBNI)
- The Regional Autism Spectrum Disorder Network
- N.I. benchmarking forum for 16+ services
- Regional Fostering and Adoption Project.
- Regional Hidden Harm Implementation Group
- The Children Order Advisory Committee

Additionally, where applicable, account is taken of the NICE and SCIE guidance to ensure that recent research and best practice has been taken into account. The Strategic Partnership has developed a research sub group which will assist in informing the range of stakeholders on what works well for families and also where changes are required. Account will also be taken of local research such as the Care Pathways and Outcomes Study which is being progressed. The Regulation and Quality Improvement Authority will also include consideration of equality and human rights matters in its inspection processes with the outcome

factored into commissioning priorities where required. In the past few years there has been a significant focus (inspection) on safeguarding within children's services and also an inspection into Child and Adolescent Mental Health Services which is reflected within the commissioning plan.

It should also be noted that a number of the priorities relate to review processes and staff involved are aware of the need for equality screening as needed. There are instances where this has already been progressed such as the Bamford action plans and with the development of the multidisciplinary teams for children with a disability. The Commissioning Plan is also seeking to address the placement and accommodation needs of looked after children and care leavers as a vulnerable cohort of children and young adults as one of its priorities. Delivery against a five year commissioning plan is being progressed by NIHE in collaboration with HSC Trusts to address the needs of care leavers and enhance the availability of suitable living arrangements to promote equality and the rights of vulnerable young people. A further round of inspections of these arrangements is being undertaken by RQIA which will further assist in informing any equality issues.. A Regional Reference Group jointly chaired by HSCB and NIHE is putting in place a Young People's Participation Framework to ensure that young people as service users directly input to informing service development, design and commissioning priorities.

It can be seen in reviewing the priorities which are contained within the Children and Families section that the section 75 groups being considered explicitly include age and disability. The other groups either have been or will also be taken into account in that if gender is a particular issue for the reconfiguration of residential child care provision this will be stated in any such review. It is also intended that the views of service users will be integrated within the work schedule, either through representatives or with direct engagement of users which already applies to some of the working groups in place.

Reference has been made previously to best practice and learning from other areas and the work to be taken forward on reviewing speech and language therapy support in special schools will be informed by a model of practice which has been successfully introduced in Scotland and will provide a template for local discussion.

Equally the review of Inter-country Adoption Practice will take account of models operating in other parts of the UK. The adoption legislation in NI is different than that which applies in other parts of the UK as unmarried or gay couples cannot jointly adopt. This matter is currently the subject of a judicial review.

10. Mental Health and Learning Disability

A key priority in the areas of mental health and learning disability is to take forward the recommendations and actions arising from the Bamford Review. The Board and the Public Health Agency, in partnership with Trusts, established a range of working groups across the region in partnership with Local Commissioning Groups. Within the Taskforce service users and carers have been incorporated as equal partners.

Within Learning Disability the key focus for service delivery will be the continuation and promotion of inclusion and independence in line with 'Equal Lives'. This will support people with a learning disability in the areas of housing, training, further education and employment opportunities.

Some additional strategic drivers include:

- 'Protect Life', Suicide Prevention and Promoting Mental Health and Wellbeing Strategy
- New Strategic Direction for Drugs and Alcohol
- Psychological Therapies Strategy
- Personality Disorder Strategy
- Autism Action Plan.

The Board and PHA will also work with Trusts and other stakeholders to ensure that targets relating to mental health and learning disability as set out in the DHSSPS Commissioning Direction for 2013/14 are also delivered.

11. Prison Health Service

From 1 April 2008 the DHSSPS has had responsibility for Prison Health Services. The commissioning of Prison Health Services is now a function of the HSC Board and the management of prison health systems is the responsibility of the South Eastern Health and Social Care Trust. A Prison Partnership Board has been set up to coordinate prison health strategies and policies and to take forward the aims of the Prison Health Partnership Agreement.

The commissioning priorities for prison health have been informed by The Health Care to Prisoners in Northern Ireland: Needs Assessment Review, November 2009.

The Bamford review has informed commissioning priorities within the prison setting. A screening questionnaire is being piloted in Maghaberry prison to recognise those with needs in relation to having a learning disability. The Commissioning team have also identified commissioning objectives in relation to people with learning disability and have noted that people with a learning disability should be identified and their care managed in line with "Equal Lives".

More recently a Health Needs Assessment of Prisoners within the Northern Ireland Prison Service has been carried out across the 3 main prison sites, Hydebank, Maghaberry and Magilligan. Three separate reports have been produced detailing the outcome of the needs assessment in each of the three sites. These reports are currently in draft format. It should be noted that this exercise identified the need for more robust information.

12. Specialist Services

Specialist Services for acute care include highly specialist tertiary services delivered through a single provider either in Northern Ireland or via a service level agreement with a tertiary centre in GB. They further include services which are in the process of evolving from a single provider model to provision in a number of local settings. High cost specialist drugs also fall within the remit of this branch of commissioning.

Some individual specialist services will display a particular age and gender profile reflecting the nature of their service. For example, treatment of age related wet AMD is exclusively for the treatment of an eye disease which is prevalent in older people. Cancer drugs are condition targeted and this can result in differences in expenditure between men and women and also between social class (lung, throat and tongue cancers associated with smoking, emerging volumes of obesity related cancer - both of which are associated with social class which could be linked to race, age, dependencies or disabilities). However, cancer drugs are commissioned on an annual basis with new regimes becoming available each year – the availability of which is exclusively dependent upon whether or not they gain NICE approval rather than a commissioning determination to target one specific form of cancer.

Specialist services are relatively low volume and Northern Ireland has small population of 1.8m.

The key issue in respect of inequalities for specialist care is access to services. Specialist care is primarily provided in Belfast with only one or two specialist services provided elsewhere. This can mean journey times in excess of 1.5 to 2 hours each way for some patients. The cost of travel for people less well able to afford it or the degree of increased difficulty (dependencies, disabilities or age) experienced by some groups of people may create inequalities in access to care.

The profile of patients receiving specialist care forms part of any new service development or growth. This will include data regarding waiting times and activity volumes recorded by hospital data systems. Waiting times for all baseline services are also monitored.

Specific data monitoring is also routinely collected for biologics for rheumatoid conditions, biologics for psoriasis, Wet AMD, disease modifying therapies for Multiple Sclerosis and haemophilia blood products.

Specialist Services has established forums focusing on nephrology and transplantation, biologics for rheumatoid conditions, Wet AMD for macular degeneration, orphan enzymes, paediatric cardiac surgery, rare diseases, disease modifying therapies for MS, and vulnerable paediatrics. All of these have

representation from Trust management and clinicians, HSCB and the PHA. Some of the groups have representation from DHSSPSNI, voluntary organisations and patients.

Specialist services also utilise data and guidance from NICE and other nationally recognised policy documentation (NHS, Department of Health and DHSSPSNI and PCC publications).

The recently completed capacity planning exercise provided intelligence regarding the productivity and efficiency of current services based on working practices and national peer benchmarking systems.

On the basis of the analysis undertaken by the 12 Commissioning Teams, the key inequalities are identified as follows:

Category	***What is the makeup of the affected group? (%) Are there any issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?***
Gender	*Elective Care* Variation is not necessarily inequality of service particularly in relation to usage of the multi–faceted services we call elective care - from paediatric surgery to geriatric medicine or urology. The academic literature suggests a complex interaction of underlying need reflecting hereditary factors, risk behaviours, age, gender and for some conditions ethnicity. This is then influenced by health seeking behaviour and attitudes/knowledge or perceived barriers to access or expectations on either the patient or clinicians part. Individual specialties or conditions will reflect a specific age and gender profile. Access and outcome of services can be driven by physiological and behavioural characteristics eg the suitability of a particular surgical intervention for an individual will be influenced by the impact of co-morbidities which may be related to age or risk factors such as smoking or obesity which may in turn have higher

	prevalence in more deprived groups or those with particular disabilities. Hence we can have differential need and differential outcomes between individuals and groups. Access from primary care to secondary care may vary reflecting individual health seeking behaviour or primary care attitudes. What would appear to be substantial variations in referral patterns from primary care are currently under investigation by LCGs. Health Inequalities monitoring data showed that people from the most deprived areas in 2001/02 had 9% higher age and gender standardised elective admission levels than the Northern Ireland average across the combined basket of all elective specialties. More recent data appears to show deprived areas slightly below the Northern Ireland average and rural areas have overtaken urban areas in usage. Survey or focus or interest group work has identified some broader communication issues that can arise around appointments or providing information at clinics or in hospital -for BME, elderly, disabled or those with literacy problems. A phone call through partial booking may be problematic to elderly, hard of hearing or someone for which English is not their first language while those with dependents may have difficulties regarding the flexibility of appointment times. *Specialist Services* Gender profile accessing specialist acute care should reflect the gender profile of Northern Ireland as care is available on demand on the basis of clinical need. The pattern of uptake will be similar to that of general acute care. It would be inappropriate to take any action to address this as service provision is in line with clinical

need.

Unscheduled Care

Non-elective admissions and the bed days associated with them are broadly similar for men and women but vary reflecting different age groups. Admissions for men peak in their late sixties and seventies while admissions for women peak in their late seventies and eighties. This reflects known differentials in life expectancy and the higher death rate at an earlier age for men in relation to cardiovascular, respiratory and cancer conditions. In contrast the age profile of A&E attenders tends to be much younger.

Health Inequalities monitoring data showed that people from the most deprived areas in 2001/2 had 37% higher age and gender standardised non-elective admission levels than the Northern Ireland average. More recent data shows admissions from deprived areas at 23% above the Northern Ireland average. The higher levels of non elective admissions are in seen in both respiratory (+24%) and circulatory disease (+8%). There appear to be geographical differences across NI in admission levels.

Cancer

The standardised incidence rate for all cancers has been consistently higher in the most deprived areas than the NI average however the gap between the rates has declined form being 20% higher in 1999 to 9% higher in 2006. The male gap reduced from 22% to 7% while the female gap fell from 18% to 11% over the period. Much of this reflects variation in risk factors particularly tobacco consumption which are substantially higher in more deprived areas. This is reflected in the difference in lung cancer incidence rates between deprived areas and NI as a whole. These have narrowed from being 81% higher in the most deprived areas in

1999 but remained 65% higher in 2006.

The proportionate decreases between 2001 and 2008in the standardised death rates due to cancer in deprived areas and NI as a whole were broadly similar which meant that the inequality gap remained around a third higher in deprived areas than the Northern Ireland average. The gap for males was higher (35%) than that for females (28%). This is consistent with UK data which showed that unskilled workers are twice as likely to die from cancer as professionals.

Downing et al focused upon women with breast cancer and found that those living in deprived areas were:

- More likely to be diagnosed with advanced cancer
- More likely to have a mastectomy, rather than breast conserving surgery
- Less likely to receive radiotherapy
- Less likely to have surgical treatment
- Less likely to have survived five years

A recent International Cancer Benchmarking Partnership study of four main cancers showed that for colorectal cancer, 8% of patients in Northern Ireland died between 1995 and 2007 within one month of diagnosis compared with 11% in England and Wales. One in ten women with ovarian cancer died within one month of diagnosis in Northern Ireland, while 12% died in England and 13% in Wales. The report highlights that the survival rate for patients with breast, lung and colorectal cancers have improved in Northern Ireland from 1995 to 2007. However, ovarian cancer is included as an example of a less common cancer with large variations in survival across

countries. The specific variations for ovarian are shown http://eu-cancer.iarc.fr/cancer-16-ovary.html,en#block-9-27

The international survival trends showed persistence differences between countries, although the trends in cancer incidence and mortality were broadly consistent with the trends in survival. This work has provided the basis for the priorities of the Cancer Commissioning Team. A copy of the full report can be obtained from http://www.lshtm.ac.uk/eph/ncde/cancersurvival/icbp_paper1.pdf

Older People

There are differences in the incidence of dementia according to gender with a higher proportion of men in the ages 65-74 years and a higher proportion of women aged over 75 having dementia. There will also be differences in the nature of care required according to the gender of individuals.

Children and Families

Evidence exists on the relationship between the exposure to poor social conditions and unhealthy behaviours for young women in the care system, the risk of early pregnancy and poor mental health.

Mental Health and Learning Disability

It is crucial that services in relation to mental health takes into account the needs of marginalised women. High levels of mental ill health among women with disabilities and lesbians.

Prison Health

English data showed that almost half of all prisoners have no educational qualifications and were unemployed prior to entering prison. The same psychiatric census identified that

	female prisoners reported very high levels of domestic violence and previous sexual abuse and over a quarter of both male and female prisoners were in local authority care as children. *Long Term Conditions* Stroke and diabetes are more common in men but women have higher levels of morbidity and premature mortality.
Age	*Specialist Services* Age profile accessing specialist acute care should reflect the age profile of Northern Ireland as care is available on demand on the basis of clinical need. The pattern of uptake will be similar to that of general acute care where there may be more of a bias towards older age groups. It would be inappropriate to take any action to address this as service provision is in line with clinical need. A needs assessment exercise carried out by the Public Health Agency on the paediatric intensive care requirements for Northern Ireland concluded that Northern Ireland needs to increase the current number of PICU beds to meet demand in the 0-14 age group. *Cancer* In Northern Ireland one in three of the population develops a cancer by the time they reach 75 years of age. Excluding the rarely fatal non-melanoma skin cancer (NMSC) the risk for both males and females is about one in four. The risk of dying from cancer before the age of 75 is lower than that for developing cancer but varies by sex; among males the risk is one in seven while in females it is one in nine. In general men are at

	significantly greater risk than women from nearly all of the common cancers that occur in both sexes (with the exception of breast cancer) (White 2009, Wilkins 2006, DH 2007). Even after allowing for higher risk factors in smoking and alcohol consumption it has been suggested that additional influences of symptom awareness and treatment avoidance may be impacting on this. Rates of new cases of cancer in Northern Ireland are fairly static although the actual number of cases is increasing due to the ageing of the population. Despite this as survival continues to improve mortality rates are decreasing in Northern Ireland along with other countries in the UK. However as the recent ICBP study of four main cancers highlighted despite the improvements between 1995 and 2007 survival in Northern Ireland and other parts of the UK is lower than that in Australia, Canada, Sweden and Norway particularly in the first year after diagnosis and for patients aged 65 years and older. There has been some evidence in the UK of older patients receiving differing cancer care to their younger counterparts. Evidence from the Cancer Reform Strategy in England found that older women were less likely to receive standard management such as radiotherapy for their breast cancer even after taking account of tumour type and older patients with lung cancer were less likely to receive radical treatment for their disease. *Palliative Care* The Centre for Policy on Ageing Report for the DOH (2009) identified that people under 65 had disproportionate access to palliative care and older people had unmet needs in palliative care and pain management. There was evidence that palliative care in nursing homes for older people was poorly organised and that older people were experiencing persistent pain without appropriate

	assessment and treatment. While no similar report is available locally. A recent International Cancer Benchmarking Partnership study of four main cancers highlighted despite the improvements between 1995 and 2007 survival in Northern Ireland and other parts of the UK is lower than that in Australia, Canada, Sweden and Norway particularly in the first year after diagnosis and for patients aged 65 years and older. This report compared the international differences in survival across Colon, Lung, Breast and Ovarian, and showed the age standardised relative survival at one and five years. *Older people* In terms of dementia the incidence of dementia increases with age but it is far from being inevitable and is certainly not a natural consequence of the ageing process. There is some evidence that age equality in psychiatry services is taken to mean 'one size fits all ages' approach. *Health & Social Wellbeing Improvement* Older People as a key population group are also particularly vulnerable to health inequalities. A focus on the needs of older people and promoting their health and wellbeing including social isolation is an important theme of future programmes and service developments. *Mental Health and Learning Disability* There is a tendency to overlook the needs of older people with mental health problems *Long Term Conditions*

	Long term conditions are more common in older age groups. Children with diabetes have a lower life expectancy than children without diabetes.
Religion	Services are available on the basis of need irrespective of religion. Those areas with the highest incidence rates of cancer have higher percentages of protestants (8%) than in NI overall.
Political Opinion	Political opinion is not a determining factor for access to health care.
Marital Status	*Cancer* In terms of incidence of cancer there is a higher proportion of people who are separated / widowed / divorced (5% higher) in the fifth of wards with the worst incidence rates. *Children and Families* Less than 3% of lone parents are teenagers. The majority, (80%) are aged 25-49 years. In the UK as a whole 1 in 4 families is headed by a single parent who is bringing up 3 children. Statistics show that a high percentage of lone parents are living on low incomes, in rented accommodation, without savings and may be experiencing debt. Lone parents with a disability or with a child with a disability who lack family support are vulnerable to stress.
Dependent Status	*Unscheduled Care* There is recognition that persons with dependents can find it more difficult to access in-hours unscheduled care. *Elective care* Those with dependents may have difficulties regarding the flexibility of appointment times.

	Cancer In terms of the incidence of cancer there is a higher proportion of households without dependent children (8% higher) than the average in the fifth of wards with the worst incidence rates. *Disability* There is an inadequacy of service knowledge based practice relating to groups of disabled parents. More research is also needed on groups of disabled adults who care including adults with a learning disability who care for their children or care for older parents. As parents get older the caring role often reverses. Negative attitudes or anticipation of negative attitudes can act as a barrier to people seeking support from social services for example parents with mental health problems, learning disability or those with drug or alcohol problems. Parents with a disability are least likely to have information made available to them in a way that meets their needs. *Long Term Conditions* Gestational diabetes and Type 2 diabetes is more common in overweight and obese women which are more commonly seen in disadvantaged areas.
Disability	*Specialist Services* Evidence would suggest that there is a differential risk of cancer reflecting different risk behaviour such as smoking, alcohol and diet. Cancer drugs are condition targeted and this can result in differences in uptake between men and women. Lung, throat and tongue cancers and obesity related cancers are associated with social class which could be linked to race, age, dependencies or disabilities.

	Access and outcome of services can be driven by physiological and behavioural characteristics, for example the suitability of a particular intervention for an individual will be influenced by the impact of co-morbidities which may be related to age or risk factors such as smoking or obesity. This may in turn have higher prevalence in more deprived groups or those with particular disabilities. *Unscheduled Care* Unscheduled care can create particular problems for those with learning difficulties, those are hearing or sight impaired, have language issues in both Accident and Emergency or when being admitted. *Cancer* There is a higher proportion of disabled people in the fifth of the wards with the worst cancer incidence rates than in NI overall. UK Research suggests that one in six patient information leaflets produced by hospices and palliative care units can only be read by 40% of the population and that only 30% of GP surgeries have accessible information for people with learning disabilities. The Social Exclusion Unit in UK found that those with low literacy were 6% less likely to attend cervical screening than women with higher basic skills. Screening rates are low in women with a learning disability although higher rates of the risk factors of obesity and overweight have been found in those with learning disabilities and mental health problems. *Sensory Disability* There is inappropriate communication support for people with a hearing impairment when accessing health and social care services. For example, lack of availability of sign language interpreters and often loop systems are not available to enhance communication.

Learning Disability

People with a learning disability are more likely to have a visual impairment when compared to the general population. Approximately 40% of people with a learning disability are reported to have a hearing impairment, with people with Down's syndrome at particularly high risk of developing vision and hearing loss. Those living independently or with family are significantly less likely to have had a recent eye examination than those living with paid support staff. Diabetes is more common in
Children and adults with learning disability.

Children and Families

Disabled children and their families frequently raise issues about poor or late assessments of needs. Services to meet these needs are not always available. Over 20% of children under 18 year suffer mental health problems.

Young carers are recognised in the HSCB's Audit of Inequalities and Action Plan (2010) as having specific needs. This is particularly important for those aged 16-24 years who often remain hidden. The Action Plan requires that appropriate services be developed for young carers including transition planning; an identification of the supports required for young carers and redesign carer support for this group the need.

Mental Health Issues in Learning Disability

The prevalence of psychiatric disorders is significantly higher among adults whose learning disabilities are identified by GPs, when compared to general population rates. Challenging behaviours (aggression, destruction, self-injury and others) are shown by 10%-15% of people with learning disabilities, with age-specific prevalence peaking between ages 20 and 49. In some instances, challenging behaviours result from pain associated with untreated medical disorders. Reported prevalence rates for anxiety and depression amongst adults with learning disabilities vary widely, but are generally reported to be at least as prevalent as the general

	population and higher amongst people with Down's syndrome (Based on UK figures). Stroke survivors may develop disability and require prolonged periods of rehabilitation following a stroke. High quality diabetes care and early detection of complications in Diabetes can reduce the frequency of disability.
Ethnicity	*Unscheduled Care* The All Island Travellers Health Study highlighted that Travellers access health services more frequently than the general population, with attendances at A&E departments/hospitals rated as more positive than those at GPs. Perceived communication issues (not listening, unempathetic doctors), Travellers' literacy problems and difficulties in following prescribed instructions are seen as contributors to such negative experience, with waiting lists (46.8%) and embarrassment (50.0%) cited as major barriers to access. Men in particular delay access of health care when needed and present generally late and then more so in A&E departments. *Health and Social Wellbeing Improvement* The specific needs of Travellers have been well documented through the All Island Travellers Health Study. Prejudice, poor living conditions and lack of meaningful employment are everyday experiences for Travellers which profoundly affect health and wellbeing. In particular, Traveller men experience greater illness and reduced life expectancy. Migration and health and social wellbeing are linked in many ways. Historically, patterns of migration have been driven by work opportunities and/or the need to escape from poverty or persecution and create a better life.

More recently, migration has increased as a result of the enlargement of the European Union. In addition, numbers of refugees and asylum seekers coming to Northern Ireland have increased since the introduction of the Immigration and Asylum Act (1999).

In the main, the majority of newcomers have no greater health needs than those of the general population; however, issues can arise as a result of difficulties in communication and in trying to settle in a new country. There are, however, some migrant groups which are particularly vulnerable e.g. Romanian Roma and where there are both extremely difficult living conditions and a lack of access to care.

Elective Care

Variation is not necessarily inequality of service particularly in relation to usage of the multi–faceted services we call elective care - from paediatric surgery to geriatric medicine or urology. The academic literature suggests a complex interaction of underlying need reflecting hereditary factors, risk behaviours, age, gender, and for some conditions, ethnicity. This is then influenced by health seeking behaviour and attitudes/knowledge or perceived barriers to access or expectations on either the patient or clinicians part.

Cancer

99% of cancer cases occurred in white people in both the worst fifth wards and NI overall. Incidence did not appear to be related to ethnicity.

Language can be a significant barrier to accessing cancer services for many people from BME groups, particularly but not limited to asylum seekers and refugees. UK data in the report Focus on social inequalities found that 41% of people with additional language needs had no one to help with interpreting when visiting a GP or

health centre.

Maternity
Births to mothers born outside the UK and Ireland have increased considerably over the last decade. Births to women from A8 countries have risen particularly dramatically (from 12 in 2001 to 1,210 in 2011). Births to women from other foreign countries roughly doubled over the period 2001 to 2011 (from 678 to 1,267). Births to fathers mirror the pattern for mothers.

A Health Intelligence Briefing on minority ethnic groups prepared by the PHA (Jan 2012) identifies the following potential issues that may be relevant to some women from other countries who access maternity services in Northern Ireland:

Language barriers; Women more seriously affected by migration than men: lower social status than men in many cultures, fewer in employment, lack of social and family supports – lonely and isolated, dependent on male family members for decision-making

Lacking awareness and uptake of antenatal care

Lack of support network of other female family members during pregnancy, after birth and when looking after young children: increased isolation, higher rate of postnatal depression

Domestic violence more prevalent; financially dependent on husbands where they have no recourse to public founds

Preference for female doctors due to cultural modesty rules

In addition staff report that a small but increasing number of women who have had female genital mutilation are now presenting to maternity services here, and this poses risks for their pregnancy and for staff in managing their care.

Women from the Travelling Community have been found in the All

	Ireland Travellers Study* to have higher still birth neonatal and post natal mortality rates , later booking , younger mothers, more low birth weights, lower breast feeding rates. *http://www.dhsspsni.gov.uk/aiths-partd.pdf *Older People / Physical Disability* Evidence suggests lack of knowledge by BME groups about social care services and about social services' functions and lack of awareness about some services particularly services such as respite services for people with disabilities. Public information campaigns to support the Dementia Strategy do not always reach ethnic minorities so targeted campaigns may be necessary to raise awareness of dementia within these groups. There is also an issue as to whether current services for people with dementia take account of cultural differences. A Dementia UK report noted that ethnicity can be a significant factor in the extent to which dementia is understood or acknowledged, or in people's willingness to seek help. Current services may not meet the needs of BME groups with dementia or their carers. Employed people men and women in the Pakistani, Bangladeshi and Indian communities have particularly high rates of caring. Bangladeshi men are 3 times more likely to be carers than white men. Overall age population of black and minority ethnic population is younger than white population of carers this has additional socio economic impacts. *Children and Families* 63% of travellers are aged under 25 compared with 35% nationally;

	42% of Travellers are under 15 years of age compared with 13% nationally. There is an increased rate of mental illness among children in child asylum seekers in Northern Ireland. A number of barriers exist that may prevent parents of these children seeking health and social care services. These include language barriers, no permanent address; lack of awareness of GP services and social isolation. Absence of child facilities operating in hours of shift work causes particular difficulties for BME families. *Mental Health* There is evidence of high rates of mental ill health for Traveller women. Traveller men often deny that they have depression. Women from ethnic minorities are particularly vulnerable to mental illness with women of Asian descent having higher suicide and self harm rates. For those newly arrived in the country who often arrive to join partners there is evidence of depression, including post natal depression, and feelings of isolation and low self-esteem. Similarly depression amongst asylum seekers tends to be high. There is an increased rate of mental illness among child asylum seekers in Northern Ireland. Additionally there is often a lack of expertise amongst social care workers in identifying the mental health problems experienced by children seeking asylum. *Long Term Conditions* Diabetes is more common in BME groups and hypertension is more common in Asians.
Sexual Orientation	*Specialist Services*

	In terms of investment in HIV care, research indicates that 44% of new cases of HIV relate to men who have had sex with men. *Maternity* Concerns have been raised by some LGBT groups that same sex couples expecting a baby are unwilling to reveal their sexual orientation in case they are treated differently. Like every other couple expecting a baby they should expect that any information they share is treated confidentially. The care received is tailored to meet individual need, so it is important that all women are comfortable discussing their circumstances with the midwife or the doctor and appropriate advice and care is given. *Cancer* Concerns have also been raised in local survey data and nationally regarding lesbian and bisexual women having higher behavioural risk factors but being less likely to be screened. *Community Care / Elderly / Physical Disability* Studies on the experience of lesbian, gay, bisexual and trans-gender people have not been identified in relation to dementia. However, lesbian women and gay men are likely to face particular challenges in caring for partners or friends with dementia which are not faced by others in society. No robust data is available on carers by sexual orientation. Some studies point to networks and communities that are a useful resource for lesbian, gay, bisexual and transgender carers for emotional and practical support. Evidence suggests however that existing networks cannot always be relied on for this support and there is also unequal access to these networks. *Mental Health* There are high rates of mental health issues among lesbian, gay

	bisexual and transgender people. This is higher than average for rates of anxiety, depression, self harm and suicidal behaviours including problems associated with smoking, drugs and alcohol use. 1 in 4 young gay men in NI have attempted suicide. *Prison Services* Data on ethnicity or literacy is not routinely available here although Scottish and English data suggests low literacy levels. The All Ireland Travellers Health Study 2010 did not include NI prisons due to the relatively small numbers of Travellers in Northern Ireland however data from ROI showed that the risk of a male Traveller being imprisoned was between 5-12 times that of the general male population and for women 11-35 times. *Health & Social Wellbeing Improvement* It is recognised that there is nothing inherent about a person's sexual orientation that predicates an increased risk of experiencing health inequalities, rather, same sex attracted people suffer inequalities due to the "stigma" associated with being attracted to someone of the same sex, homophobic bullying, issues around coming to terms with their sexual orientation and coming out to friends, family and colleagues coupled with the conservative nature of our society in Northern Ireland. This experience is reflected in higher levels of alcohol and drug misuse, emotional wellbeing and depression, and increased levels of deliberate self harm and suicide.
Multiple Issues	*Specialist Care* Having reviewed the range of specialist services within the context of the Section 75 Groups the Specialist Services Commissioning Team has taken the view that the key issue in respect of inequalities for specialist care remains access to services. *Elective Care* Health Inequalities monitoring data showed that people from the

	most deprived areas in 2001/2 had 37% higher age and gender standardised non-elective admission levels than the Northern Ireland average. More recent data shows admissions from deprived areas at 23% above the Northern Ireland average. The higher levels of non elective admissions in seen in both respiratory (+24%) and circulatory disease (+8%). There appear to be geographical differences across NI in admission levels.

2.5 Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

Ensuring successful screening during the commissioning year remains a key objective. The reliance of previously used data collection echoes one of the findings that emerged out of the HSCB's Audit of Inequalities.

Through the newly convened Equality and Human Diversity Working Group arrangements will be made to ensure equality and decisions that affect equality are informed by robust and up to date information.

Specific actions include:

- Ensure each commissioning team and local commissioning office has systems in place to build and update relevant policy and population based information.
- Ensure that all staff receives training on equality and related issues.
- Develop the capacity of staff to use the information to inform policy or decision making and regularly reviewed.
- Regular updates to Commissioning Programme Board on equality reviews and equality issues from the commissioning teams.

These efforts will include mechanisms to engage with ethnic minorities, people with disability, gay lesbian, bisexual and trans-gender people, older people and younger people, who often face barriers in engaging in Commissioning processes.

In developing the policy or decision what did you do or change to address the equality issues you identified?	*What do you intend to do in future to address the equality issues you identified?*
Health and Social Wellbeing Improvement Work has been undertaken in a number of areas to include: sexual orientation, race and ethnicity, including specific thematic action plans to address areas of particular need such as Travellers, Minority Ethnic groups (ME), Lesbian, Gay, Bisexual and Transgender (LGB&T), older people, poverty; as well as community development. Consideration of minority groups has influenced the strategic direction of the PHA, and one of the key pillars for achieving our objectives is to 'ensure a decent standard of living for all'. Specific examples of work undertaken in 2012/13 included: • development of an E-learning programme on Sexual Orientation training, website development, further development of the LGB&T Staff Forum, linkages with other HSC and wider	In order to address these needs the PHA and HSCB intends, through its commissioning activities to monitor, evaluate and respond to the needs of those groups facing health inequalities and deprivation. We will continue to collect data to highlight population deprivation in Northern Ireland and ensure that staff are trained to deliver services to those groups affected by health inequalities.

organisations;

- development of a costed LGB&T Action Plan;
- The NI New Entrant Service (NINES) has started providing screening and health promotion clinics and should be fully operational by April 2013.
- Establishment of a Migrant Health and Social Wellbeing Multisectoral, Collaborative Network.
- Training needs relating to minority ethnic health and social wellbeing issues Identified and addressed.
- analysis conducted of the All Ireland Travellers Health report and a specific briefing prepared on mental health and wellbeing;
- establishment of a Regional Travellers Forum and action plan;
- PHA working in partnership with other health and social care organisations, and sectors including DHSSPSNI;
- Ensured there has been

community involvement in each aspect of decision making.

- PHA has established a Homelessness Programme Board to ensure a co-ordinated approach to meeting the needs of homeless people.
- PHA has invested in the regional FareShare Food Poverty initiative and food banks in order to improve access to healthier affordable choices.
- Development of a range of programmes to address poverty including fuel poverty eg Maximising Access in Rural Areas.
- The development of a holistic strategy and implementation plan to promote the health and wellbeing of prisoners.
- development of an Older People's Action Plan
- New opportunities have been developed to address social inclusion eg Arts and Health programmes with Older People.

The health improvement teams will continue to commit to advocating the importance of the equality agenda by ensuring consideration to those groups named under Section 75 within our action plans. Any evidence or research which has been undertaken and endorsed will form the basis for commissioning plans which address the issues of health inequalities in Northern Ireland.

Specialist Services

During 2011/12 investment of over £650,000 was made in vulnerable specialist paediatric services to ensure their continued safety and sustainability to maintain access within Northern Ireland. This involved additional staffing and initiation of clinical networks in a number of areas. Support was also given to the services in the RBHSC in order to provide network support across the region into local paediatric services in managing more care locally. Paediatricians with a specialist interest in local centres will also be supported through this investment.

This work will be supported by a specifically funded Network Co-ordinator will be funded for 3 years to drive forward implementation.

Investment will continue for Wet AMD in the 2 centres.

Investments in biologic therapies for severe, debilitating psoriasis will be made in all Trusts in 2012/13.

The Specialist Services Commissioning Team will continue to work with the Northern Ireland Rare Disease Partnership in the planning and delivery of services for people with rare diseases.

ordinator.

It is proposed to expand Paediatric Intensive Care Capacity (PICU) in the Belfast Trust. This will address the need to increase the current number of PICU beds to meet demand in the 0-14 age group. An increase from 8 to 12 beds will ensure that refusals to PICU due to capacity reasons would be exceptional. Costs for the expansion are in the region of £2.25m and it is expected that the additional 4 beds would be fully established by June 2013.

Investment in Wet AMD services in the West as well as Belfast in 2012/13will support a higher degree of local access for older people with this condition.

Investment in biologics for Rheumatoid conditions in all Trusts will support better geographic access for this group of patients who will have a degree of disability.

Investments in rare genetic conditions will support improved outcomes for some ethnic groups.

The Specialist Services Commissioning Team will work with

the Northern Ireland Rare Disease Partnership to develop and pilot a regionally agreed patient journey for Duchenne Muscular Dystrophy.	
The Board has taken a decision that primary percutaneous cardiac intervention services should be delivered from two centres, one in Belfast and one in Altnagelvin. These centres give the greatest geographic coverage for the population of Northern Ireland.	
Elective Services During 2011/12 The Board funded additional capacity in the Trusts and in the Independent Sector to ensure equity of access for all patients who required treatment. The Board also held Trusts to account for delivering agreed maximum waiting times for specialties.	The commissioning team will strive towards agreeing detailed data returns for selected specialties from Trusts which identify patient numbers in relation to the categories in 2.2 /2.3 This data will be used to identify any inequalities in service provision.
Older People The Team has arranged two seminars with Older Peoples and Disability constituencies to share	Ensure effective user/carer input to implementation arrangements. Ensure regular dialogue with

Commissioning intentions and to take feedback from them.

Equality issues were not strongly articulated in the discussions by voluntary sector representatives.

Cancer

Research suggests that cancer survival could be improved by as much as 40% with improved awareness of the early signs and symptoms and early detection. It is known that awareness of early signs and symptoms is related to deprivation and BME. Work will commence in year to undertake a baseline survey to identify current levels of knowledge and awareness and to identify key messages for a public awareness campaign. This campaign will consider how best to target hard to reach groups, including BME.

Unscheduled Care

Plans to develop dedicated paediatric assessment units are evidence of the importance of voluntary/user representatives as a feature of Commissioning Team functioning.

having dedicated unscheduled care pathways for children.

Consideration will also be given to the development of unscheduled care pathways for patients with long term conditions, most of whom will be older people with complex needs.

Palliative Care

The development of a palliative care service specification for nursing homes will improve the access to palliative care for older people.

The development of disease specific service specifications for non cancer conditions such as heart failure, renal failure, cystic fibrosis etc will address age and gender inequalities in relation to palliative care services.

Long Term Conditions

The development of a programme of enhanced primary care management of cardiovascular risk

factors will address health inequalities.

The review of the pilot projects on pre pregnancy care and structured patient education programmes for children and adolescents.

Maternity and Child Health

Maternity and pregnancy related gynae services are available at point of need for all women who are pregnant.

The gap in infant mortality between the most deprived and least deprived areas in Northern Ireland has narrowed.

The Commissioning priorities have been established based on the evidence above, relevant data and an understanding of the variance between services here and standards set nationally The regional Maternity Strategy is the basis for commissioning and service priorities for Maternity services in Northern Ireland for the next 6 years. One of the aims of

implementing the strategy is to ensure that services are easily accessible in the community so they are available to vulnerable groups of women.

The maternity information system (NIMATS) is being developed to capture data on mother's ethnicity.

A scoping exercise is being developed (resources permitting) to gain more information on the specific needs of ethnic minority pregnant women and their impact on maternity services.

A pilot regional maternity obesity intervention programme for pregnant women with a BMI over 40 will commence in all Trust's early in 2013.

The Family Nurse Partnership pilot programme targeting 100 teenage mothers who will be recruited up to the 28th week of pregnancy in the Western area is being taken forward by the Public Health Agency to provide enhanced services to pregnant young women

during and after their pregnancy. The outcomes for this target group are demonstrably poorer than for other mothers and this pilot will test a proven effective model of service delivery for this group in Northern Ireland for the first time.

Physical Disability

Address the recommendations of the Physical Disability Strategy, in particular the needs of carers.

Introduction of a re-ablement model to promote rehabilitation, self care and independence.

Children and Families

The priorities which are contained within the Children and Families section of the Commissioning Plan demonstrate that the Section 75 groups being considered explicitly include age and disability. The other groups either have been or will also be taken into account in that if gender is a particular issue for the reconfiguration of residential child care provision this will be stated in any such review. It is also intended that the views of service users will

be integrated within the work schedule, either through representatives or with direct engagement of users, which already applies to some of the working groups in place.

Reference has been made previously to best practice and learning from other areas and the work to be taken forward on reviewing speech and language therapy support in special schools will be informed by a model of practice which has been successfully introduced in Scotland and will provide a template for local discussion.

Equally the review of Intercountry Adoption Practice will take account of models operating in other parts of the UK. The adoption legislation in NI is different than that in other parts of the UK in that unmarried or gay couples cannot jointly adopt. This matter is currently the subject of a judicial review.

Mental Health and Learning Disability

It is widely evidenced that people with a learning disability have increased mortality and live with

higher levels of illness both physical and mental than the non learning disabled population.

Previously the HSCB/PHA commissioned a Directed Enhanced Service for Learning Disability. This DES ensures that all adults with a learning disability have an annual health screening for both physical and mental health with their GP. It also follows up the health plans put in place and any secondary care referrals made to ensure that better health results can be monitored. The DES relies on dedicated health facilitator in each Trust to contact hard to reach patients.

During 2011/2012 the HSCB/PHA began implementing the Specialist Visual Assessment Clinics for Learning Disability across all Trusts. This service delivers specialist visual assessment clinics in settings where people with a learning disability live and attend for day support. It aims to pick up undiagnosed visual acuity problems and address these through treatments or prescriptions. It also makes referral

to secondary services where more serious conditions are found.

Recognising the higher levels of mental ill health allocated to learning disability and to young adults generally the HSCB/PHA invested in Transition Services in 2011/2012 to put in place a greater capacity and range of post school day opportunities to promote inclusion in training, further education and vocational settings. There is also further investment in specialist services which aim to support people with a learning disability who also have mental health issues, which often manifest themselves in challenging behaviour which in turn can lead to admissions to hospital.

Additional investment has been provided to help assist those people with a mental illness and who have particularly challenging/complex problems. This includes the development of services for people with forensic mental health problems and also services for people with a personality disorder. Individuals

within these services tend to have, in general, much higher levels of ill health and morbidity than the general population. These services endeavour to provide person centred care and assistance to the particularly vulnerable cohort of clients/individuals referred to them. Regionally, the HSCB/PHA have brought together service providers within Network arrangements to promote best practice and more standardised care within these services. In turn, the output of these groups aims to improve outcomes for/care provided to people with serious mental illness.

Screening

Work has been undertaken to promote informed choice in cancer screening programmes to optimise uptake amongst eligible populations. There is particular focus on groups known to experience difficulties in attending for cancer screening: LGBT, BME groups, travellers, prisoners, people with physical or sensory disabilities, and people with learning disabilities.

- Take relevant action to remove any identified obstacles to attending for cancer screening.
- Continue to engage as appropriate with community and voluntary organisations who represent Section 75 groups
- Keep abreast of research and developments throughout the UK to improve access to cancer screening programmes.

Prison Health

The commissioning priorities for prison health services are based in the principal of providing an equivalent health service to prisoners as that provided to the general population. The provision of health care is, however, subject to a number of restrictions due to the nature of the prison environment. Priorities include:

- Improve the committal process for people with complex needs; including substance misuse, diabetes and epilepsy.
- Work with the South Eastern Trust to ensure the introduction of the stepped care model within prisons to address mental health problems.
- Encourage the development of appropriate care pathways for prisoners with a learning disability.

2.6 GOOD RELATIONS

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact

Please note: When detailed implementation plans are available in relation to each of the theme areas, these will be subjected to equality screening and will take full account of good relations.

Group	*Impact*	*Suggestions*
Religion		
Political Opinion		
Ethnicity		

(3) Should the policy or decision be subject to a full Equality Impact Assessment?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

The plan outlines an overall direction of travel. The detail of implementation has yet to be worked out. When the implementation plans become clearer, specific actions within the plan will be subject to robust screening and where applicable EQA and public consultation.

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

Major impact	
Minor impact	
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	x

Please give reasons for your decisions.

The Commissioning Plan impacts on the population of the whole of Northern Ireland so consideration of inequality, deprivation and geography is an integral part of it.

Through our commissioning activity we believe that we can increase the probability that decisions will better promote equality of access and outcomes. We recognise however that in some instances an assessment of the equality and human rights implications can be limited by lack of local data or evidence including the or lack of disaggregated data.

Data collection will therefore be a key consideration, as are our organisational efforts to embed equality and human rights in our commissioning activity; promote personal and public involvement and engagement; work in partnership with community, voluntary and other public sectors and increase the capacity of

staff to use the evidence, including disaggregated data on the equality categories, in decision making processes. This remains a key consideration by Service teams who are taking forward the themes identified throughout the Commissioning Plan.

As the Commissioning Plan is implemented we are committed to assessing potential effects on particular populations in a rigorous way, through further equality and human rights screening.

(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	*What else could you do to encourage disabled people to participate in public life?*
Disabled people are involved in many working groups and Committees which will play a critical role in the delivery of the plan and contribute to the ongoing identification of commissioning priorities: • Bamford task groups - service user and carer representation on all groups. Steps are underway to facilitate service user representation at Taskforce meetings. • Regional Brain Injury Review and Implementation • Older peoples service framework • Sensory impaired regional group • Children services planning • Think Family, Think Child • Autism implementation groups - active participation of users and carers on the regional reference group and local Trust groups • Direct payment regional group • Self directed support forums/groups • Safeguarding forums • Regional Wheelchair Reform (awarded the first engage award in	The organisation is committed to engaging with all its stakeholders in the identification and delivery of its commissioning priorities. The relevant service teams will actively, and on an ongoing basis, seek to identify opportunities to engage with disabled people in the development and delivery of their priorities. For example, the Community Care Team will ensure effective implementation arrangements are established with PPI Steering Group.

NI for its involvement of service users) There are a number of upcoming strategies, which will be critical in guiding commissioning. The HSCB will be establishing working groups to take forward priorities identified in these strategies. Patient and / or carer involvement will be central to that process. • Advocacy strategy • Physical Disability Strategy • Dementia Strategy The PDSI strategy strongly reinforces, and explicitly states, the need for the involvement of disabled people in public life with clearly identified responsibilities placed on a number of public agencies to ensure this happens. The plan also seeks to enhance and to underpin the key legislative and good practice arrangements for children with disabilities and their carers.	

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	*What else could you do to promote positive attitudes towards disabled people?*
Meet with groups advocating on behalf of specific groups needs. This plan will positively enhance and support CWD and their carers by reference to the legislative and rights based requirements which will inform commissioning and service provision	Seek to examine impact of communication materials and make resources available in various formats.

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

The Commissioning Plan will inevitably impact on the lives of individuals in Northern Ireland so by its very nature it will impact on people's human rights. The overall aim in commissioning as identified in the Commissioning Plan is to ensure that the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. This also relates to people's human rights. It is intended that Commissioning outcomes will positively impact on people. Hence, there are no known issues at this point in time. As the precise elements of the Commissioning Plan are further screened and implemented the human rights aspects of decisions will be examined in order to identify any areas of potential interference and how it might be possible to limit this interference.

5.2 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

As part of the training provided to Commissioning Teams on improving the links between Equality, Inequalities, Human Rights and Commissioning human rights issues were also addressed. This should assist in on-going work in relation to implementation of the Commissioning Pan including any screening activity and engagement.

The HSCB is also considering best practice in relation to adopting and promoting a Human Rights Based Approach. Once pilot activity is undertaken in one Directorate it is our intention to consider the wider applicability including to Commissioning.

(6) MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights?

In some instances an assessment of the equality and human rights implications can be limited by lack of local data or evidence including the or lack of disaggregated data.

Data collection will therefore be a key consideration, as are our organisational efforts to embed equality and human rights in our commissioning activity; promote personal and public involvement and engagement; work in partnership with community, voluntary and other public sectors and increase the capacity of staff to use the evidence, including disaggregated data on the equality categories, in decision making processes. This remains a key consideration by Service teams who are taking forward the themes identified throughout the Commissioning Plan and specifically addressed in Section Two.

Equality & Good Relations	Disability Duties	Human Rights
Ongoing monitoring and screening of health and social wellbeing plans in accordance with Section 75, equality legislation and human rights legislation. Monitoring of complaints	Ongoing monitoring of patient and / or carer involvement in key planning / working groups with an emphasis on disability groups to monitor their participation in commissioning.	Monitoring of complaints & Serious Adverse Incidents

Approved Lead Officer: Dean Sullivan

Position: Director of Commissioning

Policy/Decision Screened by: Cara Anderson

Signed:
Date:

Glossary of Terms

The Bamford Report – a major study commissioned by the Department of Health in Northern Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and need regular treatment and medication.

Community and Voluntary Sector – the collective name for organisations working in health but not publicly funded.

Evidence Based Commissioning – the provision of health and social care services based upon proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, work in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these are a development of Primary Care Partnerships which join together the full range of health and social care services

in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector.

Lesbian, Gay, Bisexual & Transsexual (LGBT) –this is an abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – these are committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the Board arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Clinical Excellence – an expert organisation based in London that guides health care organisations across the UK on the effectiveness of new treatments, new drugs and other innovations.

Northern Ireland Block – this refers to the total amount of financial support given to Northern Ireland by the Treasury in London.

Palliative Care – services for people who are typically in their last year of life and who suffer from conditions such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of Northern Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Population Plans – Plans developed by LCGs and Trusts to radically reshape the way services are delivered from 2012 -2015 and beyond

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) –These pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

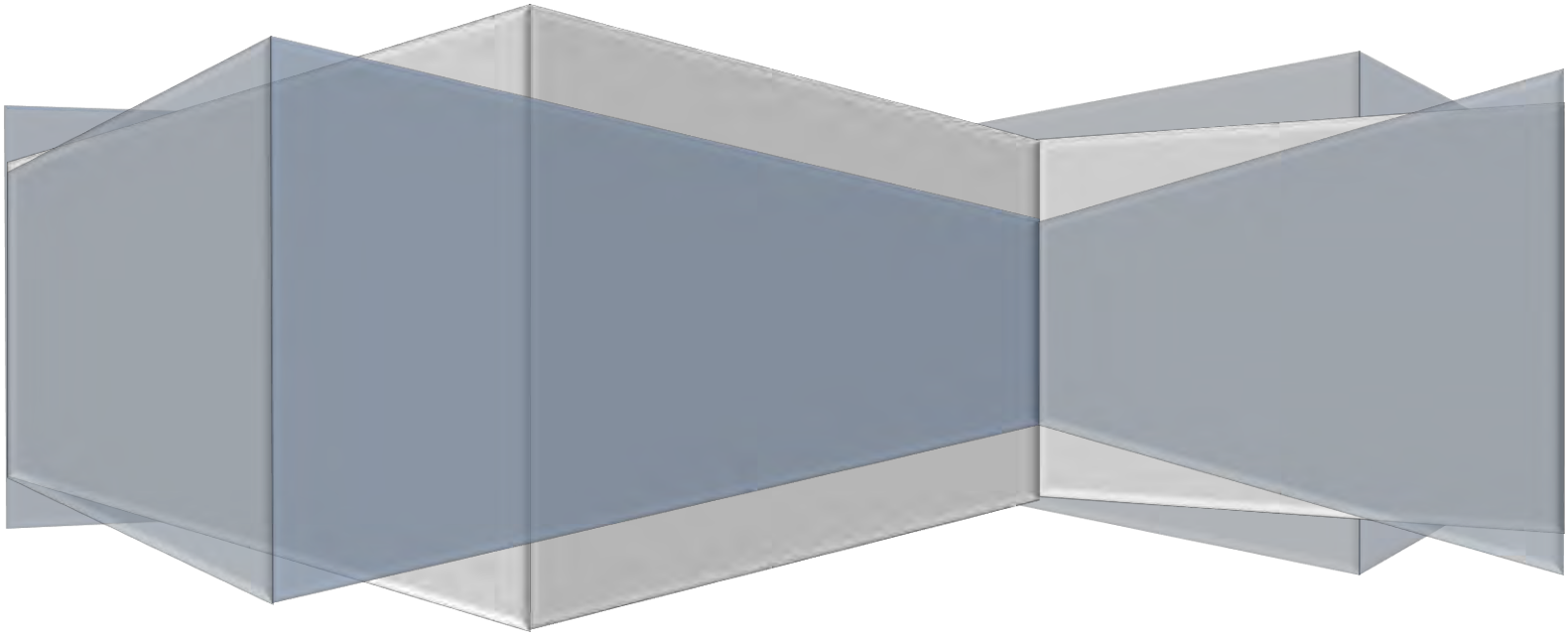
Transforming Your Care – This is a strategic assessment across all aspects of health and social care services examining the present quality and accessibility of services.

HSC Public Health Agency

HSC Health and Social Care Board

Commissioning Plan 2014/15

Draft - 26 January 2015



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FOREWORD

The HSC Board, working in partnership with the Public Health Agency (PHA), is committed to securing high quality health and social care services within available resources which meet the needs of the Northern Ireland population. Over the last number of years, continuing to meet these needs within the budget available has become increasingly challenging. A number of factors, including a growing and ageing population, the rising prevalence of long-term conditions, and advances in medical technology, have resulted in growing demand for increasingly costly services. In this context, a draft Commissioning Plan for 2014/15 was submitted to the DHSSPS in March 2014, which identified a funding shortfall of £160m required to meet the priorities, standards and targets set out in the Commissioning Plan Direction 2014. In the months following submission of the initial draft Plan the HSCB and PHA have been working closely with the DHSSPS and the various health and social care providers to resolve this funding gap and develop a financial plan which will deliver financial balance across the HSC system.

In addition, increased pressures identified by Trusts which emerged following the development of the original plan have been addressed through in year contingency measures within each Trust.

Revised Financial Plan 2014/15

The draft Commissioning Plan 2014/15 submitted to the DHSSPS in March 2014 identified the funding sources available to the HSCB and PHA, including additional funding from the DHSSPS and savings opportunities from baseline commissioning investments. These funding sources were then compared to costs associated with the delivery of the service priorities set out in the Commissioning Plan Direction and maintain existing services. The result was the estimated funding shortfall of £160m referred to above.

The HSCB, in conjunction with DHSSPS has now agreed a balanced financial plan for 2014/15. This has been achieved primarily through:

- securing additional non recurrent resources from Monitoring Rounds in June, £20m, and October, £53.5m
- curtailing a number of pressures through a delay or rephasing in implementation of some developments whilst protecting essential and

unavoidable service investments
- taking the decision not to proceed at this time with a number of planned service developments.

Table 17 in Chapter 3 of the Plan provides a summary of the revised financial plan to provide financial balance across the HSC after taking account of slippage, productivity and the agreed reprioritisation of planned investments. The main changes to the draft Commissioning Plan submitted to the DHSSPS in March 2014 are as follows:

(a) Pay Pressures

The original pay pressure of £22m has been reduced to £8m following further refinement of the assumptions in the HSC pay model.

(b) Revenue Consequences of Capital Expenditure

The revised plan incorporates a £3.5m reduction in expenditure requirements as a result of re-phasing of a range of planned schemes.

(c) Learning Disability Resettlements

The revised plan reflects a £2.5m reduction in expenditure requirements on resettlements. This was achieved through re-phasing of the original plan.

(d) Transforming Your Care (TYC)

The revised plan reflects a £6m reduction in expenditure requirements in relation to TYC. Notwithstanding this reduction, significant investment is being put in place including £4.5m for local and regional reform projects; £3.5m in Integrated Care Partnerships; £2.1m for implementation support staff; £1.5m to support release of frontline staff to deliver local Trust reforms; £1.1m for specialist foster carers and £0.7m for enhanced stroke care services.

(e) Family Health Services

The revised plan reflects an £18m reduction in pharmacy expenditure in both acute and primary care sectors.

(f) Baseline Funding

In addition to the reprioritisation or rephasing of investments and the monitoring funds secured by the DHSSPS the HSCB has reduced funds from baseline allocations totalling £21m in the areas of Elective, blood transfusion, DIS and Revenue Consequences of Capital Investment.

(g) Service developments

The original draft plan proposed service developments amounting to £51m; this figure has been reduced down to £38m through the curtailment of various planned service developments. The HSCB and PHA prioritised planned service developments taking account of a range of factors including:

- Whether the service development was already fully or substantially on the ground, or contractually committed.
- Whether the service development was essential to the safety and /or sustainability of services
- Whether the service development was essential to discharge statutory requirements

The table below details the £38m service developments approved to proceed during 2014/15.

Service developments to be funded 2014/15

Service pressure	In year (£m)
Elective care	18.50
Implementation of elements of the Cancer Care Framework	0.029
Hospice funding	0.200
Emergency Department capacity building	2.500
Haematology training posts	0.036
Radiology diagnostics	1.000
24/7 blood sciences	1.650
GMC recognition and approval of trainers	0.250
24/7 acute and community working	0.470
Dementia strategy	0.180
CHOICE (Education programme for children and young people with diabetes)	0.090
Lakewood secure provision	0.420
Availability of personal advisers as required under the Leaving Care Act	0.225
Extended fostercare scheme	0.300
Supported accommodation (Young Homeless and Care Leavers)	0.285
Safeguarding child exploitation	0.600
Assessment & approval support kinship foster carers	0.125
Health visiting	0.750

Expansion of Family Nurse Partnership programme	0.100
NHSCT Looked After Children Specialist Nurse	0.024
Primary care infrastructure	0.250
Out of Hours General Medical Services	0.600
Alcohol/substance liaison services	0.100
Revalidation – Medical and General Medical Services	0.106
10,000 Voices	0.256
Review of AHP services in special needs schools	0.083
Normative nursing	9.000
TOTAL	**38.127**

Service developments that were not able to proceed in 2014/15 included plans to extend existing IVF services, to expand GUM services, addiction services, sleep apnoea services, additional nursing support for looked after children and a range of health improvement initiatives.

In addition to the planned service developments which were not taken forward, it has been necessary to pause the assessment and treatment of patients within the Independent Sector, which had been planned to supplement shortfalls in capacity in the Health and Social Care service. It is regrettable that this will result in significantly increased waiting times for elective care by March 2015. The HSCB continue to have performance management processes in place to ensure that Trusts keep waiting times as short as possible through the delivery of core volumes and effective waiting list management approaches.

The values and volume of services commissioned as a result of the revised finance plan are set out in the values and volumes tables contained within the main plan. These are detailed at both regional and local level.

(h) Trust Contingency Plans

At the outset of 2014/15 the planned pressures within Trusts amounted to £87m. Trust Financial Monitoring during the early months of the financial year showed a deteriorating position with the reports for the four months to the end of July projecting a deficit for the year of £134m.

Trusts were asked to propose a range of contingency measures aimed at addressing this difficult financial position, minimising as far as possible, any potential adverse impact on patient and client care, and at all times putting the

safety of patients and clients as a first priority. The funding made available through the June and October Monitoring Rounds has enabled HSCB to significantly reduce the scale and range of contingency measures required to ensure the HSC system achieves balance in 2014/15.

The HSCB and PHA liaised closely with the Trusts, and critically reviewed, assessed and revised the proposals as appropriate with a view to safeguarding as far as to possible the quality of services, and maintaining the safety and integrity of services. The HSCB and PHA then provided their assessment to the DHSSPS and Minister, who, after consideration of and challenge to the plans, in conjunction with the HSCB, PHA and Trusts, approved the implementation of the contingency proposals.

Trust contingency proposals included:

- A range of workforce control measures to reduce expenditure on overtime and agency/temporary staff, whilst endeavouring to ensure that the integrity of the service is maintained.
- A reduction in planned elective activity with the focus being on ensuring that urgent patients are seen and treated in a timely way.
- A reduction in domiciliary care spend.
- Restrictions to bring aids and equipment expenditure in line with budget while ensuring urgent clinical need continues to be met.
- Restrictions on Travel Expenditure by minimising Non-Clinical travel where practical.
- Temporary closure of some Minor Injuries Units.
- Temporary closure of wards / beds.

The HSCB, PHA and Trusts will continue to take all proactive steps to protect critical and urgent frontline services and to monitor and review temporary arrangements that are put in place to ensure the impact on services is minimised, through the challenging winter period.

1.0 Introduction

1.1 The Purpose of the Plan

This Commissioning Plan is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Service and Public Safety for 2014/15. It includes the underpinning financial plan and outlines how commissioning will serve to deliver the planned transformation of services consistent with Transforming Your Care. Consequently, a key area of focus within the plan is the shift left of services from hospital into primary and community. While the plan focuses predominantly on 2014/15, it also signals a direction of travel for 2015/16.

The Plan identifies the key strategic priorities, including NI Executive, Ministerial and Departmental priorities, that will influence the commissioning of health and social care services over the next two years and provides direction for the development of those services for the population of Northern Ireland. In line with established commissioning arrangements, the plan provides an overview of regional commissioning priorities and decisions for 2014/15 and 2015/16 (Section 4) together with information on the priorities and decisions being taken forward at local level by the five Local Commissioning Groups (LCGs; Sections 6-10).

The Plan makes explicit those areas of service development and delivery that providers will be expected to respond to in their development plans for 2014/15 and against which they will be monitored. The document does not attempt to encompass all of the many strands of work that HSCB and PHA will continue to progress with providers during 2014/15. Rather it provides focus on a discrete number of key strategic and service priorities which we feel will have the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level, and those which represent a step change in how we deliver our services.

The commissioning priorities and decisions outlined within the Commissioning Plan have been identified through regional and local needs assessment and with reference to evidence-based or agreed best practice. In particular, they aim to

respond to the seven strategic priorities and statutory obligations identified by the Minister in the Commissioning Plan Direction:

- To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion anticipation and early intervention.
- To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting.
- To improve the management of longterm conditions in the community with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more longterm conditions.
- To promote social inclusion, choice, control, support and independence for people living in the community, especially older people, and those individuals and their families living with disabilities.
- To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the community, voluntary and independent sector.
- To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities.
- To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services.

In responding to these priorities the document seeks to outline how commissioning will support the implementation of a range of Government and Departmental strategies and standards including:

- Achievement of Ministerial standards / targets 2014/15 (see Chapter 6)
- *The Executive's Programme for Government, Economic strategy and Investment Strategy*
- *Transforming Your Care* (TYC)
- *Quality 2020*
- *Public Health Strategic Framework: Making Life Better 2013-23*
- *Other Departmental guidance and guidelines such as (e.g. Service Framework documents, NICE, Maternity Strategy).*

Within the plan, both regional and local commissioning priorities are presented largely by Programme of Care (PoC). PoCs are divisions of health care, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. In total, there are nine PoCs. Definitions of each PoC are provided in Appendix 1. Regional commissioning priorities in relation to the nine PoCs are presented in Section 4; local priorities for each PoC are outlined in Sections 6-10.

For each PoC, at regional and local level, the plan details the commissioned values volumes of activity during 2013/14 together with the indicative additionality for 2014/15. The activity figures cover various contract currencies depending on the PoC. A contract currency is a term used to briefly describe or define the activity. Examples include inpatient episodes, births, domiciliary care hours and face-to-face contacts. The activity data presented does not attempt to account for all of the spend or commissioned activity for a given PoC, rather it selects anywhere between two and six "activities" or "currencies" which account for the large majority of the total spend for that PoC.[1]

The plan also outlines how we will meet our Equality duties under the Northern Ireland Act 1998(b) and how we have sought to embed Personal and Public Involvement (PPI) in our commissioning processes. The equality screening template that accompanies this document can be found on the HSCB website (www.hscboard.hscni.net/publications/Commissioning%20Plans).

Commissioning priorities and decisions also seek to take account of opportunities for and the benefits of partnership working with other Departments and agencies whose policy; strategy and service provision impinges on health and social care.

1.2 Placing communities at the centre of commissioning

The HSCB and PHA are committed to ensuring that commissioning priorities are focused upon need, are locally responsive and reflect the aspirations of local communities and their representatives. There are five Local Commissioning

[1]The remaining proportion of the spend may be made up of in excess of 20 other currencies which are not easily grouped.

Groups (LCGs) and each is a committee of the HSCB: Belfast; Northern; South Eastern; Southern; and Western. LCGs are responsible for assessing local health and social care needs; planning health and social care to meet current and emerging needs; and supporting the HSCB to secure the delivery of health and social care to meet assessed needs.

In line with established commissioning arrangements, the plan provides an overview of regional commissioning themes and objectives for 2014/15 together with information on the priorities and decisions being taken forward by the five Local Commissioning Groups (LCGs; see Sections 6-10).

1.3 Monitoring Performance

The priorities and targets detailed in the *Commissioning Plan Direction* are complemented by a number of indicators of performance indicated in a separate *Indicators of Performance Direction* for 2014/15, which can be found on the HSCB website (www.hscboard.hscni.net/publications/Commissioning%20Plans).

The *Indicators of Performance Direction* has been produced to ensure that the Health and Social Care sector has a core set of indicators in place, on common definitions across the sector, which enable us to track trends and performance. The HSCB, PHA and Trusts monitor the trends in indicators, taking early and appropriate action to address any variations / deterioration in unit costs or performance or in order to ensure achievement of the Ministerial targets.

2.0 Strategic context & drivers

This section outlines the key strategic drivers that have shaped our commissioning priorities for 2014/15 and 2015/16. These include:

- The assessed needs of the population
- Transforming Your Care
- Programme for Government
- Quality 2020
- Public Health Strategic Framework – 'Making Life Better'.

2.1 Assessing the health and social care needs of the population

This section provides an overview of the assessed needs of population of N Ireland. This assessment is based on demographic changes and information we have relating to health inequalities. These needs inform the commissioning of services at regional and local level.

2.1.1 Demographic Changes

(i) Introduction

N Ireland has the fastest growing population in the UK. Some of the key demographic changes are noted below:

- Recently published Census figures for 2012 indicate that there are approximately 1.824m people living in N Ireland (NI).
- There are a total of 273,000 older people (65+ yrs) in N Ireland.
- Current population projections anticipate the population will rise to 1.918m by 2022.
- This increase is characterized by a marked rise in the proportion of older people – up to 2022, number of people aged 65+ is estimated to increase by 26% (71,000) to 344,000. This is 18% of the total population compared with 15% currently.
- Revised population projections are not available until Spring 2014 however, 2008 based projections suggest, at sub-regional levels, the areas with the highest projected growth overall is the Southern LCG (+14%), for the aged 65+ and 75+ cohorts of the population is in the West is the Western LCG at +40%, and for aged 85+ years is in the Southern LCG (+74%).
- Births in N Ireland have remained stable over the last 5 years; there were some 25,300 live births registered during 2012.

- 14,756 deaths were registered in N Ireland during 2012 which is an increase of 552 or 3.9% since 2011.
- The main cause of death was cancer accounting for 28% of deaths in N Ireland (4134).
- Life expectancy across the region has improved by 8 years for females and 6 years for males since 1980/82. In 2008/10 males can expect to live to the age of 77.1 years and females to the age of 81.5 years
- The prevalence of long term conditions such as COPD, diabetes, stroke and hypertension is increasing. In conjunction the number of people coping with co-morbidities is increasing.
- Deprivation has an impact on health and wellbeing in many ways resulting in the lack of social support, low self-esteem unhealthy life style choices, risk taking behaviour and poor access to health information and quality services.

(ii) Demographic changes

Mid-year estimates for 2012 estimated the N Ireland population to be 1.824 million. This is an increase of an estimated 9,300 (0.5%) people since 2011. The highest increase can be found in the population aged 85 and over, which increased by 3.0% (from 31,800 to 32,700) between mid-2011 and mid-2012 (NISRA, 2013).

Northern LCG has the highest share of the N Ireland population, with 466,000 residents or 26% of the N Ireland total (Table 1). The resident population of the Southern LCG is the second largest at 363,000 (20% of NI total). Belfast and South Eastern LCGs have similar resident total populations and contribute 19% each to the N Ireland total population (348,000 and 350,000 respectively). The Western LCG has the smallest population of the five LCGs at 297,000 or 16 % of the N Ireland population.

N Ireland Resident Populations by Local Commissioning Group:

Table 1

Age Band (Years)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	66,000	96,000	72,000	83,000	65,000	382,000
16-39	124,000	144,000	105,000	119,000	96,000	589,000
40-64	105,000	152,000	117,000	112,000	95,000	580,000
65+	53,000	73,000	57,000	49,000	40,000	273,000
Overall	**348,000**	**466,000**	**350,000**	**363,000**	**297,000**	**1,824,000**

Source: NISRA, 2012

The age structure of the LCG resident populations varies. Belfast LCG has the lowest proportion of younger people aged 0-15 yrs, in comparison to other LCGs (19% or 66,000) and the Southern LCG has the highest percentage at (23% or 83,000). The Northern LCG however has the highest number of younger people within its population at 96,000 or 21% of its population. Persons of working age account for the highest proportions across all LCGs, ranging from 66% of the population in Belfast to 64% in the South Eastern LCG.

As people grow old the likelihood of illness increases and therefore also does the reliance on health and social care services. Over all in N Ireland there are 273,000 older people (those aged 65 and over) which equates to 15% of the total population. In terms of geographical distribution of this age category, 19% of these or 53,000 persons aged 65+ are in Belfast LCG, 27% or 73,000 are in Northern LCG; 21% or 57,000 reside in South Eastern; 18% or 49,000 are in Southern LCG and the remaining 15% or 40,000 live in Western LCG.

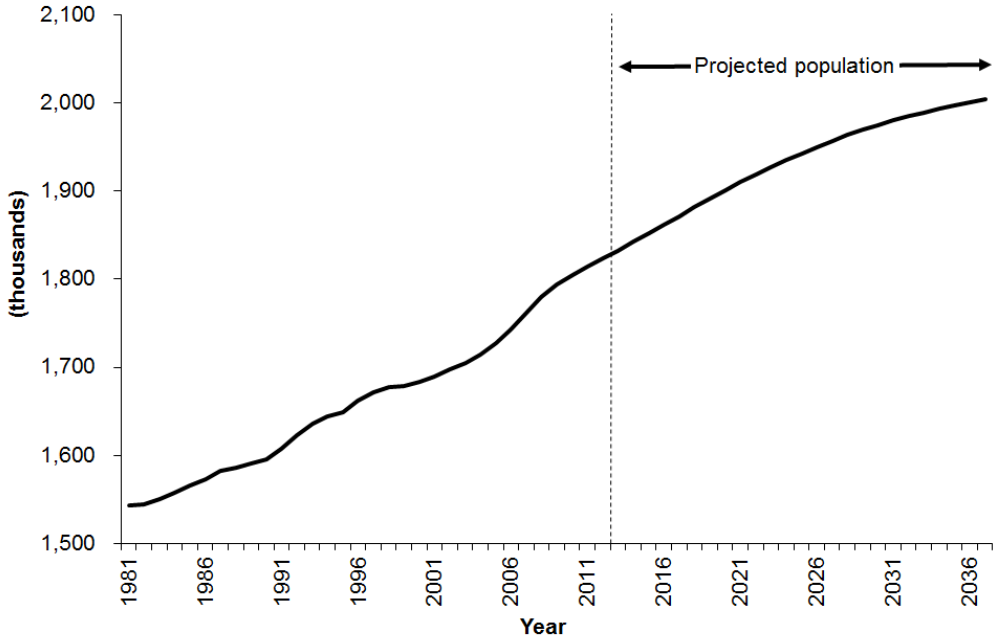
Population Projections

The N Ireland population is projected the population is projected to increase to 1.918 million in 2022 from 1.824 million in 2012, an average annual rate of growth of 0.5%.

- Natural growth is the driver of the projected population increase: between 2012 and 2022 there will be 99,000 more births than deaths.
- While the population aged under 65 is projected to increase by 1.5% (24,000 people) from 2012 to 2022, the population aged 65 or more will increase by 26% (71,000 people);
- Longer-term projections show the real impact of the marked increase in the size of the population at older ages. The number of people aged 65 and over is projected to increase by 44% in the next fifteen years (2012-2027).

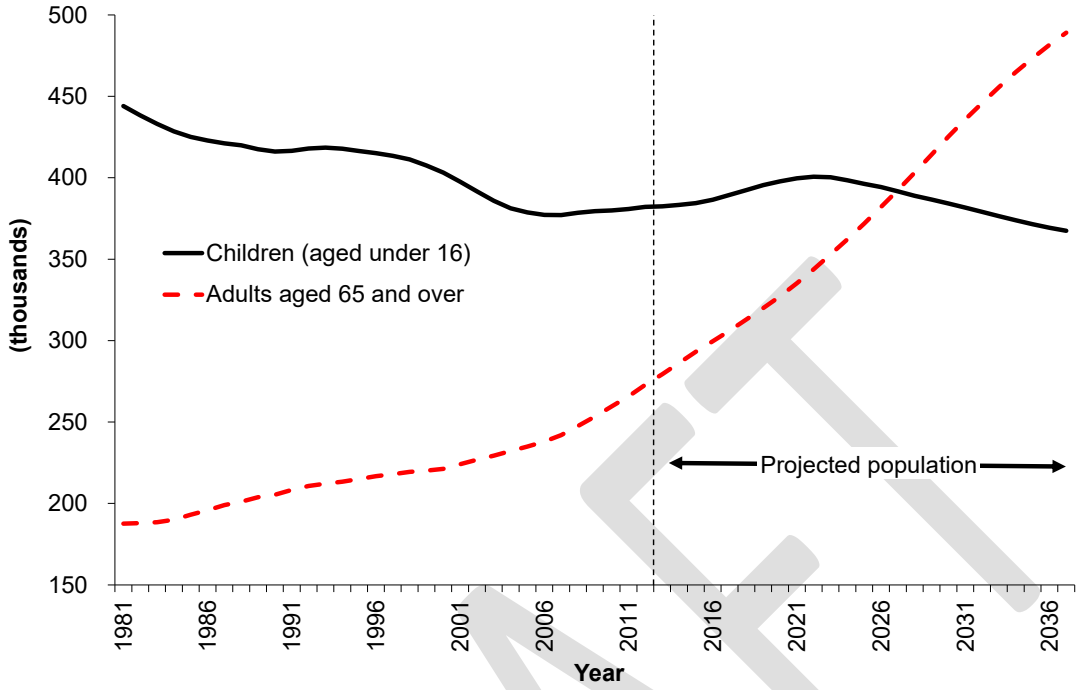
Population of N Ireland, actual and projected, 1981-2037 (non-zero y-axis)

Figure 1



Children aged under 16 and adults aged 65 and over, actual and projected, 1981-2037 (non-zero y-axis)

Figure 2



Source: NISRA

Projected age distribution of population, 2012-2037 (percentages)

Table 2

	2012	2017	2022	2027	2032	2037
Children (Under 16)	*21*	*21*	*21*	*20*	*19*	*18*
Adult Population (16-64)	*64*	*63*	*61*	*60*	*58*	*57*
Older population (65+)	*15*	*16*	*18*	*20*	*22*	*24*
Working age population[2]	*62*	*62*	*62*	*61*	*60*	*60*
Pensionable population[2]	*17*	*17*	*17*	*19*	*21*	*22*

Source: NISRA

Births

In 2012 there were 25,269 live births registered in N Ireland, which is a small change from the 25,273 births registered in 2011. The number of births in N Ireland has remained relatively stable since 2008 following an increasing trend from a record low in 2002 when there were 21,385 births. In 2012, there were

1,100 births to teenage mothers, which according to NISRA is the lowest on record.

Deaths

In 2012, there were 14,756 deaths registered in N Ireland, an increase of 552 deaths (3.9%) compared to 2011. The average age at death has increased over the last 30 years from 70.1 years in 1982 to 76.4 years in 2012 (NISRA, 2013).

The main causes of death in 2012 were cancer 4,134 deaths (28% of all deaths) – the largest number of cancer deaths on record, diseases of the circulatory system 4,001 deaths (27% of all deaths) and diseases of the respiratory system 2,023 deaths (14% of all deaths).

Of the 14,756 deaths registered in 2012, just under half (49%) of deaths occurred in hospital. A further 27% died in their own home, followed by 18% in a nursing home. The remaining 6% of deaths occurred elsewhere (NISRA, 2013).

Typically more deaths occur in the winter months, however last year we witnessed higher numbers of deaths occurring in spring, with the exception of January in which over 1,400 deaths were registered. On average there were around 6% more deaths in the spring months of March to May (around 1,300 each month) than the monthly average for the year (1,230). In contrast there is virtually no variation on the day of the week that people die (NISRA, 2013).

Standardised morality ratios (SMRs) for 2012 are presented in the table below. Belfast and Western LCG areas exhibited higher than average standardised mortality rates (SMRs) for all causes of death in 2012 (112.3 and 101.4 respectively). SMRs for Northern and South Eastern LCG areas were lower than average (94.4 and 94.0 respectively).

Standardised Mortality Ratios 2012 by Local Commissioning Group for the main causes of death (All causes, Cancer (including trachea bronchus or lung), Circulatory diseases (including Ischemic heart disease and Cerebro-vascular disease), and Respiratory disease (including Pneumonia).

Table 3

Area	All deaths	Malignant neoplasms			Circulatory diseases			Respiratory diseases	
		All sites (C00-C97)	Trachea, bronchus & lung (C33-C34)	Breast[1] (C50)	All circulatory diseases (I00-I99)	Ischaemic heart disease (I20-I25)	Cerebro-vascular disease (I60-I69)	All respiratory diseases (J00-J99)	Pneumonia (J12-J18)
NORTHERN IRELAND	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***
Belfast	***112.3***	***114.9***	*129.8*	*107.6*	***107.5***	*104.5*	*115.6*	***123.7***	*109.4*
Northern	***94.4***	***96.4***	*88.4*	*93.0*	***97.0***	*92.4*	*100.0*	***91.2***	*94.2*
South Eastern	***94.0***	***90.7***	*84.6*	*100.6*	***97.0***	*91.9*	*92.1*	***83.7***	*96.8*
Southern	***100.1***	***98.4***	*99.3*	*108.4*	***100.1***	*114.1*	*86.2*	***96.6***	*80.8*
Western	***101.4***	***101.7***	*104.9*	*90.9*	***98.6***	*101.8*	*106.5*	***110.3***	*124.9*

Female deaths only

Note: Rates relate to the 2012 mid-year population estimate for 2012

Source: NISRA.

Health Status

It is well know that many factors impact on the health status of individuals and populations. These include age, gender and genetic makeup, lifestyle and behaviour, and other social and environmental factors. Health status of a population may be monitored through a combination of measures for example mortality, life expectancy, morbidity and perceived health status.

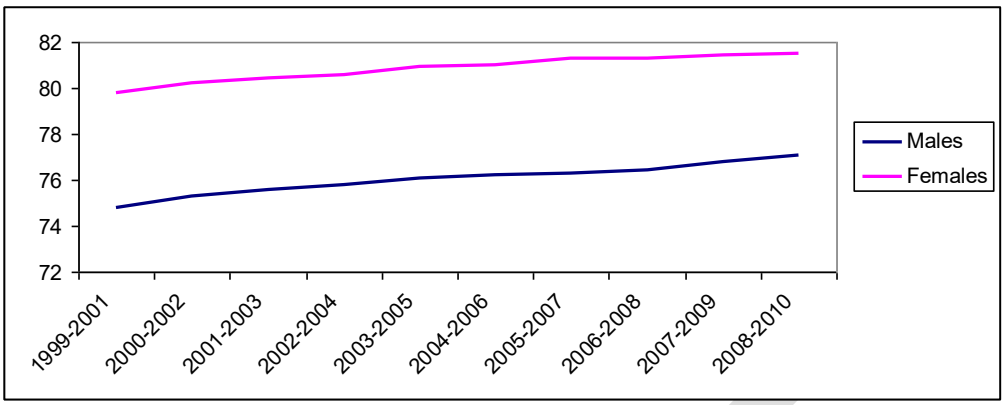
Life Expectancy

Life expectancy is used internationally as a measure of population health. For the period 2008-2010, life expectancy in NI was lower than in England and Wales, but higher than in Scotland. Males and females in N Ireland could expect to live 1.4 and 1.0 years less on average than their counterparts in England respectively (Source: PHA, 2012).

In Northern, life expectancy has increased between 1999-2001 and 2008-2010 from 74.8 years to 77.1 years for men, and from 79.8 years to 81.5 years for women.

Life Expectancy by Gender in N Ireland, 1999-2000 to 2008-2010.

Figure 3



Source: NISRA, 2012

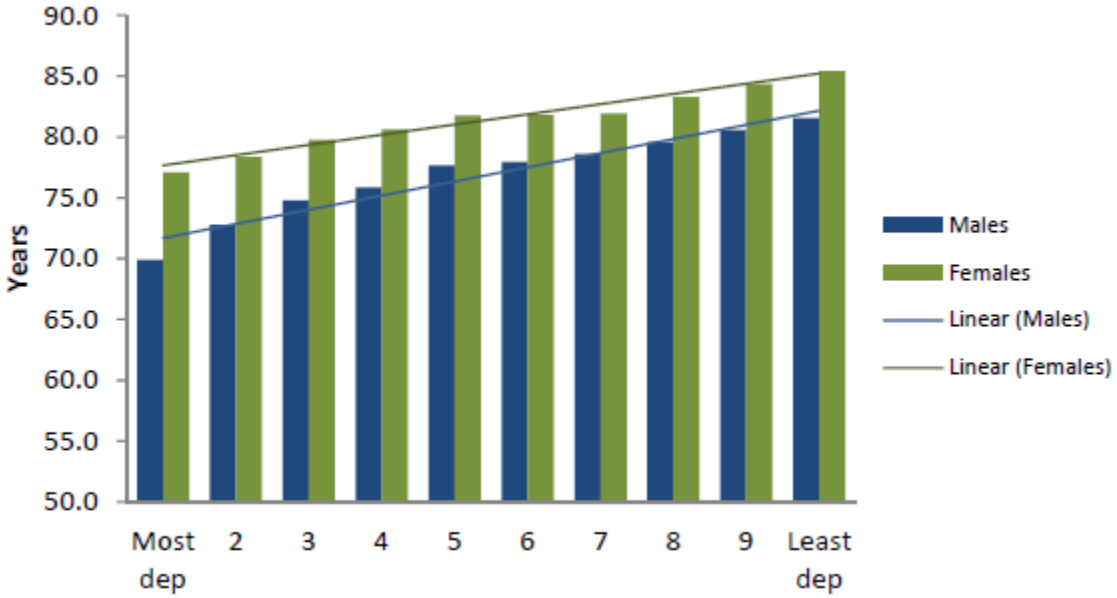
While there are some signs of general improvement in life expectancy, not everyone has been able to avail fully of the benefits of this progress. Social inequality has endured to the extent that health outcomes for some groups remain poorer than for others, and smoking, obesity, misuse of drugs and alcohol, teenage conception rates, poor mental health are disproportionally concentrated amongst particular deprived groups (Source: PHA, 2012).

The influence of social conditions and lifestyle behaviour is evident when we compare life expectancy and other health outcomes across geographical areas and population groups.

For example, males living in the 10% least deprived areas in NI could expect on average to live almost 12 years longer than their counterparts living in the 10% most deprived areas. For females, the gap is more than 8 years. Figure 4 below shows life expectancy at birth by deprivation decile. For females the scope of inequalities in life expectancy across the population is lower than for males, which is evidenced by the steeper gradient across the deciles for males.

Life expectancy by Deprivation decile 2008/10

Figure 4



Source: PHA, 2012.

Recently published findings of a study of health inequalities reveal that health outcomes are generally worse in the most deprived areas within an LCG area than when compared to the LCG as a whole.

Chronic Illness / Long term conditions

Self-assessed health and long term limiting illness (Census, 2011)

The 2011 Northern Ireland Census asked respondents how they perceived their health, whether they had a long term limiting illness and if they provided unpaid care. Approximately one fifth of the N Ireland population stated that they had a long term limiting illness and almost 80% felt they were in good health.

Percentage of population with a long term limiting illness, with good or very good general health, Census 2011

Table 4

	Long term limiting Illness	General health: Good or Very Good
Belfast	23.04	76.71
Northern	19.65	80.43
South Eastern	19.82	80.84
Southern	19.64	80.60
Western	21.85	78.46
Northern Ireland	20.69	79.51

Source: Census 2011

When asked about the type of long term condition suffered 6.6% of the N Ireland population stated they had a chronic illness and 10% suffered long term pain or discomfort Table 5).

Type of Long Term Condition as assessed by the Northern Ireland Census 2011

Table 5

LCG	Deafness or partial hearing loss (%)	Blindness or partial sight loss (%)	Communication difficulty (%)	A mobility or dexterity difficulty (%)	A learning, intellectual, social or behavioural difficulty (%)	An emotional, psychological or mental health condition (%)	Long-term pain or discomfort (%)	Shortness of breath or difficulty breathing (%)	Frequent periods of confusion or memory loss (%)	A chronic illness (%)	Other condition (%)	No condition (%)
Belfast	5.6	2.0	1.9	13.1	2.6	7.4	11.4	10.3	2.5	7.2	5.6	66.0
Northern	5.2	1.6	1.5	10.7	2.0	5.1	9.7	8.4	1.7	6.6	5.1	69.2
South Eastern	5.6	1.7	1.6	11.1	2.2	5.1	9.9	8.5	1.9	6.7	5.3	68.4
Southern	4.5	1.6	1.6	10.8	2.0	5.3	9.5	7.8	1.8	5.9	4.9	70.8
Western	4.8	1.7	1.8	11.9	2.4	6.6	10.2	8.8	2.0	6.4	5.3	68.2
Northern Ireland	5.1	1.7	1.7	11.4	2.2	5.8	10.1	8.7	2.0	6.6	5.2	68.6

Source: Census 2011

QOF Disease Registers

The Prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions

there is a link between prevalence and deprivation (PHA, 2011). Across N Ireland the most prevalent LTCs are hypertension (127.38 per 1000 patients), asthma (59.81 per 1000 patients) and diabetes (39.95 per 1000 patients).

Emergency Admissions to hospital for LTC

During 2011/12 long term conditions such as asthma, COPD, diabetes, heart failure and stroke accounted for a total of 11, 620 emergency admissions to hospital (where relevant ICD-10 codes were coded as a primary diagnosis or main condition treated on the admission episode). COPD accounted for just over 40% of this total, at a rate of 342 admissions per 100,000 population (aged 18+).

Total number of emergency admissions and rate per 100,000 population (aged 18+) to hospitals in N Ireland for selected long term conditions 2011/12

Table 6

	Asthma	COPD	Diabetes	Heart Failure	Stroke
Number of Emergency Admissions	835	4,717	1,008	2,363	2,697
Rate per 100,000 popn.	61	342	73	171	195

Source: PAS, HSCB PMSI 2013.

Cancer

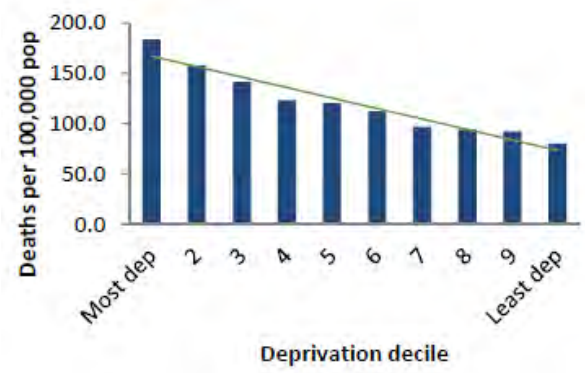
According to NIISRA, cancer now accounts for the largest number of deaths attributable to a single cause. The proportion of deaths due to cancer in N Ireland has increased from 18% in 1981 to 29% of all deaths in 2011. By way of contrast, deaths in 2011 due to ischemic heart disease decreased by 60% since 1981 from 4,909 to 1,966.

In 2011, the most common cancer sites for males and females was the trachea, bronchus or lung which accounted for 26% of deaths in males and 19% of female deaths. Breast cancer accounted for 18% of female deaths in 2011, and prostate cancer for 11% in males. The graphs in Figure 5 illustrate the social gradient in relation to the death rate under 75 due to (i) cancer (all sites) and (ii) lung cancer.

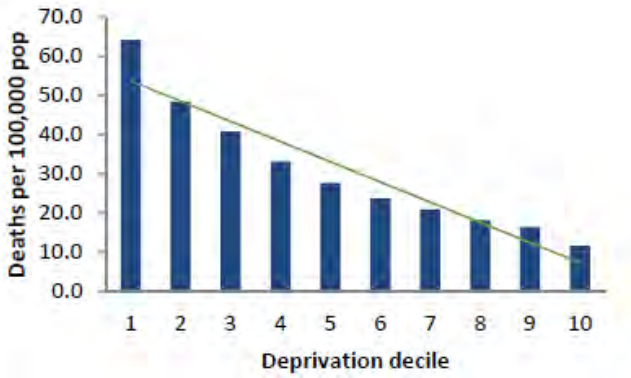
Standardised death rate (SDR) for cancer (all sites) and lung cancer for the aged under 75yrs, by deprivation decile, 2005-2009

Figure 5

i. SDR due to cancer (U75) - all causes, 2005-09



ii. SDR due to lung cancer (U75) - 2005-09



Source : PHA, 2012.

Cancer related mortality in the most deprived decile was more than twice that in the least deprived and one and a half times that in N Ireland as a whole. Lung cancer related mortality in the most deprived decile was five and a half times that in the least deprived.

Lifestyle and behaviour

Smoking

Smoking rates are highest among people who earn the least and lowest amongst those on higher incomes, for example while smoking prevalence amongst the general population is now 24%, amongst manual workers it remains high at 31%.

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in N Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 48 individuals every week (PHA, 2012).

Generally smoking related deaths have decreased by around 9% over the last number of years (Table 7). This trend has been observed at sub regional level for all LCGS with the exception of Belfast which has remained relatively stable. In

general, Belfast LCG residents experience significantly higher death rates due to smoking related causes (figure 6). South Eastern residents experience the lowest mortality rates due to smoking related causes.

Standardised death rates by LCG of Residence for smoking related causes

Table 7

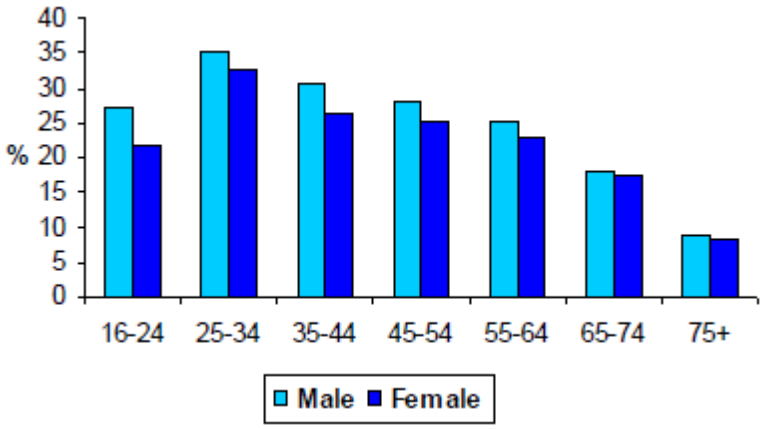
LCG/ Trust Area of Residence	00/01-02/03	08/09-10/11	% Change
Belfast	161	164	2%
Northern	129	119	-8%
S-Eastern	122	115	-6%
Southern	134	127	-5%
Western	148	141	-5%
N. Ireland	134	122	**-9%**

Source: NI Health and Social Care Monitoring System, 2012.

Results published from the Health Survey Northern Ireland (2011/12) reveal that a quarter of respondents indicated that they currently smoke, 27% of males and 23% of females (DHSSPSNI, 2012). Smoking prevalence was higher within the 25-34 age group at 33% and lowest amongst the over 75s (Figure 6).

Smoking prevalence by age and gender 2011/12

Figure 6



Source: Health Survey Northern Ireland DHSSPSNI, 2012.

The survey also revealed that just over three quarters (76%) of smokers had tried to quit smoking at some stage.

Alcohol

Alcohol and drugs misuse have been a significant issue in N Ireland for many years. The number of alcohol related deaths has been increasing over the past decade. Since 2001, there has been a total of 2,785 alcohol related deaths, 68% of which have been deaths to males. Of this total, 854 or 31% were registered to Belfast LCG area of residence.

Alcohol related admission rates have also been on the increase in N Ireland over the past decade. In general admission rates have increased for all LCGs with the exception of Northern which has fallen by 11%.

Standardised alcohol related admission rates by LCG of Residence

Table 8

LCG/ Trust Area of Residence	00/01-02/03	08/09-10/11	% Change
Belfast	805	943	17%
Northern	470	419	-11%
S-Eastern	418	551	32%
Southern	479	602	26%
Western	476	670	41%
N. Ireland	**528**	**641**	**21%**

Source: NI Health and Social Care Monitoring System, 2012.

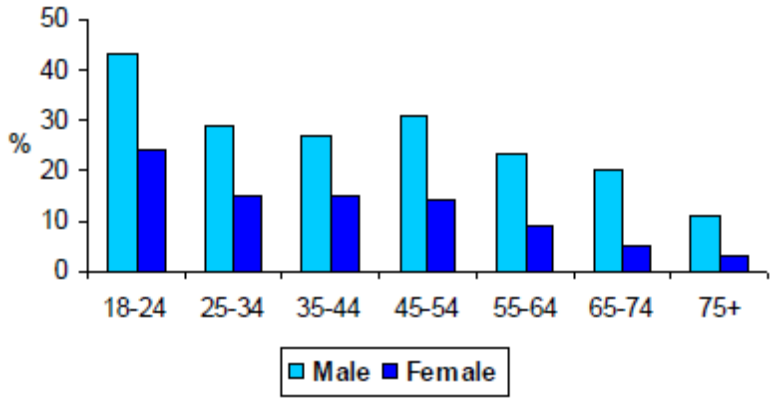
Alcohol related standardised admission rates and death rates for Belfast LCG residents are significantly higher than all other LCGs.

Findings reported from the Northern Ireland Health survey show that three quarters (75%) of respondents aged 18 and over indicated that they currently drink alcohol, 81% of males and 72% of females. In general the proportion of respondents indicating that they drink alcohol decreased with age, from between 85% - 88% of 18-34 year olds to 44% of those aged 75 and over. Almost one fifth

of all respondents aged 18 and over reported drinking in excess of the weekly drinking limits.

It is well known that health outcomes are generally worse in the most deprived areas, with alcohol related mortality in the 10% most deprived areas of N Ireland being almost 9 times that in the least deprived areas (PHA, 2012). The same is true within an LCG area than when compared to the LCG / trust as a whole. For example, within Belfast LCG alcohol related hospital admission rate was 120% higher in the most deprived areas than in the LCG area as a whole (DHSSPSNI, 2012).

Respondents drinking above weekly limits by age and gender, 2011/12
Figure 7



Source: Health Survey Northern Ireland DHSSPSNI, 2012.

Obesity

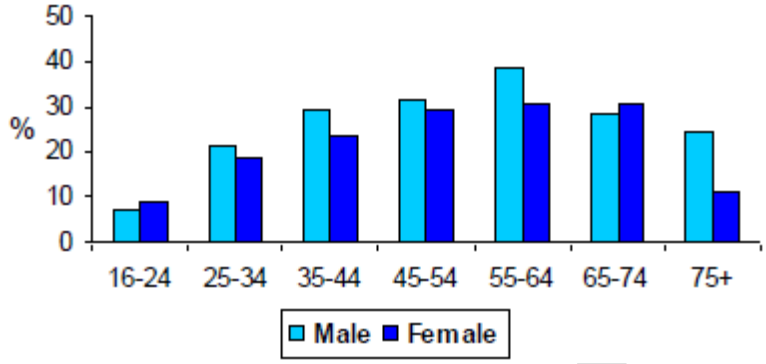
Obesity is one of the most important public health challenges in N Ireland today, and indeed the prevalence of obesity has been rising over the past number of decades. Projections suggest that half of the UK will be obese by 2030 – a rise of 73%. Research has shown that obesity can reduce life expectancy by up to 9 years as well as increasing the risk of coronary heart disease, cancer, type II diabetes as well as affecting mental health and self -esteem and quality of life (CMO, 2010).

Recently published findings of the Health Survey Northern Ireland shown in Figure 8 indicate that 10% of 2-5 year olds were assessed as being obese. Overall, 61%

of adults measured were either overweight (37%) or obese (23%), with a higher prevalence in males (25%) than females (34%).

Obesity levels by age and gender

Figure 8



Source: Health Survey Northern Ireland DHSSPSNI, 2012.

Rurality

Generally health outcomes in rural areas tend to be better than in NI overall. However evidence suggests that health inequalities have a significant impact on people living in rural communities. Challenges faced by many people living in rural areas include:

- Deprivation and fuel poverty;
- Social isolation and social exclusion - small, sparsely distributed populations;
- A growing ageing population and changing population patterns; and
- Adequate access to services.

Pressures felt by wider society as a result of the economic climate are often exacerbated in rural areas resulting in increasing numbers of rural people finding themselves in positions of poverty and exclusion. These challenges are compounded with many needs and issues hidden as a result of isolation in the rural setting. Rural poverty manifests itself differently from poverty in urban areas; it is not spatially concentrated and is therefore more difficult to identify. Rural poverty is clearly associated with the remote rural regions although obviously not confined to them.

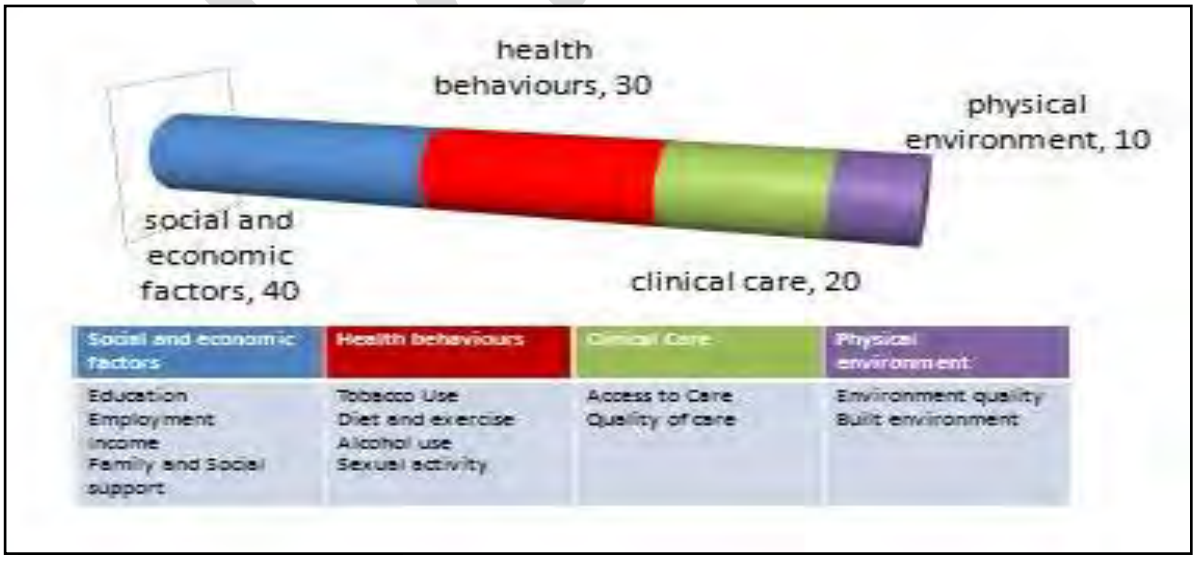
The *New Policy Institute* found, for example, that disadvantage was more prevalent in western districts of N Ireland. Broader research carried out across rural areas in the UK indicates that most rural areas are affluent, with rural poverty scattered and hidden amongst general affluence. People in rural communities are less likely to identify that they are in poverty and there is a culture of making do. This is evidenced in part by the lower than average take-up of benefits in rural areas (*see Bramley et al 2000)*. In 2007 – 2008 in N Ireland, of those who earned 50 per cent below the UK Mean Income before Housing Costs, almost half (46 per cent of individuals) lived in rural areas (PHA, 2012).

2.1.2 Health Inequalities

In N Ireland between 2001 and 2011 37,500 people died prematurely of conditions which were potentially preventable. An additional 8,765 people died prematurely of conditions which, if diagnosed and treated early enough, might have been avoidable[2]. Figure 9 illustrates the potentially preventable causes of death which contribute most to this situation. Not all these conditions are directly related to healthcare and many reflect lifestyle and underlying social and environmental influences or what are referred to as the 'social determinants' of health. Work by the University of Wisconsin Population Health Institute has estimated the relative weight of various factors on health outcomes (see Figure 10).

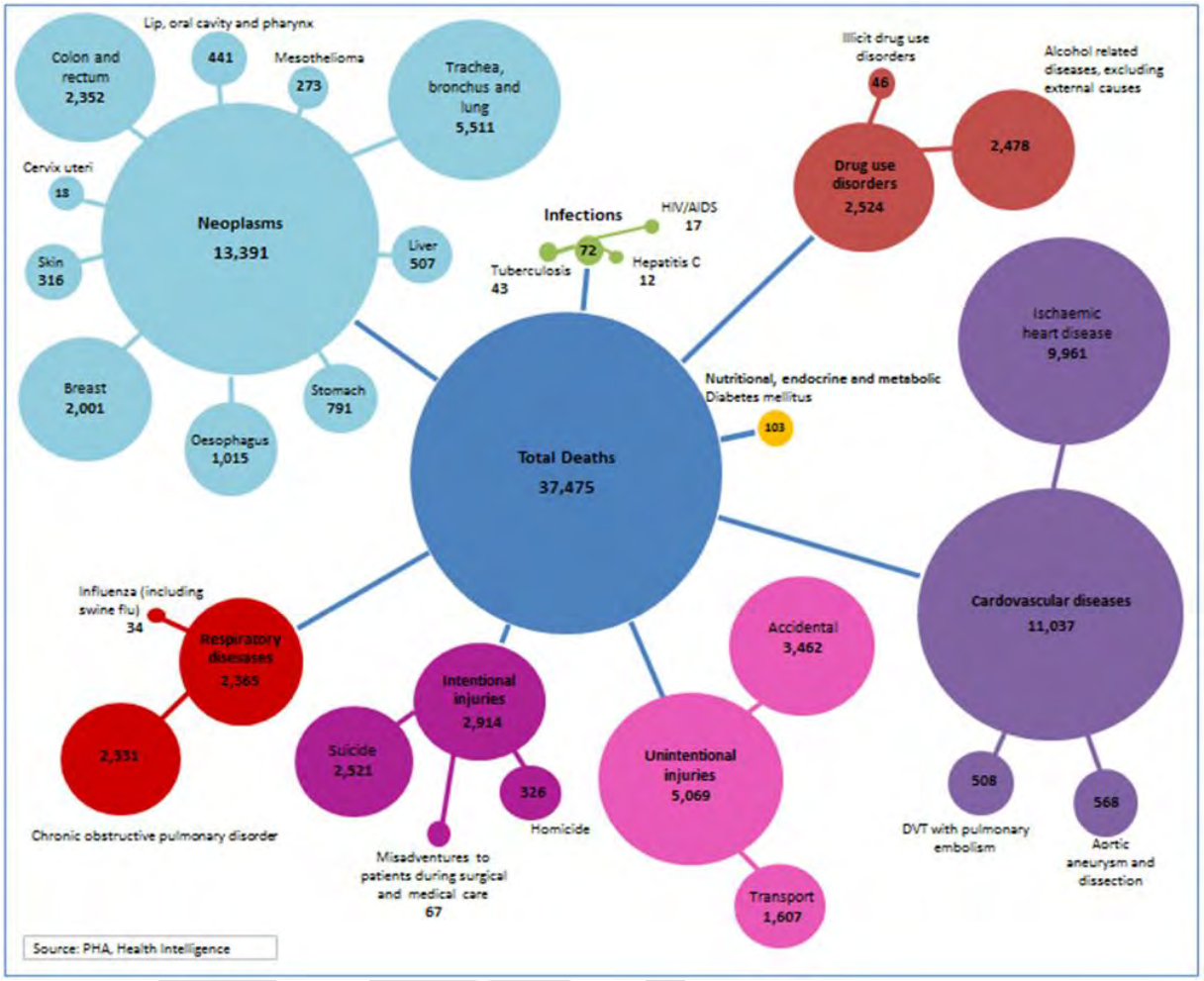
Percentage contribution to health outcomes

Figure 9



[2] PHA Health Intelligence briefing on avoidable deaths.

Relative Weighting of Factors on Health Outcomes
Figure 10



While N Ireland has seen reductions in inequalities (for example in relation to infant mortality, cancer incidence rates, teenage births) gaps still exist and the improvements have not been seen in all groups at the same rate. The position of inequality has been persistent over time. Those most likely to die prematurely include men (63%), reflecting the four and a half year gap in life expectancy between men and women, and those living in our most deprived areas. Residents of most deprived areas are twice as likely to die prematurely of preventable causes as those in least deprived areas. This increases to a factor of six for drug related deaths, four times for alcohol and respiratory problems and three times for suicide, diabetes and lung cancer.

The DHSSPS disaggregation of life expectancy differentials in N Ireland[3] highlighted the reducing impact of circulatory disease on premature mortality with the increased contribution of cancers and accidental injuries and suicide amongst the younger age groups, particularly in more deprived areas.
While life expectancy in N Ireland is broadly similar to that in the rest of the UK, 'healthy life expectancy' is significantly below that of England, Scotland and Wales[4].

The 2011 census reported that over 80,000 (6%) aged 16-74 years in N Ireland described themselves as in bad or very bad health. [5] There was a marked socio-economic gradient ranging from 2% of those in higher managerial and professional occupations to 12% of those in routine occupations and nineteen per cent of those who had never worked. This increased to 13% overall of those aged sixty- to sixty-four years with 21% of those in routine occupations in this age group describing their health as bad or very bad. These people were likely to identify long term health problems and disabilities that limited their day to day activities and this pattern has a strong age gradient.

In terms of preventable illness, GP QOF data for N Ireland (March 2013) identified some 245,000 registered adult patients with hypertension, 169,000 with obesity, 79,000 with diabetes, and 33,000 with cancer.

The World Health Organisation in 2010 [6] identified major contributors to the 'Global Burden of Disease' and ranked the ten most influential risk factors for Western Europe as shown in Table 9.

[3] http://www.dhsspsni.gov.uk/hscims_life_expectancy_decomposition_2013.pdf
[4] http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-and-age-65-in-the-united-kingdom/2008-10/index.html
[5] http://www.nisra.gov.uk/Census/2011_results_detailed_characteristics.html
[6] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61766-8/abstract

Ranking of Risk Factors Contributing to Quality Adjusted Years of Life Lost in Western Europe

Table 9

1. Tobacco use	2. High blood pressure
3. Overweight/obesity	4. Low physical activity
5. High blood glucose	6. Alcohol use
7. Diet low in fruits	8. High cholesterol
9. Diet low in nuts and seeds	10. Sodium levels in diet

Table 10 illustrates the substantial variations in the prevalence of risk behaviour within different groups across N Ireland. Other communities, for example Lesbian, Gay, Bisexual and Transgender (LGB&T) have higher levels of reported risk from tobacco, excess alcohol and drugs[7].

Many of these risk factors cluster in individuals. While 58% of people did not meet physical activity guidelines in 2010/11 and 68% did not eat the recommended five a day, 41% of people did not do either.[8] Of the five main healthy lifestyle behaviour choices [9] 20% of people in more deprived areas meet only one or none (NI value 12%)[6].

[7] http://www.publichealth.hscni.net/publications/all-partied-out

[8] Bulletin 6 Lifestyle choices 2010/11 Health survey http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health.htm

[9] Ensuring alcohol intake is within weekly guidelines. Not being overweight or obese by maintaining Body Mass Index (BMI) of less than 25 kg/m2. Eating at least 5 portions of fruit and vegetables a day. Meeting the recommended weekly level of physical activity (i.e. exercising for at least 30 minutes five days a week). Not smoking cigarettes.

Individual risk factors from the Northern Ireland Health survey 2011/12

Table 10

	N.I.	Gender		Age Group			Trust/LCG					Deprivation	
		M	F	16-24	45-64	75+	Belfast	Northern	South Eastern	Southern	Western	Most deprived	Least Deprived
General health - 'not good' (%)	14	13	14	4	16	22	16	13	14	13	13	18	12
Eating ' five a day' (%)	32	26	37	26	33	28	30	30	33	36	33	27	34
Obese or overweight (%)	61	67	56	28	70	63	58	63	60	58	64	63	55
Smoking (%)	25	27	23	24	26	8	28	24	22	23	23	39	15
Drinking > weekly limit (%)	25	28	13	M 43 F 24	M 31 F14	M 11 F 3	32	20	26	18	26	M 44 F 22	M 32 F18
Meeting Physical activity levels (%)	35	40	31	35	38	13	30	37	31	41	34	34	30
Mental health – potential psychiatric disorder (GHQ12) (%)	19	17	20	18	23	15	23	16	22	17	15	27	16

Widowed, divorced or cohabiting were more likely than respondents that were separated, married and single to not meet the Health recommendations. Females were more likely than males to meet three or more of the lifestyle recommendations (61% and 50%, respectively). [6]

Known inequalities in health have been identified across a range of groups. Some specific examples of these include:

- For male Travellers life expectancy at birth is 61.7 years – 15years less than that of the general population and now at the level of the ROI overall population on the later part of 1940s. For female Travellers life expectancy at birth is 70.1 years – 11 years less than the general population and equivalent to that of women in the early 1960s.
- Traveller men had a 6.6 times higher suicide risk compared to settled men (AITHS Team, 2010b – based on ROI data [10]).
- Carers UK 2013 survey of over 3000 carers in the Uk said that 84% of carers said that caring had a negative impact on health.[11]
- Almost a third (31%) of those caring for 35 hours or more per week received no practical support for caring. [9]
- At the 2011 census 6,065 people aged 65+ who described themselves as being limited 'a lot' in their daily activities due to a long term condition were themselves providing twenty or more hours of unpaid care to family or friend. Of these 4,743 were providing fifty or more hours a week.[12]
- An estimated 2/3 of prisoners have mental health problems.
- Thirty-six per cent of unskilled manual workers smoke – four times more than the level amongst professional groups [13] (2010/11 Health survey).
- A survey of 967 homeless people in Salvation Army centres within the UK and Ireland revealed a high level of reported traumatic childhood experiences including sexual abuse (3%), physical abuse (25%) and

[10] AITHS Team (2010b). *All Island Traveller Health Study. Our Geels. Technical Report 1: Health survey findings*. Dublin: UCD. http://www.dohc.ie/publications/aiths2010/TR1/AITHS2010_TechnicalReport1_LR_All.pdf?direct=1

[11] The State of Caring 2013 CarersUk http://www.carersuk.org/professionals/resources/research-library/item/3090-the-state-of-caring-2013

[12] http://www.nisra.gov.uk/Census/2011_results_detailed_characteristics.html

[13] 2010/11 Health Survey http://www.dhsspsni.gov.uk/health_survey_2010-11_socio-economic_group.pdf

emotional abuse (30%)[14].

- High levels of mental health problems, self- harm, suicide and alcohol and drug abuse are reported in the homeless population[15].
- A survey of homeless people revealed a smoking prevalence of 77% with only half (55%) having been offered smoking cessation advice (UK data)[16].
- Analysis of the mortality of homeless people in England between 2001 and 2009 revealed that the average age of death is substantially lower than the general population (47 years compared with 77 years) and that they were 9 times more likely to die by suicide than the general population[17].
- In a NI survey of young same-sex attracted men, over one quarter (27.1%) of the respondents had attempted suicide and over two thirds (71.3%) of respondents had thought about taking their own life.[18]
- LGB&T people are nearly three times more likely to have taken an illegal drug in their lifetime compared with the N Ireland population as a whole (62% compared with 22%).
- LGB&T people are more likely to drink alcohol (91%) compared with 74% of the N Ireland population and of those who drink, LGB&T people are twice as likely to drink 'daily' or 'most days' compared with the N Ireland average (13% as opposed to 6%).
- 44% of LGB&T people smoke cigarettes compared with 24% of the N Ireland population.[19]
- NI rates of fuel poverty in 2011 (42%) were noticeably higher than England (15%) or Scotland (25%). [20]
- In NI in 2011 52% of those aged 60-74 and 66.3% of those over seventy-five were in fuel poverty (under 60 =34%).[21]

[14] The seeds of exclusion report (2009) http://www.doorwayproject.org.uk/Documents/SA%20Seeds%20of%20Exclusion%202009.pdf

[15] See PHA Health Intelligence briefing on Homelessness for more information.

[16] The health and wellbeing of people who are homeless: Evidence from a national audit. Homeless Link (2010). http://homeless.org.uk/sites/default/files/Health%20Audit%20Findings_National%20evidence.pdf

[17] Homelessness Kills: An analysis of homeless mortality in early twenty-first century England. www.crisis.org.uk/data/files/publications/Homelessness%20kills%20-%20full%20report.pdf

[18] http://www.rainbow-project.org/assets/publications/out_on_your_own.pdf

[19] http://www.rainbow-project.org/assets/publications/All%20Partied%20Out.pdf

[20] http://www.ofmdfmni.gov.uk/tackling-fuel-poverty-in-ni-liddell-lagdon.pdf

[21] http://www.nihe.gov.uk/news-energy-efficiency-has-impact-on-fuel-poverty

- In NI in 2011/12 sixteen per cent of mothers were smoking at the time of first booking. This increased to twenty-nine per cent of mothers from the twenty per cent most deprived areas.[22]

The cost of some health behaviours is significant. For example, the misuse of alcohol is estimated at some £900million each year with an impact of approximately £250million costs to health and social care[23].

The WHO office in Europe in 2012 reviewed the evidence at that point and concluded that - 'Real health benefits can be attained at an affordable cost by investing in health promotion and disease prevention'.[24]

[22] PHA internal profile of Child Health 2013.

[23] Social Costs of Alcohol Misuse in Northern Ireland for 2002/0. Research commissioned by Public Health Information and Research Branch, DHSSPS.

[24] http://www.euro.who.int/__data/assets/pdf_file/0020/170093/RC62wd08-Eng.pdf page 26

2.2 Transformation

Transforming Your Care (TYC) proposes a different model for health and social care, designed with the person at the centre and with health and social care services built around the individual, supporting them to make good health decisions and achieve the best health outcomes.

One of the key drivers for transformation is the demographic change described in Section 2.1 above. With an increasing ageing population comes an increased burden in terms of longterm conditions and the resulting demands on our services. Population projections indicate that we need to act now in order to preserve and sustain our services in the face of these increasing demands and to meet the care needs of the population. In particular, we need a greater focus on prevention so that people live healthier and independent lives for longer and we need to introduce measures to reduce the reliance on secondary care and begin to shift more provision into community and primary care.

The main aims of the "shift left" approach outlined in TYC are to prevent ill health in the first place, provide care closer to home, personalise care through empowering patients and service users and reduce unnecessary hospital admissions. Within this, there should be more control (including financial control) for patients, users and carers, more choice about the services we access and those services should be better joined up across the health and social care sector and beyond.

This vision and these aims, received widespread support and implementation has commenced. As this Commissioning Plan demonstrates transformation and service improvement is embedded across all those services that we deliver, and the implementation of TYC is critical to ensuring that the services we commission meet the population's needs and expectations.

The TYC aims have been translated into five strategic outcomes which all TYC related projects map back to, and will be tracked to ensure progress towards achievement. These are:

- The individual at the centre
- Improving health and well being

- Providing safe, sustainable and resilient services
- Living independently
- Home as the hub of care

The HSCB, supported from the beginning of 2014 by external expertise, will work alongside Trusts to develop shift plans for 14/15 and 15/16 which will translate the shift left from secondary care into primary and community care. Integrated Care Partnerships (ICPs) will play a critical role in improving the management of longterm conditions through greater integration across primary, secondary and community care and will be central to the delivery of shift left.

Transformation is the key focus of commissioning across all PoCs in 2014/15. Consequently, a consistent theme is the need to reduce our reliance on hospital and institutional care while focusing investment on the development of more responsive and individualised care closer to home and the promotion of early intervention, prevention and greater choice and independence. This means that the way in which we deliver care will change; patients will be able to access new services in different places. How we are commissioning these different services are set out throughout this plan within each PoC.

The transformation agenda is throughout this plan, and this is augmented by the information below which outlines how some of the key overarching 'shift left' commissioning priorities in 2014/15 will change how we deliver care through investment in community based alternatives. Often these will impact on a range of PoCs; these include:

1. Expansion of 7 day working
2. Review of domiciliary care
3. Short Break services for carers
4. Re-ablement
5. Self-Directed Support
6. Day Opportunities
7. Social Care Procurement

In addition, one of the major changes to the way we are commissioning services will be through the development of Integrated Care Partnerships (ICPs). ICPs are providers of services and bring together a range of primary, secondary, community, voluntary and independent sector providers who work together to identify opportunities to provide more seamless care, closer to home, reducing reliance on hospital-based care.

As noted in Section 2.1, demographic information indicates that the prevalence of long term conditions such as COPD, diabetes, stroke and hypertension is increasing in conjunction with an increase in the number of people living with co-morbidities. Hence, in addition to a focus on the frail elderly, ICPs will prioritise the following clinical areas across people of all ages: respiratory conditions, diabetes and stroke. Their work will include palliative and end of life care in respect of these agreed condition groups. The work of the ICPs will therefore impact across all PoCs.

ICPs will aim to improve the integration of care for these patient groups by identifying how the blockages and barriers to the integration of services might be overcome and creating opportunities to integrate and streamline care, through delivery of the RICE agenda, namely:

(1) Risk stratification of service users with specific longterm conditions to allow the provision of more appropriately targeted care.
(2) Information sharing across partners to ensure a coordinated and prioritised approach to the development and delivery of integrated care pathways.
(3) Care pathways – local application of fully integrated, Commissioner approved care pathways.
(4) Evaluation – reviewing how well the new pathways are working with a view to supporting continuous improvements in care.

During 2013/14, LCGs asked ICPs to bring forward service investment proposals which support the shift left agenda. It is anticipated that a number of these services will be formally commissioned during 2014/15. Further information on these is included in LCG plans.

7 day working

A significant commissioning priority for 2014/15 is the development of 7 day working within secondary care together with the development of primary care aligned 7 day Community Nursing Services, including District Nursing to deliver acute and complex care at home and palliative and end of life care at home or in the most appropriate community facility. These developments will enable patients to receive diagnostics, treatment and care on a "same or next day" basis, delivering better patient outcomes. Within secondary care, this will improve patient flow, enable earlier discharge and easing pressures on Emergency Departments. It will also mean that a GP who has a patient with worsening symptoms will be able to speak to a secondary care clinician to get advice about their management. This will enable GPs to provide more of care in the community; perhaps with support from rapid response teams/acute care at home were necessary.

Domiciliary care

As we know more people want to stay in their own home, and to be as independent as possible, we are increasing our investing in a range of services to support them to do so. Within this, we recognise the importance that domiciliary care plays in allowing people to remain in their own home. It is against this backdrop that the HSCB will undertake a review of domiciliary care in 2014/15. The purpose of the review is to ensure that we have in place a 'fit for purpose' model of domiciliary care that can respond to the needs of clients and service transformation.

Carers' Support

Carers also play a key role in supporting people to remain at home/near home for as long as possible. The Transforming Your Care Review and subsequent public consultation acknowledged the important role that carers play and the HSCB are continuing to progress the implementation of the Carers Strategy. In working to address the needs of carers in 2013/14 a range of short break/respite pilots were established in each of the five LCG areas. Short breaks are designed to minimise the risk of breakdown of carer support, help the carer to deal with crisis situations that might prevent them continuing in their caring role, prevent

a sense of isolation for the carer and provide positive benefits for both carer and service user.

During 2014/15 the HSCB will work with the LCGs to evaluate the short break pilots undertaken to take and ensure that the lessons learned are embedded in future short break schemes. Work will also be undertaken to increase the uptake of carer's assessments, and enhance how carer's access information about our services.

Reablement

Many people being discharged from hospital or otherwise entering the care system as a result of crisis, are often referred to a single profession / service or have a number of separate referrals for different care professionals / services (e.g. social work, AHP, domiciliary care). It may take a number of weeks for a service to respond to a referral. Reablement is a short-term programme (typically 6-12 weeks) of intensive support and therapy provided in a person's own home. It is for people of any age who have suffered from a health or social care crisis, and those who are recovering from an illness or injury and have become frail as a result. Support usually involves practical support with input from occupational therapists, physiotherapists, nurses, case managers and trained support workers, who work with a person to help them relearn the skills of daily living and build their confidence to live independently.

During 2014/15 the HSCB aim to roll it out more fully so that by the end of 2015, it will be available to everyone who needs it. This means that rather than have to stay in hospital or be admitted to a nursing home until they regain their independence, the person, can be referred to a reablement service and receive care at home. In order to further drive improvements associated with reablement the key actions in 2014/15 are:

- An assessment of the current baseline of reablement service provision and uptake, including benefits delivered
- Refinement of the reablement pathway to ensure inclusion of core components to deliver successful outcomes for clients

Self-Directed Support

During 2014/15 the HSCB will continue to progress the implementation of Self Directed Support (SDS). Self Directed Support allows people to develop tailored support plans to meet their assessed needs. The provision of a personalised budget results in people having greater choice, independence and control over how their support needs are met.

Key activities associated with Self Directed Supported in 2014/15 will include:

- A stocktake to establish the current uptake and benefits associated with SDS
- Progression of a regional target for uptake with designated client groups
- Progress the development of a resource allocation model which promotes the sustainability of SDS.
- Support Trusts in the development of HSC staff capability to facilitate a the cultural change associated with progression of SDS.
- Work with HSC Trusts and the Community and Voluntary sector to raise awareness of SDS.
- Engagement with the community and voluntary sector regarding the administration of SDS.

Regional Day Opportunities

In 2013/14 the HSCB undertook a consultation on regional day opportunities. The recommendations arising as a result of the consultation will commence implementation in 2014/15. It is likely that this will mean that young adults with a learning disability can access a more diverse and innovative range of day opportunities outside of the traditional day centre model. Working with the individual and their family, community learning disability services will provide community support which is tailored to their needs and interests so that they might choose to attend college two days a week, attend a supported employment placement one day a week and have one evening a week where they are supported to attend their local leisure centre.

Social Care Procurement

The transformational changes associated with social care will mean that the HSC as a system will need to have the ability to procure services differently. For

example, the model for procurement will need to acknowledge an increasing role for the voluntary, community and independent sector within the context for a mixed economy of care advocated in TYC. In addition, 2014 will see the implementation of new EU Directives which aim to modernise procurement processes. It's against this context that during 2014/15 the HSCB will be working towards the development and implementation of a new social care procurement model and strategy.

This plan sets out what services we will be commissioning in future, and how they differ to those which are currently commissioned. In each Programme of Care, the recommendations and activities associated with Transforming Your Care are integrated and embedded to demonstrate how health and social care services will develop and invest in primary and community based alternatives, promote choice and diversity, and enhance earlier intervention and prevention. Taken together, these will represent a further step in the journey towards the model of care set out in Transforming Your Care, and the 'shift left' of activity contained therein.

2.3 Programme for Government 2014/15

The Programme for Government (PFG), launched March 2012, sets the strategic context for the Budget, Investment Strategy and Economic Strategy for Northern Ireland. It identifies the actions the Executive will take to deliver its number one priority – a vibrant economy which can transform our society while dealing with the deprivation and poverty which has affected some of our communities for generations.

PFG identifies a number of key priorities to be delivered over a three year planning cycle across all Government departments. Health and social care have committed to the achievement of a number of related targets across the three year plan to support the delivery of the Executive's priorities. Table 11 outlines the targets for 2014/15 and references the section of the plan which provides detail regarding implementation.

In line with the PFG commitment 22, an additional £10m (from the 2011/12 baseline) is expected to be invested in public health during 2014/15. PHA has responsibility for investing this funding in a range of programmes that will help to reduce health inequalities and improve health and well-being outcomes. In 2013/14, the first tranche of the funding was invested in a number of new areas including:

- The provision of additional services to help support people affected by suicide and mental health issues;
- Establishment of a regional Self Harm Registry
- new initiatives to support vulnerable young children and their families, including the establishment of 2 additional Family Nurse Partnerships;
- development of new programmes to help older people to continue to live independently;
- additional investment to support research focused on improving health and well-being and addressing health.

PfG Targets 2014/15

Table 11

Commitment	2014/15 target	Referenced
Commitment 22: Allocate an increasing percentage of the overall health budget to public health	During 2014/15, invest an additional £10m in public health (increase based on 2011/12 baseline)	Section 4.9 - POC8 Health Promotion & Disease Prevention
Commitment 44: Enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic condition management programme	During 2014/15, people with a longterm condition will be offered access to appropriate education, information and support programmes relevant to their needs, including innovative application of connected health.	Section 4.1 - POC1 Non-specialist Acute; LCG plans
Commitment 45: Invest £7.2 million in programmes to tackle obesity	During 2014/15, invest £2.8m in tackling obesity through support of obesity prevention framework.	Section 4.9 - POC8 Health Promotion & Disease Prevention
Commitment 61: Introduce a package of measures aimed at improving safeguarding outcomes for children and vulnerable adults across N Ireland	During 2014/15, develop an updated Inter-Departmental Child Safeguarding Policy Framework.	Section 4.5 - POC4 Elderly Care

PfG Commitment	2014/15 target	Referenced
Commitment 79: Improve Patient and Client outcomes and access to new treatments and services	During 2014/15, expand cardiac catheterisation capacity to improve access to diagnostics intervention and treatment and further develop the primary percutaneous coronary intervention (pPCI) service to reduce mortality and morbidity arising from myocardial infarction.	Section 4.2 - POC 1 Acute Specialist Services
Commitment 80: Reconfigure, Reform and modernise the delivery of Health and Social care services to improve the quality of patient care.	During 2014/15, secure a shift from hospital-based services to community-based services together with an appropriate shift in share of funding in line with the recommendations from *Transforming Your Care*.	Section 4.1 - POC1 Non-specialist Section 4.5 - POC4 Elderly care Section 4.6 - POC5 Mental Health Section 4.7 - POC6 Learning Disability Local Commissioning Plans (Sections 6-10)

2.4 Improving Quality, Outcomes and Patient Experience - Quality 2020

The HSCB / PHA place the quality of patient care in N Ireland, especially patient safety, above all other aims, and works continually to improve services. Whilst healthcare is complex and pressurised, the HSCB / PHA are focused on ensuring that patients, carers and users experience remains a priority and appropriately influences commissioning. The Francis report highlights that statistics, benchmarks and action plans are not ends in themselves and should not come before patients and their experiences. This is reflected in the strategic direction and the comprehensive programme of work undertaken by the HSCB, PHA in conjunction with HSC Trusts in the Patient Client Experience Standards.

The DHSSPS Quality 2020 is the strategic framework that ensures patients and their experiences remain at the heart of service design and delivery by defining Quality under three headings:

- *Safety*: Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.
- *Effectiveness*: The degree to which each patient and client receives the right care (according to the scientific knowledge and evidence-based assessment), at the right time in the right place, with the best outcome.
- *Patient and Client focus*: All patients and clients are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Quality 2020's vision for the HSC is "to be recognised internationally, but especially by the people of N Ireland, as a leader for excellence in health and social care". It highlights five strategic goals to realise this vision:

1. Transforming the culture
2. Strengthening the workforce
3. Measuring the improvement
4. Raising the standards
5. Integrating the care

During 2014/15 the DHSSPS Quality 2020 Steering Group will provide strategic direction to the implementation team and ensure that the work of the task

groups will continue to align with the strategic goals of the Quality 2020 strategy. In 2014/15 the task groups will continue to:

- *Develop HSC Trust Annual Quality Reports*
  HSC Trusts will produce an annual quality report by January 2015 to include core quality indicators. Phase 2 will focus on community care, social care, and mental health-related indicators, as well as other developmental areas e.g. patient-reported measures, and research. The membership of the Task Group has been amended to reflect this.

- *Implement the DHSSPS Patient Client Standards*
  During 2014/15 the Patient and Client Experience Steering Group will provide strategic direction for the implementation of the DHSSPS Patient and Client Experience Standards and agree the annual work plan.

- *Review the policy framework for safety and quality*
  A report from Phase 1 will be made available to the Quality 2020 Implementation Team in January 2014. The task group will continue to review the current policy framework and develop a catalogue of standards.

- *Develop professional leadership*
  A Leadership competency framework is to be developed and mapped to existing leadership development programmes.

- *Develop an E-Learning system to support and track training*
  Minimum mandatory training content has been agreed for medical staff and is now being developed for social care and nursing staff. A preferred option to host an E-learning programme has been identified and will roll out in 2014/15

- *Ward level review of the quality of clinical & social care*
  In early 2014 the task leads, CMO, CNO and implementation team co-chairs will review the learning from the ward-level review pilot of patient and client care.

- *Review the literature on changing organisational culture*

Task Leads will identify key priorities from the Literature review on Organisational Culture which was published in 2013/14 and along with feedback from the Stakeholder event will be used to develop proposals to drive improvements.

In 2014 the DHSSPS, Patient Client Council and RQIA will plan a Stakeholder Forum and engagement workshop which will include key stakeholder involvement from patients, clients and professionals from Health and Social Care. The aim is to share progress from Phase 1, seek stakeholder views on the priorities for Phase 2 and develop proposals for 2014/15 tasks for Steering Group approval.

A Quality 2020 Project Manager has been appointed and will lead the communication plan with support from Communications staff in HSC organisations. A key aim will be to raise awareness of the Quality 2020 strategic direction amongst staff, patients/clients and carers in N Ireland. The HSCB and PHA will, through the Commissioning Plan and more generally, seek to support the taking forward of Quality 2020.

The PHA and HSCB have established an overarching Quality Safety and Experience Group to enhance current arrangements and provide an overview of all sources of information in relation to the Safety Quality and Patient Experience of services. This group will consider issues and learning identified from SAI's, Complaints, Patient Experience, patterns/themes and Medicines Safety; to determine the most appropriate way to put learning into practice, monitor progress and seek assurance on implementation.

Quality and Safety Assurance Programme

The PHA and HSCB will continue to work to develop a comprehensive Quality and Safety Assurance programme linked to the DHSSPS Quality 2020 strategy (see Appendix 2). This programme includes:

- Monitoring and analysis of the HSC Trust Quality Improvement Plans
- Implementation and monitoring of the DHSSPS Patient and Client Experience Standards

- Working in partnership with the DHSSPS in reviewing the most appropriate methodology for a Regional Learning System.
- Measure and monitor the Key Performance Indicators for Nursing and Midwifery Care and develop further indictors to improve quality of care.
- Provide support in relation to patient safety across a range of initiatives from emergency medicine to falls prevention.
- Workforce Planning within Nursing and Midwifery Services

Evidence from recent reports such as the Francis Report, the Keogh Review and the Berwick Review highlight the importance of placing the quality and safety of patient care and safety above all other considerations. The commissioning of safe, high quality Health and Social Care Services is a top priority and core responsibility of the HSCB and PHA, and the monitoring of feedback from the Patient Experience Standards and Patient stories, as well as the learning identified from complaints and Serious Adverse Incidents provide an opportunity to continually strive to improve the safety and quality of services. The HSCB and PHA will continue to ensure that the lessons from the above reports, along with any recommendations from the imminent O'Hara report into the Inquiry into Hyponatraemia Related Deaths, are fully embedded and prioritised in the services we commission.

It is anticipated that HSC Trusts will use this funding to continue to develop a Gateway or single point of entry approach for adult safeguarding. In particular, Trusts should use this funding to support the recruitment of 1.0 (WTE) appropriately trained and experienced Nurse in each Trust to act as professional lead on adult safeguarding for nursing within all adult Programmes of Care (including Acute) as required across the HSC Trust.

Implementation of Service Frameworks

Service Frameworks for Cardiovascular Disease, Respiratory Conditions, Cancer, Mental Health, Learning Disability and Older Peoples will continue to be implemented through engagement with clinicians and other practitioners, charities and voluntary groups, people with these conditions and service managers. A framework for children is being developed.

- The cardiovascular framework has been revised and consulted on and is due to be reissued. Significant work was undertaken during 2013 to commence primary PCI in Belfast in September 2013. Further work and investment in 2014/15 will be required to complete the roll-out of this service to cover the whole of N Ireland and provide the necessary technical infrastructure to support interventional cardiology requirements for N Ireland residents.
- The respiratory framework is also undergoing revision. Specific priorities include expansion of end of life care at home, patient education programmes, timely GP access to diagnostics and increased provision of insulin pumps for children.
- The Service Frameworks for Mental health, Learning Disability and Older People have specific priorities which include; promoting health and well-being, social inclusion, person centred care and setting standards for people over 65 whilst taking into account the needs of those over 50 in relation to preventative measures. Arrangements are in place to ensure progress is made with each framework.
- Work continues to progress to ensure that standards within the Cancer Services Framework (CSF) are achieved and sustained. Audits undertaken during 2013/14 have confirmed baseline positions which had not previously been available for a small number of standards. Full implementation of the CSF has been costed and further progress on achievement of standards is anticipated.
- Palliative Care Standards are contained with Cancer, Learning Disability, Older People, Respiratory Service Frameworks

NICE Clinical Guidelines

NICE regularly produces guidance on current best practice in health and social care, including public health, health technologies and clinical practice. The HSCB is responsible for commissioning and monitoring the implementation of all NICE guidance endorsed by the DHSSPS in N Ireland and has in place robust arrangements to ensure the dissemination and implementation of all guidelines within Departmental timelines.

Strategies and Reviews

The Public Health Agency continues to work to progress a number of strategies launched by the DHSSPS such as:

- A Strategy for Maternity Care in Northern Ireland
- A Strategy for the Allied Health Professions in Northern Ireland
- Quality 2020
- Breastfeeding - A Great Start
- Transforming Your Care - Vision to Action
- Nursing and Midwifery Strategy
- Healthy Child Healthy Future

2.5 Reducing Health Inequalities - Public Health Strategic Framework

As outlined in Section 2.1.2, there are a number of known health inequalities within N Ireland. Improving health and wellbeing and reducing health inequalities is a central goal of the PHA and HSCB and we are committed to addressing these inequalities where they exist. A new Public Health Strategic Framework, 'Making Life Better' is expected by the Government, will provide direction for policies and actions to improve health and wellbeing and reduce inequalities over the coming year period. The new Framework will make clear the need for cross departmental action to address the wider socio-economic determinants of health through shared priorities, coordinated action and use of resources.

The Framework is reflected in the PHA and HSCB approach to reducing inequalities and improving health and wellbeing. Action is centred on four key building blocks:

1. <u>Give every child the best start</u>
   Evidence suggests that effective intervention in early child development will bring significant benefits long into adult life in terms of educational attainment and economic status. The PHA and HSCB will advance investment in and extend evidence based initiatives such as the Family Nurse Partnerships, parenting support and infant mental health programmes as well as advancing with the HSCB the Early Intervention Transformation Programme. HSCB is also investing in Family Support Hubs.

2. Ensure a decent standard of living

   The current economic climate presents a challenge, both in terms of available government resource and as a direct influence on health and wellbeing. For example, there is clear evidence of the link between unemployment and poor health with every 1% increase in unemployment met with 0.8% increase in suicide. Approximately one fifth of the NI population are in relative poverty[25]. The PHA and HSCB will work with government and across sectors to ensure a decent standard of living, in particular working to address poverty.

3. Build sustainable communities

   It is recognised that some groups experience increased inequality and marginalisation which contributes significantly to poorer outcomes. The PHA and HSCB will coordinate action to address the needs of people and communities including those living in disadvantaged areas and population groups such as Travellers, migrants, Lesbian, Gay, Bisexual and Transgender (LGBT), Looked After Children, those with Disability, Older People and Homeless people. Action will focus on partnership models which include the active engagement of those most affected alongside other agencies that can influence the determinants of health.

4. Make healthy choices easier

   This work will include action on alcohol and drug misuse, tobacco, mental health and suicide prevention and sexual health and wellbeing. It will also, in line with Programme for Government, focus on halting the rise in obesity. The PHA will take a lead role in implementing the Fitter Futures strategy.

In line with TYC, the PHA will address active ageing as a key priority, working with HSCB and other partners, including local communities, to promote the inclusion and full engagement of older people in improving their health and wellbeing. It will also work closely with OFMDFM, Councils, Age sector partners and others to support the realisation of Age Friendly and Dementia Friendly Communities across the province. These themes and related priorities are expanded on in Section 4.9, POC 8 Health Promotion and Disease Prevention.

[25] Broke- not Broken, Princes Trust 2012

3.0 Ensuring Financial Stability & Effective Use of Resources

3.1 Introduction

Ensuring financial stability across the HSC is one of the core objectives of the Health and Social Care Board. The current Spending Review period 2011/12 to 2014/15 has been characterised by significant financial constraints within the Public Sector and this pattern is likely to continue into the next Spending Review period. Therefore, the HSC has and will continue to experience unprecedented challenges in delivering this objective whilst ensuring quality standards are maintained and performance targets are met. Central to the achievement of financial stability in 2014/15 is the early development of comprehensive financial plans across the HSC. This involves projecting initial funding requirements and funding shortfalls, identifying realistic savings targets across the HSC to contribute towards anticipated funding shortfalls and early identification of other options to enable overall financial breakeven.

3.1.1 Approach to the Financial Plan

In each year of the Spending Review period projected increases in financial pressures have significantly outstripped additional income sources available. The financial strategy to break even has been to address this funding shortfall through challenging cash and productivity savings from within the HSC. Where possible these have been delivered recurrently however, in order to break even in year, these have also been supplemented by one off income sources and savings measures. This has meant the system has been able to break even in year but carries forward opening deficits into the following financial year.

In 2014/15 the HSCB and PHA expect to receive allocations totalling £4.2bn, this includes £84m additional resources from DHSSPS (£124m 2013/14). The first part of this section sets out the position regarding opening deficits carried forward from 2013/14 into next year and additional expenditure requirements 2014/15. These are then compared to the available income to identify the shortfall in funding which requires to be addressed if the key target of financial break-even is to be met. It also shows how total resources are planned to be deployed across local populations, providers and Programmes of Care.

A key aim of commissioning is that the HSC uses its resources to ensure local populations receive maximum benefit from health and social care services. Central to this is a performance framework which seeks to maximise productivity without impacting on services and to oversee and monitor the delivery of the cash and productivity targets set to allow the system to break even. As Trusts have not been able to fully deliver the savings targets set by the HSCB over the Spending Review period a more strategic approach to performance management of these targets will be taken during 2014/15. This will involve the HSCB reviewing and concluding on the totality of the potential savings available within the current HSC system within the relevant timeframe. Focused and detailed performance monitoring will be aimed at ensuring these are then fully delivered. Section 3.3 sets out in more detail the proposed approach.

Whilst Transforming Your Care is not driven by the financial and productivity agenda there will be opportunities to improve efficiencies in the longer term through the shift left approach. Much of the improved financial efficiency that is required to return the system to financial stability will require investment in community and non-hospital services in order to develop new service models. This will be consistent with the shift left approach. However, in the interim there are bridging costs to facilitate the delivery of Transforming Your Care and these are set out in section 3.4.

3.2 Producing the Financial Plan 2014/15/2015/16

This section sets out an overview of the HSCB/PHA financial plan for 2014/15 with indicative spending commitments for 2015/16 covering:

- An assessment of opening deficit positions across the HSC 2014/15;
- An overview of the additional inescapable pressures of Health and Social Care Board and Public Health Agency in 2014/15 and indicative 2015/16;
- A summary of income sources available to HSC;
- Potential options to address funding shortfalls;
- An analysis of total planned investments by POC, LCG and Provider; and
- An equity analysis across Local Commissioning Group area.

3.2.1 Assessment of opening financial positions across the HSC 2014/15

The Commissioning Plan 2013/14 identified £275m pressures (£303m including TYC). At the time of the Commissioning Plan funding solutions to these pressures were identified as per Table 12.

2013/14 Funding Solutions

Table 12

2013/14	**£m**
Total Pressures	(275)
TYC Pressures	(28)
Less DHSSPS & DSD funding	154
Projected deficit	**(149)**
Sources:	
In year easements	31
Trust Cash and Productivity Targets	93
FHS Targets	25
Total resource requirement	**149**

The in year easements in the table above, which allowed 2013/14 expenditure to be deferred until 2014/15 will manifest as an opening deficit of £29m, as they are one off in nature and not automatically repeatable.

Following detailed engagement between the HSCB and Trusts it has become evident that Trusts will also carry forward significant deficits into the opening 2014/15 Financial Year. During 2013/14 Trust reported positions have experienced significant volatility and deterioration. This is a result of a combination of

- recurrent under-delivery of cash savings targets £51.3m and
- unavoidable additional pressures £35.9m carried forward into 2014/15.

Table 13 sets out closing recurrent deficits in 2013/14 carried forward into 2014/15 of £116.2m.

Total closing deficit by organisation 2013/14

Table 13

Organisation	Cash Savings Deficit £m	Pressures Deficit £m	TOTAL £m
Trusts Total	51.3	35.9	87.2
HSCB	-	29	29
TOTAL	51.3	64.9	116.2

3.2.2 Planned additional investment 2014/15 (indicative commitments 2015/16)

This section provides an overview of additional pressures identified in 2014/15 – 2015/16. Total pressures across the two years are detailed in Table 14. In arriving at these forecasts the approach has sought to identify only those which are likely to be viewed as inescapable in the context of delivering the requirements of the Executive, Minister and Department as set out in the Commissioning Direction and elsewhere.

Narrative on each of the pressure areas is also provided in Appendix 3.

Total new pressures 2014/15

Table 14

Summary	2014/15 £m	2015/16 £m
Pressures:		
Pay & Non Pay	52	112
Demography	35	35
Specialist Hospital Services	7	2
NICE Drugs	19	16
Revenue Consequences of Capital Expenditure (RCCE)	7	3
Mental Health resettlements	4	3
Learning Disablity resettlements	13	3
Service Pressures/Service Developments(including Elective Care £15m& Normative Nursing)	77	28
Family Health Services	37	37
Public Health Agency	4	10
Transforming Your Care (net)	21	44
Total pressures	**277**	**292**

3.2.3 A summary of income sources and options to address identified funding gap

This section sets out the assumed additional income for 2014/15 (Table 15).

Income 2014/15

Table 15

	2014-15 £m
HSCB opening allocation	4,035
PHA opening allocation	86
DHSSPS additional HSCB	80
DHSSPS additional PHA	4
DSD additional	6
Sub total Additional Income	90
TOTAL	**4,211**

Table 16 below shows additional income sources which will contribute towards the additional funding pressures identified for 2014/15. These comprise cash and productivity targets for Trusts, the HSCB and PHA totalling £99m.

Other income sources 2014/15

Table 16

	2014/15 £m
Trust Original Cash Target	50
Trust Original Productivity Target	22
FHS	25
PHA	2
TOTAL	**99**

In addition to these, as in prior years there will be in-year easements.

3.2.4 Options to Ensure Financial Stability

The plan suggests that maintaining existing levels of service and meeting predicted levels of growth will be linked to the financial budget settlement. In the event that the HSC system does not have a break even plan, urgent

consideration of other options available to ensure that financial stability is maintained through 2014/15 will be necessary. These might include:

- Choices to be made between Maintaining Existing Services and the implementation of service developments/pressures including avoidance of all 'non critical' service developments;
- Workforce expenditure controls;
- Changing access to elective and drug therapy services, with resultant impact on waiting time performance; and
- Other options to increase income and / or reduce expenditure.

In addition there may be further opportunities in the context of support for major service redesign/ consolidation. However such major service redesign would not be deliverable within the required timeframe.

If the HSC is to deliver the challenging targets set out in the 2014/15 Commissioning Plan Direction and establish recurrent financial balance across the system, a realistic financial plan needs to be finalised as a matter of urgency.

Table 17

Revised Financial Plan 2014-15

Summary	Original Plan less Slippage & Productivity £m	Curtailed Plan Less Slippage & Productivity £m
Opening Gap	**(30)**	**(30)**
Pressures:		
Pay Pressures	(22)	(8)
Non Pay inflation	(30)	(30)
Demography	(12)	(11)
Specialist Hospital Services	(6)	(6)
NICE Drugs	(11)	(10)
Revenue Consequences of Capital Expenditure	(6)	(2)
Mental Health resettlements	(3)	(3)
Learning Disability resettlements	(10)	(7)
Service Pressures/Service Developments**(including Elective Care £15m& Normative Nursing)**	(51)	(38)
Family Health Services	(12)	6
Public Health Agency (PHA)	(2)	(0)
Add Costs of Transforming Your Care (TYC) Reforms	**(29)**	**(23)**
Less reduction to Demography & elective care pressures above which will be used to part fund TYC Reforms	8	8
Total pressures incl TYC	**(213)**	**(154)**
Assumed income from DHSSPS net of savings	84	84
Trust Savings	50	50
Baseline Funding		21
DSD	6	6
June Monitoring		20
Oct Monitoring		54
Add DHSSPS Sources	0	0
Total Pressures net of income	**(73)**	**80**
To Trusts		(80)
HSCB/PHA Projected (Deficit)/Surplus	**(73)**	**0**
Trust Gap	**(87)**	**(134)**
Already included in HSCB Pressures		**16**
Trust and Board Contingency Plans		23
Additional Low Impact Measures from Trusts		15
Contribution from HSCB/PHA- Above		80
Trust Gap/Surplus	**(87)**	**(0)**
Total HSC Gap/Surplus	**(160)**	**0**

3.2.5 Analysis of total planned investments by POC, LCG and Provider

The Health and Social Care Board and Public Health Agency will receive some £4.2bn for commissioning health and social care on behalf of Northern Ireland 1.8m resident population for 2014/15.

Of the total received, over £3bn is spent in the six provider Trusts and other providers of care such as Family Health Services and voluntary organisations. Figure 11 illustrates this for both the HSCB and PHA.

Figure 11

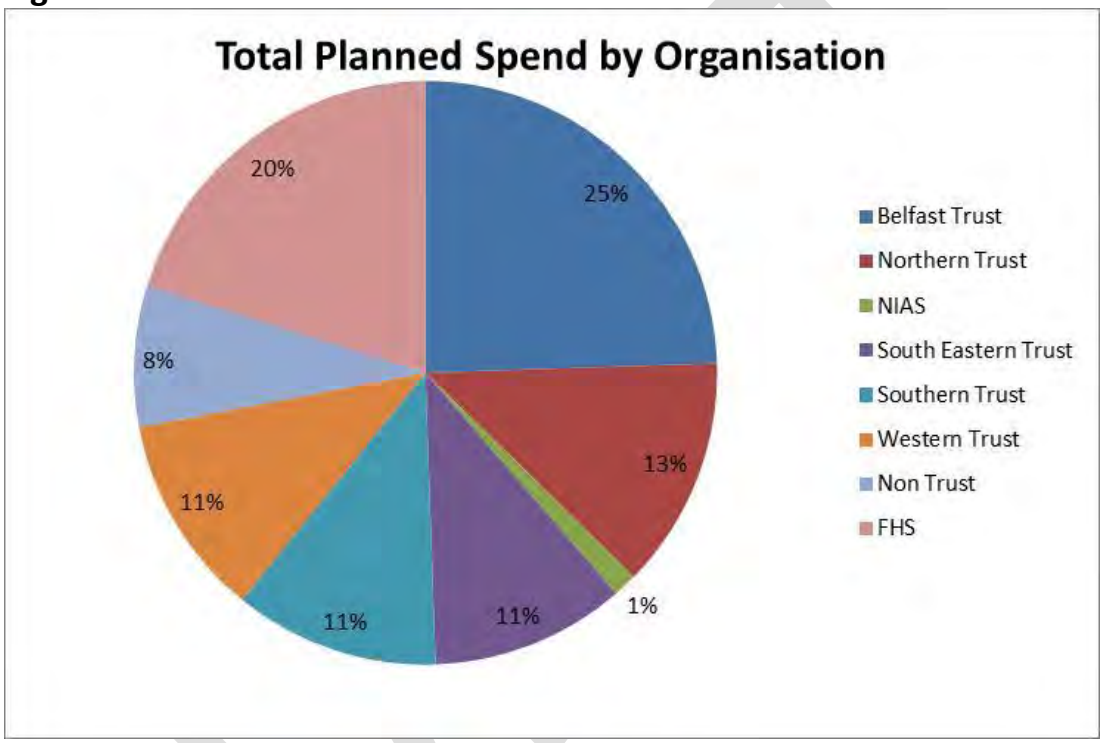


Table 18 sets out how the total resources are planned to be spent across the Programmes of Care and Family Health Services.

Planned Expenditure by Programme of Care

Table 18

Programme of Care	PHA		HSCB		TOTAL	
	£m	%	£m	%	£m	%
Acute Services	5	6.90%	1,454	44.52%	1,459	43.73%
Maternal & Child Health	0	0.06%	139	4.25%	139	4.16%
Family & Child care	-	0.00%	212	6.48%	212	6.34%
Older People	0	0.05%	662	20.28%	662	19.85%
Mental Health	14	19.34%	241	7.39%	255	7.64%
Learning Disability	-	0.00%	245	7.50%	245	7.34%
Physical & Sensory Disability	-	0.00%	103	3.14%	103	3.08%
Health Promotion	51	73.30%	49	1.50%	101	3.01%
Primary Health & Adult Community	0	0.35%	161	4.93%	161	4.84%
Sub Total	*70*		*3,265*		*3,336*	
FHS			861		861	
Not allocated to PoC*	19		69		88	
Total	**89**		**4,195**		**4,284**	
* BSO, DIS, Management &Admin						

Ensuring resources are fairly distributed across local populations is a core objective in the Commissioning process. The HSCB commissions by LCG population. Table 19 shows how the HSCB resources are planned to be spent across localities. This reflects the different population sizes and need profiles within each locality (e.g. the Northern LCG crude resident population is the largest with 25.56% and the Western LCG the smallest with 16.31%). Family Health Services (FHS) are not assigned to LCG as these are managed on a different population base. A&E, prisons and other regional services have not been assigned to LCG.

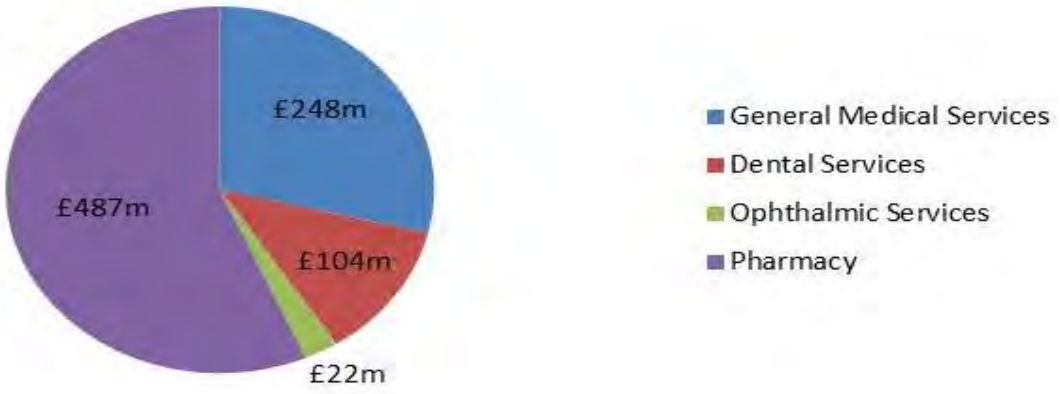
Resources by LCG

Table 19

TOTAL	Local Commissioning Group									
Trust	A&E £m	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Prisons £m	FHS £m	Regional £m	Total £m
BHSCT	22	541	135	125	53	29	-		152	1,056
NHSCT	16	2	517	1	1	2	-		13	551
NIAS	56	0	0	0	0	0	-			57
SEHSCT	18	40	6	355	9	2	8		26	463
SHSCT	15	1	6	8	447	3	-		9	488
WHSCT	12	1	8	1	4	437	-		17	481
Non Trust - Vols, Extra Contractual Referrals etc	9	49	55	41	44	39	-	861	3	1,100
Sub Total	**147**	**634**	**726**	**531**	**559**	**512**	**8**	**861**	**219**	**4,197**
Not Assigned to LCG*										88
TOTAL										**4,284**
* BSO, DIS, Management &Admin										

The Board commissions services from a range of Family Health Services. Figure 12 below shows the breakdown of planned spend across these services.

Planned Spend for Family Health Services
Figure 12



3.2.6 Equity

Achieving equity in commissioning health and social care for its local population is a key objective of the Health and Social Care Board. At its November 2012 Board meeting the Health and Social Care Board commissioned an equity review to be led by the Capitation Formula Review Group (CFRG) across its five Local Commissioning Group (LCG) areas covering four main strands of work:

- The provision of Capitation Formula fair shares to reflect the latest available population data and models together with an assessment of any associated statistical risks and confidence intervals;
- The development of a robust expenditure analysis against which the Capitation Formula fair share resources can be measured to identify potential equity gaps in funding;
- An assessment of significant differences in access to services and performance across LCG populations including waiting lists and times; and

- An assessment of significant differences in health outcomes and quality of service in health and social care services provided to LCG populations.

The findings are set out below and will inform the longer term equity strategy of the HSCB and future annual Commissioning Plans.

Capitation Formula

The Capitation Formula has been developed over the past two decades to measure the relative health and social care needs of local populations and to provide resource allocation fair shares for local populations. It takes account of factors which differentiate one population's need from another including age, socio economic factors and the cost of rural versus urban living. For this exercise updated Capitation Formula shares have been calculated to reflect the Census 2011 population.

Expenditure

The expenditure analysis identifies investment on local populations across all Programmes of Care (excluding regional services and A&E). The 2013/14 figures show the most material variance is £21.1m (3.8%) relative underspend in the Southern LCG with the greatest relative overspend in the Belfast LCG £7.2m. These variances do not only capture expenditure differences in access to services but also differences in efficiency levels within the Trusts accessed by local populations. In order to extract the efficiency component, which should be subject to a separate strategy, reference cost indices have been applied to restate variances. When applied these show that the variance in the Southern LCG is primarily the result of higher levels of efficiencies within the Southern Trust compared to the NI average. Southern LCG reduces to £3m relative underspend bringing the variance in the Southern LCG to less than 1%.

The financial plan for the HSCB has in recent years been skewing additional resources and efficiency targets with the specific aim of reduction capitation variances within a manageable process. More material adjustments would potentially destabilise services, however, it is recognised that the best strategy

would therefore be to ensure increased access to local populations within the existing infrastructure.

Access and Performance

The access and performance element of the review focuses largely on the distribution of activity across LCGs and the impact that this activity has had on access to services (primarily in terms of waiting times). Within the acute programme of care there are some geographical variations in the distribution of care and treatment. There is no evidence of any significant impact in waiting times for services (and hence on the presence of unmet need) in both the acute and community programmes of care.

Quality and Outcomes

Many of the general health outcome measures used by the PHA and HSCB reflect the additional needs patterns identified in the Capitation Formula. However, over time the relative under investment identified in the Southern LCG does not appear to have a clear correlation with differential investment levels. Over the past decade, for example, Standard Mortality Rates (SMRs) in the Southern Locality have improved relative to the Northern Ireland average. The quality analysis shows no significant variations across local Trusts.

One of the recommendations in the Equity review was that the HSCB should continue actively skewing additional commissioning resources in its annual Commissioning Plan to address expenditure equity variances at Local Commissioning Group level. The following table illustrates how the additional resources and efficiencies targets are planned across LCG areas for 2014/15.

The Equity Review was approved by the HSC Board in May 2013, and submitted to the DHSSPS in that month. A Departmental view on the strategy is required to inform future strategy for this area.

Impact of 2014/15 Plan Compared to Capitation Share

Table 170

LCG	Belfast £m	North £m	South E £m	South £m	West £m
Additional Funding above/(below) Capitation share	-2.7	0.9	0.9	-0.1	1.0
Cash Savings requirement below/(above) capitation share	-2.1	-0.1	-0.2	2.1	0.3
Impact on Equity	**-4.8**	**0.8**	**0.7**	**2.0**	**1.4**

The cash savings differential reflects the HSCB policy to address the differential efficiency levels within local Trusts. Belfast LCG has a relatively lower level of demography increase and this is reflected in the differential share of additional funding.

3.3 Improving Productivity

The financial projections for 2014/15 set out an unprecedented challenge if we are to ensure the HSC breaks even financially. Over the Spending Review period challenging annual cash and productivity efficiency targets have been set for all organisations to support the objective of breakeven and maximise productivity. These are set out for 2014/15 and previous years below in Table 21.

Savings Targets

Table 21

	12/13	13/14	Cum
	£m	£m	£m
Trust Cash target	78	69	147
Trust Achieved recurrently/Planned	44	52	96
Trust Carry forward Cash deficits	34	17	51
Trust Productivity Target	29	24	52
FHS Productivity Target	42	25	67
TOTAL Achieved	115	100	215

To date productivity savings targets have generally been met however Trusts have increasingly struggled to recurrently deliver the cash elements of their savings targets.

In recognition of these difficulties and the significant funding shortfall set out in Section 3.2, the HSCB, in conjunction with key staff from the DHSSPS, has undertaken a comprehensive review of all potential cash and efficiencies savings opportunities across the HSC. This has drawn on benchmarking activity and performance levels with a range of peers both within Northern Ireland and GB.

The conclusion of this review is that cash (£50m) and productivity (£22m) targets, should be achievable during 2014/15. However, there is limited capacity to address shortfalls from previous years.

The following table summarises by Trust the Cash and Productivity targets.

Savings Targets by Trust

Table 22

	Belfast £k	Northern £k	South Eastern £k	Southern £k	Western £k	NIAS £k	Total
Cash Target 2014/15	19,300	8,900	7,100	6,400	7,500	800	50,000
Productivity Target 14/15	4,442	4,795	3,813	5,135	3,535	400	22,120

Performance Monitoring Arrangements

A set of productivity and efficiency indicators have been developed to support the development and subsequent delivery of the cash and productivity targets. These are:

- Excess bed days
- Length of stay
- New/Review ratio
- DNA rate new
- DNA rate review
- Day case rates based on the British Association of Day Surgery trolley of procedures
- Cancelled operations
- Cancelled appointments
- Theatre utilisation

- Sickness levels
- Staffing number

Further work is being undertaken on the development of robust community indicators.

Working with the Local Commissioning Groups a process for the on-going performance management and review of the key productivity and efficiency indicators is currently being developed. This will form part of the Board's routine performance management arrangement with Trusts and will be discussed at routine performance meetings, with escalation as necessary. The aim is to demonstrate improved performance against the indicators at pace and to enhance accountability arrangements for the delivery of the necessary reform required to realise the cash and productivity targets.

3.4 Shifting Financial Resources Through Transforming Your Care (Based on Gross Costs)

A key financial objective with the TYC reforms is to ensure that financial resources appropriately reflect the proposed new service models across all areas of care. This was described in TYC as a *Shift Left.* The TYC report highlights the intention to shift approximately 5% (£83m) of recurrent funding in real terms out of the projected cost of hospital based care and into a primary/community based setting within 3 years of a fully funded transformation programme commencing. As a consequence, spend is anticipated to increase in Personal and Social Services, Family Health Services, Primary Care Services and Community Services.

3.4.1 Effecting the shift

In order to effect this shift of care and funding out of hospital services and into the primary / community setting, the HSCB will commission services to be delivered in a different way. There will be a number of strands to this work including:

(1) *Integrated Care Partnerships (ICPs)* - It is anticipated that the initial focus of ICPs will be on the Minister's priorities of frail elderly and aspects of long term conditions for all ages, namely diabetes, stroke care and respiratory

conditions. This should include Palliative & End of Life Care in respect of these agreed condition groups. Care will also move to community and primary care settings through reform of commissioner -approved care pathways and more active anonymised casework, information sharing and improvement in control and prevention of inappropriate hospital admission, it is expected that these collaborative networks will shift £1.5m during 2014/15 which is equivalent to 30 beds and 3,000 Emergency Department attendances.

(2) *Acute care* - It is envisaged that a number of reform initiatives will be undertaken specifically within acute care, which ultimately will shift care out of hospital settings. Examples of potential initiatives where shift left from acute care could be delivered in 2014/15 and beyond are listed below. These will be confirmed via the Trusts response to this Commissioning Plan.

- Patients being admitted to an acute stroke unit as the ward of first admission
- Increased hyper acute care post thrombolysis treatment
- Increased Stroke Community Infrastructure to support Early Supported Discharges from hospital
- Establishment/further roll out of Community Wards
- Increased use of Rapid Response Nursing Teams
- Increased use of Community Mental Health Teams
- Primary Percutaneous Coronary Intervention services
- Sepsis Screening, Early Detection and Intervention
- Virtual respiratory clinics
- Implementation of Day of Surgery Units
- New Ambulance Response Models
- Ambulatory Wards
- Increased Access to Renal Home Therapies
- Increased review by Hospital Pharmacists of Prescribed Medicines
- Introduction of Home Based Diabetes Management Systems
- Reforms in relation to Palliative Care pathways.

(3) *Learning disability & mental health resettlement programmes* - Resettlement programmes will see a significant amount of resource shift from acute care

provision to the community in order to strengthen community services and prevent people from being readmitted to hospital.

For the Learning Disability programme, an estimated 179 people will move from a hospital to a community setting over the 3 year period 2012/13 to 2014/15, with 50 PTL patients planned to be resettled in 2014/15.

For the Mental Health programme, an estimated 220 people will move from a hospital to a community setting over the 3 year 2012/13 to 2014/15, with 39 PTL patients planned to be resettled in 2014/15.

Following an initial assessment, it is anticipated that £41m (at 2014/15 prices) of health and social care will be shifted by the end of 2014/15 from hospital services budgets to community/primary care budgets as a result of the service changes outlined in the table below.

This represents a shift left of approximately 2.75% from hospital based care before the range of further possible measures as outlined in para 3.42 are taken into consideration. The Board will continuously review, through the TYC programme, the potential to shift more care out of the hospital services budget than is currently projected.

Table 23
Overview of financial resources to be shifted into primary/community setting

	2012/13	2013/14	2014/15	Total
	£m	£m	£m	£m
	Actual	Projected	Estimated	Cum
ICPs	0	0	2	2
Acute Care	0	0	4	4
MH Resettlement	4	7	5	16
LD Resettlement	7	7	5	19
	11	14	16	41

Note: The HSCB also plans to shift circa an additional £4m of resources through implementation of re-ablement by March 2015.

As confirmed in the table above, £11m of care previously delivered in a hospital setting has been transferred to a community/social care setting as at March 2013.

Table 23 reflects the full year effect of service transfers from the hospital services budget that is expected to be made by March 2015.

- The 2013/14 Commissioning Plan identified that £19m of financial resources would have shifted left through the introduction of ICPs by 2014/15. The updated 2014/15 figure above, of £2m, recognises the delays encountered in the establishment and development of ICPs in 2013/14 and the likely impact on the timing of the delivery of Shift Left benefits.
- The 2013/14 Commissioning Plan identified that £7m of financial resources would have shifted left through the development of Acute Care proposals (largely represented Stroke Service Changes). The updated 2014/15 figure, above of £4m, recognises the challenges encountered during 2013/14 when seeking to design and develop Stroke Service change initiatives and the consequent impact on the timing of Shift Left benefits.
- In regard to Mental Health Resettlement the updated 2014/15 figure, of £5m, is only slightly lower than the £6m figure included within the 2013/14 Commissioning Plan. This lower value is in recognition of the reduced Shift Left benefits, from £18m to £16m, over the 3 year period 2012/13 to 2014/15.
- In regard to Learning Disability Resettlement the updated 2014/15 figure, of £5m, is only lower than the £6m figure included within the 2013/14 Commissioning Plan. This lower value is in recognition of the reduced shift left benefits from, £20m to 19m, over the 3 year period 2012/13 to 2014/15.

Through the existing governance arrangements, HSCB will monitor both the CYE and FYE of each transformation proposal across all programmes of care.

More robust and detailed planning of the new integrated clinical service models is required in order to determine the precise financial impacts on the primary care, community and personal social services sectors of the resources that shift out of hospital settings.

3.4.2 Further shift left considerations

In addition to moving care outside of the hospital setting, a shift left of services can also be considered when moving service provision along a continuum of care. This includes shifting care, in terms of both numbers and intensity of care packages, along the continuum of care from institutional residential and nursing home care through to domiciliary care by implementing re-ablement models, which promote more independent living away from hospital/ institutional settings.

Therefore, in addition to the hospital based initiatives noted above, the HSCB plans to shift some £4m of financial resources at 2014/15 prices by implementing re-ablement models by March 2015.

The HSCB will continue to investigate all opportunities to commission services in a different way to ensure that more services are provided either outside a hospital setting or moved along the care continuum. In that context, the shift left plan will continue to be refined and updated throughout the year informed by the HSCB.

3.4.3 Monitoring the Delivery of Financial Shift Left

The delivery of this shift in resources will be monitored and measured on a monthly basis by the HSCB and reported through the TYC Transformation Programme Board and associated governance structures. It is anticipated that this will be demonstrated both through a review of key activity levels/metrics as well as an analysis of the associated financial resources.

4.0 Regional Commissioning Priorities 2014/15 by Programme of Care

This section provides an overview of commissioning priorities for each of the nine Programmes of Care (POC) and for a number of other regionally led service areas. Each POC section details priorities to be taken forward at regional and local level. Strategic drivers are outlined in brackets after each of the regional priorities as appropriate. Specific local commissioning requirements to be taken forward by the five LCGs are outlined in the local plans (Sections 6-10).

4.1 POC 1: Acute Services (Non-specialist)

(i) Introduction

Acute non-specialist services are those which provide emergency and planned patient care, from investigation and treatment through to rehabilitation and palliative and end of life care. They therefore include radiology, endoscopy and other diagnostic services, planned day case procedures or inpatient surgery, and care of patients with acute illness that requires hospital admission. They cover many disease conditions with the most common being cardiovascular and respiratory disease, cancer, diabetes and neurological conditions.

As outlined in the Commissioning Direction and Transforming Your Care, the strategic direction in 2014/15 and beyond, is to provide patients with the assessment, investigation and treatment they need, when they need it, thereby enabling earlier diagnosis, simpler treatment, and better outcomes. Services which respond on a 'same or next day' basis, are safer and higher quality, provide a much better patient experience, and are substantially more efficient than services where patients have long waits. The importance patients place on being treated promptly was highlighted in the Patient Client Council Report in July 2013 "Care When I Need It: A Report on Urgent Care".

Key issues for acute non-specialist services are therefore firstly to reduce waits at all stages of a patient's journey from their GP to, and through, secondary care; secondly, to enable GPs to complete more of a patient's management through timely support from secondary care; and thirdly, to free resources from

intermediate care and acute beds by reducing the total number of beds and/or sites, to enable investment in early intervention and intensive acute care. Addressing these issues will require a move towards 7 day working and a transformation in the way in which secondary care supports GPs. Haematology services in the Western Trust, Nephrology in the Southern Trust, Genitourinary Medicine services in the South Eastern Trust, direct admission to hospital in the Belfast and Northern Trusts, are examples of new ways of working whereby GPs can easily get advice from secondary care colleagues on the management of patients or admission, without the need for the patient to go to an Emergency Department or traditional Outpatients.

In addition to transformation of local acute services, a number of developments will be progressed in services which are provided on a networked basis for the region, for example, vascular services, chemotherapy and radiotherapy, interventional cardiology, paediatrics, neonatal services, trauma and orthopaedics.

(ii) Regional commissioning priorities for 2014/15 and 2015/16

Key commissioning priorities to be taken forward at regional level during 2014/15 are:

- Establish a regional Trauma Network and develop protocols for patient management (*Ministerial targets 7&8 and TYC Recommendation 72)*
- Develop and implement "see and treat" protocols for NI Ambulance Service paramedics on (*Ministerial target 7 and TYC Recommendation 74)*
- Undertake work with Trusts to reduce cancelled sessions, increase day case rates, increase the number of patients per session, and reduce new:review ratios where appropriate (*Ministerial targets 6,10,12 & 30)*
- Implement the recommendations from the Review of Vascular Services and establish networked services across NI
- Assess chemotherapy services' capacity, service model and skill mix and revise the current arrangements, as appropriate
- Enable earlier diagnosis and treatment of ovarian cancer and therefore better 5-year survival rates by auditing adherence to the 2013 Ovarian

Cancer Pathway *(NICE Quality Standard for Ovarian Cancer, Cancer Service Framework, & Improving Outcomes 1,2,3,4 & 5)*

- Commission an Acute Oncology Service for all Trusts and introduce a Haematology Advice Service *(Chemotherapy service review & Improving Outcomes 1,2,3,4 & 5)*
- Take forward priority recommendations in the DHSSPS Paediatric review, once published and arrangements for a networked approach to providing general paediatric surgery
- Work with Trusts to establish a sustainable, robust paediatric radiology service for NI to enable emergency diagnostic and interventional work 24/7 (*Ministerial targets 6, 11 & 12)*
- Engage with clinicians to review the management of conditions of lower clinical priority and as necessary, revise the Effective Use of Resources Policy
- Commission a service to provide self-management education programmes for patients with long term conditions and their carers (*Ministerial targets 9 & 21, TYC Recommendation 21 and PFG Commitment 44)*
- Commission a service to train members of the public in emergency life support to improve survival rates following cardiac arrest *(Resuscitation Strategy for Northern Ireland)*
- Expand substance misuse liaison services to achieve the Commissioning Direction target for a 7-day service in all appropriate HSC acute settings (*Ministerial target 3)*
- Commission sufficient capacity to meet demand for planned care *(Ministerial targets 6,10,11 and 12)*
- Undertake a scoping exercise to identify opportunities to provide more effective care for patients living with chronic pain (*Patient & Client Council Report – The Painful Truth)*
- Enhance end of life care, particularly in the community and Nursing Home sector *(Living Matters, Dying Matters, DHSSPS)*
- Undertake a scoping exercise to identify opportunities to raise awareness in patients and in primary care of endometriosis as a condition, and to further integrate and streamline the care pathway for women living with severe (stage 4) endometriosis. *(Patient & Client Council – Peoples Priority)*

Key commissioning priorities to be taken forward by the five LCGs in 2014/15 are as follows:

- Enabling GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to reduce/flatten demand for outpatients, and Emergency Department attendances.
- Reducing waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions at the large hospital sites.
- Enabling district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present.
- Review and take forward opportunities to consolidate the number of intermediate care beds and acute beds and the sites on which they are provided.

Specific local commissioning requirements in relation to these priorities are included in each of the LCG plans.

4.2 POC 1: Acute Services (Specialist)

(i) Introduction

Specialist services for acute care include specialist tertiary services delivered through a single provider in Northern Ireland or in Great Britain. They are often high cost, low volume and provided by small clinical teams. There are some 30-40 sub-specialist or small specialist areas within this area.

Services which fall within this branch of commissioning include rare diseases, renal services, genetics, specialist services for children, specialist ophthalmology services; specialist neurology services and cardiac surgery.

As some of these services evolve they will move to multicentre provision, for example renal dialysis and biologic therapies.

Due to our small population the most specialist services are becoming increasingly difficult to sustain. Opportunities to link our clinical teams to larger centres outside Northern Ireland in a network arrangement are essential to supporting the long term sustainability.

(ii) Commissioning Priorities for 2014/15 and 2015/16

The commissioning priorities to be taken forward at regional level during 2014/15 and 2015/16 include:

1. ***Catheterisation Laboratory Expansion and pimary Percutaneous Coronary Intervention (pPCI)*** (PfG Commitment 79)
   - Securing the provision of primary PCI services for STEMI heart attacks in the West of the Province. This will ensure the service is available across N Ireland.
   - Further expansion in capacity with a particular emphasis on electrophysiology and ablation cases.

2. **Expand Radiotherapy Capacity**
   - To commission additional radiotherapy services in Belfast by September 2014 and a new radiotherapy unit at Altnagelvin Hospital in late 2016

3. ***Growth in the use of existing specialist drug therapies / introduction of new drugs and other specialist therapies*** *(Ministerial target 15)*
   - Maintenance of waiting times and achievement of targets for specialist drug therapies – rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, psoriasis, inflammatory bowel disease, multiple sclerosis and wet age related macular degeneration.
   - Introduction of newly approved drugs to include services for retinal vein occlusion and diabetic macular oedema.
   - Explore opportunities to support the delivery of services associated with the provision of specialist drug therapies in more local settings e.g. increase the number of sites providing specialist therapies for multiple sclerosis and increase the number of locations able to provide imaging services for specialist ophthalmology conditions.

- Ensure access to HIV drugs to support increase in numbers presenting with the condition.
- Ensuring timely access to new specialist drugs and other therapies in line with Departmental circular HSC(SQSD) 04/11 - NICE Technical Appraisals and Clinical Guidelines.
- Ensuring timely access to new specialist treatment regimes.

4. Specialist paediatrics

To ensure safe, sustainable and resilient, high quality clinical care in specialist paediatric services by:

- Further development of clinical network arrangements within and outwith N Ireland;
- Redesign and delivery of the acute care clinical pathway for children with cancer;
- Redesign and modernisation of paediatric cardiology services to support service provision across N Ireland and linkages to other tertiary providers as appropriate;
- Equity of waiting times, irrespective of where a child lives;
- Transition to adult services;
- Implementation of the recommendations relating to specialist care in the Review of Paediatrics. This will involve working closely in partnership with commissioners of general acute paediatric services in agreeing pathways for paediatric surgical and paediatric medical services; and,
- Putting in place arrangements to ensure the timely diagnosis of hip dysplasia.

5. Renal services (Ministerial target 14)

The HSCB and PHA will continue to work closely with the service towards optimising the potential for organ donation to include:

- Continuing to provide at least 50 live donor transplants per annum;
- Increasing the number of kidneys retrieved and transplanted in Northern Ireland that are kidneys donated after circulatory death (DCD);
- Increasing consent rates for deceased organ donation; and,

- Increasing the use of peritoneal dialysis / home haemodialysis during 2014/15 and beyond.

6. Rare Diseases *(NI Rare Disease Implementation Plan)*

In response to the development of a four nations UK Strategy for Rare Disease, N Ireland is expected to launch its Rare Disease Implementation Plan in early 2014. The Board will establish a process to:

- Progress the agreed priorities contained with the Northern Ireland Rare Disease Implementation Plan;
- Work with the Northern Ireland Rare Disease Partnership in the planning and delivery of services for people with rare diseases;
- Co-ordinate services for people living with neuromuscular conditions;
- Ensure the provision of timely information and support; and,
- Ensure transition arrangements are in place for young people.

7. Clinical Partnerships With Other Health Economies

There is a need to ensure the resilience of a range of specialist services that are currently delivered in N Ireland by one or one or two person clinical teams. This will allow services to be delivered in line with agreed access times and will secure resilience in the provision of services for the local population.

Much progress has been made within specialist paediatrics in developing clinical partnerships with other tertiary and quaternary providers outside NI but some adult services are also highly vulnerable. To achieve this, the Board will work with and support Belfast Trust in identifying tertiary and quaternary partners outside N Ireland and thereafter developing appropriate pathways to support these as formal clinical partnerships.

8. Paediatric Congenital Cardiac Surgery (PCCS)

Pending a Ministerial decision on the longterm provision of PCCS, the HSCB and PHA will work with Belfast Trust and other providers in the RoI and Great Britain to ensure that NI children continue to have access to timely, safe care.

9. Closure of Belfast Blood Cord Bank for Unrelated Donations

The DHSSPSNI has requested that the HSCB takes forward the implementation of the closure of the Belfast Cord Blood Bank for unrelated donations and to put in place arrangements for the continuation of collection, processing and storage of directed cord donations.

Consistent with the Board's equality obligations, a public consultation exercise on this change will be undertaken during 2014/15 to ensure that people in Northern Ireland can be fully informed about the changes and have the opportunity to comment and seek clarification on how the new system would operate.

Specific objectives for Trusts to take forward in relation to these priorities are outlined below.

Trust requirements in relation to Specialist Services 2014/15

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Key Deliverables***	***2014/15***	***2015/16***
Western Trust (networking with NIAS) should establish 24/7 primary Percutaneous Coronary Intervention (pPCI) services at Altnagelvin Hospital.	●			Rec 89	Programme for Government Clinical Engagement Activity predicted in the NI stocktake National estimates used by DOH Demand as seen from Belfast pilot, uplifting activity in BHSCT residents for NI
By March 2015, Belfast Trust should ensure the delivery of a minimum of 80	●		√		Clinical engagement

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Key Deliverables***	***2014/15***	***2015/16***
kidney transplants in total, to include live, DCD and DBD donors.			Target 14		2008 DHSSPS Update of renal review DHSSPS 2011 Current Activity and Future Prediction of Need for Renal Replacement Therapy in NI
Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access specialist ophthalmology regimes, such as Wet AMD	●				NICE Clinical engagement Equity of access
Belfast Trust should progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast	●			Rec 45 & 89	Demand capacity analysis DHSSPS Review of

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Key Deliverables***	***2014/15***	***2015/16***
Hospital for Sick Children Network Plan					Paediatric Health Care Services Provided in Hospitals and in the Community 2013
Belfast Trust will supply a plan to expand ICU capacity to funded levels in 2014/15	●				Service Continuity

Values and Volumes

These commissioned values and volumes include figures for Specialist Services

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**[26]	53,248	1,216	54,464
	Daycases[27]	146,508	1,878	148,386
	New Outpatients	532,244	14,173	546,417
	Review Outpatients	741,209	22,652	763,861
Unscheduled	**Non Elective admissions - all**	187,811	3,714	191,525
	ED attendances	710,965	1,473	712,438
	NIAS Journeys	180,070	3,328	184,998
	VALUE OF COMMISSIONED ACTIVITY[28]	£1,376m	£81m	£1,457m

[26] Four scopes excluded (OGD,ERCP,Flexi Sigm,Colonoscopy)

[27] Four scopes excluded (OGD,ERCP,Flexi Sigm,Colonoscopy)

[28] This includes activity in addition to that set out above.

4.3 POC 2: Maternity and Child Health Services

(i) Introduction

This PoC encompasses the following services: maternity; neonatal; non-specialist acute and community paediatrics / child health; and subfertility services.

Maternity services

The total number of births in hospital in N Ireland has decreased by 2.9% from 25,994 births in 2008/09 to 25,234 births in 2012/13. Between 2011/12 and 2012/13, hospital births decreased by 469 (1.8%) overall, although there is variation between different LCG areas.

The number of births in NI hospitals to women who are not resident in NI has fallen from around 500 such births each year to 343 in 2012/13. There continue to be very few home births (26 planned home births in 2012/13). During 2012 there was a continuing trend towards later child bearing, with more than 50% of births to mothers aged 30 years and over. The number of births to teenage mothers was the lowest on record during 2012 at 1,100. In 2012/13 58% of all births in N Ireland were normal deliveries, and 29% of deliveries were by caesarean section. NI has the highest rate of caesarean sections in the UK.

A Strategy for Maternity Care in N Ireland 2012 / 2018 has provided a strategic framework for maternity care and work is underway to implement its 22 objectives. During 2013/14 a number of NICE clinical guidelines relevant to maternity care were issued to the service for implementation, including NICE guidance on multiple pregnancy (CG 129); ectopic pregnancy and miscarriage (CG 154); caesarean section (CG 132); and pregnancy and complex social factors (CG 110). As the NICE guideline on multiple pregnancy recommends a networked approach, work is underway to develop a regional networked service model and agreed care pathways in N Ireland.

Neonatal services

Neonatal services have developed rapidly in the past 30 years. Demand in more recent years is also associated with increased numbers of complex pregnancies and assisted conception. The widespread use of antenatal steroids, use of replacement surfactant and advances in technology has also led to an increase in survival of very preterm, vulnerable babies and for infants with complex congenital and perinatal problems.

Around 8% of all babies born in Northern Ireland require admission to a neonatal unit. Of those needing neonatal care, around two-thirds receive either intensive or high dependency care. Neonatal is a high cost, low throughput service in which clinical expertise is a key determinant of the outcomes for babies born pre-term or who become ill in the early new born period.

A Neonatal Network for Northern Ireland was formally launched in 2013 with the central aim of 'ensuring that babies who require neonatal services get the right standard of care in the right environment by the right staff. Work has commenced across a number of key areas to further improve and streamline services across the neonatal pathway from antenatal care to discharge including the implementation of relevant clinical standards and guidelines, infection prevention and control, service specification and further development of data systems to support monitoring of key outcomes. A series of quality focused initiatives are also planned for 2014/15 in the areas of breast feeding and parent and user engagement.

A review of neonatal capacity is also planned for 2014 in line with the network's quality improvement approach.

Paediatric / child health

There are 430,763 children and young people under the age of 18 in N Ireland. Most enjoy good health and can expect to live longer, healthier lives than ever before. There are significant numbers of children with long term conditions, for example, asthma, epilepsy or diabetes. In addition, technological and clinical advances mean that an increasing number of children with serious and complex

conditions survive infancy and require expert input from health services to ensure they lead as long and full a live as possible.

Most children who need to access health services are treated in the community. However, around 80,000 children and young people attend an emergency department each year and around 60,000 are admitted to hospital each year. Admission to hospital is particularly common in the first year of life, information from hospital systems suggests that around one quarter of children in N Ireland are admitted to hospital in their first year of life. Admission to hospital, while sometimes unavoidable and in the child's best interest, can be traumatic for children and their families. The HSCB/PHA is working with all Trusts to develop short stay paediatric assessment and observation units across NI. These units are designed so acutely unwell children can be assessed and treated rapidly by specialist paediatric doctors and nurses and avoid the need for many hospital admissions.

The needs of children who are admitted to hospital are different to adults. The 2014/15 commissioning plan sets out the HSCB/PHA commitment to ensure that children and young people who are admitted to hospital are looked after in age appropriate settings by staff who have expertise in looking after children and young people.

A consultation document on "Enhancing Healthcare Services for Children and Young People in Northern Ireland" (from birth to 18) has recently been issued by DHSSPSNI and draft recommendations from the review have been considered in this commissioning plan. The HSCB/ PHA await the final published review which will shape commissioning direction in 2015/16 and beyond.

(ii) Commissioning priorities for 2014/15 and 2015/16:

Key commissioning priorities to be taken forward at regional level in 2014/15 include:

Maternity *(Inequalities information)*

- To ensure implementation of the strategic recommendations of the "Strategy for Maternity Care" to ensure safe, resilient maternity service models across Northern Ireland, the objectives of the maternity strategy including the strategic shift towards the provision of more maternity care in the community and more midwife-led care *(Strategy for Maternity Care)*;
- To ensure the provision of safe, sustainable maternity, neonatal and child health hospital and community services;
- To facilitate the regional implementation of NICE Guideline 129 on Multiple Pregnancy which requires a regional cooperative approach to agree care pathways (*NICE)*
- To develop a regional resource (a specialist midwife post) to develop expertise and promote awareness among health care professionals of the special maternity needs of BME and migrant pregnant women (subject to funding).

Neonatal

- To undertake a review of neonatal nursing workforce
- In collaboration with Neonatal Network, to undertake a review of numbers and geographical location of neonatal cots across all levels of care within N Ireland
- To develop of escalation and contingency plans for neonatal services for capacity and extraordinary events
- To develop processes to improve user engagement to inform improvements in the neonatal pathway from antenatal care to discharge.

Paediatric / Child Health *(Paediatric Review)*

- Establish on a phased basis an operational paediatric network which will include paediatric medicine, paediatric surgery and specialist paediatric services

- Work with Trusts to establish sustainable services that meet the standards in the Review
- Work with Belfast and other Trusts with a view to informing the configuration and profile of the planned new Children's Hospital
- Work with Trusts to ensure services meet Commissioning requirements to standardise the minimum upper age limit for children in Paediatric wards (15 years in 14/15)
- Commence a review of transition arrangements across specialties

Sub-fertility *(NICE Guidance)*

- The HSCB will consider NICE Clinical Guideline 156: Fertility: assessment and treatment for people with fertility problems (update) which has significant implications for the available budget for subfertility services

Key commissioning priorities to be taken forward by the five LCGs in 2014/15 include:

- Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy (*TYC Recommendations 34 & 37)* including:
  - Written and oral communication for women to enable an informed choice about place of birth
  - Services in consultant-led obstetric and midwife-led units available dependent on need
  - Promotion of normalisation of birth, leading to reduction of unnecessary interventions
- Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129
- Trusts to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife led antenatal care in the community for women with straightforward pregnancies
- Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained variation in intervention rates throughout Northern Ireland.

- Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.

Local commissioning requirements associated with these priorities are outlined in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	Births	25,714	48	25,762
	Comm Midwives	Contacts	362,757	581	363,338
	Health Visiting	Contacts	302,692	0	302,692
	Speech and Language Therapy	Contacts	137,420	0	137,420
		VALUE OF COMMISSIONED ACTIVITY[29]	£137m	£6m	£143m

[29] This includes activity in addition to that set out above.

4.4 POC 3: Family & Child Care

(i) Introduction

Children in need, including children with a disability, children on the Child Protection Register, and those in care are among the most disadvantaged in society and have significantly reduced life chances. These children and young people encounter significant obstacles to having a stable family life and to progressing in education to enjoying learning and achieving and reaching their potential.

In line with Transforming Your Care (TYC), there has been, and will continue to be, a significant focus on early intervention and this agenda is being pursued on a uni-disciplinary, single agency and multiagency basis. There is a strong commitment to partnership working to progress this agenda through vehicles such as the Children and Young People's Strategic Partnership, Childcare Partnerships and Child Development Board. The strategic direction for the statutory social work component is taken forward through the Children's Services Improvement Board with the involvement of senior HSCB and Trust staff. The Partnership arrangements allow for service user involvement and the participation of representative umbrella organisations to convey and ensure that the views of children, young people and families are taken into account.

Improving the experience of young people with disabilities as they transition to adulthood is a key priority for the HSCB during 2014/15. This work is being taken forward by the Children and Young People's Strategic Partnership and will be underpinned by the participation of young people with disabilities throughout. The Partnership will explore a range of measures aimed at improving the experience of transition to adult services for the young person and their families focussing on key areas such as Integrated Plans and the development of individual Passports.

As referenced, relevant actions, as detailed in TYC, are being progressed on the early intervention front and further into the system where services are provided for looked after children. The DHSSPS has also commenced a review of all

existing strategy and guidance for looked after children, with a view to developing a strategic statement which will encompass services from the edge of care through to leaving and aftercare. Neither early intervention nor adoption will be included but it is envisaged that new legislation, Adoption and Children Bill, will be progressed and the HSCB is engaged with the DHSSPS and other stakeholders in consideration of content and the implications of same.

The Safeguarding Board for N Ireland is now fully operational with the HSCB and Trusts included as members. The HSCB will continue to monitor performance in the area of safeguarding as this is a key delegated statutory function and both agencies continue to ensure communication and sharing of information.

There continues to be significant demand across Children's Services. The HSCB/PHA recognise the role of Health Visiting in providing support and interventions at the earliest possible stage in a child's life. We are committed to addressing the shortage of Health Visiting staff across the Health and Social Care Trusts, consistent with the Healthy Child/Healthy Futures Strategy.

The numbers of referrals into Children's Social Services has also continued to increase with the consequent impact across the system. There has been a slight decline in the overall number of children on the Child Protection Register (-8% currently 1,961) at the end of year. However, when examining these figures as rates per 1000 child population, an upward trend is evident across all Trust areas.

In line with the national trend, there has been a steady and significant growth in the number of children coming into the looked after system - there are currently around 2,800 looked after children within N Ireland; an increase of 13.9% between 2009 and 2013. This increase reads through into leaving and aftercare and has placed considerable demands on acquiring appropriate placements with a rise in the percentage of children placed within kinship placements. This is consistent with policy and legislative direction, although there remains a need to ensure that placements can meet the assessed needs of children. The DHSSPS has issued Kinship Standards which recognise the requirement for quality

placements with robust assessment and safeguarding practices in place. The growth of kinship placements, aligned with the introduction of the standards, has been highlighted by Trusts as a capacity issue.

The numbers of unallocated cases and waiting lists for CAMHS and Autism Services have fluctuated across Trusts and continue to be subject to review and service improvement. Further work is progressing to review demand and capacity within these service areas.

The underinvestment in Children's Services has been recognised previously and reinforced within a number of independent reports. The Trusts report, however, that further financial efficiencies requiring to be made within Children's Services have compounded this pressure. In this regard, the HSCB continues to seek assurance that care delegated services are being delivered to a required standard. The growing concern being articulated is that this focus could result in circumstances being referred when they are even more entrenched. Whilst not possible at this stage to provide a strong evidence base, it has been postulated that there is a correlation between the economic downturn and the rise in demand.

(ii) Regional commissioning priorities for 2014/15 and 2015/16

Key commissioning priorities to be taken forward at regional level in 2014/15 include:

- To ensure that a child only becomes looked after where their long term outcomes will be improved or there is a need for the child to be removed as a safety measure *(Commissioning Specification)*
- To ensure an adequate range of placements to meet assessed needs of LAC and care leavers *(TYC Recommendation 48, Children (NI) Order and Children Leaving Care Act and a Commissioning Specification)*
- Work with CYPSP and outcomes groups to progress the establishment and consolidation of family support hubs by 1st September 2014.
- PHA/HSCB to strengthen early year's provision and family support through parenting programmes.

- Ensure a robust needs assessment and localised service for children with complex needs including those with learning disabilities or challenging behaviour *(Commissioning Specification).*
- Engagement in review of AHP support for children with statements of special educational needs attending both special schools and mainstream education.
- Full implementation of RQIA recommendations of CAMHS review and Departmental CAMHS "step care" model *(TYC Recommendation 51).*
- Implementation of the RQIA Fostering Review recommendations
- Engage with the regional review of fostering and development of a commissioning specification for fostering/permanence *(TYC Recommendations 49 & 50).*
- Full implementation of the RQIA Review of Community Services for Children with a Disability.
- The Forensic Adolescent Consultation and Treatment Service will become operational *(Consistent with proposed developments in Residential Child Care Review and CAMHS developments).*
- The PHA, in collaboration with NIPEC, will carry out a normative staffing exercise for Health Visiting with a view to enhancing the HV workforce to provide the full Core Universal Service as set out in Healthy Child Health Future (Ministerial target 28ii).
- Work with the CYPSP and cross-departmental Early Intervention Transformation Programme to deliver integrated services through pooled budgetary arrangements *(TYC Recommendation 47).*
- Family Nurse Partnership programmes will be expanded to include access within all five Trusts *(Ministerial target 2).*

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Family and Childcare	**Social Work**	Caseload	21,000	0	21,000
	Residential Homes	Occupied bed days	61,000	0	61,000
		VALUE OF COMMISSIONED ACTIVITY[30]	£205m	£8m	£213m

While there has been an increase in investment within this POC, as reflected in the values above, the uplifts in activity during 2014/15 relate to currencies other than those presented above, for example, increased investment in foster care provision, safeguarding and transition planning for young people with a learning disability.

[30] This includes activity in addition to that set out above.

4.5 POC 4: Older People's Care

(i) Introduction

As outlined in Section 2.1, N Ireland has a growing ageing population and with that come a number of service challenges, including an increase in the number of people living with longterm conditions and comorbidities and an increasing reliance on secondary care. Older people's services need to be reconfigured if we are going to continue to meet increasing needs now and into the future. Transforming Your Care focuses on home as the hub of care. Shift left will aim to deliver more services closer to home with a focus on promoting healthy ageing, providing support for those who wish to remain at home, developing diversionary services to maintain independence and more targeted specialist support for highly dependent individuals.

This approach has been underpinned by the recent launch of the Service Framework for Older People which thematically focuses on: person-centred care; promoting health and well-being; support for carers; safeguarding individuals at risk of neglect, abuse or exploitation; medicines management; care of conditions more common in older people; significant points of transition within older people's services and palliative and end of life care. It will significantly shape the agenda for change within this programme.

Alongside on-going attempts at service reform through the development of reablement and efforts to reform statutory residential care, during 2014/15 we will also need to respond to significant pressures on domiciliary care services and to develop a more consistent approach to the provision of intermediate care. There are also significant service pressures resulting from increased awareness of adult protection and the need for an adequate safeguarding response to protect individuals at risk of neglect, abuse or exploitation. Funding will be made available to support the continued development a Gateway or single point of entry approach for adult safeguarding

Underpinning all of these strands is the need for effective assessment of individual need through the implementation of eNISAT.

ICPs will be focusing on the integration of care for the frail elderly. It is anticipated that LCGs will work with ICPs to develop and commission new services which will better meet the needs of this group of people, to include the development of a focused case management approach which will improve the coordination and delivery of care to "high risk" individuals thereby avoiding unnecessary hospital admissions and facilitating early supported discharge and a return to independence.

(ii) Commissioning Priorities for 2014/15 and 2015/16

Key commissioning themes to be taken forward at regional level during 2014/15 are:

- Complete consultation processes regarding statutory residential care and agreed Trust proposals for service reform *(TYC Recommendations 9 & 10).*
- Undertake review of domiciliary care services and revised contractual arrangements *(TYC Recommendation 9).*
- Development of enhanced safeguarding arrangements *(TYC Recommendation 17, PfG 61 and Service Framework for Older People).*
- Agreed service developments in dementia services with associated performance targets *(Dementia Strategy).*
- Regional implementation of e-NISAT including the functionality to share information within and across Trusts *(TYC Recommendation 16).*

Commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive. *(Ministerial target 22; TYC Recommendation 19).*
- Access to more options for carers in the provision or arrangement of their respite/short breaks. *(TYC Recommendation 13& 19)*
- Increased uptake of direct payments *(Ministerial target 23; TYC Recommendation 18).*
- Working with ICPs to improve the care of the frail elderly *(TYC)*.

- Enhancement of dementia services *(Dementia Strategy).*
- Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements (TYC Recommendation 13).
- Continued roll-out of targeted PHA preventative health and well-being improvement programmes *(TYC Recommendation 14).*
- Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact *(TYC Recommendation 11)*.

Specific local commissioning requirements in relation to these priorities are included in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied bed days	247,770	-3,822	243,948
	Day Care	Attendances	309,899	0	309,899
	Domiciliary Care	Hours	10,721,105	252,151	10,973,256
	Residential and Nursing	Occupied bed days	3,736,807	29,930	3,766,737
	Community Nursing	Face to face	1,956,389	9,302	1,965,591
	Social Work	Caseload	40,661	0	40,661
		VALUE OF COMMISSIONED ACTIVITY[31]	£644m	£27m	£671m

[31] This includes activity in addition to that set out above.

4.6 POC 5: Mental Health

(i) Introduction

Mental health has a significant effect on life expectancy and is a key cause of health inequalities. People who live in the most deprived areas experience the highest levels of poor mental health. Indeed many mental health problems start in early life and are associated with multiple deprivation. N Ireland has a 25% higher overall prevalence of mental health problems compared to England. N Ireland has a unique range of problems as a result of 'the troubles'. It also experiences high levels of socio-economic deprivation which is more pronounced in some geographical areas by the prolonged effect of 'the troubles'.

This year's Commissioning Plan reflects the commitment to tackle a number of serious and ongoing issues. The continued high level of suicides in N.I will be addressed by the further implementation of the Protect Life Strategy. The recent National Inquiry into Suicides and Homicides, August 2013, University of Manchester, highlights the disturbing role of substance misuse, primarily alcohol, in suicides in N.I. at a higher rate than Great Britain. Consequently, efforts to tackle harmful drinking at all of the four tiers of the Drugs and Alcohol Commissioning Framework must be strengthened.

The stigma still associated with seeking help for mental health issues needs to be reduced by increasing access to appropriate talking therapies in primary care and by improving the patient experience in secondary mental health care by implementing more recovery focused approaches working in partnership with mental health service users and carers.

In line with the reduction in hospital beds as resettlement ends, there is a need to continue to improve the quantity and quality of Crisis Resolution and Home Treatment services alongside other specialist community services for assessment, treatment and care.

The Board will also work to improve the quality, safety and service user experience of all commissioned services in line with feedback from service users, carers and lessons learned from analysis of SAI's and RQIA reports.

The crucial role which carers play in supporting people who use mental health services to live in the community needs to be further recognised and supported by practical measures, such as short breaks/ respite, as well as increased information on and better access to services. These services should increasingly be delivered in line with the Regional Care Pathway in order to meet the Mental Health Service Framework standards and N.I.C.E guidance.

(ii) Regional Commissioning Priorities for 2014/15 and 2015/16

The key commissioning priorities to be taken forward at a regional level during 2014/15 and 2015/16 are:

- All Trusts should ensure the resettlement of the remaining long stay population *(Ministerial targets 27 & 32, TYC Recommendation 62 and Bamford Action Plan 2012-15 DHSSPS).*
- All Trusts should deliver Recovery Approaches and the Regional Mental Health Care Pathway *(TYC Recommendations 56 & 57 and Bamford Action plan 2012-15).*
- A range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual referrals based on the 01/04/12 baseline - *Personality Disorder Strategy 2010 & New Strategic Direction for drugs and Alcohol DHSSPS).*
- The implementation of the regional Tier 4 Substance Misuse Model including the development of agreed Tier 3 supporting community services *(Ministerial Target 3)*
- The implementation of services to identify, assess and treat first episode psychosis (age 16+) including CAMH's *(Ministerial Target 33 and TYC Recommendation 59.)*
- Ensure delivery of Bamford Action Plan for Mental Health 2012-2015 (46 Targets) *(Ministerial Target 31, TYC Recommendations 39 and 55 and Bamford Action plan 2012-15)*

- Implementation of Mental Health and Wellbeing Service Framework *(Safety and quality requirement)*
- Implementing the Commissioner Guidance for Advocacy

Key commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive. *(Ministerial target 22; TYC Recommendation 19).*
- Access to more options for carers in the provision or arrangement of their respite/short breaks. *(TYC Recommendation 13& 19)*
- Increased uptake of direct payments *(Ministerial target 23; TYC Recommendation 61).*
- Implementation of the Protect Life Strategy *(TYC Recommendation 53)*.
- Establishment of integrated care arrangements for the care and treatment of patients with common mental health needs *(Ministerial target 33; TYC Recommendation 60)*.
- Implementation of the Crisis Resolution Home Treatment services for CAMHs *(TYC Recommendation 58)*.
- Further development of specialist community services *(TYC Recommendation 59)*.
- Improved psychiatric liaison services *(TYC Recommendation 57)*.
- Consolidation of mental health inpatient beds - Mental health inpatient beds have been consolidated to a single site within Southern Trust. The development of a single site for Belfast is underway. The development of a new site is also underway within the Western Trust. Acute in-patient facilities are also planned for the Northern and South Eastern Trust areas, with a second site planned for the Western Trust. The timescale for delivery of these sites will be subject to their prioritisation within the capital investment programme.

Specific local commissioning requirements in relation to the above are included in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied bed days	287,124	0	287,124
	CPN	Contacts	239,242	1,000	240,242
	Res & Nur homes & supported housing	Places	204,379	0	204,379
	Day Care	Attendances	206,963	0	206,963
	Domiciliary Care	Hours	348,743	602	349,345
		VALUE OF COMMISSIONED ACTIVITY[32]	£246m	£7m	£253m

[32] This includes activity in addition to that set out above.

4.7 POC 6: Learning Disability

(i) Introduction

There are a number of key demographic factors and strategic priorities which underpin this year's commissioning plan for Learning Disability. The population of people with a learning disability is continuing to rise in line with the very welcome increase in the average lifespan. Consequently, there are greater numbers of people with a learning disability reaching adulthood and requiring day opportunities and appropriate community support. As adults continue to reach old age in greater numbers, planning is required for their future long term care and housing and support for carers, in particular older carers, is more necessary than ever.

Evidence such as "Health Inequalities and People with Learning Disability in the UK" (E. Emerson & S. Baines, 2010) showed that people with a learning disability on average had a higher rate of poor ill health and of mortality than their non-learning disabled peers. The HSCB/PHA evaluation of the learning disability D.E.S highlighted progress on providing annual physical and mental health checks for adults with a learning disability in primary care. The evaluation's recommendation for improving health promotion activities for people with a learning disability within the overall health promotion strategy is being implemented as a further measure to tackle this health inequality.

This year will see the completion of the resettlement of the long-stay population from learning disability hospitals and the opening of the last of the 3 new in-patient assessment and treatment hospitals for learning disabilities on the Craigavon Area Hospital Site. Alongside the continued reduction of hospital beds for learning disability community services there will be an increase in those specialist support services which were previously mostly provided in hospital settings.

2014/15 will also see a continued focus on the promotion of self-directed support and on improving the support we provide to carers.

(ii) Commissioning Priorities for 2014/15 and 2015/16

Commissioning priorities to be taken forward at a regional level during 2014/15 and 2015/16 include:

- All Trusts should resettle the remaining long stay population *(Ministerial Targets 27 & 32, TYC Recommendation 71 and Bamford Action plan 2012-15).*
- All Trusts should work with primary care to further develop the Directed Enhanced service (DES) for learning disability in line with the findings of the current evaluation *(TYC Recommendation 64 and Implementation of Directed Enhanced Service Evaluation Recommendations).*
- Bamford Action plan for learning disability 2012-15, 24 targets to be implemented by all Trusts *(Ministerial Target 32, TYC Recommendation 66 and Bamford Action plan 2012-15).*
- Development and implementation of Learning Disability specific Health Promotion initiatives within overall Health Promotion Strategy.
- Develop a Learning Disability Information Portal for inclusion on NI Direct-HSCB *(TYC Recommendation 69 and Bamford Action plan 2012-15).*
- Learning Disability Service Framework Year 2-targets to be implemented by all Trusts *(Safety and Quality).*
- Implementing the Commissioner Guidance for Advocacy *(TYC Recommendation 70).*
- During 2014/15 the HSCB, in partnership with Trusts, will extend its scoping of the numbers of adults with a learning disability who require future plans to be made for their care from 50 years and above to 35 years and above.

Commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive. *(Ministerial target 22; TYC Recommendation 19).*

- Access to more options for carers in the provision or arrangement of their respite/short breaks. *(TYC Recommendation 13& 19)*
- Delivery of day services in line with the Regional Day Opportunities Model *(TYC Recommendation 67)*.
- Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.
- Increased uptake of direct payments *(Ministerial target 23; TYC Recommendation 68).*
- Development and implementation of health promotion initiatives for people with a learning disability.

Specific local commissioning requirements in relation to the above are included in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied bed days	113,602	-27,372	86,230
	Day Care	Attendances	663,981	12,115	675,996
	Domiciliary Care	Hours	829,569	5,271	834,840
	Residential & Nursing	Occupied bed days	539,226	6,234	545,460
	Community Nursing and AHPs	Face to face contacts	144,478	0	144,478
	Social Work	Active Caseload	8,716	0	8,716
		VALUE OF COMMISSIONED ACTIVITY[33]	£232m	£17m	£249m

[33] This includes activity in addition to that set out above.

4.8 POC 7: Physical Disability & Sensory Impairment

(i) Introduction

According to results from the Northern Ireland Survey of Activity Limitation and Disability conducted by NISRA in 2006/07, 18% of all people living in private households in N Ireland have some degree of disability.

Developments in services for people with Physical and Sensory Disabilities have received a renewed impetus with the recent publication of Departmental and OFMDFM strategies. Implementation has benefitted from the involvement of voluntary sector partners and emphasis on the participation of service users. There has been a strong emphasis on the importance of inter-agency working in the fields of housing, transport and employment. There is also a need to review and reform traditional models of service delivery through an increased emphasis on giving people more control over their support needs through the promotion of personalised budgets, support for carers and advocacy.

In terms of specific initiatives there is a need to remain focussed on improving and sustaining performance in the provision of wheelchairs and equipment, reviewing and piloting initiatives to progress the reform of existing day care provision, establishing appropriate links with reablement, building on the recent service enhancements in sensory services and promoting community based accommodation options for people with brain injury.

(ii) Regional Commissioning Priorities 2014/15 and 2015/16

Commissioning priorities to be taken forward at regional level during 2014/15 and 2015/16 include:

- Improve performance in the provision of wheelchairs and prosthetics. This will involve greater regional coordination of referral and eligibility processes and alignment of equipment and maintenance/repair budgets.
- Progress further roll out of eNISAT/NISAT in this programme to promote further integrated working and improved assessment processes.

- Complete regional reviews of the Communication Support Services and the needs of Deaf Blind individuals to assess potential for enhanced service provision in these areas.
- Promote and pilot the potential for telecare to maintain individual independence and security in the community.

Commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive. *(Ministerial target 22; TYC Recommendation 19).*
- Access to more options for carers in the provision or arrangement of their respite/short breaks. *(TYC Recommendation 13& 19)*
- Increased uptake of direct payments *(Ministerial target 23; TYC Recommendations 28 & 32).*
- To review Trust progress in relation to the review and reform of day service opportunities to ensure alignment with personalisation strategies *(TYC Recommendation 28).*

Specific local commissioning requirements in relation to these priorities are outlined in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability and Sensory Impairment	**Hospital services**	Occupied beddays	58,199	0	58,199
	Day care	Attendances	127,129	0	127,129
	Domiciliary care	Hours	1,627,123	19,000	1,646,123
	Resid & Nursing Home	Occupied beddays	143,634	0	143,634
	Community nursing & AHPs	Contacts	121,947	1,167	123,114
	Social work	Active caseload	10,895	0	10,895
		VALUE OF COMMISSIONED ACTIVITY[34]	£101m	£4m	£105m

[34] This includes activity in addition to that set out above.

4.9 POC 8: Health Promotion & Disease Prevention

This POC comprises three key areas:

- Health and wellbeing improvement
- Health screening
- Health protection

Each of these areas is addressed separately below.

4.9.1 Health & Wellbeing Improvement

(i) Introduction

Improving the health of the N Ireland population is an imperative, both because of the impact on quality of life and life expectancy, and also because the costs of not doing so leave a financial challenge to the entire health and social care system. The 'shift lift' toward prevention is essential, with clear evidence of its cost-effectiveness. Yet it is also recognised that the patterns of inequality are persistent over time and mirror wider inequalities in society. Action is required across government departments in order to influence the socio-economic determinants of health. The new Public Health Strategic Framework 'Making Life Better' will provide such direction over the coming ten year period. The focus will support a broad population approach, whilst also highlighting the need to provide specific support to those experiencing particular disadvantage and inequalities.

The need to engage all sectors, including communities, has led to important partnerships across N Ireland which will provide essential infrastructure to assist with implementation of the new Framework. Current engagement with community and voluntary sector partners in particular has been essential in shaping service design and delivery, for example, standards for mental and emotional wellbeing services, the implementation of the new Strategic Direction for alcohol and drug services and the rural community networks in the delivery of programmes designed to promote wellbeing and reduce rural poverty and isolation.

(ii) Regional Commissioning Priorities 2014/15

The commissioning priorities for 2014/15 and 20151/16 to be taken forward at regional level are to focus on consolidating action based around the four building blocks identified within the Public Health Strategic Framework:

1. *Give every child and young person the best start in life* - through the Implementation of Healthy Child, Healthy Futures and expansion of the Early Intervention programmes including: Roots of Empathy; Family Nurse Partnership; Infant Mental Health Training and Parenting support.

2. *Work with others to ensure a decent standard of living* - Development of social economy businesses and community skills development through public procurement.

3. *Build Sustainable Communities* – During 2014/15 we will continue to implement the HSCB / PHA Community Development strategy and work to ensure that existing service provision is tailored to meet the needs of vulnerable groups including the delivery of programmes to promote the health and wellbeing of older people.

4. *Make Healthier Choices Easier* - through the implementation of key public health strategies (e.g. 'Fitter Futures for All' framework, tobacco cessation; treatment and support for substance misuse and associated mental health; emotional wellbeing and suicide prevention).

Key priorities to be taken forward by the five LCGs during 2014/15 include:

- Expansion of the early years intervention programme.
- Incremental expansion of social economy businesses and community skills development.
- Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.
- Implementation of the "Fitter Futures for All Framework".
- Implementation of key public health strategies.

- Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland".

Specific local commissioning requirements in relation the above are included in each of the LCG plans.

4.9.2 Screening

(i) Introduction

Screening is an important public health function that involves inviting members of the public, who have no symptoms of a particular disease, to be tested to see if they might have the disease, or are at risk of getting it.

Population screening allows certain diseases and conditions to be identified at an early stage when they are more amenable to treatment. The PHA is the lead organisation for commissioning and for quality assuring population screening programmes.

(ii) Commissioning Priorities for 2014/15 and 2015/16

Commissioning priorities to be taken forward at a regional level during 2014/15 and 2015/16 include:

- Complete the roll out of digital mammography for the breast screening programme.
- Extend the capacity of the bowel cancer screening programme to include the population aged 60-74.
- Implement the new UK blood spot standards to support the newborn blood spot programme.
- Within the diabetic retinopathy screening programme complete the implementation of the electronic system to support the direct referral and information flow to GPS and ophthalmologists.

Specific objectives for Trusts to take forward in relation to these priorities are outlined below.

Trust requirements in relation to Screening 2014/15

POC 8 Screening 2014/15 & 2015/16	***Timescale for achievement***		***Strategic Driver/Needs Assessment***		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
1. From April 2014, all Trusts should work with PHA and HSCB to increase screening colonoscopy capacity across the region by 25% to facilitate age extension of the bowel screening programme to age 74	●		Target 1		PFG commitment
2. Increase the number of JAG accredited units by one in 2015/16	●	●	Target 1		Bowel Cancer Screening programme Board.
3. All Trusts should deliver a bowel cancer screening service from April 2014 to the eligible population aged 60 -74	●		Target 1		PFG commitment 22

POC 8 Screening 2014/15 & 2015/16	***Timescale for achievement***		***Strategic Driver/Needs Assessment***		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
4. Achieve the target uptake for the bowel cancer screening programme of 55%	●	●	Target 1		
5. All Trusts should report on the implementation of their action plan to enhance informed choice for the eligible populations for bowel, breast and cervical cancer. These should be aligned with the PHA's Action Plan on Promoting Informed Choice in Cancer Screening.	●	●	Target 1		PHA corporate plan
6. PHA, HSCB, Primary care and BHSCT should work together to ensure robust processes are in place to maintain the screening interval and grading for diabetic retinopathy.	●				PHA corporate plan

POC 8 Screening 2014/15 & 2015/16	***Timescale for achievement***		***Strategic Driver/Needs Assessment***		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
7. BHSCT, NHSCT, SHSCT and WHSCT should implement their local action plans to complete the roll out of digital mammography across N Ireland by October 2013.	●				PHA corporate plan
8. BHSCT, NHSCT, SHSCT and WHSCT should ensure that they have a quality management system (QMS) in place which supports the safe and effective provision of breast screening.	●				PHA breast screening quality assurance visit reports
9. From April 2014 all hospital Trusts to have robust referral mechanisms into the screening surveillance programme for newly identified women at higher risk (X8) of breast cancer.	●				Target from CMO PHA corporate plan

4.9.3 Health Protection

(i) Introduction

The Health Protection Service was established in April 2009 within the Public Health Directorate in the Public Health Agency. The Service is a multi-disciplinary service comprising Consultants in health protection, nurses in health protection, epidemiology and surveillance staff, and emergency planning staff. The health protection service is responsible for the prevention control of communicable disease and environmental hazards and provides the acute response function to major issues, such as outbreaks of infection. The PHA Health Protection Duty room, located in Linenhall Street at PHA headquarters, is the first point of call for all acute issues in relation to infectious disease incidents and for notifications of infectious diseases. The Health Protection Service has a number of work programmes in key areas with regional consultant leads for each area. These include areas such as healthcare associated infections, immunisation, emergency preparedness, gastrointestinal infections, sexually transmitted infections, influenza, and tuberculosis.

The Health Protection Service has led a major programme of work in partnership with colleagues in Trusts, Primary Care, RQIA, and the independent sector in relation to reducing healthcare associated infections. The immunisation programme in N Ireland is one of the most successful public health programmes in terms of preventing disease and protecting health, both in children and in adults. Immunisation uptake rates N Ireland are the highest in the UK for a range of the childhood immunisation programmes, due to efforts of colleagues across the HSC system. The Health Protection Service has led the public health response to a number of major public health issues in recent years, including Pandemic 2009, the Pseudomonas outbreaks of 2012, and the E coli outbreak of 2012.

Communicable diseases disproportionally affect certain groups in the population including those at social disadvantage, living in poor housing conditions, migrants from countries that have higher prevalence of infectious diseases, and

those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities.

(ii) Commissioning Priorities for 2014/15

Commissioning priorities to be taken forward at regional level during 2014/15 and 2015/16 include:

- Extend the seasonal flu immunisation programme to include all pre-school children aged two and over and achieve an uptake of 60%, and all primary school children, and achieve 75% uptake for these school-aged children *(DHSSPS Immunisation Policy)*
- Achieve high uptake (50%) of seasonal flu immunisation among all front line healthcare workers to support prevention of spread of flu in the population and to alleviate winter pressures for Trusts *(DHSSPS Policy)*
- During 2015, test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards, and disruptive events *(Departmental Objective)*
- During 2014/15, test and review business continuity management plans to ensure arrangements to maintain services to a predefined level through business disruption *(Departmental Objective)*
- Through the Microbiology Forum of the Regional Pathology Network, investigate and confirm full standardisation of laboratory antimicrobial testing practice across Trusts*(Awaiting confirmation from CMO)*
- Trust microbiologists to work with health protection consultants in PHA to scope up a core set of priority organisms for a routine antimicrobial resistance surveillance *(Awaiting confirmation from CMO)*
- Belfast Trust to ensure Regional Virology Service Preparedness for surge in respiratory infections such as Flu during winter *(Required to Implement DHSSPS requirements for Seasonal Flu Planning)*
- To maintain the current capability and capacity of existing Hazardous Area Response Team within NIAS *(DHSSPS Policy in Parenthesis).*

4.10 POC 9: Primary Health and Adult Community

This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability. There are therefore five key areas:

1. General Medical Practitioners Services
2. General Dental Services
3. General Opthamology Services
4. Community pharmacy provision
5. Community nursing and AHP provision

Primary care and adult community services play a critical role in terms of supporting people to stay well, for as long as possible in the community and avoiding unnecessary hospital attendance and admissions. The development of these services in line with the transformation agenda is therefore key to reducing pressure on scarce resource within secondary care.

In conjunction with the ICPs the Transforming Your Palliative and End of Life Care Programme will redesign service across sectors to improve the quality of life for those in the last year of life. Marie Curie have been commissioned to deliver this programme, as they have demonstrated success in 19 other programmes across the UK.

4.10.1 General Medical Practitioners Services

(i) Introduction

General Medical Services are delivered across the Health and Social Care Board (HSCB) by 351 general medical practices, through a contract between the HSCB and each individual practice (Contractor).

The GMS contract covers three main areas:

- The Global Sum – funds Essential and Additional Services

- The Quality and Outcomes Framework (QOF) – including primary and secondary prevention indicators. Practices can choose whether to deliver these standards.
- Enhanced Services – covering services which practices can choose to provide. They can be commissioned regionally or locally to meet the populations healthcare needs. There are four categories of enhanced services:
  - Directed Enhanced Services (DES)
  - Northern Ireland Local Enhanced Services (NI LES)
  - National Enhanced Services (NES)
  - Local Enhanced Services (LES) which are commissioned through the Local Commissioning Groups.

General Medical Practices can opt out of providing Out of Hours Care. The HSCB remains responsible for 24 hour high quality care is available to all patients. The Out of Hours service is commissioned from three Trusts and two 'mutual' organisations to provide urgent care for people when their normal GP surgery is closed.

The Strategic Framework for GP Out of Hours aims to simplify access, improve operational efficiency and improve alignment with other healthcare services and will be the vehicle to deliver a single telephone number to access GP Out of Hours services. Out of Hours services do not function in isolation, but need to integrate in each locality with other community based unscheduled care services as identified in the Strategic Framework. Investment in Out of Hours to meet increasing demand needs to be matched by additional funding for community unscheduled care services, in particular nursing, to ensure coordinated capacity building. In this regard, LCGs will play an essential role in commissioning interface unscheduled care services, integrated with GP Out of Hours services. Engagement has already commenced with LCGs to coordinate such service development through implementation of the GP Out of Hours Strategic Framework (approved by HSCB Board, January 2013 and still awaiting final DHSSPS approval) and relevant Transforming Your Care policies.

A financial review for GP Out of Hours was completed in 2013 and passed by HSCB Board. It identified the need to harmonise budgets between the five providers by redeploying resources based on demand. Currently, over bank holidays demand outstrips capacity and requires additional resources. Commissioning an increase of clinical professional skill mix will help reduce reliance on GPs within Out of Hours, alleviating inflationary pressures within the service due to reduced GP availability. Implementation of all the recommended actions in the Financial Review will deliver greater equity in the funding allocation, and, based on efficiency measures agreed between providers and HSCB officers, without any diminution in the quality of service experienced by the public accessing it. Continued progress is dependent upon the allocation of £1.95m recurrent that has been requested from the Department. This will provide a sound platform to enable future re-investment of resource in order to support continuous improvement in the quality of service delivery; through education, patient focus and through supporting improved access to and integration of the service, as envisaged in the regional Out of Hours Strategic Framework.

(ii) Commissioning priorities 2014/15 and 2015/16

Commissioning priorities to be taken forward at a regional level during 2014/15 include:

- Continue to commission a range of Enhanced Services which align to strategic commissioning priorities including NI LES Advance Care planning for Residential & Nursing Homes, DES Adults with Learning Disability and NI LES Chronic Respiratory Conditions.
- Implementation of the GP Out of Hours Strategic Framework.
- Continue to work with LCGs to produce LES which support the transformation and integration of care for example, development of Enhanced Services for the Care of Older, Frail Patients in their Own Home.

Commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.

Local commissioning requirements in relation to this priority are included in the LCG plans.

4.10.2 General Dental Services (GDS)

(i) Introduction

There are currently 1049 independent contractor dentists working in N Ireland and the General Dental Services (GDS) expenditure in 2012/13 was £117m. The Department has described the overall outline of the new GDS contract and has asked the HSCB to pilot and test aspects of this. The Board is responsible for piloting this contract and has established a Pilot Working Group and a Project Board to ensure that appropriate pilots are set-up and evaluated within the agreed timescales. It is anticipated that the new GDS contract will focus on prevention, maintain access for N Ireland's population, help dentists to focus on care quality, allow HSCB to locate practices in areas of greatest need and make management of the GDS budget easier.

The new contract will be piloted in 3 waves over the 2014-2016 period with the roll-out of the contract to all practices scheduled for 2016-17. The first wave of the pilot is due to begin by June 2014 and will involve 5 dental practices. It is anticipated that this pilot wave will run for 9 months when a further 15 practices will be added in wave 2. This again will run for 9 months before being evaluated with wave 3 commencing at the end of this period. Each successive wave of pilots will refine the contract with the intention that on completion of the final evaluation in June 2016, a thoroughly tested and N Ireland appropriate contract will be ready for implementation across the region.

The Oral Surgery pilot ended in September 2013 and it is hoped that the full evaluation will be completed by early 2014. However, while the pilot focussed on Oral Surgery provided by primary care specialists, the appointment of three new Consultant Oral Surgeons in the School of Dentistry has led to a significant increase in secondary care Oral Surgery capacity.

The challenge now for HSCB is to take account of the evaluation of the Oral Surgery pilot and the potential for increasing the proportion of patients who

receive their specialist Oral Surgery care in the primary care setting while at the same time working with the Commissioning Directorate to maximise the utility of the new School of Dentistry staff. The goal is to ensure that patients requiring outpatient Oral Surgery care are seen within 15 weeks by 1 April 2014 and that in-patients and day-cases are seen within 26 weeks. The Board will need to agree mechanisms with Trusts to move Oral Surgery patients from areas where demand exceeds capacity to areas where the reverse is true. At the same time, through the dissemination and implementation of Oral Surgery referral guidelines, HSCB will seek to ensure that only those patients who actually need to be seen in the secondary care environment are seen by Trust Oral Surgery services.

(ii) Commissioning Priorities 2014/15 and 2015/16

Key commissioning priorities to be taken forward at regional level during 2014/15 include:

- Implement pilots to test proposed new General Dental Services contract
- Complete final evaluation of Oral Surgery pilot and use findings to help address excessive waiting times for Trust Oral Surgery Services

4.10.3 General Ophthalmic Services (GOS)

(i) Introduction

GOS is going through a period of change in line with the principles of Transforming Your Care. In addition to provision of core GOS, contractors will be more fully involved in the delivery of extended services in primary care, and more fully integrated care pathways for long term ophthalmic conditions, largely for the frail elderly population.

This commissioning direction is set against a backdrop of a review of the current GOS contract in line with objectives contained within “Developing Eyecare Partnerships (DEP); improving the commissioning and delivery of eyecare in Northern Ireland”.

DHSSPS Policy document DEP (Developing Eyecare Partnerships) contains 12 objectives, set within a 5 year planning cycle, and DHSSPS have asked HSCB and

PHA to jointly lead on the delivery of these objectives. In terms of commissioning, DEP will deliver care pathways on the following long-term conditions:

- Glaucoma
- Cataract
- Age-related Macular Degeneration (AMD) /Maculopathies
- Diabetic Retinopathy

(ii) Commissioning Priorities 2014/15 and 2015/16

Key priorities to be taken forward at regional level during 2014/15 include:

- AMD/Maculopathies – Work with all stakeholders, including providers and users, to develop pathway approach (with increased resilience) to maculopathy treatments. This will include better access to diagnostics, and better use of the available skills mix.
- Work with ICPs to develop fully integrated care pathways for long term ophthalmic conditions, largely for the frail elderly population and develop associated enhanced services as required.
- Diabetic Retinopathy (DR)
  - Use the resource resilience identified within AMD pathways to assess and treat diabetic macular oedema.
  - Work with GP's and Trusts to add resilience to DR screening, and apply safe and robust hospital discharge policies back into screening programme.
- Deliver essential and enhanced services in line with DHSSPS clinical priorities.
- Deliver Electronic Claims and Payment System and secure email communications and referral system.
- Glaucoma - Reduce demand by referral refinement and commencement of consultant-led multi-skill clinics

Key priorities to be taken forward at LCG level during 2014/15 include:

- Roll-out and evaluation of pilot on primary care facing advice and treatment of non-sight-threatening Minor Eye Conditions in Southern LCG Area.

Specific commissioning requirements in relation to these objectives are included in the LCG plans.

4.10.4 Community Pharmacy Services

(i) Introduction

Pharmaceutical services are delivered across the HSC by a range of providers, the biggest group of which is community pharmacy with over 530 pharmacies across N Ireland. The vision for community pharmacy services is to further integrate and apply clinically focussed activity which utilises the skills of community pharmacists to improve outcomes for patients.

It has been proposed in successive strategic reviews (and most recently TYC) that the Health Service should commission health improvement and medicines management activity through pharmacies. Patients and clients repeatedly score community pharmacy exceptionally well with respect to the services that they provide. Community pharmacy has potential to contribute to the transformation agenda in a number of ways:

(1) *Extended roles in supporting chronic disease management* - In 2013/14, medicines use review services were introduced in community pharmacies and are initially targeted at improving understanding and adherence to medicines for respiratory patients who are taking multiple medicines. In the first six months, over 3500 patients have had a review through the services. Further commissioning is being considered to support strategies for managing other chronic diseases such diabetes and to support medicines adherence following introduction of new medicines or changes to medication at hospital discharge.

(2) *Supporting self-care and providing advice and treatment for minor ailments thereby reducing demand for GP services both in hours and out of hours* - A

review of the current minor ailment service has been started to inform the future commissioning arrangements for this service.

(3) *Supporting health improvement strategies through provision of brief advice and interventions, specialist smoking cessation services and community development initiatives* - Health + Pharmacy is a new initiative which has been developed enhance the public health role of participating community pharmacies. In 2013/14, training was delivered for the first cohort of pharmacies leading to a process of accreditation as a Health + Pharmacy. The focus for this accreditation is to drive up the quality and improve outcomes for patients. There will also be co-ordination of health improvement activities through the introduction of a Health Promoting Pharmacy service.

It should be noted that these innovations have taken place within the context of the current contract model which is over fifteen years old and provides limited opportunities to clarify commissioning specifications for the existing funding or for the development of further enhanced and additional services.

(ii) Commissioning Priorities 2014/15 and 2015/16

Commissioning priorities to be taken forward during 2014/15 include:

- Clarify/update commissioning specifications for current pharmacy service
- Develop further activity through community pharmacy which will promote better patient understanding of medicines to improve adherence and reduce waste
- Develop enhanced level of health improvement activity through community pharmacy
- Complete review of current minor ailment service in order to inform future commissioning of the service.

4.10.5 Community Nursing and AHP Provision

(i) Introduction

District nurses play a crucial role in the primary health care team. They visit people in their own homes or in residential care homes, providing care for patients and supporting family members, to include the provision of palliative and end of life care.

As well as providing direct patient care, district nurses also have a teaching role, working with patients to enable them to care for themselves or with family members teaching them how to give care to their relatives and therefore play a critical role in terms of the effective management of longterm conditions.

District nurses play a vital role in keeping hospital admissions and readmissions to a minimum through supporting the provision of intermediate care and through the provision of acute and complex care at home. They also facilitate early supported discharge, ensuring that patients can return to their own homes as soon as possible.

AHPs will also play a fundamental role in the transformation of care through the use of preventative upstream approaches which enable people to live well and for as long as possible in their own homes and communities:

- undertaking roles in health promotion, health improvement, diagnosis, early detection and early intervention;
- supporting service users to avoid illnesses and complications through enhanced rehabilitation and re-ablement to maximise independence; and
- supporting people of all ages to manage long term conditions.

Investment in community nursing and AHP provision will be fundamental to the successful delivery of the integrated care pathways and the new models of care (e.g. community wards, rapid response teams) that will be developed and implemented by ICPs across the clinical priority areas during 2014/15.

(ii) Commissioning Priorities 2014/15 and 2015/16

Commissioning priorities to be taken forward at regional level during 2014/15 include:

- To develop a Regional Commissioning Framework for Community Nursing.
- To complete a review of current AHP workforce and activity to include Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics to ensure the DHSSPS targets are fully achieved and that these services respond appropriately to patients presenting within Emergency Care settings during the 24 hour period.
- To introduce electronic referrals for the AHP professions (Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics).
- SE Trust to work with the commissioner to pilot and evaluate self-referral physiotherapy for people experiencing musculoskeletal pain with a view to roll out to all Trusts.
- To commence the implementation of Independent Prescribing in Physiotherapy and OT services.

The main priority to be taken forward by the five LCGs during 2014/15 is:

- Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility.

Specific local requirements in relation to this priority are outlined within the LCG Plans.

4.11 Prisoner Health

(i) Introduction

Within N Ireland there are just over 5,000 committals annually and approximately 1,800 – 1,900 prisoners throughout the prison estate at any time. Prisoner Health Services are delivered within three prison establishments and are managed by the South Eastern Health and Social Care Trust. These are;

- HMP Maghaberry, which is a high security prison for adult males (both remand and sentenced).
- HMP YOC Hydebank Wood which provides accommodation for young male offenders. Women prisoners are also accommodated (in Ash House).
- HMP Magilligan. This is a medium to low secure prison for sentenced adult males.

Prisoners receive a full range of healthcare services. The majority of services provided within the prison are primary care services, complemented by dedicated services for a number of mental health and addiction needs. Access to secondary care services are usually provided in acute hospitals through normal referral processes.

The Board takes as an underlying principle of prisoner healthcare delivery that people in prison should be entitled to the same level of healthcare as those in the community, although it is accepted that security considerations may modify exactly how healthcare is structured and delivered. There are in addition a number of factors arising from the prison environment and the nature of prison populations which need to be taken into account in taking forward service development and change agendas:

- Prison populations are rising, placing increasing pressure on health care resources.
- There is a particular need to address the healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities.
- Rates of mental ill health for those in prison are higher than the general population, with the prison population having a much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses.

- There is a continuing need to consider how prison healthcare systems can develop greater integration with community and secondary care services on committal and discharge.
- There is a need to ensure that, following the identification of prisoners' healthcare needs at committal, these are followed up with appropriate action.
- There are issues associated with the misuse of prescribed medicines and the supply of illicit drugs.
- There is a need for improved cooperation between the criminal justice system and Health and Social Care.

A Prison Review Team (PRT) was established in 2010 by the Department of Justice under the chairmanship of Dame Anne Owers "to conduct a rolling review…encompassing the conditions of detention, management and oversight of all prisons" in N Ireland. While the main thrust of the review and the majority of its recommendations addressed the issue of improved prison management, a small number of the recommendations related to the delivery of healthcare.

In response to the recommendations contained within the Owers Review, the Department of Justice and the Department of Health are now working together to develop a joint Healthcare and Criminal Justice Strategy. A Steering Group has been established incorporating key stakeholders and work-stream leads have been appointed to take forward the development of strategy in the following areas:

- Prevention and diversion
- Offenders in the community
- Offenders in custody
- Re-integration

(i) Commissioning Priorities 2014/15 and 2015/16

The basic approach adopted by the Prisoner Health Commissioning Team is an incremental one which seeks to:

- Agree annual targets for the improvement of information systems and data gathering mechanisms.

- Use these improved information systems to produce more accurate and timely needs assessments of those in prison.
- Where additional prison – specific funds have been identified, work with the South Eastern Health and Social Care Trust to identify appropriate service developments in line with assessed need.
- Ensure that prisoner health needs are also considered where additional funds are identified for broader health service developments.
- Work with the South Eastern Trust and the Northern Ireland Prison Service to ensure that the prisoner health systems are gradually re-engineered to bring them into line with best practice in the broader HSC system.

In addition to the general commissioning approach described above, the Board considers it important to take forward in 2014/15 the recommendations of the Owers Review relating to healthcare delivery in cooperation with the Department of Justice, the Department of Health and the South Eastern Trust.

Specific objectives for Trusts to take forward in relation to these priorities are outlined below.

Commissioning Objectives Prisoner Health 2014/15 and 2015/16

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
1. SET should continue to progress the development of healthcare services and chronic disease management in line with the principle of equivalence	●	●			*HSCB/PHA Strategic Intent*
2. Mental Health services for the prison population should be further developed in accordance with delivering the Bamford Action Plan 2012 – 2015 for people with Mental Health and Learning Disability	●	●	Bamford Action Plan		
3. SET should produce a 2014/15 implementation plan directed toward the implementation of the Health & Social Well-being Strategy for Prisoners.	●				*HSCB/PHA Strategic Intent*

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
4. Trusts should continue to work together to develop care pathways, into and out of prison, for prisoners with complex needs.	●	●			*HSCB/PHA Strategic Intent.* *PRT Recommendation*
5. Trust based information systems should be further developed to help facilitate a whole systems approach to prisoner healthcare.	●	●			*HSCB/PHA Strategic Intent*
6. SET should produce a 2014/15 Health Needs Assessment.	●				*HSCB/PHA Strategic Intent.* *PRT Recommendation*
7. SET will produce proposals for improvements in Medicines Management, with a particular emphasis on the safe use of prescription medications.	●				*HSCB/PHA Strategic Intent*
8. The Board and the PHA will revise its processes for the production of the annual Commissioning Plan to	●				PRT Recommnedation

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
incorporate feedback from the Northern Ireland Prison Service.					
9. The Board and the PHA will work with the Dept of Justice, the Dept of Health and the South Eastern Trust in taking forward PRT recommendations relating to healthcare delivery and improved working with key stakeholders.	●	●			PRT Recommendation
10. The Board and the PHA will work with other key stakeholders in the development of the Joint Healthcare and Criminal Justice Strategy	●	●			PRT Recommendation
11. SET will progress service developments in psychological therapies in line with HSCB guidance.	●		Bamford Action Plan		

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
12. SET, in co-operation with commissioners and other relevant Trusts, will actively explore the potential for tele-health alternatives for specialist and/or emergency assessments and reviews.	●				*HSCB/PHA Strategic Intent*

4.12 Medicines Management

Medicines are the most frequently used healthcare intervention with challenges from a quality and efficiency perspective in that in Northern Ireland there is:

- A need to ensure a high and consistent level of quality in the prescribing, dispensing and administration of over 35 million prescriptions
- An investment of over £500m per year on medicines across primary and secondary care
- An ongoing need, as with other modern healthcare systems to focus on improving medicines safety.

Policy has highlighted the need to optimise how medicines are managed through the selection of the most appropriate medicine through to how medicines are ordered, supplied and administered such that the desired therapeutic benefits are achieved, adverse events and waste are minimised.

(iii) Commissioning priorities for 2014/15 and 2015/16

Commissioning priorities to be taken forward at regional level during 2014/15 include:

- Development and implementation of NI formulary
- Refinement of the mechanism to manage entry (and exit) of medicines into routine use on the HSC
- Delivery of more cost effective prescribing
- Improved use of medicines such that there is less risk and waste

Specific objectives for Trusts and ICPs to take forward in relation to these priorities are outlined in the Table 24 below.

Trust and ICP requirements in relation to Medicines Management 2014/15

Table 24

	Timescale for achievement		*Strategic Driver*		
Commissioning Objectives	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts and ICPs to ensure the formulary is embedded within prescribing practice through active dissemination within electronic prescribing platforms	●	●	Target 18	Rec 91	
All Trusts and ICPs will work with the Health & Social Care Board in 2013/2014 to establish the baseline position with ICPs ensuring 70% compliance by end 13/14 and Trusts attaining target delivery in 2014/2015.	●	●	Target 18	Rec 86	
All Trusts and ICPs should put in place arrangements to manage regional monthly managed entry	●	●			DHSSPS requirement for managed entry arrangements

	Timescale for achievement		*Strategic Driver*		
Commissioning Objectives	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
recommendations including monitoring, reporting and disinvestment arrangements					
All Trusts and ICPs to ensure 100% compliance with local delivery against the Regional Pharmaceutical Clinical Effectiveness Programmes such that all targets are met	●	●			Efficiency programme
All Trusts and ICPs should support development of e-prescribing in hospitals through identification of clinical champions and leads and co-ordination of local Trust implementation teams	●	●		Rec 91	Medicines Safety
All Trusts and ICPs should ensure that all patients with highest risks (complexity; high risk medicines) have their medicines	●			Rec 77	Medicines Safety; NICE Guidance

	Timescale for achievement		*Strategic Driver*		
Commissioning Objectives	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
reconciled on admission and at discharge in line with NICE guidance (http://guidance.nice.org.uk/PSG001) – baseline in 13/14; delivery 14/15					

5.0 Achievement of Ministerial Targets 2014/15

Overview of Ministerial Targets

This section provides a brief overview of performance against the Ministerial targets set out for 2013/14. It also outlines the proposed approach to the delivery of the Ministerial targets set out in the Minister's Commissioning Plan Direction 2014. It does not address every target; rather it seeks to outline how we intend to:

(1) support the achievement of a number of new targets introduced for 2014/15
(2) support the achievement of targets where the performance standard has been extended for 2014/15
(3) address underperformance against existing targets through the commissioning of additional capacity or other actions during 2014/15.

A copy of the Commissioning Plan Direction and Indicators of Performance can be found on the HSCB website (www.hscboard.hscni.net/publications/Commissioning%20Plans).

Areas of progress 2013/14

During 2013/14, the HSCB continued to closely monitor Trusts' progress against the standards and targets set out in the Minister's Commissioning Plan Direction 2013 and take action as necessary.

Particular progress was made in 2013/14 in a range of areas including:

- there has been a significant reduction in the number of patients attending A&E Departments who waited more than 12 hours to be admitted or discharged home compared to 2012/13
- The number of patients waiting longer than nine weeks for access to a diagnostic test has reduced significantly
- The target associated with Child and Adolescent Mental Services access within nine weeks has been substantially achieved

There have also been a number of performance challenges on which the HSCB will continue to work with Trusts during 2014/15 to secure further improvements, including:

- A&E (4 hour)
- Cancer (62 day)
- Elective Care waiting times
- Access to AHP services

The HSCB and PHA will work with Trusts during 2014/15 to maximise performance against all of the standards and targets set out in the Department's Commissioning Direction.

Bowel screening: The HSC will extend the bowel cancer screening programme from April 2014 to invite, by March 2015, 50% of all eligible men and women aged 60-74, with an uptake of at least 55% of those invited.

The Bowel Cancer Screening Programme (BCSP) was extended to include all eligible men and women aged 60-71 from April 2012. A further age extension, up to 74 years, will be introduced from April 2014. Capacity within all elements of the programme will be expanded in 2014/15 to facilitate the increased demand which will result from age extension. This includes the call/recall process, the screening laboratory and the screening colonoscopy service.

The programme operates on a 2-year screening round: this means that approximately 50% of the total eligible population is invited to participate in any one year. The service will aim to invite 50% of the eligible population aged 60-74 in 2014/15 with the remaining balance invited during 2015/16.

The PHA intends to continue to raise awareness of the screening programme so that the eligible population can make an informed choice as to whether they wish to complete the screening test. Uptake rates continue to improve, and further work will be taken forward in 2014/15 to promote informed choice both to the general population and to those population groups who are less likely to participate in screening.

Family Nurse Partnership: By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust.

Around 2,600 children are born each year to first-time mothers in more vulnerable circumstances. Family Nurse Partnership (FNP) is a voluntary preventive programme for teenage mothers, which offers intensive and structured home visiting, delivered by specially trained 'family nurses', from early pregnancy until the child is two years of age. The aim of FNP is to improve the health and wellbeing of our most disadvantaged families and children, and to prevent social exclusion.

FNP is now in place in three Trusts in N Ireland, the Western, Southern and Belfast Trust. During 2014/15 the programme will be expanded to the Northern and South Eastern Trusts.

Substance misuse: By March 2015, Services should be commissioned and in place that provide seven day integrated and co-ordinated substance misuse liaison services within all appropriate HSC acute hospital settings undertaking regionally agreed Structured Brief Adviser Intervention Programmes.

During 2014/15 the HSCB and PHA will work with Trusts to establish effective substance misuse liaison services within appropriate acute hospital settings. This will include:

- Undertaking alcohol-related case-finding and delivery of brief advice and structured brief interventions within the E.Dept and general hospital setting
- Contributing to the management of patients identified with alcohol-related problems and/or arrange input from other medical services
- Liaison with community based alcohol and other specialist services and also work with other relevant services/teams, in particular those undertaking self-harm, child/family care and crisis related work also the community/voluntary sector.

- Improving the capacity of Trust staff: Training the wider range of medical/nursing staff, particularly those undertaking assessment functions, to better identify patients with latent alcohol-related problems is therefore a vital component of the liaison practitioner's role. This training will enable hospital staff to provide brief advice and undertake appropriate referral where necessary. This can be achieved through training which focuses upon identification (screening tools) and provision of brief advice and motivational skills training in the hospital setting.

Tackling Obesity: By March 2015, ensure all pregnant women, aged 18 years or over, with a BMI of 40kg/ m^2 or more at booking, are offered the Weight to a Healthy Pregnancy Programme, with an uptake of at least 65% of those involved. (New target)

Obesity during pregnancy carries significant risk of complications. Children born to women who are obese are also at increased risk of childhood obesity. Data from the Child Health System indicate that approximately 2% of all maternities in NI are to women with a BMI≥40; approximately 500 women per year.

The Weigh to a Healthy Pregnancy programme is a regional pilot to develop and test an approach to providing extra information and support to pregnant women with a BMI≥ 40 at booking, with the aim of limiting gestational weight gain to recommended levels. During 2014/15, on a pilot bases across the five Trusts, support will be delivered within maternity services by designated midwives, dieticians and physiotherapists through face to face contacts, group sessions and telephone or text support during pregnancy and up to 6 weeks post-natal. Information and support will involve encouraging healthy eating habits, promoting appropriate levels of physical activity and promoting breastfeeding. The longer term aims of the programme are to enable women to sustain pregnancy lifestyle changes, and to support a longer term reduction of weight during the post-natal period.

Cancer Care Services: From April 2014, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should

receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.
During 2013/14 good progress has been made by the HSC to reduce the longest waits experienced by cancer patients. Further efforts will be required in 2014/15 to improve the percentage of patients with a diagnosis of cancer who commence definitive treatment within 62 days of urgent referral.

To support the delivery of the cancer targets, the HSCB will continue, during 2014/15, to seek to commission adequate capacity across all relevant specialties as required to ensure all patients have timely access to assessment, diagnosis and treatment. During early 2014/15 the HSCB will also complete its current review of urgent 'red flag' referrals for suspected cancer which have increased very significantly in the last two years without any apparent increase in the incidence of cancer.

The HSCB will work with primary and secondary care professionals to ensure the effective application of regional referral guidance from the NI Cancer Network. The Board will also explore the potential to use the electronic referral system to support effective practice in this regard.

Unscheduled Care: From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.
During 2013/14 good progress has been made to reduce the number of 12-hour breaches. However further progress is required to eliminate such breaches and to improve significantly the percentage of patients attending A&E who are treated and discharged, or admitted within four hours of arrival.

During 2014/15 the HSCB will, as far as possible within available resources, move to a position where at the large hospital sites key services (diagnostics, AHPs, social care, etc.) are delivered on a seven-day basis, thereby improving

patient flow at weekends. The HSCB will also continue to work with Trusts to ensure that available resources for unscheduled care are used as effectively as possible to include full implementation of agreed best practice actions.

Finally, the HSCB working with Trusts directly, and with Trusts and primary care through Integrated Care Partnerships, will seek to reduce the need for patients to attend A&E and/or be admitted to hospitals. Measures in this regard will include the establishment of more effective arrangements to provide GPs with specialist advice, and the greater provision of ambulatory care services for patients.

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

The HSCB will continue to ensure this area is prioritised in 2014/15, seeking as far as possible within available resources to maintain the current momentum and secure further reductions in maximum waiting times for patient assessment and treatment.

Further improvements in performance will be secured through a combination of ensuring Trusts deliver agreed levels of core capacity for 2014/15, together with investment in additional in-house or Independent Sector activity where this is required, and through the recurrent investment that was applied during 2013/14 being realised as activity as quickly as possible.

In relation to diagnostics reporting, the HSCB/PHA will continue to work with Trusts to ensure timely reporting of urgent tests. The HSCB will work with Trusts to ensure the effective planning and implementation of those RQIA review recommendations for which the HSCB is in the lead.

Specialist drugs: From April 2014, no patient should wait longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis, ankylosing sponylitis or psoriasis.

During 2014/15 the HSCB will ensure that sufficient services are commissioned to ensure continued timely access for these NICE-approved specialist therapies, with all new patients commencing treatment within three months.

Medicines Formulary: From April 2014, ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area.
As a result of work taken forward by the HSCB to date; from April 2014 almost 90% of prescribing choices will be covered by the formulary.

With the development of each formulary chapter, monitoring arrangements have been developed and in 2013/14 a compliance rate of 70% is expected to be achieved. The launch of the public facing NI formulary website is planned for March 2014.

Work will be taken forward in 2014/15 to identify and research outlying prescribing practice with the aim of aligning this to the regional average. 2014/15 will also see incorporation of the formulary within electronic prescribing systems.

AHPs: From April 2014, no patient waits longer than nine weeks from referral to commencement of AHP treatment.
The number of people waiting longer than 9 weeks for commencement of AHP treatment has increased significantly since March 2013. 140 clients were waiting beyond nine weeks at the end of March 2013 and at the end of September 2013 it was 4337.

A number of Trusts have reported an increase in demand as a contributing factor to the increased waiting times. The HSCB and PHA are working with Trusts to undertake a rapid demand and capacity exercise, with an initial focus on occupational therapy (OT) and physiotherapy. Trusts have also been allocated funding in-year to undertake additional activity to improve the waiting time position, and will continue to receive support as appropriate in 2014/15.

- Complete the review of current AHP workforce and activity to include Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics.
- Evaluate current demand in Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics.
- Introduce regionally consistent monitoring of AHP services specific to individual sub-specialty for each profession (Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics.)
- Define the percentage of each profession (Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics) which are delivered as scheduled and unscheduled.
- Introduce the monitoring of individual AHP MDTs and special schools activity in the ministerial 9 week target.
- Introduce electronic referrals for the AHP professions (Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics).
- Put a mechanism in place to ensure patient identities are available to the PHA/HSCB for individual breachers.

Telehealth: By March 2015, deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.

This target remains the same as the 2013/14 target. 440,000 patient days were delivered during 2014/15. During 2014/15, the HSCB and PHA will be working with Trusts and the NI Telemonitoring service provider to further increase the number of telehealth monitored patient days to the target level. Specific actions include:

- The development of an implementation plan for the integration of Telemonitoring data into the Electronic Care Record (ECR)
- The development of services for hypertension, palliative care needs, and for multi-user settings such as residential/nursing facilities and prisons

- Amendments to the Telemonitoring NI service to increase flexibility to step-up and step-down care and to facilitate easier referrals for new conditions in the future.
- Work to explore the role of telemonitoring in supporting the clinical care provided by GPs and under the development of ICPs.

Unplanned admissions: By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions
Integrated Care Partnerships will play a key role in the delivery of reductions in unplanned admissions for people with longterm conditions, ensuring integration among primary and secondary care providers to meet patient needs with clear arrangements for dealing with patients with long term conditions, multi-morbidity and complex medication regimes, and access to specialist medical or nursing advice. In addition, the HSCB and PHA will ensure the provision of one-to-one and group education programmes to support self-management that have agreed content and arrangements for patients to receive regular updates.

Moreover, the introduction of risk-stratification, provision of integrated community teams and enhancements to remote telemonitoring during 2014/15 will all contribute to a reduction in ED attendances, emergency admissions, and length of stay and/or bed days.

Telecare: By March 2015, deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.
This target represents an increase of 80,000 monitored patient days over and above the 2013/14 target. During 2014/15, the HSCB and PHA will be progressing work with Trusts to establish the appropriate utilisation and deployment of telecare across a range of client groups, including older people, dementia, learning disability, physical and sensory disablement.

In addition the following will be progressed:

- Refining the service specification including electronic referrals;
- Migrate existing Telecare clients from old service to new service
- Specify and commission an evaluation to the service

This will be supported with a range of appropriate communication and engagement activities.

ICPs: By March 2015, 95% of patients within the four ICP priority areas (frail elderly, diabetes, stroke, respiratory) will have been identified and will be actively managed on the agreed Care Pathway. (New target)
During 2014/15 this issue will be progressed as part of the on-going process for the implementation of ICPs. The achievement of the target will require risk stratification at primary care level of patients at medium of high level of likelihood to require admission to hospital, and ensuring these patients are care-managed in line with agreed care pathways.

Delivering Transformation: By March 2015, transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. (New target)
Transforming Your Care requires a shift in healthcare with the potential for more acute care to be delivered in the home and community and that the resources from hospitals and institutions will be transferred to primary, community and social care settings to allow a more diverse provision of services, delivered closer to home. The HSCB will ensure effective arrangements are in place to plan and deliver the required transformation of services and associated resource transfer.

Normative Staffing: The Regional Agency should continue to lead and monitor the programme of work to develop and implement Normative Nurse Staffing which should be used to commission and deliver services as follows:
From April 2014, the Normative Nurse Staffing Tool should be applied to all inpatient general and specialist adult hospital medical and surgical care settings and by March 2015 normative staffing ranges will be developed and

introduced for Health Visiting within a range which secures the delivery of the service model detailed within the Departmental Strategy 'Healthy Futures'. (New target)

The PHA will continue to lead on the implementation, monitoring and development of The Normative Nurse Staffing framework "Delivering care" for N. Ireland. Specifically during 2014/15 the PHA will take forward the following:

- The development of regionally agreed workforce tools including health visiting to support the delivery of safety, quality and patient/client experience outcomes in community and primary care settings.
- The Normative Nurse Staffing Tool will be applied to all inpatient general and specialist adult hospital medical and surgical care settings. A range of key performance indicators will be developed to monitor the implementation process. In addition E- rostering will be in place across all HSCT settings.
- During 2014/15, work will continue on the implementation of Specialist Nurse Job planning. This work is aimed at delivering on Safety Quality and Patient Experience outcomes within hospital services. Work will commence on the development of similar plans for Specialist Community Nursing Services.
- The development of normative staffing ranges for Health Visiting.

Unnecessary Hospital Stays: By March 2015, reduce the number of excess bed days for the acute programme of care by 10%

Transforming Your Care requires a shift in healthcare with the potential for more acute care to be delivered in the home and community. Extended community nursing services, including acute care at home and ambulatory care within primary care centres, will support early discharge.

The development of Integrated Care Partnerships will lead to greater collaboration in the delivery of care with prevention and early intervention in the management of long-term conditions. Moreover, *Transforming Your Care* means GPs will have improved access to diagnostics and rapid outpatient

assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion between GP and senior hospital doctor and agreed decision on steps to take in patient management.

Cancelled Clinics: By March 2015, reduce the number of hospital cancelled consultant-led outpatient appointments by 17%. (New target)
Building on improvements made in 2013/14 through the creation of a Short Life Working Group to more accurately code and record the reasons for clinics being cancelled and to assess the impact on patients, this target is designed to monitor a reduction in the numbers now that they can be accurately and consistently measured. Although not formally a target to date, cancellations have been reducing year on year since 201/11 at a rate of around 5% per year.

Learning Disability & Mental Health: By March 2015, resettle the remaining long-stay patients in learning disability and psychiatric hospitals to appropriate places in the community.
At September 2013 Trusts had plans in place to ensure that both these Standards for the 2013/14 year would be met and to ensure the resettlement of all the mental health and learning disability long stay patients by 2015, in line with the Minister's overall target.

Children in Care: From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%
Children in Care: By March 2015, ensure a three year time frame for 90% of children who are to be adopted from care
Children in Care: From April 2014, ensure that all school-age children who have been in care for 12 months or longer have a Personal Educational Plan (PEP)
These priorities continue to reflect the need for stability and permanency for children in the looked after system. The HSCB will work with Trusts to ensure that a range of looked after placements which meet the assessed needs of the children are available to deliver on this target.

The focus within TYC is for children to have experience of family life, if at all possible, which may see a reduced reliance on residential child care. This is however contingent on the development of additional foster care services and adequate support services to maintain children within their placements.

The adoption standard continues to confirm the need to expedite permanency via adoption where this is the preferred care plan for the children in question.

The HSCB will work with Trusts to review existing processes to identify any areas adding to delay and seek to resolve same. Equally, it is acknowledged that legal processes are also a contributory factor and the Family Justice Review will afford an opportunity to identify areas where court processes could be expedited.

6.0 Belfast Local Commissioning Plan

6.1 LCG Population

This section provides an overview of the assessed needs of the population of the Belfast LCG. This assessment is based on demographic changes and information we have relating to health inequalities and will inform the commissioning of services at a local level.

Demography

The total resident population of the LCG area is just over 348,000 (NINIS) accounting for 19.23% of the Northern Ireland (NI) total. However, the population using local health and social services in Belfast, which the LCG must commission on behalf of the HSCB, extends to parts of Northern and South Eastern LCG areas. Belfast Trust also delivers a range of regional acute, rehabilitative and social care services to the whole of the NI population.

Characteristics of the LCG population include:

- The population of Belfast LCG is projected to be stable over the next decade (NINIS 2008)
- Belfast LCG area has the smallest proportion of population aged under 16 of any LCG (NISRA 2012)
- The number of people in Belfast LCG area aged over 65 is projected to increase by 11% over the next decade, however the number aged over 85 will increase by 27% (NINIS 2008)
- 3.5% of the population are from an ethnic minority group(NINIS 2013).
- In 2012 there were almost 5000 births to Belfast mothers (NISRA 2013). While the number of births has increased over the past decade, there are signs that this may now be stabilising or declining.

Deprivation

Deprivation has an impact on health and wellbeing in many ways, resulting in the lack of social support, low self-esteem unhealthy life style choices, risk taking behaviour and poor access to health information and quality services. The extent of deprivation in Belfast Council area is greater than in any other Local Government District in Northern Ireland with 46% of the population estimated to be living in multiple deprivation (NINIS 2010). The risk of ill health is known to be greater where there is multiple deprivation as key risk factors for poor health outcomes are more prevalent, including obesity, smoking, drug and alcohol abuse, common mental health conditions, suicide and self-harm and births to teenage mothers.

Premature mortality

Life expectancy for people living in the most deprived areas within the Trust was 6.7 and 3.9 years lower than in the LCG as a whole for males and females respectively. (DHSSPS 2012). Between 2001 to 2011, those living in the most deprived areas were twice as likely to die prematurely from potentially avoidable deaths as those in the least. These were driven primarily by ischaemic heart disease (IHD), lung cancer, chronic obstructive pulmonary disorder (COPD) and suicide.

Standardised Mortality Ratios (SMRs) for the main causes of death are higher than in any other LCG and 12% higher than the NI average. The highest proportion of avoidable premature deaths by main cause was from cardiovascular diseases. The death rate in Belfast LCG area was 89.03 per 100,000 (3,082 people) whereas the NI average was 74.72. While the numbers have declined in the last ten years, ischaemic heart disease remains the leading cause of avoidable deaths for both genders. The rate in Belfast is highest at 63.84 per 100,000 population (2,210 people) compared to the NI average of 55.43 per 100,000. The death rates from neoplasms were the most common main cause of preventable deaths, of which the trachea, bronchus and lung was the most common cancer site. Death rate from neoplasms per 100,000 people was 95.56 (3,308 people in total), NI average 74.51.

Chronic illness/Long Term Conditions

In Belfast 23% of people are living with a long term illness (Census 2011), which is a significantly higher proportion than in other LCG areas. The prevalence of long term conditions such as COPD, stroke, diabetes and hypertension is increasing in Belfast and for many of these conditions there is a link between prevalence and deprivation (PHA 2011). Belfast consistently shows higher prevalence of patients on registers per 1000 of all the key QOF measures eg heart failure, heart disease and COPD than the NI average.

Risk Factors

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in Northern Ireland. It is known to be an important factor in a wide range of diseases including respiratory disease, heart disease, stroke and cancer. Between 2001-05 and 2006-10, the standardised death rate (SDR) due to smoking related causes decreased within NI but increased by 2% in the Belfast LCG. The inequality gap between the most deprived areas and the LCG as a whole remained fairly constant at around 50% throughout the period.

Alcohol related standardised admission rates and death rates for Belfast LCG residents increased by 17% from 2000-01/2001-2 to 2008-9/2009-10 and are significantly higher than all other LCGs. Within Belfast LCG, alcohol related hospital admission rate was 120% higher in the most deprived areas than in the LCG area as a whole (DHSSPSNI, 2012).

Obesity is one of the most important public health challenges in Northern Ireland and the prevalence of obesity has been rising over the past number of decades. The average number of obese children in the Belfast LCG and its most deprived areas in 2009-11 was higher in NI as a whole. The LCG inequality gap was 47%, with the most deprived areas being higher than across the whole LCG. In 2013 the raw prevalence of patients aged 16 plus (per 1000 patients) on the obesity register was 102.3 for the Belfast HSCT.

Issues raised during Public and Personal Involvement

The LCG has a continuous programme of engagement with patient and carer advocates, local community partnerships and older peoples' forums. Monthly LCG Public Meetings are well-attended enabling issues to be raised through discussion with members. BHSC Trust also has a range of engagement forums where issues are raised and these are shared with the LCG.

The LCG is a partner in the Belfast Strategic Partnership (BSP) which has a range of stakeholder engagement methods which raise issues which the LCG takes into account. BSP workshops on drugs and alcohol issues and poverty have been particularly informative.

The BSP Thematic Group for Mental Health of which the LCG is a member has had over 3000 responses to its engagement on its draft Emotional Health and Well Being Strategy. The LCG will take the response to this consultation into account in planning mental health services for common conditions within local communities.

The Healthy Ageing Strategic Partnership, chaired by the LCG, is carrying out a baseline survey and developing an Action Plan for submission to the World Health Organisation as part of the development of an Age Friendly City.

Engagement with the Greater Belfast Seniors' Forum and the many groups it represents has been a core component of the baseline survey. The issues raised will provide guidance to the LCG in planning for older people's services.

Formal public consultation around Transforming Your Care enabled engagement across the broad range of health and social care. Local engagement on TYC and the LCG Population Plan has included the local Councils and political parties as well as the local Health and Well Being Forums.

The LCG has closely involved a range of voluntary organisations, community groups, minority ethnic groups and the older people's forums in the

development of new care pathways and the design of new services. Carers groups have been and will continue to be fully involved in decisions about the deployment for funding ring-fenced to meet the needs of carers.

The LCG pays close attention to the health and well-being priorities highlighted within the strategic programmes and action plans of Belfast Area Partnerships and Neighbourhood Renewal Partnerships and engages with these partnerships in developing joint approaches. A key aspect of the LCG's approach to the development of the Primary Care Infrastructure Programme in Belfast has been engagement with local community and voluntary organisations through workshops facilitated by the Area Partnerships.

Some broad themes have emerged from engagement:

- The importance of health improvement, early intervention and supported self-care and in particular targeting people at risk of poor health outcomes
- The impact of the misuse and abuse of alcohol and drugs in local communities
- The important role that emotional well-being plays in underpinning physical health
- Psycho-social and practical support for people living with long term conditions
- The need for joined up planning across agencies and with the community and voluntary sectors
- The importance of sustainable community and voluntary provision to provide alternatives to more specialist Trust services
- Links between GPs, Pharmacists and community and voluntary support at local level and the uncertainty among people about the availability and use of local services
- Problems in accessing GPs

6.2 Key Challenges

This section provides an overview of the key challenges which will be faced by the LCG within 2014/15 and 2015/16. These inform and underpin Belfast LCG commissioning objectives for 2014/15 and 2015/16.

Challenge 1: Contribute effectively to reducing life inequalities and improving health outcomes.

The extent and scale of deprivation presents the most significant risk to poor health outcomes in Belfast. The LCG, in conjunction with the Public Health Agency and Belfast Trust, is engaging with local communities and other agencies, particularly through the Belfast Strategic Partnership, to address the multiple social determinants of health outcomes. The LCG views the work of the Partnership as a significant opportunity to address these wider risk factors to health and social well-being. It sets the strategic direction for health and wellbeing improvement in Belfast, through the development of agreed priorities for Belfastand the alignment of corporate plans and resources of the key service providers.

The Partnership aims to reduce life inequalities through:

- Improving outcomes for children and young people
- Promoting physical activity, active travel
- A strategic approach to healthy ageing
- Developing emotional resilience and coping with stress
- Reducing poverty
- Tackling drug and alcohol abuse

Challenge 2: Commission integrated service provision for people living with long term conditions and the frail elderly through ICPs and plan future infrastructure to support integrated working.

The greater prevalence of a range of long term conditions and disability in Belfast, and higher rates of emergency admission, especially in areas of deprivation, makes integrated working a priority for the LCG.
However, a major opportunity for the LCG lies in the previous work it took forward with Primary Care Partnerships over the past three years which

demonstrated the commitment from the Trust, GPs and particularly community and voluntary providers to work together for a common purpose on integrated care pathways.

The Belfast LCG will commission from four Integrated Care Partnerships, whole pathways of care, including end of life care, for the frail elderly and people living with respiratory disease and diabetes, and those who have survived a stroke. The Integrated Care Partnerships will aim to implement the 5 strategic outcomes identified in Transforming Your Care:

- The individual at the centre
- Improving Health and Wellbeing
- Provide safe, sustainable and resilient services
- Living independently
- Home as the Hub of Care

This will require primary and community care, specialist secondary care and community and voluntary organisations working closely together for the promotion of self-care and healthy lifestyles which address inequalities, the identification of patients who are at risk of requiring an unplanned hospital admission and the integrated planning of support for them to remain at home and to lead lives as independently as possible, including support for their carers.

The LCG will produce a strategic framework for commissioning primary and community care 'Hub and Spoke' infrastructural configurations to support this integrated working and which targets health improvement and inequalities of access to services.

The LCG will continue to direct investment towards community services to reduce unnecessary use of hospitals. However, comparisons with other HSC Trusts indicate that there is also room for improvement in the productivity of community resources in Belfast Trust. This will be facilitated through innovation, integrated working with primary care and greater use of information and communications technology.

Challenge 3: Commission timely, appropriate and equitable access to safe, sustainable and efficient hospital services, ensuring people can return home as soon as they are able to.

Waiting times for planned appointments and treatments and for emergency care are longer in Belfast Trust for a wide range of services than for other Trusts. Standardised admission rates are higher, partly due to higher levels of need particularly in areas of deprivation. Increasing standards and difficulties in recruiting and retaining key staff presents a challenge in ensuring that Emergency Departments and hospital wards continue to be staffed to a level which provides sufficient senior medical nursing cover.

Benchmarking with average performance in other parts of the UK has demonstrated considerable opportunities for greater efficiency in the way acute hospital services in Belfast are used. In particular, patients tend to stay in hospital longer than elsewhere for the same conditions. Performing at the average of comparative hospitals elsewhere would reduce the need for a substantial number of hospital beds and enable the re-deployment of investment into ambulatory care and community support.

The LCG will expect the Belfast Trust to make more productive use of its assets including 7 day working and extended hours of access. It will continue to work with the Trust to re-configure its infrastructure to meet developing service needs.

The LCG has agreed core performance baselines with the Belfast Trust for planned episodes of care, which are kept under review as circumstances change. Year on year improvements in productivity by the Trust will be expected so that more patients can be treated within the same capacity.

A challenge for the LCG is to commission sufficient outpatient, theatre and diagnostic capacity to meet the current demand for planned care.

Challenge 4: Commission alternatives to hospital attendance and admission which can better meet the needs of patients.

Studies by the Belfast LCG have shown that the majority of people who use Emergency Departments are not admitted to hospital and many could have had their needs addressed in primary care. A challenge for the LCG is to ensure people are aware of and can readily access appropriate alternatives to Emergency Departments, including primary care services or community support, when clinically, required on a 24/7 basis.

GPs now have direct access to advice and assessment from a senior hospital doctor in considering admission. For those patients whom the GP and hospital doctor consider should be admitted, this should be available directly to an assessment and admission unit rather than through an Emergency Department. Opportunities for new ways of working are presented by the reconfiguration of emergency care within Belfast Trust and the potential of a strategic approach to out of hours care.

Admission rates in the Belfast Trust remained higher than in the wider region. Admissions in the most deprived areas within the LCG remained 30% higher than then overall LCG area in 2010/11 (PHA 2011). Integrated Care Partnerships are an opportunity to develop alternatives to admission by providing care for patients in their own home.

The LCG will continue to seek integrated approaches by primary and secondary care to develop innovative ways of providing planned care in community settings rather than on acute hospital sites. The development of primary care infrastructure in particular presents the opportunity for new one-stop clinics which bring together assessment, diagnosis and treatment such as the LCG has commissioned in eye services.

Challenge 5: Commission a Stepped Care Model of recovery for common mental health conditions.

Poor mental health and stress underlie many of the physical health problems which affect the LCG population, especially in areas of deprivation where there is low income, employment and educational attainment. A challenge for the Belfast LCG is presented by the relatively higher use of mood disorder medicines. The LCG has been working to make use of the opportunity presented by the wide range of emotional health support provided by the many community and voluntary providers in Belfast.

The LCG will also continue to contribute to the strategic approach to emotional resilience being taken forward by the Belfast Strategic Partnership PHA investment in Protect Life services. This will complement LCG investment in Step 2 of the Stepped Care Model to expand where the provision of talking therapies by community and voluntary organisations to avoid the need for referral to Trust services and provide patient-centred care.

Challenge 6: Contribute to cost-effective Medicines Management, reducing the over-use, misuse and abuse of medicines.

Prescribing rates in Belfast LCG are lower than in other LCGs but Northern Ireland as a whole has higher prescribing costs than the rest of the UK. The LCG will work to address this by reducing the over-use and misuse of medicines, investing in targeted physical activity interventions, re-investing prescribing savings in talking therapies as an alternative or complement to medicines, piloting a pain management programme to support self-care, promoting adherence to the new evidence-based NI Medicines Formulary, promoting good nutrition for older people.

Challenge 7: Ensure best value for commissioned investments.

Given the increasing needs of its population in the context of a restricted financial outlook, the LCG must ensure that the services it commissions are delivering best value in terms of:

- the evidence-base for benefits to patients, clients and the public
- effective delivery of what has been commissioned
- the coverage of the service
- equity of access and
- productivity in the utilisation of assets

This requires systematic monitoring of service delivery, the intense scrutiny of investment proposals and evaluation of benefits. The LCG will review its Service and Budget Agreement with the Belfast Trust to ensure it reflects best value, deliverable expectations and clarity of accountability. New forms of agreement with multiple provider networks will be explored to facilitate commissioning from Integrated Care Partnerships for whole care pathways.

6.3 Ensuring Financial Stability & Effective Use of Resources

Use of Resources

The Belfast LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £603m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Baseline investment by Service Area in 2014/15

Table 25

Programme of Care	£m	%
Acute Services	209.5	34.8
Maternity & Child Health	24.0	4.0
Family & Child Care	44.6	7.4
Older People	144.2	23.9
Mental Health	64.4	10.7
Learning Disability	49.5	8.1
Physical and Sensory Disability	22.1	3.6
Health Promotion	26.9	4.5
Primary Health & Adult Community	18.0	3.0
POC Total	**603.2**	**100.0**

This investment will be made through a range of service providers as follows:

Proposed investment by Service Provider in 2014/15

Table 26

Provider	£m	%
BHSCT	523.57	86.8
NHSCT	1.85	0.3
SEHSCT	38.84	6.4
SHSCT	0.69	0.1
WHSCT	0.98	0.2
Non-Trust	37.29	6.2
Provider Total	**603.2**	**100.0**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2014/15 in respect of Emergency Care by the Belfast Trust is in the region of £26m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2014/15 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Belfast area and additional investment in the therapeutic growth of services.

Financial Pressures in 2014/15

Table 27

Pressures	**£m**
Demography	2.22
Learning Disability	2.99
Mental Health	1.49
Pay	4.41
Non Pay (Goods & Services)	5.57
RCCE	2.58
PHA Pressures	0.70
Service Pressures	16.34
NICE Drugs & Therapies	4.00
Learning Disability Resettlement (Bridging)	4.25
Total	**44.55**

6.4 Commissioning Priorities and Requirements by POC

This section provides an overview of the LCG's commissioning priorities for 2014/15 and 2015/16 by Programme of Care

6.4.1 POC1: Acute

Introduction

The LCG will continue to invest in outpatient, day case and elective outpatient capacity to meet the demand for planned care within health and social care services.

The LCG will also enhance the ability of primary care to manage demand outside hospital through referral guidelines, peer education and enhanced practitioners. Lessons learned from the ENT Pathfinder for Demand Management of elective care in East Belfast were similar to research into demand management approaches in GB (King's Fund 2010). A greater focus needs to be applied to peer education, feedback from specialists and the dissemination of best practice guidelines within primary care. The LCG has worked closely with the Trust, Optometry NI, NIGPC and RNIB to transform Eye Care pathways. It has put in place cataract referral guidelines and a Glaucoma Referral Refinement scheme to reduce demand for secondary care. The LCG has also invested in an Integrated Eye Care Pathway which will reduce referrals for general Ophthalmology. This approach will be extended to other specialties in 2014/15.

Comparison with other parts of the UK shows that the use of hospitals in Belfast could be significantly reduced with appropriate access to diagnostics, day procedures and primary and community services. The LCG will produce an Unscheduled Care Improvement Plan which will ensure that key components of health and social care are available when they are needed. Investment in Integrated Care Partnerships will be aimed at avoiding unnecessary admissions and expediting discharge.

In 2013/14 the HSCB led the consultation process on the future of the Belfast City Hospital Emergency Department enabling local people to have a say in the future of ED service. A decision by the minister on the future of Emergency Departments in Belfast is awaited.

Overview of Local Needs and Demands

Demand for planned care exceeds the capacity which the LCG commissions from the Belfast Trust. Up to 19000 new outpatient assessments and nearly 5000 treatments are required to meet current demand, of which Orthopaedics comprises 10000 new appointments and 4000 inpatients and day cases. In addition there are also shortfalls in capacity for key diagnostic tests such as MRI and CT. There are almost 40,000 patients requiring a follow up review appointment who wait longer than clinically indicated. Between March and November 2013 the outpatient list grew by 9000 and the inpatient/day case list by 1000.

Admission rates for emergency care are higher in Belfast than elsewhere, partly as a consequence of a higher level of deprivation. Although the number of attendances at Emergency Departments reduced by 12,500 (7%) from 2011/12 to 2012/13, the number of those patients who were then admitted to hospital increased over the same period. Many of these patients are discharged on the same or next day suggesting that with better coordination of and access to community support their admission could have been avoided.

Ministerial Targets

The LCG will commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. Delivery of waiting time targets for elective and emergency care present a major challenge for the LCG and will require significant additional investment as well as delivery by the Belfast Trust of the activity which has been commissioned. However, in orthopaedics, a shortage of Consultants will make it very difficult to reduce waiting times to an acceptable level.

Delivery of new pathways of care by Integrated Care Partnerships will be fundamental to reducing unplanned admissions through the transformation of primary and community care.

Commissioned Services:
The LCG will commission additional outpatient, inpatient, day case and diagnostic capacity in Elective Care to meet assessed need in the following specialties:

- Orthopaedics
- Rheumatology
- Pain Management
- General Surgery
- Gynaecology
- ENT
- Dermatology
- Oral Medicine

The LCG will also contribute to the regional development of Urology services.

The LCG will review the hospital capacity it requires to commission to meet the needs of its population for emergency and urgent care based on reasonable expectations of performance by the Belfast Trust in ensuring that patients are only admitted where necessary and are discharged as soon as they can safely return home. This will reduce the hospital capacity required and increase the capacity in primary and community care commissioned by the LCG.

The LCG will commission additional capacity in community and primary care services, including the community and voluntary sectors, to further reduce the hospital capacity required to meet the needs of the frail elderly and those with diabetes or those who have had a stroke or who have a respiratory condition, including patients who are at the end of life.

The LCG will commission an integrated approach to minor illness which provides an alternative to attendance at Emergency Departments. This will build on the Choose Well Campaign and research undertaken by the PHA, Trust and West Belfast Partnership on the motivations of people living in communities who use the Royal Hospitals most often. This will reduce attendance at Emergency departments but may increase the number who access Community Pharmacy, community nursing and community and voluntary providers.

The LCG will commission the further transformation of Eye Care and Musculo-skeletal pathways which ensure that patients receive the right advice, support or care at the right place at the right time. This will increase the proportion of patients seen in community settings by suitably qualified healthcare professionals but may increase the capacity commissioned from the community and voluntary providers and primary care.

The LCG will also work with ICPs to commission a risk-stratified approach to follow up appointments, promoting and supporting self-care, commissioning appropriate reviews from primary care and ensuring that Consultants only see patients requiring specialist review. This will reduce the number of new appointments seen by specialists and may increase the number seen by primary care.

Commissioning Priorities and Requirements

POC 1: Acute	
Regional Commissioning Objective	**Associated Local Requirement**
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians.	Belfast Trust is expected to work with GPs through ICPs to provide timely advice, assessment and diagnostic support. including providing GPs with direct access to a range of options for urgent care including: a mobile phone carried 24/7 by a designated senior decision-making doctor in hospital to provide immediate telephone support, assessment beds, ambulatory services, direct access to a range of diagnostic services, urgent outpatient slots and, where appropriate, direct admission to all acute hospitals, avoiding the need for attendance at Emergency Departments.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions	Trusts are expected to put in place any arrangements necessary across the whole week and in the evenings to ensure that all patients can be discharged as soon as clinically appropriate. This will require the Expected Date of Discharge for each patient to be clearly understood as soon as possible after admission by all hospital and community staff as well as the patient and their carers and to be a focus of patient management. The Trust should ensure that the 18 key actions identified for Unscheduled Care to be fully implemented. The LCG will develop an Unscheduled Care Improvement Plan which will ensure that appropriate hospital and community services are commissioned to support this.
Enabling district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than	Belfast Trust should ensure that there is sufficient core District Nursing capacity to meet demand from primary care in a timely way. The Trust should also ensure that there is sufficient capacity to ensure there are no

at present.	delays in discharge from hospital Nurses should work with social workers and AHPs in Integrated Care Teams in 8-10 Hubs to support clusters of GP practices. Nurses and GPs should meet regularly within Hubs to agree care plans for patients at risk of admission to hospital. Integrated Care Teams should also support the health improvement activities of local community and voluntary groups.
Review and take forward opportunities to consolidate the number of intermediate care beds and acute beds and the sites on which they are provided.	The Belfast Trust has re-modelled its intermediate care bed provision and transferred rehabilitation resources into community teams to provide more support in the patient's home. The Trust should ensure that this does not result in delays in discharge of patients requiring complex packages of care from acute hospitals. The Trust should continue to seek opportunities to reduce intermediate care beds and re-deploy the resources to support patients to return home directly from hospital.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The LCG will produce an Unscheduled Care Improvement Plan which will ensure that demand for emergency and urgent care is effectively managed. ICPs are expected to bring forward plans for investment in community services to reduce admissions including rapid response from a Community Urgent Care Team.

	The Trust should ensure that discharge planning is enhanced. Day to day variation in discharges should be reduced. All patients having an agreed Expected Date of Discharge and Outcome Focused Management Plan with patients and carers fully prepared for discharge by the EDD, with timely imaging and pharmacy input and sufficient capacity in community teams to ensure 7 day timely discharge. The LCG will commission from ICPs a networked approach to management of minor illness and minor injury which reduces attendance at EDs by providing a range of easily accessible alternatives.
Ensuring that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.	The LCG has provided the Belfast Trust with an updated Indicative Opportunities Pack which benchmarks its inpatient, day case, outpatient and community services against peers. The Trust should continue to progress towards the top quartile of performance in the UK.
Local Priority	Providers within ICPs are expected to contribute to the transformation of outpatient services including a risk stratified approach to follow up care. Hospital-based review will in future be exceptional rather than routine. Protocols will be developed which identify those patients who can safely be discharged with advice on self care and when to contact their GP; those patients who can be followed up in primary care and those patients who require review by a Consultant.
Local Priority	The Trust should work with ICP partners to work towards the provision of an integrated Musculo-skeletal service

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	20,289	200	20,489
	Daycases	573,376	20	57,396
	New Outpatients	125,400	0	125,400
	Review Outpatients	266,691	0	266,691
Unscheduled	**Non Elective admissions - all**	187,811	3,714	191,525
	ED attendances	211,667	0	211,667
	NIAS Journeys	47,699	777	48,476
	VALUE OF COMMISSIONED ACTIVITY[35]	£209.5m	£18.5m	£228m

[35] This includes activity in addition to that set out above.

6.4.2 POC2: Maternity and Child Health Services

Introduction

The LCG will contribute to progressing the objectives of the maternity strategy including the strategic shift towards providing more maternity care in the community, more midwife-led care and tackling inequalities.

The paediatric review led by the DHSSPS will set a framework for the future development of inpatient services which are safe and sustainable. The LCG will continue to work closely with the Trust, GPs and West Belfast ICP in ensuring that children receive the best possible care in the most appropriate settings, only being admitted to hospital when this is the best place for them to be cared for.

Overview of Local Needs and Demands

In 2012 there were almost 5000 births to Belfast mothers (NISRA 2013). While the number of births has increased over the past decade, there are signs that this may now be stabilising.

Teenage pregnancy rates in the most deprived areas of Belfast are twice as high as the average Belfast rate (Health and Social Care Inequalities monitoring system HSCIMS, 2012). Belfast Trust also has higher prevalence of low birth weight babies than NI generally. The rate in Belfast is 64 per 1000 population, this compared with the NI rate of 59 per 1000 population (Child Health System, 2012). Obesity in pregnant women is becoming more prevalent, Between 2010/11 and 2012/13 there has been a 24% increase in pregnant women who have a BMI of over 30 recorded at time of booking in Belfast Trust. (NIMATS, 2013)

Attendances at RBHSC Emergency Department have not changed significantly over the past two years. However, local analysis of attendances has been followed up with local focus groups and showed significant potential to provide community-based alternatives for minor illness in children.

The LCG will also consider the commissioning implications of the scoping study of the maternity needs of black and minority ethnic (BME) and migrant women in Northern Ireland, highlighting the growing number of births in Northern Ireland to BME and migrant women, and that there are particular sub-groups of very vulnerable migrant pregnant women who have difficulty accessing services and have worse pregnancy outcomes.

Ministerial Targets Local Relevance

The LCG will seek to commission services in response to assessed need and ensure delivery of Ministerial Targets at a local level. The Family Nurse Partnership and Weigh to a Healthy Pregnancy programmes are particularly important in addressing local needs in Belfast. Parenting Your Teen programme will be delivered to 25 families experiencing difficulties in behaviour of teenager/pre-teenager children, and particularly to families with social complexity and/or wider disadvantage.

Commissioned Services:

Maternity services in Belfast Trust were reconfigured in 2013 to provide a stand-alone midwife-led unit in the Mater supported by a consultant led service in the Royal Maternity Hospital and the impact of this change on the choices made by women on their place of delivery will inform commissioning by the LCG in 2014/15.

The LCG is working closely with the Trust, GPs and West Belfast ICP to put in place appropriate alternatives to attendance at the RBHSC for people with a minor illness.

A significant investment in the general paediatric service in the Royal Belfast Hospital for Sick children has enabled the establishment of a dedicated short stay paediatric assessment and observation area, an increase in consultant delivered care and improved access to senior decision makers for primary care. This will ensure that necessary admissions are timely and that these are as

short as clinically appropriate and that those children who do not need to be admitted are cared for appropriately at home.

POC 2 Maternal and Child Health	
Regional Commissioning Objective	**Associated Local Requirement**
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	Belfast Trust is expected to meet the standards of the Maternity Strategy. The Trust has re-configured maternity services to establish the Mater as a free-standing midwife led unit. This change has helped increase the number of women in Belfast with mid-wife led birth. The Trust should also ensure that a Midwife-Led Unit is available in the RJMH. The number of births in Belfast is decreasing and the LCG will commission midwifery services on the basis of demand.
Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	Belfast Trust should implement an approach working alongside a regional team ,led by PHA to develop pathways for the management of multiple pregnancies in line with NICE CG 129
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife-led antenatal care in the community for women with straightforward pregnancies	Belfast Trust should contribute to progressing the objectives of the maternity strategy including the strategic shift towards providing more maternity care in the community, more midwife-led care and tackling inequalities.

Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained variation in intervention rates throughout Northern Ireland	Belfast Trust has developed an action plan to normalise births and reduce caesarean sections, and should continue to monitor the number of 'normal deliveries' and those requiring intervention.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The LCG will work with the Belfast Trust and other partners to address the implications of the scoping study of the maternity needs of black and minority ethnic (BME) and migrant women in Northern Ireland, highlighting the growing number of births in Northern Ireland to BME and migrant women, and that there are particular sub-groups of very vulnerable migrant pregnant women who have difficulty accessing services and have worse pregnancy outcomes.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	Births	6931	0	6931
	Comm Midwives	Contacts	38,293	0	38,293
	Health Visiting	Contacts	10,687	0	10,687
	Speech and Language Therapy	Contacts	31,736	0	31,736
		VALUE OF COMMISSIONED ACTIVITY[36]	£24m	£1m	£25m

[36] This includes activity in addition to that set out above.

6.4.3 POC 3 Children and Families' Services

Introduction

Commissioning of looked after services is a regional commissioning function supported by local Outcomes Groups involving LCG together with a wide range of other partners focused on family support. The Belfast Outcomes Group is working with local community and voluntary groups to establish locality plans and Family Support Hubs.

Overview of Local Needs and Demands

There has been a continuing rise demand in Belfast over the past year for Children in Need assessments, the numbers identified as in need and the number of looked after children. It is noted that the first 6 months of 2013/14 has shown a substantial rise of 35% in the total number of children in need and the number of LAC has increased by 4 % and an overall total of 14% in the past year.

Demand for Autism services has grown from a base of 380 referrals per year to current projected level of 564 referrals per year. This is proportionately much greater
than in any other LCG area and considerably exceeds the capacity available, leading to longer waiting times for assessment and services.

There are a growing number of adolescents with learning disability and challenging behaviour which creates pressures in sustaining family placements. There is an ageing foster care population and the need to replenish capacity where there is turnover is a challenge.

The extent of deprivation in Belfast and its impact on the life chances of children presents a particular challenge for the LCG in working closely with other statutory agencies and community and voluntary groups.

Ministerial Targets

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. Belfast Trust has recruited 38 clients onto the Family Nurse Partnership programme with plans to recruit up 60 clients during this initial stage. The prospect of further expansion in Belfast may be considered.

Commissioned services

The LCG will work through the Belfast Outcomes Group to commission Family Support Hubs, giving priority to enhancing support to children 5-11 years; outreach for harder to reach families and better engagement for 11-16 year olds.

The LCG will work closely with the Belfast Health Development Unit and the Trust to ensure that the particular needs of children of migrant families are met.

Commissioning Priorities and Requirements

POC 3 Children and Families' Services	
Regional Commissioning Objective	**Associated Local Requirement**
Work with CYPSP and outcomes groups to progress the establishment and consolidation of family support hubs by 1st September 2014.	Providers will be expected to contribute to the further development of family support through locality planning and family support hubs.
Local Priority	Belfast Trust is expected to bring forward plans to manage demand for Autistic Spectrum Disorder services.

6.4.4 POC4: Older People

Introduction

The LCG works closely with the older people's forums especially the Greater Belfast Seniors' Forum, in Belfast and is playing a lead role in developing Belfast as an Age Friendly City, promoting a positive image of ageing, healthy lifestyles for older people and age-friendly and dementia-friendly neighbourhoods.

Transforming Your Care stated that up to 45% of people who are assessed as requiring continuing social care could, in fact, live at home independently without this support, though they may benefit from some practical support such as help with shopping and jobs around the home as well as befriending, particularly those who live on their own. Investment in services for those with dementia is focused on improving memory services which provide earlier diagnosis and help service provider's work with patients and carers to plan for the future. The LCG continues to recognise the important role played by carers in our community and will continue to invest in carer support and place carers at the centre of its future transformation plans.

In Belfast many hospital and intermediate care beds are occupied by older people who could be cared for in their own homes with appropriate support. The LCG is commissioning this support for frail elderly people from Integrated Care Partnerships.

Overview of Local Needs and Demands

Northern Ireland (NI) is becoming an older society with the number of people aged 65+ expected to increase by 10% by 2020 for Belfast, a slower rate of growth than in other LCGs. However, the LCG population currently has the highest proportion of older people particularly those over 85 years of age and there are significant levels of deprivation affecting older people, leading to greater levels of chronic illness and lower life expectancy.

The Belfast Trust provides domiciliary care support to approximately 5650 people within their homes. Of these, a much larger proportion is for less than 5 hours per week than in other Trusts. However, the Trust does not spend significantly more on domiciliary care than other LCGs when adjusted for need. This suggests that the Trust has been successful in helping people with low or moderate needs to live at home and the potential benefits of further re-ablement may be lower. However it also suggests that there is a potential for greater involvement of the community and voluntary sectors in providing practical support as an alternative to domiciliary care for these clients.

Assuming that research elsewhere can be applied to Belfast LGD, it has been estimated that there could be 10,000 older people living alone and a proportionately similar number in Castlereagh, and therefore more likely to suffer social isolation with consequent impacts on their mental and physical health.

Over 5% of the Belfast LCG population provide 20 hours or more per week of unpaid care and the LCG has prioritised support for carers within its plans..

It is estimated that at present in NI there are 19,000 people living with dementia, as the population ages dementia will increasingly be a major public and societal issue. The estimated number of people with dementia in Belfast Trust is 3893, of whom 2925 have an actual diagnosis. Belfast Trust had a diagnosis rate of75% in 2013 which is - the best performance in the whole of the UK.

Ministerial Targets

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. In particular, the LCG will expect ICPs to bring forward proposals for transformation of care pathways for the frail Elderly, building on evaluation of the Community Urgent Care Team pilot commissioned by the LCG and delivered by the Trust with the support of three GP practices in 2013. This provided acute care at home for

patients whom GPs considered for hospital admission and for patients in Emergency departments who were offered care at home instead of admission. The six local older people's forums and Greater Belfast Seniors' Forum were fully consulted prior to the pilot and were supportive of the approach following detailed discussions.

Commissioned services

The LCG will commission a comprehensive care pathway for the frail elderly from ICPs in 2014/15. This will focus on early intervention and intensive support for those older people at risk of hospitalisation or long term care. Local Integrated Care Teams within community hubs will support GPs in identifying older people at risk of hospitalisation and ensure appropriate support is in place. They will be able to escalate that support to specialist and secondary care teams with a single phone call which will provide acute care at home or admission to an assessment unit in hospital. This extension of acute care at home should create opportunities to consolidate the provision of hospital and intermediate care beds.

The LCG will work with the Belfast Trust, the community and voluntary sectors and ICPs to ensure that the potential for Reablement is maximised and that local implementation is consistent with the regional components. The community and voluntary sectors have formed a Reablement Stakeholder Network and have been particularly innovative in the development of a prototype for an Information Hub which will ensure that the service capacity available within local communities is easily accessible. The Network and LCG have also piloted Community Navigators to work alongside the therapists in the reablement team to source community and voluntary support as an alternative to continuing care. This will be evaluated in 2014/15 with a view to its sustainability.

Belfast LCG has invested in the establishment of a multidisciplinary model to address the substantial back log that existed within the Belfast Memory Service. Further investment has been allocated to address the increased

demand on the service and reshape the current model. Independent sector advocacy and peer support will also be available.

The LCG continues to recognise the important role played by carers in our community and will continue to invest in carer support and place carers at the centre of its future transformation plans.

Commissioning Priorities and Requirements

POC4: Older People	
Regional Commissioning Objective	**Associated Local Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	(a) Improved use of NISAT and other systems to identify carers at an early stage in the assessment process and the development of links with GP and Primary Care to assist this. (b) Information on assessment and services to be made available in a range of ways and formats (ie carer information packs, information sessions/days, posters, leaflets) and disseminated in a targeted manner to maximises exposure to carers/ potential carers. This material to be developed and disseminated in partnership with carers/ carer organisations. (c) Training and awareness sessions to be undertaken in partnership with carers/ carer organisations to ensure the assessment process is person centred and will address the range of carer needs. Carer feedback on the carer assessment process to be sought by BHSCT and formally evaluated via a representative sample of carers who have had an assessment completed.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	(a) Trust to work in partnership with the community and voluntary sector and carers to develop a range of flexible, 'non-traditional' respite and short-break options for carers (b) Cash grants and direct payments to be provided to carer

	organisations and carers to support the development of services provided via the community/voluntary sector and uptake of such services by carers.
Increase uptake of Direct Payments	Belfast Trust is expected to increase the proportion of care packages which are subject to direct payments and in particular to work with the PHA and the CLARE social enterprise in North Belfast to pilot the development of life plans as an alternative to statutory care.
Working with ICPs to improve the care of the frail elderly	ICPs are expected to bring forward proposals for the roll out acute care at home with secondary care services supporting primary and community care teams, access to social care and community and voluntary provision of practical support. ICPs are expected to bring forward proposals for transforming services for the Frail Elderly which provide a more coordinated approach to intermediate care, including arrangements for hospital discharge, direct access to specialist assessment at home or, if necessary, at a hospital or other healthcare setting.
Enhancement of dementia services	The Belfast Trust is expected to respond to commissioner specifications for the further development of memory services.
Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge	The Belfast Trust has re-modelled its intermediate care bed provision and transferred rehabilitation resources into community teams to

arrangements.	provide more support in the patient's home. The Trust should ensure that this does not result in delays in discharge of patients requiring complex packages of care from acute hospitals. The Trust should continue to seek opportunities to reduce intermediate care beds and re-deploy the resources to support patients to return home directly from hospital.
Continued roll-out of targeted preventative health and well-being improvement programmes and promote active ageing.	ICPs are expected to bring forward proposals for improved Falls Prevention and Nutrition as part of their proposals for Frail Elderly services. Belfast Trust and Age Sector organisations are expected to contribute to the Belfast Age Friendly Action Plan to be submitted to WHO following consultation and endorsement by the Belfast Strategic Partnership.
Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The LCG will support the continued roll out of the re-ablement model from its initial pilot sites to the wider Trust area and review the model with the Trust to ensure service outcomes and financial efficiencies are achieved.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied bed days	51,739	0	51,739
	Day Care	Attendances	121,816	0	121,816
	Domiciliary Care	Hours	270,0314	0	270,0314
	Residential and Nursing	Occupied bed days	924,874	0	924,874
	Community Nursing	Face to face	347,217	0	347,217
	Social Work	Caseload	118,75	0	11,875
		VALUE OF COMMISSIONED ACTIVITY[37]	£144.2m	£5.5m	£149.7m

[37] This includes activity in addition to that set out above.

6.4.5 POC 5: Mental Health

Introduction

The LCG will continue to work closely with the Regional Bamford Commissioning Team to develop services for the severely mentally ill and for those with mild or moderate mental illness, placing an emphasis on recovery through the Stepped Care model which supports people to live as independently as possible with or without on-going mental illness.

The LCG is taking a lead role, in conjunction with the Trust, ICPs and Belfast Strategic Partnership in developing a Primary Care Talking Therapies Service enabling GPs to help patient's access appropriate community and voluntary support, or specialist support when required. This approach also aims to reduce the relatively high dependency on prescription drugs for depression, anxiety and pain within Belfast.

Overview of Local Needs and Demands

Mental illness is one of the major causes of ill health and disability in Northern Ireland. In 2013, the raw prevalence of patients (per 1000) on the Mental Health Register in Belfast was 10.2 and on the Dementia Register was 6.8. In the Belfast Trust there were 72 deaths due to suicide and undetermined intent from 1999 to 2012 accounting for 26% of the overall NI total. The rate of admissions in the most deprived areas of Belfast were 3.5times that of NI (DHSSPS 2012).

The Framework for Mental Health and Wellbeing NI (2011) highlights that 10 – 20% of older people (aged 65 years or over) suffer from serious mental health problems. The LCG is also aware of the growing numbers of children and young people with mental health problems in Belfast and in the demand for services to meet their needs.

Mood and anxiety disorder prevalence in the Belfast Trust was consistently higher than that in NI generally. The Trust inequality gap remained 50% higher

in the most deprived Trust areas throughout the period 2010. (DHSSPS 2012) In 2010 Belfast West had the highest proportion of individuals of any constituency in Northern Ireland (246 per 1000) using prescribed medication for mood and anxiety disorders, followed by Belfast North (220 per 1000) (DHSSPS). In the Belfast Trust there were 168 admissions to hospital as a result of mood or anxiety disorder in 2009/10 (NIHIS.

In 2012/13 there were approximately 13,516 referrals to Belfast Mental Health Triage. Local data collection indicates that 30-40% of referrals are returned/ redirected to community and voluntary sector for Tier 2 Psychological therapies (30% = 4054)

PHA Health Intelligence Briefing for Suicide shows that Belfast LCG area had the highest rate of suicide in 2009/2011 (most recent data at the time of writing) at 23 deaths per 100,000 followed by Western area (16.4 per 100,000). From 2006 to 2011, the male and female suicide rates in Belfast were higher than the rates in all other LCG areas and above the NI average.

Ministerial Targets (local relevance)

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. In particular, the LCG will commission increased capacity for psychological therapies through the development of a Primary Care Talking Therapies and will commission sufficient diagnostic and memory clinic services to deliver Ministerial targets for access to dementia services.

Further investment will be made in the development of community infrastructure and social care services to support the shift to 60/40 ratio in favour of community based acute services for patients with severe conditions and to provide 18 new supported housing places to support the discharge of patients from Belfast Psychiatric hospitals within 7 days of their becoming medically fit for discharge. Eleven appropriate community placements will be commissioned for the remaining Belfast long-stay patients in Belfast Trust Psychiatric Hospitals.

The LCG will continue to work closely with the PHA and the Belfast Strategic Partnership to ensure that local communities are commissioned to provide sufficient capacity for the Protect Life programme.

Commissioned Services

The LCG will commission a Primary Care Talking Therapies Service in 2014/15, building on previous work in conjunction with the West Belfast Primary Care Partnership (now ICP). A pilot Referral Hub and Coordinator facilitated weekly meetings between GPs, secondary care clinicians and community and voluntary providers to discuss and agree individual recovery plans for clients as an alternative to referral to specialist services. The pilot is being evaluated and will guide the roll out of the Talking Therapies Service.

The LCG will continue to support the re-configuration of acute mental health services in Belfast in preparation for the development of the single Acute mental health unit, ensuring that community support is available for all those for whom this is appropriate. The LCG and Bamford Commissioning Team will also commission an increase in the number of carers' assessments offered to the family carers of people with a serious mental illness living in the community in Belfast and an enhancement of the Psychiatric Liaison service to ensure a maximum 2 hour response time to Emergency Departments

Commissioning Priorities and Requirements

POC 5: Mental Health	
Regional Commissioning Objective	**Associated Local Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	(a) Improved use of NISAT and other systems to identify carers at an early stage in the assessment process and the development of links with GP and Primary Care to assist this. (b) Information on assessment and services to be made available in a range of ways and formats (ie carer information packs, information sessions/days, posters, leaflets) and disseminated in a targeted manner to maximises exposure to carers/ potential carers. This material to be developed and disseminated in partnership with carers/ carer organisations. (c) Training and awareness sessions to be undertaken in partnership with carers/ carer organisations to ensure the assessment process is person centred and will address the range of carer needs. Carer feedback on the carer assessment process to be sought by BHSCT and formally evaluated via a representative sample of carers who have had an assessment completed.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	(a) Trust to work in partnership with the community and voluntary sector and carers to develop a range of flexible, 'non-traditional' respite and short-break options for carers (b) Cash grants and direct payments to be provided to carer organisations and carers to support the development of services provided via the community/voluntary sector and uptake of such services by carers.

Increased uptake of direct payments	By March 2015 the Belfast Trust should secure a 5% increase in the number of Direct Payments to individuals with a serious mental illness living in the community in Belfast.
Implementation of the Protect Life Strategy	The Belfast Trust should continue to: • develop an improved model of support for those who self-harm. • make specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. • support the on-going delivery of the Lifeline Service and implement the regionally agreed memorandum of understanding
Establishment of integrated care arrangements for the care and treatment of patients with common mental health needs	The LCG will build on the evaluation of the pilot Mental Health Referral Hub in West Belfast to commission a Primary Care Talking Therapies Service across all 4 ICPs. The Belfast Trust will appoint Referral Coordinators based in Primary Care to ensure integrated working between secondary and primary care and community and voluntary organisations. The Belfast Trust will re-configure its primary mental health teams to support each ICP.
Implementation of the Crisis Resolution Home Treatment services for CAMHs	The Trust is expected to bring forward proposals in response to a commissioning specification for further enhancement of Crisis Resolution, Assertive Outreach and Home Treatment functions. The aim of CRHT is to enhance services which support

	the needs of children and young people with complex and severe conditions, maintain individuals in the community and reduce inappropriate admissions to inpatient services. It is recognised that the service will take time to be established and expected improvements realised incrementally.
Further development of specialist community services	The Belfast Trust should further develop community infrastructure and social care services to support the shift to 60/40 ratio for community based acute services for patients with severe conditions and to provide 18 new supported housing places to support the discharge of patients from Belfast Psychiatric hospitals within 7 days of their becoming medically fit for discharge.
Improved psychiatric liaison services	Belfast Trust should Improve Psychiatric Liaison Services to ensure a maximum 2 hours response time in Emergency Departments.
Consolidation of acute inpatient beds to a single site in each of three Trust areas (Belfast Trust, Northern, Southern and South Eastern	The Trust is expected to continue to reduce the use of hospital capacity through the effective use of community capacity in preparation for the opening of the new Acute mental Health Unit.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied bed days	90,683	0	90,683
	CPN	Contacts	48,853	450	49,303
	Res & Nur homes & supported housing	Places	57,461	0	57,461
	Day Care	Attendances	59,069	0	59,069
	Domiciliary Care	Hours	131,341	0	131,341
		VALUE OF COMMISSIONED ACTIVITY[38]	£64.4m	£0.7m	£65.1m

[38] This includes activity in addition to that set out above.

6.4.6 POC 6: Learning Disability

Introduction

The Bamford principles of promoting independence and reducing social inclusion for people with a Learning Disability continue to underpin the commissioning objectives for Belfast LCG, with a focus on supporting family carers and working with other statutory, voluntary and community partners to deliver services that enable people with a Learning Disability to maximise their potential and enjoy health, wellbeing and quality of life.

Overview of Local Needs and Demands

In 2013, the raw prevalence of patients aged 18 plus (per 1000 patients) on the Learning Disability register was 5.7 for Belfast HSCT.

Ministerial Targets (local relevance)

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level.

In particular, further community infrastructure and social care services will be commissioned to support the shift to 60/40 ratio for community based/acute services. Community services infrastructure and (in partnership with NIHE and Independent Sector providers) accommodation based services will be commissioned to support the discharge of patients from Belfast Psychiatric hospitals within 7 days of their becoming medically fit for discharge. In partnership with NIHE, 18 new supported housing tenancies will be developed for people with a Learning Disability. An additional 24 appropriate community placements will be commissioned for the remaining long-stay patients in learning disability Hospitals

Commissioned Services

The LCG has recently invested in additional carer support which will have a full year impact in 2014/15, including an increase in the level of flexible support options/ short term breaks made available to carers.

The LCG will continue to support Belfast Trust to implement its “Big Plan” to modernise day care services and further develop day opportunities, particularly for young people with complex conditions.

Commissioning Priorities and Requirements

POC 6: Learning Disability	
Regional Commissioning Objective	**Associated Local Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	(a) Improved use of NISAT and other systems to identify carers at an early stage in the assessment process and the development of links with GP and Primary Care to assist this. (b) Information on assessment and services to be made available in a range of ways and formats (ie carer information packs, information sessions/days, posters, leaflets) and disseminated in a targeted manner to maximises exposure to carers/ potential carers. This material to be developed and disseminated in partnership with carers/ carer organisations. (c) Training and awareness sessions to be undertaken in partnership with carers/ carer organisations to ensure the assessment process is person centred and will address the range of carer needs. Carer feedback on the carer assessment process to be sought by BHSCT and formally evaluated via a representative sample of carers who have had an assessment completed.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	(a) Trust to work in partnership with the community and voluntary sector and carers to develop a range of flexible, 'non-traditional' respite and short-break options for carers

	(b) Cash grants and direct payments to be provided to carer organisations and carers to support the development of services provided via the community/voluntary sector and uptake of such services by carers.
Delivery of day services in line with the Regional Day Opportunities Model	The LCG will continue to increase its investment in Day Opportunities for young adults with complex needs. The Trust should ensure that services are delivered in line with the Regional Day Opportunities Model.
Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	Belfast Trust should ensure that specialist community services respond to the needs of people whose behaviours challenge services
Increased uptake of direct payments	Belfast Trust should ensure that by March 2015 there is a 5% increase in the number of Direct Payments to individuals with a Learning Disability living in the community in Belfast.
Development and implementation of health promotion initiatives for people with a learning disability.	GP Practices are expected to respond to the opportunity presented by the DES to offer annual physical and mental health checks to people with a learning disability.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied bed days	47,855	-8,034	39,821
	Day Care	Attendances	136,378	6,300	142,678
	Domiciliary Care	Hours	361,510	0	361,510
	Residential & Nursing	Occupied bed days	111,071	0	111,071
	Community Nursing and AHPs	Face to face contacts	22	0	22
	Social Work	Active Caseload	1,635	0	1,635
		VALUE OF COMMISSIONED ACTIVITY[39]	£49.5m	£4m	£53.5m

[39] This includes activity in addition to that set out above.

6.4.7 POC 7: Physical Disability and Sensory Impairment

Introduction

The LCG will continue to support regional approaches to increasing supported living and self-directed support. A particular focus for Belfast LCG is ensuring that patients with complex acquired disabilities are able to be discharged as soon as appropriate from specialist acute inpatient services to specialist rehabilitation or local settings where they can avail of the most appropriate care and maintain as much independence as possible.

The Belfast LCG has also taken the lead in ensuring that supporting Trusts in implementation of the NICE guidance is implemented for people suffering from ME-Chronic Fatigue Syndrome. The current regional pilot will be evaluated in with a view to roll out to all areas in 2014/15.

Overview of Local Needs and Demands

Prevalence of a range of long term conditions for the Belfast LCG includes: 5.6% for deafness or partial hearing compared to 5.1% for Northern Ireland, 2.0% for blindness or partial sight with the regional level being 1.7%. For mobility or dexterity difficulty for NI as a whole the level is 11.4% whereas the LCG area is 13.1%

Prevalence (existing cases) for CFS/ME: c.3500-7000 for NI, with incidence (new cases per year)-c.500 of which approximately 20% live in Belfast. Of these 90% of these have mild to moderate illness.

Over 5% of the Belfast LCG population provide 20 hours or more per week of unpaid care.

Ministerial Targets (local relevance)

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level.

Belfast LCG made a substantial investment in carer support in 2013/14 in conjunction with additional regional investment funding in Belfast which will increase capacity within the Trust and voluntary organisations over the next year.

Commissioned Services

The LCG is reviewing the causes of discharge delays in Neurosurgery and has committed additional funding to the Regional Rehabilitation Unit at Musgrave Park Hospital to ensure that there is sufficient medical cover for service continuity on site as well as outreach to local rehabilitation centres and support for Community Rehabilitation teams. Belfast and South Eastern LCGs are working together to ensure that Thompson House, Lisburn is able to accept new patients transferred from the specialist services.

The LCG continues to recognise the important role played by carers in our community and will continue to invest in carer support and place carers at the centre of its future transformation plans.

Following discussions with patients and carers and with commissioners in Scotland, the LCG has commissioned a regional pilot Chronic Fatigue Syndrome service which will provide additional therapeutic support for patients to manage their symptoms, in line with NICE guidance. GPs have also been offered advice as to how to support patients with mild or moderate conditions. The pilot will be evaluated in 2014/15 with a view to a regional roll-out.

Commissioning Priorities and Requirements

POC 7: Physical Disability and Sensory Impairment	
Regional Commissioning Objective	**Associated Local Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	(a) Improved use of NISAT and other systems to identify carers at an early stage in the assessment process and the development of links with GP and Primary Care to assist this. (b) Information on assessment and services to be made available in a range of ways and formats (ie carer information packs, information sessions/days, posters, leaflets) and disseminated in a targeted manner to maximises exposure to carers/ potential carers. This material to be developed and disseminated in partnership with carers/ carer organisations. (c) Training and awareness sessions to be undertaken in partnership with carers/ carer organisations to ensure the assessment process is person centred and will address the range of carer needs. Carer feedback on the carer assessment process to be sought by BHSCT and formally evaluated via a representative sample of carers who have had an assessment completed.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	(a) Trust to work in partnership with the community and voluntary sector and carers to develop a range of flexible, 'non-traditional' respite and short-break options for carers (b) Cash grants and direct payments to be provided to carer organisations and

	carers to support the development of services provided via the community/voluntary sector and uptake of such services by carers.
Increase uptake of Direct Payments	Belfast Trust is expected to increase the proportion of care packages which are subject to direct payments and in particular to work with the CLARE social enterprise in North Belfast to encourage the development of life plans as an alternative to statutory care.
Review Trust progress in relation to the review and reform of day service opportunities to ensure alignment with personalisation strategies	BHSCT will participate in the stocktake of progress with the reform of day services locally.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability and Sensory Impairment	**Hospital services**	Occupied beddays	24,301	0	24,301
	Day care	Attendances	38,439	0	38,439
	Domiciliary care	Hours	339,886	0	339,886
	Resid & Nursing Home	Occupied beddays	39,649	0	39,649
	Community nursing & AHPs	Contacts	7,110	0	7,110
	Social work	Active caseload	3,418	0	3,418
		VALUE OF COMMISSIONED ACTIVITY[40]	£22.1m	£1m	£23.1m

[40] This includes activity in addition to that set out above.

6.4.8 POC 8: Health Promotion

Introduction

The LCG will continue to work closely with other statutory agencies and the community and voluntary sectors through the Belfast Strategic Partnership to address the multiple social determinants of ill health which are associated with the high levels of Multiple Deprivation in Belfast and with some ethnic groups and recent migrants who have a high prevalence of specific health conditions or experience difficulties in accessing health and care services.

The LCG will continue to encourage and support local community partnerships in developing community-led approaches to supporting self-care through raising awareness of the risks of ill health, identifying those who may be at risk and providing evidence-based interventions or signposting them to services which will minimise those risks, and providing support and rehabilitation services for those who are recovering after treatment.

Overview of Local Needs and Demands

The NI Heath and Social care Monitoring System 2012 encouragingly showed that in over half of the indicators used, there was a narrowing of the health inequality gaps across the Belfast LCG area – for example, noticeable improvements were recorded for infant care and cancer incidence and there was a narrowing of the Trust inequality gap in almost half of the indicators analysed.

In contrast to this, however, the most noticeable widening of gaps over time occurred for day case admissions, low birth weights, respiratory mortality, amenable death rates and suicide. The report showed that the impact of health inequalities in Belfast LCG area is still acute in areas such as and alcohol related and self-harm admissions

Communicable diseases disproportionally affect certain groups in the population including those at social disadvantage, living in poor housing

conditions, migrants from countries that have higher prevalence of infectious diseases, and those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities. The LCG is particularly concerned about the rise in the incidence of TB in the community and has invested in an enhanced nurse-led service.

Ministerial Targets
The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level.

Commissioned Services
In 2014/15 the LCG will review outcomes from the community-led Healthy Hearts West programme it funds jointly with the Public Health Agency. The programme involves integrated working between community groups, Community Pharmacists, GPs and the Trust in providing education in community and school settings and providing or sign-posting to risk reduction and rehabilitation programmes including provision of support for physical exercise, smoking cessation, dietary advice and good mental health. It has been proposed by the ICPs that the approach could be extended to other conditions with similar risk factors to underpin the pathways being developed by the ICPs for a range of chronic conditions.

The LCG hasalso extended the funding it provides to Active Belfast Partnership for the commissioning of additional physical activity interventions to which GPs refer appropriate patients. This supports theCardiac, Cancer and Pulmonary Rehabilitation programmes as well as Health Hearts West and the pre-Diabetes care pathway.

The LCG will work closely with Belfast Trust, PHA and other funders within the Belfast Strategic Partnership to align procurement processes and pool funding where this can better meet shared objectives and provide a more sustainable basis for the community and voluntary sector. The LCG and Trust will encourage community and voluntary organisations to develop networks

around the holistic needs of individuals and to share administration resources for greater efficiency. The Belfast Trust is expected to provide training support to volunteers to assist then in meeting governance standards.

Commissioning Priorities and Requirements

POC8 – Health Promotion	
Regional Commissioning Objective	**Associated Local Requirement**
Expansion of the early years intervention programme.	Belfast Trust is expected to continue to consolidate the implementation of the Roots of Empathy Programme across 35 schools in the Belfast LCG area. 60 Health and Social Care staff will receive infant mental health training to improve their assessment and intervention capacity
Incremental expansion of social economy businesses and community skills development.	The LCG will commission, through the BHSCT, additional capacity from the community and voluntary sectors in services for: • Older people •Long term conditions •Mental health •Learning disability •Physical disability Including additional support for carers. Commissioning will focus on services which can demonstrably reduce demand for more specialist services or prescribing. The LCG will work closely with BHSCT, PHA and other funders within

	the Belfast Strategic Partnership to align procurement processes and pool funding where this can better meet shared objectives and provide a more sustainable basis for the community and voluntary sector. The LCG and BHSCT will encourage community and voluntary organisations to develop networks around the holistic needs of individuals and to share administration resources for greater efficiency. The BHSCT should provide training support to volunteers to assist then in meeting governance standards
Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	Belfast Trust is expected to submit an action plan to the LCG by June 2014 showing how it will improve the accessibility and uptake of services by vulnerable groups. The Trust is expected to raise awareness amongst LAC staff of support for smoking cessation services and BHSCT smoke-free policy. All LAC staff to be offered BIT and key staff to be identified to attend specialist smoking cessation training.

Implementation of the "Fitter Futures for All Framework".	Providers within ICPs are expected to continue to support the roll-out and development of the Healthwise programme in conjunction with PHA, Belfast City Council and Sport NI. Belfast Trust is expected to continue to support the rollout of the RAFAEL programme aimed at increasing the proportion of fresh, local and sustainable food in HSC facilities.
Implementation of key public health strategies.	Belfast Trust should ensure smoking cessation services available to the following groups: •150 professional staff for brief intervention training •200 pregnant women to participate in smoking cessation services •1500 routine manual workers •20 children in LAC residential homes BHSCT to develop common guidelines and policy on smoke free facilities including LAC residential homes Providers within ICPs are expected to support the development and implementation of and Emotional Resilience Strategy and its integration with the suicide prevention strategy and Primary Care Talking Therapies Service.

	Belfast Trust is expected to support the delivery of new community-based service model for self-harm throughout the Belfast LCG area.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	Belfast Trust is expected to provide a monitoring report outlining range of specialist sexual health services available, numbers and age groups accessing services.
Roll-out and evaluation of pilot on primary care facing advice and treatment of non-sight-threatening minor eye conditions in Southern LCG area	Belfast LCG has commissioned an integrated pathway for minor eye conditions involving primary care and will evaluate the impact of this on demand for secondary care in 2014/15.

6.4.9 POC 9: Primary Health and Adult Community

Introduction

Effective primary and community services prevent unnecessary use of more expensive and limited specialist and secondary care resources. It is essential that primary and community care providers work in an integrated way and respond flexibly to the needs of local populations, supported where necessary by specialist services in a timely way.

ICPs have a critical role in developing proposals which address the LCG commissioner specifications for service transformation and integration in a comprehensive way, including health improvement and promotion of self-care as well service development and follow up, leading to maximising the return of patients to independence.

Overview of Local Needs and Demands

A higher percentage of the population has a long term limiting illness in Belfast (23%) than in other LCGs. For many chronic illnesses there is a link between prevalence and deprivation, leading to higher admission rates to hospital and other secondary care services. Belfast area has a higher proportion of the population with mobility or dexterity difficulty and frequent periods of confusion or memory loss indicating frailty.

QOF Registers indicate a higher prevalence of chronic disease in Belfast than elsewhere in Northern Ireland and significant differences between ICP areas within Belfast. A study by the HSCB of QOF indicators in 2011 showed that the prevalence of COPD is more than 60% higher in North Belfast than in NI as a whole and in East Belfast Stroke was 20% higher and Diabetes 14% higher.

Reviews of referrals from High Street Optometrists and Dentists have shown that with improved equipment, new guidelines and additional capacity, the numbers of patients referred for specialist consultations could be substantially reduced.

Research estimates indicate that up to 50% of patients who have Glaucoma, a hidden chronic disease, do not visit Optometrists and therefore have a significantly increased risk of irreversible impaired vision or even blindness. A project led by RNIB in West Belfast in 2013 was successful in working with local community and voluntary groups to raise awareness of the risks and increase uptake.

Ministerial Targets

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. Four ICPs have been established in Belfast and each is bringing forward respective proposals for the management of patients on care pathways for Frail Elderly, Respiratory, Diabetes and Stroke patients and end of life care as it relates to these. Commissioning enhanced primary and community services from ICPswill deliver targets related to the reduction of planned admissions to hospital, particularly for those with long term conditions.

The use of Tele-monitoring technology will be extended where evidence shows this to indicate an increased risk of hospital admission, for example for patients at risk of heart failure..

Commissioned Services

The LCG will commission proposals from the Belfast ICPs specifically aimed at providing escalated care at home as an alternative to unplanned admission to hospital for patients with long term conditions, including frail elderly patients who have fallen or who have a transient loss of consciousness, patients with an exacerbation of their respiratory condition and patients who require additional support at the end of life. The LCG will also commission Early Supported Discharge arrangements for Stroke patients to enable them to return home more quickly. The Diabetes and pre-Diabetes pathways developed by South Belfast Primary Care Partnership will be extended across Belfast.

The LCG will expect the proposals from ICPs to transform care pathways comprehensively, showing how all providers are involved in delivering health improvement and prevention, reducing risk factors, promoting and supporting self-care, developing close working relationships between GPs, Integrated Care Teams and specialists based on risk stratification to identify and plan care around those patients most likely to have an unplanned hospital, providing timely access to specialist care, rehabilitation and re-ablement.

POC 9: Primary Health and Adult Community	
Regional Commissioning Objective	**Associated Local Requirement**
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	ICPs should bring forward proposals for developments in primary care which will enhance its capacity to avoid unnecessary hospital admissions and improve health and well-being in the clinical priority areas.
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate community setting.	Belfast Trust should ensure that there is sufficient core District Nursing capacity to meet demand from primary care in a timely way. The Trust should also ensure that there is sufficient capacity to ensure there are no delays in discharge from hospital Nurses should work with social workers and AHPs in Integrated Care Teams in 8-10 Hubs to support clusters of GP practices. Nurses and GPs should meet regularly within Hubs to agree care plans for patients at risk of admission to hospital. Integrated Care Teams should also bring forward proposals for the effective management of palliative and end of life care which avoids admission to hospital wherever appropriate.

6.5 Other Commissioning Priorities 2014/15 – 2015/16

6.5.1 Primary Care Infrastructure Development

The LCG will provide input to a HSCB Strategic Implementation Plan for PCID. This will set out initial proposals for 'Hub and Spoke' configurations which will support the service models within each programme of care and particularly the transformation of care pathways for people with long term conditions and the promotion of health improvement and self-care.

The LCG will continue to consult with the Belfast Trust, primary care and community and voluntary organisations and work closely with both Castlereagh Borough and Belfast City Councils to develop proposals for combined health and well-being hubs which provide the opportunity to provide services as locally as possible, optimise integrated working and support health improvement in areas of greatest need.

6.5.2 Medicines Management

Prescribing rates in Belfast LCG are lower than in other LCGs but Northern Ireland as a whole has higher prescribing costs than the rest of the UK. The HSCB has set target reductions for the LCG and the LCG will in turn work closely with the Belfast ICP Medicines Management Group to improve quality and reduce expenditure. It will also expect Belfast Trust to ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area, in line with the Ministerial target.

Belfast LCG actions will include:

- Investment in targeted pharmacy support to GP practices
- Supporting regional campaigns to reduce the overuse of anti-biotics and waste of medicines
- A programme to address the over-use and misuse of medicines for pain relief
- Investment in a pilot Pain Management Programme to support self-care

- Re-investing prescribing savings in talking therapies as an alternative or complement to medicines,
- Investing in specialist Dietetic advice to Nursing Homes to promote good nutrition for older people.
- Investment in community-based physical activity programmes tailored to individual needs
- Requiring adherence to NICE guidance and NI Formulary as a condition for investment in services

7.0 Northern Local Commissioning Group Plan

7.1 LCG Population

The Northern Local Commissioning Group (Northern LCG) covers an area of 1,670 square miles and includes ten Local Government Districts (LGDs) with a total population of 465,529 (49% or 228,291 are male and 51% or 237,238 are female). The Northern LCG has the highest share (26%) of the Northern Ireland population.

Mid-Year population estimates by broad age bands, 2012

Table 28

	Northern HSCT	Northern Ireland
Total Population (2012)	465,529	1,823,634
Children (0-15 years)	96,199	382,141
Young Working Age (16-39 years)	144,457	588,557
Older Working Age (40-64 years)	151,622	580,117
Older (65+ years)	73,251	272,819
Population Change % (2002-2012)	8.0%	7.4%

Source: NISRA

Age profile (numbers) of Northern LCG Population by Local Government District area

Table 29

	2012										
Age Band (Years)	Antrim LGD	Ballymena LGD	Ballymoney LGD	Carrickfergus LGD	Coleraine LGD	Cookstown LGD	Larne LGD	Magherafelt LGD	Moyle LGD	Newtownabbey LGD	Northern Trust
0-15	12,090	12,891	6,668	7,535	11,335	8,321	6,038	10,530	3,440	17,351	96,199
16-39	16,946	19,348	9,886	11,404	17,637	12,928	9,064	15,270	4,914	27,060	144,457
40-64	17,313	21,284	10,201	13,626	19,720	11,158	11,350	13,751	5,778	27,441	151,622
65+	7,486	11,028	4,796	6,531	10,301	5,004	5,739	5,899	2,997	13,470	73,251
Overall	**53,835**	**64,551**	**31,551**	**39,096**	**58,993**	**37,411**	**32,191**	**45,450**	**17,129**	**85,322**	**465,529**

Source: NISRA,2012

The age structure of the LCG resident populations varies. The Northern LCG has the highest number of younger people within its population at 96,199 or 21% of its population.

As people grow old the likelihood of illness increases, as does the reliance on health and social care services. In terms of geographical distribution of the 65+ population, the Northern LCG has the highest percentage at 27% or 73,251.

Population Projections

The Northern LCG is expectedto have an overall population growth of 5.2% between 2013 and 2023. This is slightly lower than the Northern Ireland average. The number of children under 16 is expected to increase by 1.6% from 2012-23. Not surprisingly, the greatest increase is found in the number of older people (85+) which is expected to rise by 65.1% in that period hence indicating a rapidly ageing population.

It has the second fastest growing population in Northern Ireland with Cookstown, Antrim and Magherafelt projected to increase by approximately 11% from 2010-20.

Life Expectancy

Life expectancy is used internationally as a measure of population health. For the period 2008-2010, life expectancy in Northern Ireland was lower than in the rest of the UK, with the exception of Scotland (ONS Interim Life Tables).

In tandem with the overall growth in population, there is an improvement in life expectancy. When looking at the Northern LCG as a whole, for people born between 2008 and 2010, life expectancy is higher than the Northern Ireland average.

While there are some signs of general improvement in life expectancy, not everyone has been able to avail fully of the benefits of this progress. Unfortunately, social inequality has endured to the extent that health

outcomes for some groups remain poorer than for others, and smoking, obesity, misuse of drugs and alcohol, teenage conception rates, poor mental health are disproportionally concentrated amongst socially vulnerable, excluded and particularly deprived groups.

The 2011 Northern Ireland Census asked respondents how they perceived their health, whether they had a long term limiting illness and if they provided unpaid care. Approximately one fifth of the Northern Ireland population stated that they had a long term limiting illness. Almost 80% felt they were in good health, and almost 12% said that they provide unpaid care.

Chronic Illness / Long Term Conditions
Self assessed health, long term limiting illness and provision of unpaid care
Table 30

	Long term limiting Illness	General health: Good or Very Good	Providing Unpaid care
Belfast	23.04	76.71	12.33
Northern	19.65	80.43	11.55
South Eastern	19.82	80.84	12.82
Southern	19.64	80.61	11.34
Western	21.85	78.46	11.04
Northern Ireland	20.69	79.51	11.81

Source: Census 2011

When asked about the type of long term condition suffered 6.6% of the Northern area population stated they had a chronic illness and 9.7% suffered long term pain or discomfort (Table 31).

Type of Long Term Condition as assessed by the NI Census 2011

Table 31

LCG	Deafness or partial hearing loss (%)	Blindness or partial sight loss (%)	Communication difficulty (%)	A mobility or dexterity difficulty (%)	A learning, intellectual, social or behavioural difficulty (%)	An emotional, psychological or mental health condition (%)	Long-term pain or discomfort (%)	Shortness of breath or difficulty breathing (%)	Frequent periods of confusion or memory loss (%)	A chronic illness (%)	Other condition (%)	No condition (%)
Belfast	5.6	2.0	1.9	13.1	2.6	7.4	11.4	10.3	2.5	7.2	5.6	66.0
Northern	5.2	1.6	1.5	10.7	2.0	5.1	9.7	8.4	1.7	6.6	5.1	69.2
South Eastern	5.6	1.7	1.6	11.1	2.2	5.1	9.9	8.5	1.9	6.7	5.3	68.4
Southern	4.5	1.6	1.6	10.8	2.0	5.3	9.5	7.8	1.8	5.9	4.9	70.8
Western	4.8	1.7	1.8	11.9	2.4	6.6	10.2	8.8	2.0	6.4	5.3	68.2
Northern Ireland	5.1	1.7	1.7	11.4	2.2	5.8	10.1	8.7	2.0	6.6	5.2	68.6

Source: Census 2011

QOF Disease Registers

The prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation (PHA, 2011).

At sub regional level, the Northern LCG has higher than average rates of asthma, diabetes, hypertension and stroke. It also has the highest rate of emergency admissions per 1000 population for asthma, diabetes, heart failure and stroke.

Deprivation

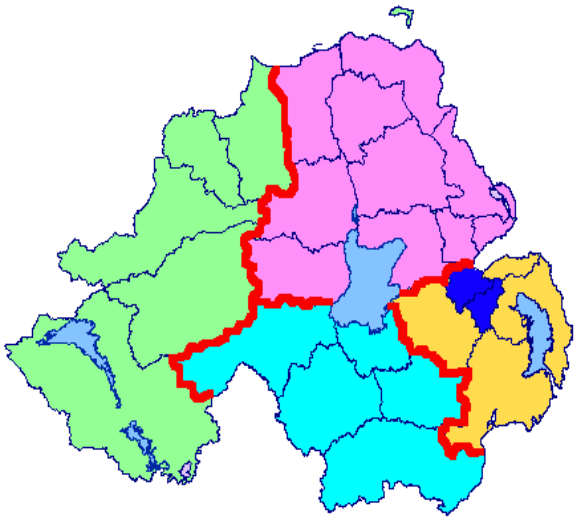
In 2010, NISRA updated the NI Multiple Deprivation Measure (NIMDM). The table below highlights the most deprived areas within each of the five Trusts. The data ranks council areas based on their level of deprivation
(1 most deprived, 26 least deprived).

District Council Deprivation Rankings

Belfast Trust	Rank of Deprivation
Belfast	1
Castlereagh	21
South Eastern Trust	**Rank of Deprivation**
Lisburn	6
Down	16
Ards	18
North Down	24
Northern Trust	**Rank of Deprivation**
Newtownabbey	8
Moyle	9
Coleraine	10
Ballymena	11
Larne	13
Carrickfergus	14
Cookstown	15
Antrim	20
Ballymoney	25
Magherafelt	26
Southern Trust	**Rank of Deprivation**
Craigavon	4
Newry and Mourne	5
Dungannon	12
Armagh	19
Banbridge	23
Western Trust	**Rank of Deprivation**
Strabane	2
Derry	3
Limavady	7
Omagh	17
Fermanagh	22

Figure 13

The Northern Trust has 3 District Council areas in the top 10 most deprived: Newtownabbey (8th), Moyle (9th) and Coleraine (10th)



Personal and Public Involvement (PPI)

The Northern LCG has established a joint working forum with representatives from the 10 district councils and the Northern Trust. This group meets quarterly and more often when appropriate to discuss matters relating to health and social care locally and in particular progress the agenda relating to TYC. The group is chaired by the Chair of the Northern LCG and the Vice Chair is a local representative. The group also shares information relating to developments in local government such as community planning which is relevant to the work of local commissioning.

The Northern LCG has also established links with Causeway Older Active Strategic Team (COAST), Mid and East Antrim Agewell Partnership (MEAAP) and Age Well Mid Ulster in order to ensure that there is on-going dialogue in respect of issues of common interest relating to older people.

Service Users and Carers are involved in specific initiatives undertaken by the Northern LCG. These include work that is on-going to develop specific pathways such as the MSK pathway and the preparatory work on pathways undertaken to inform the work of the Integrated Care Partnerships for example in dementia.

Representatives from the Northern LCG also participate in the Carers Steering Group locally and in the Northern Area Promoting Mental Health and Suicide Prevention Group.

It is recognised that the Northern LCG will need to extend opportunities for engagement and user involvement in the coming year as significant reforms will continue to be progressed as part of improving efficiency and rolling out the transformational agenda.

7.2 Key Challenges and Opportunities 2014/15

Introduction

The key challenges in the Northern area are at the core of the case for change as presented in Transforming Your Care and were presented in detail in the Northern Area Population Plan. They remain as significant challenges although reforms have been initiated to begin to address issues such as a growing and ageing population; increased prevalence of long term conditions; increased demand and over reliance on hospital beds; clinical workforce supply difficulties and the need for greater productivity and value for money.

Integrated Care Partnerships

The introduction of four Integrated Care Partnerships; Antrim/Ballymena, East Antrim, Mid- Ulster and Causeway has enabled work to commence on the design of pathways to address the clinical priorities of frail elderly, respiratory conditions, end of life care, diabetes and stroke. Multi-disciplinary groups including voluntary/community sector representatives and service users and carers have been brought together to scope existing services and initiatives and to begin to design pathways. The ICPs are designing the pathways in order to address the following aims: avoiding unnecessary hospital admissions; providing alternatives to the acute hospital setting; introduction of risk stratification to identify vulnerable patients and providing preventative and self-management options. By focussing on pro-actively managing clients with long term conditions, the work of the ICPs will begin to influence the delivery of services and the real impact of the shift left agenda in transforming patient care should be realised in the shift of resources to the primary and community care sector.

Delivering Choices

A key element of TYC is the delivery of care closer to home and enhanced patient choice. Marie Curie Cancer Care and the HSCB are working in partnership to deliver the Delivering Choice Programme for palliative and end of life care in Northern Ireland. Locally, the Northern Health and Social Care

Trust (Northern Trust), the Northern LCG and other partners from the voluntary and community sector are working closely with the Integrated Care Partnerships to participate in the roll out of the Delivering Choices Programme.

Reform of Community Services for Older People

Reablement is designed to prevent or reduce dependency on services by focussing on intensive short term rehabilitative inputs. Within the Northern area, reablement has been introduced across all localities and to date a significant proportion of clients have been discharged with no further need for a service. There remains however an increasing demand on domiciliary care both in numbers of people requiring packages and in the complexity of need presented by the clients. Further work is required to understand the nature of this increasing demand and the challenges it presents.

In order to address the need to provide additional support and care for older people, supported living units will be built in the Greenisland area with plans for further units to be built in Ballycastle and Newtownabbey.

Infrastructure

With the on-going shift of care to the primary and community sector there is recognition that additional infrastructure is required. In order to address this need, planning has been on-going with primary care, the Northern LCG and the Northern Trust to prioritise the proposed location of new hubs or health and care centres which will deliver a service model specifically designed to meet the needs of a particular population catchment area. The first health and care centre is being built in Ballymena and work is on-going to assess the requirements of the spokes or practices in the surrounding area. Work is on-going to prioritise proposals for the development of further health and care centres (hubs) across the Northern area.

Service Reform

The Northern Trust has been the subject of the implementation of an Improvement Plan. As a result, a Turnaround Team has been working in the Trust and reporting directly to the DHSSPS in respect of the on-going implementation of key recommendations to improve performance. Elements of performance have already been significantly enhanced, for example for the past 4 months breaches of the 12 hour target have been greatly reduced for both the Emergency Departments in the Trust. A range of alternatives to attendance at ED have been developed in partnership with the NLCG and primary care colleagues and further initiatives are planned to ensure on-going improvements to patient care and the development of appropriate and efficient service models across a range of services throughout the Trust. The Northern LCG will continue to support the Northern Trust on this journey.

As the reforms outlined above continue to progress, the impact on the acute sector together with increased efficiency and service improvements, should all combine to result in opportunities to consolidate the number of intermediate and acute beds and the sites on which they are provided, in order to address the changing model of care. Underlying this, there is a need to examine day case surgery and theatre productivity in order to ensure that the best value for money is being achieved and the optimum service is being provided for patients in the Northern area. As highlighted in the Population Plan, when benchmarked with the rest of the UK, fewer Intermediate Care beds are required. Within the Population Plan change in the service model for Intermediate Care was signalled, in that, providing more reablement based care in the person's own home will allow alternatives to bed-based intermediate care to be developed.

7.3 Ensuring Financial Stability & Effective Use of Resources

Use of Resources

The Northern LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £692.3m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Baseline investment by Service Area in 2014/15

Table 318

Programme of Care	£m	%
Acute Services	275.0	39.72
Maternity & Child Health	32.3	4.66
Family & Child Care	46.2	6.67
Older People	154.9	22.37
Mental Health	55.5	8.02
Learning Disability	52.5	7.58
Physical and Sensory Disability	22.8	3.30
Health Promotion	20.8	3.01
Primary Health & Adult Community	32.3	4.67
POC Total	**692.3**	**100.0**

This investment will be made through a range of service providers as follows:

Table 33 Proposed investment by Service Provider in 2014/15

Provider	£m	%
BHSST	131.0	18.9
NHSST	501.7	72.5
SEHSST	5.2	0.8
SHSST	5.8	0.8
WHSST	7.3	1.0
Non-Trust	41.3	6.0
Provider Total	**692.3**	**100.0**

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2014/15 in respect of Emergency Care by the Northern Trust is £15.7m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2014/15 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation and additional funding to take account of the demographic changes in the population of the Northern area. It should be noted that the Learning Disability and Mental Health funds are indicative only at this stage.

Financial Pressures in 2014/15

Table 34

Pressures	**£m**
Demography – Acute Elective > 55 years	1.121
Demography Non Elective > 55 years	1.568
Demography General	7.032
Learning Disability	1.385
Mental Health	1.490
Non Pay	6.063
Pay	4.804
PHA	0.817
RCCE	1.461
Service Pressures	18.647
NICE Drugs	4.571
Total	**48.961**

7.4 Commissioning Priorities and Requirements by POC

7.4.1 POC 1: Acute Services (Non-specialist)

Introduction

Acute non-specialist services are those which provide emergency and planned patient care, from investigation and treatment through to rehabilitation and palliative care. They therefore include radiology, endoscopy and other diagnostic services, outpatients, planned day case procedures or inpatient surgery, and care of patients with acute illness that requires hospital admission. In the Northern area, these services are provided in both Antrim Area Hospital and Causeway Hospital. Day case surgery, outpatient services and rehabilitation are provided in Whiteabbey and Mid Ulster Hospitals. A range of other services are provided in Inver, Robinson and Dalriada Hospitals.

Overview of Local Needs

Elective Demand

GP Referrals

GP referrals to Consultant Led outpatient services account for the majority of the demand to acute services. Over the two years, 2011/12 to 2012/13, there has been approximately a 6% increase in demand across the LCG (from 100,853 to 106,908). Routine referrals increased by 4%, Urgent by 7% and red flags by 25%.

New Outpatient Appointments

The number of new outpatient appointments held has increased significantly, by 13%, (106,463 – 120,577) from 2008/09 to 2012/13 in the Northern area. The average increase across Northern Ireland between 2008/09 to 2012/13 was 14%.

In line with the increase in GP referrals there has been an 8% increase in new outpatient activity between 2011/12 and 2012/13.

Due to identified gaps in capacity and demand the HSCB has purchased additional activity over the last few years. This additionality has been provided by both in house initiatives and also additional activity purchased within the Independent Sector. All activity delivered regardless of the how it was purchased has been included here as this constitutes the demand upon the service.

Review Outpatient Appointments

Between 2008/09 and 2012/13 there has been a 6% increase in review appointments held by Northern LCG residents. There was a 5% increase between 2010/11 and 2011/12, and a subsequent increase of 3% between 2011/12 and 2012/13. The average increase across NI Northern Ireland between 2008/09 to 2012/13 was 8%.

Elective Admissions

Demand for Outpatient services will impact on elective admission and day case activity carried out. As with outpatients above additional activity has been purchased either via additional in house activity or activity being purchased from the Independent Sector and all activity has been included here. The move to meet efficiency targets, such as improved day case rates should have an impact on the admission / day case splits.

Over the five years there has been a 17.2% reduction in elective admissions across the region. Similarly over the last two years in the Northern area, 2011/12 to 2012/13 there has been a 2.9% decrease in elective admissions.

Day case Admissions

As well as increased demand in outpatients with improved efficiency targets there has been an increase in the number of day case admissions. Over the five year period there has been a 20.9% increase and over the last two years

the increase has been 5.3% with the largest increase within Northern LCG residents.

Non Elective Demand

Over the last five years Emergency Department attendances (new and unplanned review) have reduced across the region by 2.1% (from 696,832 to 683,386). Emergency Department attendances in the Northern area have reduced from a high of 171,002 to 164,384 in 2012/13.

Non Elective Admissions

Over the last five years there has been an increase in non-elective admissions of approximately 12% (40,930 - 45,616).

Non Elective Occupied Bed days

While the number of non-elective admissions has increased, the corresponding number of occupied bed days has decreased, possibly suggesting either an improvement in length of stay or an increase in zero day lengths of stay. Over the five years, the number of occupied bed days has decreased by approximately 8%.

Key issues in addressing local needs as highlighted above are:

- to reduce waits at all stages of a patient's journey from their GP to, and through, secondary care;
- to enable GPs to complete more of a patient's management through timely support from secondary care;
- review and take forward opportunities to consolidate the intermediate and acute beds and/or sites, to enable investment in early intervention and intensive acute care.

Addressing these issues will require a transformation in the way in which secondary care is provided across the local health economy. A focus on consolidating capacity and resources over the next 24 months will ensure the continued delivery of effective, efficient, safe and high quality services for the

local population. This will result in significant changes to current patient pathways across secondary (unscheduled and elective), community and primary care.

The Northern LCG will identify current capacity deficits across local Elective and Unscheduled Services and address any deficits to ensure that the local demand is met, within expected timeframes.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. Targets of particular note for the local area are:

Unscheduled care (Ministerial Target 7)

From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.

Hospital readmissions (Ministerial Target 9)

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

Elective care – outpatients / diagnostics/ inpatients (Ministerial Target 11)

From April 2014, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken.

Unplanned admissions (Ministerial Target 21)

By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions (using 2012/13 data as the baseline).

Commissioned Services

The following changes are anticipated for 2014/15.

Current areas for planned investment include:

- Gynaecology and related sub specialties
- Rheumatology
- Cardiology – Rapid Access Chest Pain Clinic
- Dermatology.

The Northern LCG is committed to improving patient access times and to developing enhanced patient pathways across:

- General Surgery (including Day Surgery)
- Pain Services
- ENT
- Gastroenterology
- 7 Day working models for key Diagnostic services
- 7 Day working models for key AHP services.

Unscheduled patient pathways will continue to be developed to ensure existing 4hr and 12hr access times are achieved. The Northern LCG is committed to providing patients with the assessment, investigation and treatment they need, when they need it, through greater Consultant support to enable GPs to manage more of their patients without formal outpatient referral, ED attendance or admission; through active inpatient management and avoiding delays during their hospital stay.

The LCG will focus on:

- Expanding and enhancing the acute assessment unit, which should include both Antrim and Causeway
- Expanding 7-day AHP and Social Work assessment of patients to allow 7-day discharge
- Enhancing 7-day district nursing support with support from specialist staff as required.

- Establishing a Home Oxygen Service for assessment and review
- Implementation of evidence based Obstructive Sleep Apnoea Service
- Development of local support services for long term ventilation in the community
- Enhancing and reforming the stroke service across both the acute and community settings
- Increasing access to insulin pumps for both paediatric and adults
- Enhancing access to self-management programmes for both children and their families and adults who are newly diagnosed with diabetes.

POC 1 – Acute (non-specialist)	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to reduce/flatten demand for outpatients, and Emergency Department attendances.	A dedicated assessment area has been developed on the Antrim site, staffed by the Acute Medical Team, for assessing and diagnosing patients referred by GPs. This service is currently available every weekday between 9am and 5pm, rapid outpatient clinics have also been commissioned aligned to this service. The Northern Trust is expected to take opportunities to build on these arrangements. The Northern Trust is expected to work with commissioners to ensure that opening times and capacity is available to meet demand for this service, and thus reduce demand and pressures on Emergency Department and outpatient clinics. The Northern Trust is also required to work with commissioners to ensure that a model which adopts the same aims and principles can be developed in Causeway.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior	The Northern Trust is expected to ensure that models are developed to allow services to be in place on a 7-day basis on

decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions.	both acute sites. This must include the senior medical decision-makers, radiology, pharmacy, nursing and other key staff necessary to allow a fully functioning 7-day service delivery. Pilots are currently being tested to promote closer liaison with staff within and across the acute sites and those in community and primary care.
Enable district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present.	Northern Trust is expected to continue to work with commissioners to develop and reform community and district nursing services so that patients can either be managed at home and hospital attendance avoided or returned home earlier allowing quicker discharge. Work has already commenced in this area through rapid response nursing developments and Northern Trust must ensure that models are developed in line with commissioner requirements and expectations.
Review and take forward opportunities to consolidate intermediate and acute care beds and the sites on which they are provided	The Northern Trust is expected to : - work to optimise performance across a range of service indicators; and - work with primary and community care to introduce alternative care pathways to, as appropriate, prevent

	admission and facilitate timely discharge.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The Northern Trust is expected to establish a fully functioning GP Access Hub at both Antrim and Causeway sites. This hub will include a fully functioning Acute Medical Assessment Service, available each day on a 9am to 9pm basis. The Access Hub will include both telephone and email advice service for the following specialties: • Care of Elderly • Cardiology • Endocrine & Diabetes • Specialist Palliative Care • Respiratory • Nephrology • Gastroenterology • Diagnostics This Access Hub will provide GP direct access to a senior decision maker at both sites with the aim of preventing ED attendances by allowing rapid outpatient assessment or ambulatory assessment and treatment within 1-2 days. GP direct access to a full range of diagnostic services will

	facilitate the management of patients within Primary Care. The Northern Trust will ensure that models are developed to allow services to be in place on a 7-day basis on both acute sites. This must include the senior medical decision-makers, radiology, pharmacy, nursing and other key staff necessary to allow a fully functioning 7-day service delivery. Pilots are currently being tested to promote closer liaison with staff within and across the acute sites and those in community and primary care.
Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.	The Northern Trust is expected to work with commissioning to improve productivity and efficiency of the commissioned bed capacity and thus achieve a reduction in LOS and thus excess bed days.
Local Priority By March 2015, secure a 5% reduction in the number of emergency readmissions within 30 days (using 2012/13 data as the baseline).	The 30-day readmission level is currently about 10% in Antrim and 7% in Causeway. Commissioning staff will work with NHSCT to reduce this rate in line with the target, by enhancing the scope and level of alternative services available throughout community settings.

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	4,835	33	4,868
	Daycases	13,872	696	14,568
	New Outpatients	51,907	2,279	54,186
	Review Outpatients	95,871	2,286	98,137
Unscheduled	**Non Elective admissions - all**	34,069	1,860	35,929
	ED attendances	130,456	0	130,456
	NIAS Journeys	32,671	696	33,367
	VALUE OF COMMISSIONED ACTIVITY[41]	£275m	£18m	£293m

[41] This includes activity in addition to that set out above.

7.4.2 POC 2: Maternity and Child Health Services

Introduction

The number of births regionally has plateaued in recent years and is now slightly decreasing. Births in the Northern area mirror this regional trend. During 2012/13 there were 4,053 births in maternity units in the Northern Trust, 2,640 in Antrim Hospital and 1,413 in Causeway Hospital. A sizeable number of mothers living in the Northern LCG area choose to deliver in maternity units outside the Northern area. In 2012/13 1,537 Northern LCG mothers delivered in Belfast maternity units, 254 in Southern Trust units, 117 in South Eastern Trust units and 72 in units in the Western Trust. The Northern Trust provides community midwifery services to Northern LCG mothers regardless of whether they deliver in a unit within or outside the Northern area.

Overview of Local Needs

The Northern Trust is now the only Trust in Northern Ireland that does not have a midwife-led maternity unit, however, it is recognised that there is a need for a stand alongside midwife-led unit at Antrim Hospital.

There continue to be very few home births (5 in the Northern area in 2012/13). There has been an increase in births in minority ethnic and migrant mothers and this can pose challenges for maternity, primary care and interpreting services in meeting the needs of these mothers. Caesarean section rates in maternity units in the Northern Trust are relatively high – 30% overall in 2012/13, with Antrim Hospital having a caesarean section rate of 32% and Causeway Hospital 29%.

The teenage birth rate per 1,000 of the female population aged 13-19 in the Northern LCG /HSCT decreased by 4 between 2001 to 2012 from 16 to 12. The Northern Ireland teenage birth rate per 1,000 of the female population aged 13-19 decreased by 3.9 for the same period, from 16.9 to 13.0.

There are challenges in staffing the consultant obstetric unit at Causeway

Hospital to a safe level. The TYC 'Vision to Action' consultation document (2012) stated that it is probable that there will be change in obstetric services at the Causeway Hospital over the next 3 to 5 years as it is not likely to be possible to maintain a safe and sustainable consultant-led service there.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. Targets of particular note for the local area are:

Family Nurse Partnership (Ministerial Target 2)

By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

The Northern LCG will work with the Trust to implement the strategic shifts recommended in TYC and the Strategy for Maternity Care in Northern Ireland 2012/2018 to provide more antenatal care closer to home in the community; and for women with straightforward pregnancies care will be provided primarily by the midwife with greater continuity of care.

The Northern Trust is taking part in a regional maternity quality improvement collaborative and a regional review of community maternity services, and is also working towards an agreed regional approach to the management of multiple pregnancies in line with a recent NICE guideline. The Northern Trust has developed a very active Maternity Services Liaison Committee 'Maternity Matters' that gives service users the opportunity to influence maternity services.

POC 2 – Maternity and Child Health	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: - written and oral communication for women to enable an informed choice about place of birth; - Services in consultant led obstetric and midwife-led units available dependent on need; - Promotion of normalisation of birth, leading to reduction of unnecessary interventions.	The Northern Trust is expected to develop proposals for sustainable service models for maternity units that meet the standards of the Maternity Strategy.
Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129.	The Northern Trust is expected to work with other Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129.
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife led antenatal care in the community for women with straightforward pregnancies.	The Northern Trust is expected to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife-led antenatal care in the community for women with straightforward pregnancies.
Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained	The Northern Trust is expected to continue to benchmark their local obstetric intervention rates against peer units

variation in intervention rates throughout Northern Ireland.	and to reduce unexplained variation in intervention rates.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The Northern Trust is to continue with the provision of a Smoking and Pregnancy Service for antenatal clinics in addition to satellite booking clinic referrals within the Northern area. - All antenatal bookings will have their smoking status recorded with the information held on the Trust NIMATs. - The NIMATs information is screened by the smoking cessation specialist working within the antenatal services at Antrim Area Hospital, Causeway Area Hospital, Mid Ulster Hospital, Braid Valley Hospital site and Larne, Carrickfergus and Whiteabbey Hospital sites. - Specialist cessation support services to pregnant smokers and their partners will be offered by four pregnancy stop smoking specialists across all sites.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	Births	4,072	-72	4,000
	Comm Midwives	Contacts	110,663	0	110,663
	Health Visiting	Contacts	98,956	0	98,956
	Speech and Language Therapy	Contacts	31,714	0	31,714
		VALUE OF COMMISSIONED ACTIVITY[42]	£32.3m	£1.5m	£33.8m

[42] This includes activity in addition to that set out above.

7.4.3 POC 3: Family & Child Care

Introduction

The Children and Families Commissioning remit includes all statutory social work services and, as such, the functions are prescribed within legislation and remain subject to a high level of monitoring and scrutiny, internal and external to the Health and Social Care Trusts, to be assured that these functions are effectively discharged.

In addition, the Health Visiting Service, AHP services for children, Child and Adolescent Mental Health as well as children with a disability, including autism, sit within this programme of care.

Overview of Local Needs

The Northern Trust has the highest population of children (aged 0-17 years of age) in Northern Ireland at 108,700 which represent 23% of the total. There were 5,052 children in need on 31st March 2013 of whom 1,593 had a disability (36.5% of all children in need in Northern Ireland). This represents the second highest in the region. There were 525 children on the Child Protection Register, the highest in the region and 701 looked after children, the highest figure of all Trusts.

In the Northern Trust, there has been a large increase in the number of looked after children in the last 10 years from 548 in 2001/2002 to 701 in 2012/2013.

In addition, there has been an Increase in the number of children on the Child Protection Register from 281 in 2001/02 to 525 in 2012/13.

The number of children in need has risen from 3,137 in 2009/10 to 5,052 in 2012/13 representing an increase of 61%.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

Children in need, children on the Child Protection Register, and those in care are among the most vulnerable and disadvantaged in society with significantly reduced life chances.

As a result of dysfunctional or fractured family relationships, abuse and neglect these children and young people encounter significant obstacles to having a stable family life and to progressing in education to enjoying learning and achieving and reaching their potential. Work undertaken within the Trust indicated that children on the child protection register did not exclusively reside in areas of highest deprivation.

In line with the TYC recommendations and Board policy, five Family Support Hubs are operational within the Trust area with a further one to be become operational during 2014/15. The Northern Outcomes Group in line with the CYPSP is in place with a focus on early intervention and commissioning aligned to priorities identified within the locality plan. The current priority is early intervention and family support to children with a disability.

In keeping with Departmental direction for CAMHs services the Trust is progressing proposals for service enhancement in line with Board commissioning requirements.

POC3 – Family and Child Care	
Regional Commissioning Priority	**Local Commissioning Requirement**
Enhance the Health Visiting workforce to provide the full Core Universal Service as set out in Healthy Child Health Future.	The Northern Trust is expected to work with the LCG to achieve this regional objective.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

7.4.4 POC 4: Older People's Care

Introduction

The main focus in this programme of care is the need to reform services in order to respond to a growing older population who seek to retain optimum health and independence for as long as possible. Transforming Your Care highlights the need to focus on prevention and supporting people at home. There is also the need to address the challenges presented by the growing numbers of people with dementia.

Overview of Local Needs

According to the 2012 Mid-Year Estimates:
15% (272,819) of the NI population are aged 65+ years.
Of the 65+ population, the Northern Trust has the highest proportion at 26.8% (73,251).

- 1.8% (32,713) of the NI population are aged 85+ years.
  Of the 85+ population, the Northern Trust has the highest proportion at 26.1% (8,541).
- Life expectancy for males in the Northern Trust area for 2008- 2010 is 77.9 years; for females is 82 years.

In the Northern area, the rise in the number of older people is placing significant demands on domiciliary care. The numbers of clients requiring packages has risen from 4,038 in 2010/11 to 4,762 in 2013/14. The average domiciliary care package per service user has also increased reflecting the increasing levels of complexity. However, it is also the case that admissions to nursing and residential care have decreased in light of the drive to maintain people in their own homes when this is a safe and appropriate option.
The number of permanent care residents has fallen from 2,486 in 2011/12 to 2,319 in 2013/14.

Alzheimer's Society Dementia UK states that 1 in 14 people over the age of 65 years have dementia. This rises to 1 in 6 over the age of 80. In 2012, the

diagnostic rates for Northern Ireland showed that 51.4% of people with dementia have received a diagnosis. The Northern Trust is ranked 52nd across the UK for diagnosis rates.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

The introduction of reablement has been a key feature in the promotion of independence for older people in the Northern area. Reablement is operational in all areas and during the period October 2012 to September 2013, 1,514 clients have been through the reablement service. This represents 2.07% of the 65+ population and 39% of this cohort of clients required no on-going care.

During 2013/14 the NLCG invested significantly in domiciliary care and reablement, recognising both the on-going pressures and the need for transformation. The LCG also worked with the Northern Trust, the PHA, local government and the voluntary and community sector to form a partnership arrangement in the Causeway area – the Causeway Community/Voluntary Sector Partnership. Funding has been allocated to a Community Navigator post which will be based in the voluntary and community sector to act as a resource for both signposting and capacity building. This is a pilot and evidence gathered will inform the future roll out of this model across the area. The NLCG has formed links with voluntary organisations such as Causeway Older Active Strategic Team (COAST), Mid and East Antrim Agewell Partnership (MEAPP) and Agewell Mid Ulster to build greater collaboration with this sector and engage in meaningful dialogue in respect of commissioning decisions.

Transforming Your Care highlighted the on-going trend towards independent living, at home, or in supported accommodation. Within the Northern area there are two existing supported housing developments, Barn Halt Cottages with 26 units and The Brook with 55 units. Work has commenced to develop a Supported housing development of 36 units in Greenisland and planning is on-going for further developments in Ballycastle and the Newtownabbey area.

In recognition of the growing numbers of people with dementia, the NLCG has invested significantly in services to support people with dementia and their carers with the overall aim of enabling people to live at home for as long as possible. The Dementia Home Support team provides a service to people whose behaviour has become challenging, thereby preventing unnecessary hospital admissions, placement breakdown for people in care homes and admissions to care homes for people living at home. The Northern Local Enhanced Service (LES) was implemented at the beginning of 2013 in order to ensure that patients on relevant registers would be reviewed and offered advice as appropriate regarding dementia. Memory clinics offering early assessment in collaboration with primary care professionals have also been introduced. As Integrated Care Partnerships develop and GPs risk stratify their high risk populations, this will assist in the identification of high risk people with dementia. Investment has been allocated to the development of respite for carers with an emphasis on exploring innovative ways of delivering respite with the voluntary and community sector.

A multidisciplinary group has been formed under the Integrated Care Partnership framework locally, in order to take forward developments for the frail elderly population. This group has begun work on a wide variety of issues ranging from the introduction of rapid response teams and initiatives to prevent social isolation and improve nutrition, to enhanced telecare/ telemonitoring arrangements and exploring the potential for virtual wards. The group is also examining the journey for the frail elderly who need acute care with the aim of enhancing this experience as part of the overall pathway.

POC4 – Older People	
Regional Commissioning Priority	**Associated Local Commissioning Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The NHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The NHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase uptake of direct payments.	The Northern Trust is expected to achieve an increase on the uptake of direct payments equivalent to a 5% increase on the 2013/14 baseline. This would equate to an additional 39 payments,
Working with ICPs to improve the care of the frail elderly.	The Northern Trust is expected to continue to participate as a member of the ICP for Frail Elderly.
Enhancement of dementia services	The Northern Trust is expected to work with local and regional commissioners and within the ICP framework to apply new funding streams for dementia as agreed.

Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements.	The Northern Trust is expected to work with local and regional commissioners to develop an appropriate model for intermediate care in the Northern area. This should progress the reforms highlighted in the Northern area Population Plan moving towards a consolidation of beds and facilities in line with benchmarked information from across the UK.
Continued roll-out of targeted Public Health Agency (PHA) preventative health and well-being improvement programmes.	The Northern Trust is expected to continue to work with PHA on preventative health and well-being improvement programmes.
Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The NHSCT is expected to work with local and regional commissioners to evaluate the reablement arrangements and structures which the Trust has implemented to date.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied Beddays	48,609	0	48,609
	Day Care	Attendances	31,066	0	31,066
	Domiciliary Care	Hours	2,141,149	13,184	2,154,333
	Residential & Nursing Homes	Occupied Beddays	956,996	18,980	975,976
	Community Nursing & AHPs	Face to face contacts	452,217	0	452,117
	Social Work	Caseload	7,461	0	7,461
		VALUE OF COMMISSIONED ACTIVITY[43]	£154.9m	£6m	£160.9m

[43] This includes activity in addition to that set out above.

7.4.5 POC 5: Mental Health

Introduction

Within mental health services, the Bamford vision remains fundamental to the development of modernised services which address the needs of the local population. To make this a reality for people with mental illness, we need to ensure the provision of recovery focussed, person-centred, community-based services, informed by the views of service users and their carers. Early intervention is a key priority alongside protecting and promoting people's mental health.

Overview of Needs

The Quality and Outcomes Framework (QOF) measures general practice achievement against a range of evidence-based indicators and provides raw disease prevalence data by a total of 17 clinical areas. In 2013, the raw prevalence of patients (per 1,000 patients) on the Mental Health Register was 7.5 and on the Dementia Register was 8.0 for the Northern Trust.

In the Northern LGD/Northern Trust, there were 103 admissions to hospital as a result of mood or anxiety disorder in 2009/10. The data is extracted from the Northern Ireland Hospital Inpatients System (HIS), but excludes mental health specialities as not all mental health information is recorded on PAS.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. Targets of particular note for the local area are:

Mental health services (Ministerial Target 33)

From April 2014, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

- Building on the success to date, in the coming year, the Northern Trust should resettle 5 mental health long stay patients and 13 delayed discharges from hospital into community placements with suitable social care and community services infrastructure to support them.
  In keeping with regional strategic direction, the Northern Trust should establish integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of Primary Care Psychological Therapy Services.
  The Northern LCG will commission an integrated care pathway for the care and treatment of patients with common mental health needs including continuing to work with the Northern Trust, primary care and the community and voluntary sectors to establish a pilot Referral Hub and Primary Care Coordinator across two sites. The pilot will be evaluated on completion in order to roll out across the Trust area in due course.

  An adult Autism Diagnostic service has been established for adults with autism, without an identified learning disability.

- The appointment of a Recovery Facilitator to enhance recovery focused work in the Trust has created a drive and impetus within mental health services. This work is progressing with the full involvement of service users, voluntary sector providers and staff from both in patient care and community services.
- Additional funding has secured to enable the psychiatric liaison service to be modernised. The enhanced care pathway, new triage format and amended assessment tools are being piloted to improve access to mental health assessment, for those presenting with self-harm, prior to discharge from Emergency departments.

POC 5 – Mental Health	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The NHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The NHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase the uptake of direct payments.	The Northern Trust is expected to achieve an increase on the uptake of direct payments equivalent to a 5% increase on the 2013/14 baseline. This would equate to an additional 5 payments per month.
Implementation of the Protect Life Strategy	The Northern Trust is expected to work to achieve the regional objectives including:

	• Contributing to the development of an improved model of support for those who self-harm. • Specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. • Supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed memorandum of understanding
Establishment of integrated care arrangements for the care and treatment of patients with common mental health needs	The Northern Trust is expected to work with the regional team to roll out the model for integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of Primary Care Psychological Therapy Services over the period of the next 2 years.
Implementation of the Crisis Resolution Home Treatment services for CAMHs	The Northern Trust is expected to work to achieve the regional objectives as specified.
Further development of specialist community services	The Northern Trust is expected to work to develop Specialist Community Services including the introduction of Adult Autism Advice Service in Ballymena initially.

Improve Psychiatric Liaison Services to ensure a maximum 2 hours response time in Emergency Departments	The Northern Trust is expected to work to achieve the regional objectives as specified.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied Beddays	69,012	0	69,012
	CPN	Contacts	45,995	0	45,995
	Res & Nur Homes + Supported Housing	Occupied Beddays	57,172	0	57,172
	Day Care	Attendances	21,415	0	21,415
	Dom Care	Hours	54,561	602	55,163
		VALUE OF COMMISSIONED ACTIVITY[44]	£55.5m	£2m	£57.5m

[44] This includes activity in addition to that set out above.

7.4.6 POC 6: Learning Disability

Introduction

The key aims of services in this programme are to promote independence for people with a learning disability in inclusive activities in the community (locally referred to as day opportunities) which promote their health and wellbeing and to support families who in care for the majority of children and adults with a learning disability. These aims should increasingly be met through partnership working with other statutory agencies and with voluntary and community providers.

Overview of Local Needs

In January 2013, 4.97 per 1,000 people over 18 years were recorded as having a learning disability in the Northern area. The regional figure is 5.16.

The population of people with learning disability is continuing to rise in line with the increase in the average lifespan. Consequently there are greater numbers of people with a learning disability reaching adulthood and requiring day opportunities and appropriate community support.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. A target of particular note for the local area is:

Learning disability (Ministerial Target 32)

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

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

Building on the success to date, in the coming year, the Northern Trust should resettle 5 Learning Disability long stay patients and 7 delayed discharges from hospital into community placements with suitable social care and community services infrastructure to support them.

There has been a Public Consultation on a regional day opportunities model for adults with a learning disability. The day opportunities currently provided in the Northern area are well established with 9 Bases in operation providing day opportunities to more than 500 people with learning disabilities, further opportunities should be explored to build on this successful model.

The Northern Trust is currently developing a Short Breaks Strategy for carers of people with a learning disability, involving key stakeholders in the review of current provision which includes bed-based services, Share the Care and use of direct payments. This will be further developed during 2014/15.

POC 6 – Learning Disability	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The NHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The NHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
Delivery of day services in line with the Regional Day Opportunities Model	The Northern Trust is expected to further enhance existing day opportunities model. This model which has resulted in the development of “bases” across the area should continue to be rolled out. Further work is planned for the Larne, Carrickfergus and Newtownabbey area. Satellite units are being developed.

Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	The Northern Trust is expected to work to achieve the regional objectives as specified.
To increase the uptake of direct payments.	The Northern Trust is expected to achieve an increase on the uptake of direct payments equivalent to a 5% increase on the 2013/14 baseline. This would equate to an additional 36 payments during 2014/15.
Development and implementation of health promotion initiatives for people with a learning disability.	The Northern Trust is expected to work to achieve the regional objectives as specified.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied bed days	32120	0	32120
	Day Care	Attendances	135146	3690	138736
	Domiciliary Care	Hours	77021	471	77492
	Residential & Nursing	Occupied bed days	115386	0	115386
	Community Nursing and AHPs	Face to face contacts	38253	0	38253
	Social Work	Active Caseload	1989	0	1989
		VALUE OF COMMISSIONED ACTIVITY[45]	£52.5m	£5m	£57.5m

[45] This includes activity in addition to that set out above.

7.4.7 POC 7: Physical disability & sensory impairment

Introduction

The Northern area has participated in the work streams arising from the roll out of the Physical and Sensory Disability Strategy 2012-2015. The key themes are: Personalisation; Service Redesign; Transition Support and Planning; Equipment – Procurement and Standardisation; Rehabilitation; Transport; Respite/Short Break Care; Information, Advice and Advocacy; Provision of Skilled Workforce; Day Opportunities and Housing.

Progressing all of these themes will be key to the further development of innovative services locally.

The Northern area will also participate in the development of self-directed support as a new and innovative model locally.

Overview of Local Needs

The following tables provide an overview of the current prevalence of a range of long term conditions and indicate where adaptations to accommodation have been required. There is also a growing need associated with the number of complex cases where patients are discharged home with high cost packages. Further work is required to analysis this trend.

Prevalence of a range of Long term conditions for the Northern Ireland Population and for LGDs in Northern Trust /LCG area from the 2011 Census.

Table 35

	Antrim	Ballymena	Ballymoney	Carrickfergus	Coleraine	Cookstown	Larne	Magherafelt	Moyle	Newtownabbey	NHSCT	Northern Ireland
All usual residents	53428	64044	31224	39114	59067	37013	32180	45038	17050	85139	**463297**	1810863
Deafness or partial hearing loss (%)	4.68	5.17	4.76	6.06	5.5	4.4	5.86	4.21	5.49	5.5	**5.17**	5.1
Blindness or partial sight loss (%)	1.38	1.54	1.5	1.74	1.58	1.46	1.83	1.4	1.81	1.69	**1.58**	1.7
Communication difficulty (%)	1.58	1.35	1.47	1.56	1.44	1.58	1.44	1.44	1.76	1.53	**1.49**	1.7
A mobility or dexterity difficulty (%)	10.01	10.1	11.13	11.98	10.33	11.53	11.22	9.44	11.61	11.14	**10.72**	11.4
A learning, intellectual, social or behavioural difficulty (%)	2.23	1.67	1.93	2.2	1.96	2.03	2.04	1.97	2.06	1.94	**1.98**	2.2
An emotional, psychological or mental health condition (%)	4.96	4.53	4.72	5.65	4.92	6.38	4.89	4.58	4.95	5.19	**5.05**	5.8
Long-term pain or discomfort (%)	9	8.79	9.86	11.07	9.52	10.34	10.53	8.42	10.41	9.91	**9.65**	10.1
Shortness of breath or difficulty breathing (%)	8.03	7.73	8.01	9.45	8.03	8.41	9.17	7.69	8.35	9.06	**8.38**	8.7
Frequent periods of confusion or memory loss (%)	1.63	1.73	1.57	1.99	1.66	1.91	1.71	1.51	1.77	1.75	**1.72**	2.0
A chronic illness (%)	6.04	6.66	6.25	7.6	6.66	5.86	7.44	5.45	6.91	7.06	**6.6**	6.6
Other condition (%)	4.99	4.97	5.2	5.48	5.01	4.86	5.51	4.82	5.03	5.34	**5.12**	5.2
No condition (%)	70.56	70.37	69.42	66.34	68.69	69.59	66.96	71.99	68.32	68.46	**69.21**	68.6

Source: Census, 2011 NISRA

Adaptation of Accommodation – Northern LCG

Table 36

LCG	All households	Wheelchair usage (%)	Other physical or mobility difficulties (%)	Visual difficulties (%)	Hearing difficulties (%)	Other (%)	No adaptation (%)
Northern LCG	**177914**	**6.1%**	**6.2%**	**0.2%**	**0.4%**	**0.2%**	**88.5%**
Antrim	20064	6.6%	6.2%	0.2%	0.4%	0.2%	88.1%
Ballymena	24817	6.5%	5.7%	0.2%	0.5%	0.2%	88.6%
Ballymoney	11508	7.8%	5.4%	0.2%	0.3%	0.1%	87.8%
Carrickfergus	16200	4.5%	6.9%	0.3%	0.6%	0.2%	89.5%
Coleraine	23508	5.4%	5.8%	0.2%	0.5%	0.2%	89.5%
Cookstown	12904	9.0%	7.7%	0.3%	0.3%	0.1%	84.4%
Larne	13297	4.7%	5.5%	0.3%	0.3%	0.4%	90.2%
Magherafelt	15037	9.2%	5.8%	0.3%	0.4%	0.2%	85.8%
Moyle	6608	7.5%	6.7%	0.3%	0.4%	0.2%	86.5%
Newtownabbey	33971	3.9%	6.5%	0.3%	0.5%	0.2%	90.2%

Source: Census, 2011 NISRA

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15.

Commissioned Services

The Northern LCG has invested in additional respite for young adults with physical disabilities, including those with brain injury and MS. These are specialist placements at Cuisle and Corrymeela. The Commissioner would want to see the continuing development of more innovative respite placements for people with a physical disability and/or sensory impairment.

Investment has also been targeted towards those clients with more complex needs in order to enable these clients to return home following treatment in a timely manner.

With the increasing demographic pressures and earlier hospital discharges, there is also on-going pressure on the wheelchair budget. The Northern LCG has invested in the wheelchair budget but acknowledges the service improvement work on-going locally to improve the efficiency and effectiveness of the service in the Northern area.

POC7 – Physical Disability and Sensory Impairment	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The NHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The NHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase the uptake of direct payments	The Northern Trust is expected to achieve an increase on the uptake of direct payments equivalent to a 5% increase on the 2013/14 baseline. This would equate to an additional 38 payments.
Review Trust progress in relation to the review and reform of day opportunities in alignment with personalisation strategies.	The Northern Trust is expected to continue to participate in the roll out of the Self Directed Support Initiative.

Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability and SI	**Hospital services**	Occupied beddays	6,660	0	6,660
	Day care	Attendances	18,985	0	18,985
	Domiciliary care	Hours	325,448	2,000	327,448
	Resid & Nursing Home	Occupied beddays	33,581	0	33,581
	Community nursing & AHPs	Contacts	49,528	1,167	50,695
	Social work	Active caseload	1,322	0	1,322
		VALUE OF COMMISSIONED ACTIVITY[46]	£22.8m	£1.1m	£23.9m

[46] This includes activity in addition to that set out above.

7.4.8 POC 8: Health Promotion & Disease Prevention

Introduction

Amongst the aims of this programme locally are the need to ensure the delivery of programmes to promote the health and wellbeing of older people by reducing social isolation (including engaging with the Arts and Health Project); improving signposting and referrals to relevant support services; falls prevention services; reducing the risk of malnutrition and dehydration; increase the provision of targeted health and wellbeing approaches within the care of individuals with dementia; provide opportunities for people to participate in physical activity and work with others to reduce the effects of poverty.

There is also a requirement for the Northern Trust to continue to engage with PHA and others to reduce the impact of poverty on clients and patients, particularly those with mental health issues, addictions, older people and families with young children.

The issue of Accident Prevention remaining a key focus and the Northern Trust should continue to work with PHA and others to reduce the incidences of unintentional injuries in the home, communities and health care settings.

Overview of Local Needs

The Northern area shows a mixed profile of prevalence of patients on registers of all key measures. Mental health, learning disability, and dementia show a lower prevalence, with a higher than average in heart disease, stroke, hypertension, obesity and diabetes

The following tables highlight particular local information for example, there were 15 obesity-related deaths in the Northern HSCT from 2007 to 2011.

Comparison of Key Health Indicators against NI Total

Table 37

Comparisons	Northern Area	NI
Alcohol related deaths (2011)	51	252
Drug related deaths (2011)	18	102
Obesity related deaths (2007-2011)	15	43
Raw prevalence of patients (per 1,000) on the Obesity Register aged 16 and over (2013)	108.1	110.8
Percentage of people who had self-reported they had successfully quit smoking at 4 weeks (2012/13)	53.0%	56.6%
Teenage birth rate (per 1,000 of the female population aged 13-19) (2012)	12	13.0

Source: NISRA

Hospital Admissions due to Accidents, 2009

Table 38

	2009			
LGD	Admissions due to accidents	Admissions due to injuries from Road Traffic Collisions	Admissions due to accidental injuries in the Home	Admissions due to accidents occurring at School
Antrim	463	44	71	11
Ballymena	505	73	82	9
Ballymoney	218	33	44	5
Carrickfergus	308	41	55	12
Coleraine	446	47	98	18
Cookstown	325	43	59	11
Larne	276	26	32	9
Magherafelt	346	50	47	10
Moyle	118	19	28	3
Newtownabbey	649	59	111	20
Northern Trust	**3654**	**435**	**627**	**108**
Northern Ireland	**14928**	**1579**	**3423**	**480**

Number of alcohol related deaths by Health and Social Care Trust and registration year, 2002-2012

Table 39

Registration Year	Northern	Total
2002	50	**238**
2003	39	**214**
2004	39	**255**
2005	49	**246**
2006	59	**248**
2007	60	**283**
2008	67	**276**
2009	58	**283**
2010	53	**284**
2011	51	**252**
2012[P]	44	**270**
Total (2002-2012)[P]	**569**	**2,849**

Source: NISRA

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however the following developments are anticipated.

A number of highly effective programmes, Maximising Access in Rural Areas (MARA), community grants programmes and the Farm Family Check Scheme, have delivered real improvements to the health and wellbeing of rural communities. It is important that the potential of these programmes is maximised during the coming year.

Emotional Wellbeing and Suicide Prevention

The Deliberate Self Harm Registry is now operational within the Northern Trust area and this unique data system is being used to inform service development and efforts to reduce deaths by suicide. Northern area also has in place a community response plan which enables an effective multi-agency response

within communities should there be a potential suicide cluster or community concern, the activation of this plan during this year was thankfully limited but effective when needed. The Public Health Agency (PHA) in Northern area works very closely with sub regional rural community networks to support community grants and community development posts to help build community capacity and reduce suicide.

Tobacco

Smoking cessation services have continued to remain effective with the quit rate steady at over 50% at 4 weeks. Three new regional public information campaigns have been successfully developed and evaluated to accompany action programmes on the ground; obesity prevention, stop smoking, and mental health and wellbeing. Within the Northern area services will continue to particularly target disadvantaged communities, workplaces and pregnant women.

Sexual Health Services

The Northern Trust and Northern Regional College have established a very successful model for sexual services within the Further Education Sector, which is reaching out to many young people who would not access services within the more traditional health and social care setting.

Joint Working with Local Government

Joint working continues across all of our local government areas and in particular with the cluster groups which have come together to reflect the proposed new local council areas. The following examples of work during this year with local government will continue to be developed and expanded on in the coming year.

Causeway Coast and Glens and Mid and East Antrim Cluster (CCGMEA)

On 17 January 2013 the work of the Cluster was officially launched as a model of good practice at a 'Tackling Fuel Poverty Together' event in Stormont. This work has included a Community Oil Drop Scheme, a Home Energy

Efficiency Service, an Energy Detectives school based awareness programme, and Motivational Interviewing Training for local Energy Efficiency Advisers. The Community Oil Drop Scheme has been rolled out in a number of other council areas and there are now 13 schemes active in the CCGMEA area, with a hope for an additional 10 to be up and running during 2014.

Launch of New Mossley Community Allotments

The Public Health Agency in partnership with Newtownabbey Borough Council, NI Housing Executive and New Mossley Community Group has launched the 'New Mossley Community Allotments.

Parkrun at Carnfunnock Country Park

The Public Health Agency provided funding to support the introduction of the Parkrun initiative in Carnfunnock Country Park within Larne Borough Council.

POC 8 – Health Promotion	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Expansion of the early years intervention programme.	• Co-ordinated approach developed across relevant areas of Trust Business. • Extend Roots of Empathy in all Trust areas. • As per FNP targets. • Delivery of infant mental health training as per agreed action plan. Implementation of 5 new Early Intervention programmes to support parents.
Incremental expansion of social economy businesses and community skills development.	Report detailing numbers of social economy businesses engaged. Poverty – Northern Trust is expected to engage with PHA and others to reduce the impact of poverty on clients and patients, particularly those with mental health issues, addictions, older people and families with young children.
Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	• A Co-ordinated approach should be developed across relevant areas of Trust Business and in conjunction with other statutory, community and

	voluntary partners. • Improved access and uptake of targeted health and wellbeing improvement services and programmes by older people.
LCGs to monitor Trust performance in relation to the HSCB / PHA Community Development strategy	The Northern LCG will work with the Northern Trust to monitor performance on an ongoing basis.
Implementation of the "Fitter Futures for All Framework".	• Weigh to a Healthy Pregnancy Programme for women with BMI >40 established in Trusts. • Report on implementation of new 'Baby Friendly' standards. • Report on provision of weight loss programmes for adults and children as appropriate. • Report on contribution to implementation of new standardised Regional Activity Referral Programme • Report from regional working group on progress towards healthier catering and vending provision in all HSC facilities.

Implementation of key public health strategies.	• Northern Trust is expected to work towards becoming smoke free at all campuses and sites within their estate, in addition "Pregnant smokers, pre-op smokers, patients with long term conditions and cancer and staff and clients within the mental health setting will avail of stop smoking support with uptake increased and quit rates at a minimum of 45% at four week follow up" • Smoking Cessation services should be available with identified groups. Brief Intervention Training should be delivered to key staff working with priority groups. • A Progress report on smoke free premises should be made available. • New service model for substance misuse liaison services is in place. • 7 days services which prioritise individuals presenting to Emergency Departments, acute

	medical/ surgical admission wards and other settings within the acute sector for identification/ health improvement (screening/ brief intervention), treatment and support for substance misuse and associated mental health; • Update of Registry and new service model developed and delivered. Northern Trust is expected to provide evidence of services pro-actively reaching out to more vulnerable groups.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	Northern Trust is expected to provide monitoring report outlining range of specialist sexual health services available, numbers and age groups accessing services.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

7.4.9 POC 9: Primary Health and Adult Community

Introduction

This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability.

GMS in the Northern area are delivered by 78 general medical practices. There are 90 general dental practitioners and 117 community pharmacies.

Overview of Local Needs

(Please see section 7.1 LCG Population)

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. Targets of particular note for the local area are:

Integrated Care Partnerships (Ministerial Target 26)

By March 2015, 95% of patients within the four ICP priority areas [frail elderly, diabetes, stroke, respiratory] will have been identified and will be actively managed on the agreed Care Pathway.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

Following an analysis of current prescribing patterns within Northern LCG GP practices and taking account of the Pharmaceutical Clinical Effectiveness Programme, a number of priority therapeutic areas continue to be of highest

cost within the Northern locality and have the greatest potential to release efficiencies. In light of this, the NLCG has funded protected time to all GP practices until March 2015. Additional funding has also been allocated to a practice support pharmacist, a medicines management dietician and to extend a pharmacist prescriber led medication review in nursing homes.

During 2013/14, non-recurrent prescribing savings were made available to the Northern LCG to fund a number of initiatives. These have included: support for the Musculoskeletal (MSK) pathway development by training and development for GPs on pain related prescribing and the use of ultrasound guided injections; the extension of the dermatology photo triage service; direct access audiology and training for GPs participating in memory assessment for people with dementia. All of these initiatives clearly demonstrate an adherence to the principles of TYC.

The Northern LCG will continue to work to improve its position with regard to prescribing costs.

Primary Care Infrastructure

In recent years, there has been relatively modest investment in primary and community care infrastructure in the Northern LCG area. An assessment of existing Trust and GP estate indicates that a significant proportion of the infrastructure is well below current standards and not fit for purpose. A new-build Health and Care Centre is being constructed in Ballymena which will accommodate a number of GP practices and a range of other community services. It is recognised that the development of primary and community infrastructure is pivotal to the delivery of TYC. In light of this, the Northern LCG has been working with GPs and Northern Trust colleagues to assess the need for hubs and spokes across the Northern area. The emphasis is on projects which will support service integration, modernisation and reform and which will be acceptable to the local population and the communities served. In addition to the Health and Care Centre in Ballymena, it is likely that health and care centres of differing scale would be required in locations throughout

the Northern area. There will also be work required to bring other practices, known in this model as spokes, up to standard, particularly with regard to space requirements for any additional services/clinics.

MSK/Pain

A project has been developed locally with the aim of identifying a solution which will provide sustainable MSK/Pain services for patients, will deliver world class outcomes, support and reduce demand from other clinical services and improve equity of access to high quality care. The project has involved a wide range of stakeholders from the Northern LCG, Primary and Secondary care and service users and carers. The pathway is being developed across 3 levels: self-help, psychological education/analgesics and health promotion; injections; surgical nerve treatment and individual psychological therapy. Across these levels scrutiny is applied to the aspects of referral management / triage; diagnostics; prescribing support/medicines management; self-management; assessment/recall/review and treatment/interventions. A group of service users has met twice to date, to provide very valuable insight into their experiences of the current services and to suggest improvements from their perspective. A draft pathway has been developed and is currently with the project team for further refinement. This will be rolled out during 2014/15.

POC 9 - Primary Health and Adult Community	
Regional Commissioning Objectives	**Local Commissioning Intent 2014/15**
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility. A Regional Commissioning Framework for Community Nursing will be developed.	The Northern Trust is expected to work with the LCG to achieve this regional objective.
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	LCG to work with ICPs to implement LES to achieve this objective.

8.0 South Eastern Local Commissioning Group (LCG) Plan

8.1 LCG Population

Demographic Drivers

The South Eastern LCG covers an area which can be characterized as a mix of urban and rural settlements. The main population centres include Lisburn, Downpatrick, Bangor and Newtownards and covers the current local government districts of Ards, Down, Lisburn and North Down. These areas are co-terminus with the boundaries of the South Eastern Health & Social Care (HSC) Trust.

- The population of the South Eastern LCG in 2012 was 350,000 this is anticipated to rise by 5% to 368,000 by 2023.

- Across the ICP areas the largest increase in population is in the Lisburn area with an 8% increase (119,000-129,000) and the smallest increase is in North Down with just a 1% change in the population (80,000-80,117). Ards and Down population is expected to rise by 5% and 6% respectively.

- Currently, people 65 years old and over account for 16% of the total population of the South Eastern LCG (57,000 people). The south east locality hosts a proportionately larger share of Northern Ireland's older population as its 65 and over population accounts for 21% of all older people in Northern Ireland (273,000 people). This fact is to be welcomed as it reflects the advances that have been made in health and wellbeing allowing current generations to enjoy longer lives.

- However, it is inevitable that as people grow older, the likelihood of illness increases as does their need for health and social care services. Older people are increasingly more likely to be living with more than one long term chronic conditions.

If we look at population projections for our older population, it is clear that there will be a sharp increase in this demographic. Our over 85 year old population (highlighted in Table 42) is increasing at a faster rate than other age bands. By 2015 there will be a 21% increase in the 85+ population compared to 2011 and by 2019 there will have been a 48% increase in that age group compared to 2011.

Population Trends by Locality (0-64 population)
Table 40

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Belfast	284,754	284,949	285,215	285,617	285,898	286,103	286,375	286,349	286,398	286,277	285,993	285,513	284,816
Northern	391,993	392,555	393,337	394,142	394,819	395,483	396,066	396,591	397,079	397,503	397,672	397,657	397,438
South Eastern	292,788	292,856	292,831	292,876	292,972	293,232	293,401	293,620	293,625	293,738	293,484	293,189	292,610
Southern	315,925	319,230	322,531	325,770	329,015	332,352	335,694	338,858	341,941	344,905	347,654	350,170	352,519
Western	262,872	263,290	263,703	263,967	264,134	264,254	264,376	264,393	264,264	263,968	263,560	263,101	262,497
Northern Ireland	**1,548,332**	**1,552,880**	**1,557,617**	**1,562,372**	**1,566,838**	**1,571,424**	**1,575,912**	**1,579,811**	**1,583,307**	**1,586,391**	**1,588,363**	**1,589,630**	**1,589,880**

(Source: NISRA, 2008 Based Population Projections)

By 2023, it is projected that the 0-64 population in NI will be approximately 1.59 million; an estimated increase of 2.7% from 2011.The South Eastern area however indicates a small projected decrease in population (0.06%) within this age band. The Southern area is projected to have the highest growth (11.6%) and the Western the lowest, with a projected decrease of 0.1%.

Population Trends by Locality (65+ population)
Table 41

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Belfast	52,285	52,697	53,017	53,183	53,467	53,836	54,143	54,744	55,268	55,936	56,734	57,683	58,802
Northern	71,527	73,876	75,912	77,834	79,785	81,725	83,706	85,693	87,661	89,630	91,777	94,024	96,386
South Eastern	55,220	57,095	59,016	60,810	62,493	63,979	65,524	66,983	68,598	70,043	71,792	73,506	75,419
Southern	48,069	49,646	51,198	52,790	54,346	55,810	57,250	58,829	60,437	62,102	63,890	65,818	67,818
Western	39,660	41,071	42,415	43,847	45,300	46,750	48,148	49,582	51,086	52,683	54,312	55,898	57,537
Northern Ireland	**266,761**	**274,385**	**281,558**	**288,464**	**295,391**	**302,100**	**308,771**	**315,831**	**323,050**	**330,394**	**338,505**	**346,929**	**355,962**

(Source: NISRA, 2008 Based Population Projections)

By 2023, it is projected that the 65+ population in NI will be approximately 356,000; an estimated increase of 33.4% from 2011. The South Eastern area is projected to witness a significant population increase (37%) within this age band. The Western area is projected to have the highest growth (45%) and the Belfast area the lowest growth (12%).

Population Trends by Locality (85+ population)
Table 42

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Belfast	6,690	6,867	7,038	7,185	7,383	7,586	7,745	7,910	8,039	8,234	8,442	8,692	8,939
Northern	8,340	8,882	9,232	9,584	10,065	10,590	11,064	11,538	12,073	12,608	13,185	13,935	14,660
South Eastern	6,937	7,236	7,502	7,843	8,127	8,449	8,786	9,146	9,546	9,970	10,426	10,927	11,419
Southern	5,430	5,715	6,009	6,306	6,651	6,995	7,296	7,675	8,072	8,463	8,951	9,473	9,915
Western	4,320	4,573	4,783	5,039	5,203	5,440	5,734	5,987	6,279	6,537	6,893	7,328	7,733
Northern Ireland	**31,717**	**33,273**	**34,564**	**35,957**	**37,429**	**39,060**	**40,625**	**42,256**	**44,009**	**45,812**	**47,897**	**50,355**	**52,666**

(Source: NISRA, 2008 Based Population Projections)

By 2023, it is projected that the 85+ population in NI will be 53,000; an estimated increase of 66% from 2012.The Southern area is projected to have the highest growth (73%) and the Belfast area the lowest growth (30%) with the South Eastern area indicating a 57% population growth, for this age group.

Population Trends Northern Ireland (0-64, 65+, 85+population)
Table 43

Age	2012	2017	2022	2027	2032	2037	2041	2046	2051	2056	2061	2062
0-64	1,550,815	1,565,184	1,574,754	1,564,277	1,538,686	1,515,427	1,507,453	1,499,769	1,488,029	1,471,007	1,457,445	1,455,059
65+	272,819	306,025	343,731	392,449	445,904	489,122	510,411	531,791	551,388	569,108	577,785	578,820
85+	32,713	39,107	47,992	58,800	75,802	89,894	100,251	118,674	140,726	157,365	164,056	164,333
Northern Ireland	**1,823,634**	**1,871,209**	**1,918,485**	**1,956,726**	**1,984,590**	**2,004,549**	**2,017,864**	**2,031,560**	**2,039,417**	**2,040,115**	**2,035,230**	**2,033,879**

(Source: NISRA, 2012 Based Population Projections)

By 2062, it is projected that the total population in N. Ireland will be 2,034,000, an estimated increase of 12% from 2012. Older people aged 85+ are projected to have the highest growth (402%) whereas the 65+ population will increase by

110% from 2012. The 0-64 population is projected to fall by 6% from 2012 to 2062.

Births

In 2012 there were 4,526 registered births to the South Eastern resident population. The Lisburn area comprised of 39% of this total and accounted for 1,7537 births. In relation to maternity services 4,069 births were recorded at the Ulster Hospital Maternity Unit, however many of the births were to residents from the Belfast and other LCG areas. The number of births at the Ulster has been impacted in recent years by the introduction of midwife led services at the Lagan Valley and Downe Hospitals and other changes to the configuration of maternity provision in Belfast.

64% of the births at the Ulster Hospital are to residents of the South Eastern LCG and a further 32% are to Belfast residents. Similarly, 64% of South Eastern births were in South Eastern Trust units.

30% of south eastern residents' births were in Belfast units (Royal Victoria and Mater Hospitals)

Life Expectancy

Average life expectancy for males in the south east is 78.5 years which compares favourably with the N. Ireland average of 77.1 years. For females the average life expectancy is 82 which again compares favourably with the N. Ireland average of 81.5 years. While there are some signs of general improvement in life expectancy, not everyone has been able to avail fully of the benefits of this progress. Unfortunately, social inequality has endured to the extent that health outcomes for some groups remain poorer than for others, and smoking, obesity, misuse of drugs and alcohol, teenage conception rates, poor mental health are disproportionally concentrated amongst particular deprived groups.

Health Inequalities–Lifestyle and Behaviour

Smoking rates are highest among people who earn the least and lowest amongst those on higher incomes, for example while smoking prevalence amongst the general population is now 24%, amongst manual workers it remains high at 31%. Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in N. Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 49 individuals every week.

South eastern residents experience the lower mortality rates due to smoking related causes when compared across N. Ireland.

Alcohol related admission rates to hospital have also been on the increase in N. Ireland over the past decade. South eastern area has seen a 32% increase in alcohol related admission rates since 2000/01 which is higher than the increase of 21% observed in N. Ireland.

Chronic Illness/Long Term Conditions

South east residents reported lower than average long term limiting illness and they perceived their health to be good or very good.

Percentage of SELCG population with a long term limiting illness, good or very good general health and providing unpaid care. Comparison with NI Table 44

LCG/Trust Area of Residence	Long term limiting Illness	General health: Good or Very Good	Providing Unpaid care
SE	19.82	80.84	12.82
NI	20.69	79.51	11.81

(NISRA)

Across N. Ireland the most prevalent long-term conditions are hypertension, asthma and diabetes. Using QOF data for 2012/13 it can be seen that the south eastern population has a higher rate of hypertension compared to the

regional rate (135.39/1,000 in South Eastern area against 128.7/1,000 in NI) and similarly with diabetes (43.37/1,000 in south eastern area against 41.41/1,000 in NI.)

The provision of unpaid care is higher (12.82%) than the average for N. Ireland (11.81%)

Cancer Incidence

Cancer incidence rates measure how much more or less an individual is likely to develop cancer in a specific geographic area compared with the N. Ireland average, having taken in to account the age and gender profiler for that area. Data shown in the table below suggests that incidence rates in the south eastern area are now marginally lower than the N. Ireland average.

Cancer Incidence Rates 1993-99 to 2003-09
Table 45

LCG/ Trust Area of Residence	1993-99	2003-09
SE	94	99
NI	100	100

Deaths

There were 2,856 recorded deaths in the south eastern locality in 2012. Lisburn had the highest number of deaths at 7.4 deaths per 1000 (893).. An analysis of the crude death rate (death rate per 1000 population) shows that North Down at 9.2 deaths per 1000 had the highest death rate in the south east locality and this was the second highest in N. Ireland next to Belfast with a crude death rate of 9.9 per 1000.

Each year in N. Ireland approximately half of all deaths take place in hospital. In recent years through the implementation of the Palliative Care and End of Life Strategy, this situation has shown a change with the proportion of deaths

taking place in hospital falling as individuals and families indicate their preference to die at home. Figures for 2011 indicate that 49% of N. Ireland deaths took place in hospitals compared to 51% during 2009. There is variation by area of residence, with the percentage of deaths in hospitals across the Northern, Belfast and Western LCGs being higher than average (53%, 51% and 50% respectively in 2011) and South Eastern and Southern being lower than the Northern Ireland average (46% and 45% respectively).

Deaths by Cause

The main causes of death in 2012 in the south east area were cancer, diseases of the circulatory system and diseases of the respiratory system. Standardised mortality ratios (SMRs) for 2012 show that the South Eastern LCG had a higher than average SMR for circulatory diseases, but lower than average SMRs for cancer, with the exception of breast cancer, and lower than average SMR for respiratory disease.

Table 46
Mortality Ratios in South Eastern Area

LCG/Trust Area of Residence	All deaths	Malignant Neoplasms			Circulatory			Respiratory	
		All sites	Trachea, bronchus and lung	Breast (female only)	All	Ischaemic Heart Disease	Cere-brovascular disease	All	Pneumonia
SE	96.0	93.2	83.0	103.3	105.1	88.8	95.9	85.5	94.5
NI	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: NISRA

Deprivation

The South Eastern LCG has an important role to play in addressing inequalities, particularly as it relates to our significant rural population in terms of accessing services. In 2010, NISRA updated the NI Multiple Deprivation Measure (NIMDM). The NIMDM outputs results at a number of geographies including local government district. The table below highlights the most deprived areas within the South Eastern Trust area. The data ranks Local Government District council areas based on their level of deprivation (1 most deprived, 26 least

deprived). Belfast Council is the most deprived in N Ireland while Magherafelt is the least deprived.

Council deprivation rank by ICP area

Table 47

South Eastern Area	Rank of Deprivation
Lisburn	6
Down	16
Ards	18
North Down	24

The table above presents the position of each of the ICP areas in the South Eastern Trust LCG areas which are co-terminus with Local Government District areas. Out of the 26 current council areas Lisburn is among the most deprived area in the south east, the other Local government areas within the South Eastern area are placed above the average and in the case of North Down is in the top three least deprived areas Local Government Districts in N. Ireland.

Personal and Public Involvement (PPI)

The South Eastern LCG proritises the need to have a strong engagement arrangement in place so that we are in touch with the health and social care need of our population and to ensure that they are appriopaitely involved in the planning and design of local services. The South Eastern LCG held a PPI workshop in October 2013 to develop a model for future engagement with local community and voluntary organisations, service users and carers. In addition the South Eastern LCG has recently lead an engagement excerise in the south east on the future prevision of dementia services and work is on-going in regard to stakeholder involement in the redesign of palliative and end of life care. The South Eastern LCG holds its monthy meetings in public, these meetings are rotated around the south eastern area to ensure access by the public who have an opportunity to contribute to the debate.

The South Eastern LCG also has arrangements in place to meet with our local political representatives, meetings with local councils on an on-going basis,

while arrangements to meeting with MLAs and MPs are also in place. South Eastern LCG officers also have a close link with officers from all four current Councils across the south eastern locality, namely Ards Borough Council, the Down District Council, the Lisburn City Council and North Down Borough Council. The reshape of local councils in 2014 under RPA will underscore the importance of this arrangement in the context of new community planning arrangements.

8.2 Key Challenges and Opportunities within the SE LCG Locality

This section considers the key topics which the South Eastern LCG will have to focus its attention on in the next number of years.
The urgent care model in the south east continues to be problematic with breeches in waiting time targets at Ulster Hospital and sustainability issues evident at the consultant lead services at the Downe and Lagan Valley Hospitals and at the Minor Injury Units at Ards and Bangor Hospitals. The South Eastern LCG will highlight the need to address these issues with new proposed commissioning arrangements for Ministerial consideration.

The unscheduled care patient pathway is one which is complex and continues to pose issues in regard to its responsiveness to patient demand. The South Eastern LCG will also prioritise this issue in 2014/15 and acknowledges that there are significant opportunities in working with primary care through the Intregrated Care Partnerships, Northern Ireland Ambulance Service, Trusts and other partners to address the pattern of demand for urgent care. The South Eastern LCG will be seeking to maximise the opportunities associated with seven-day working (both in hospital and in the community) and the opportunities where appropriate to run key community services on a 24/7 basis. There is also a need to review our community staffing infrastructure to ensure that it is responsive to the initiatives proposed under TYC.

The South Eastern LCG recognises the difficulties the South Eastern Trust faces in providing services from five hospital sites across the south east, with the main acute hospital – the Ulster Hospital geographically in Belfast, it is also providing acute hospital services for the east Belfast population. In the context of Transforming Your Care, there is a challenge for the South Eastern LCG to ensure that it commissioning services that are: safe and of a high quality; that are sustainable and not susceptible to disruption for whatever reason and that allow our population to understand where they can access the appropriate level of care at the right time. The South Eastern LCG endorses the “Choose

Well Campaign" in supporting the public to make the right choices and their urgent care requirements

These requirements need to be balanced with ensuring that services are accessible to our local populations and that appropriate services are available locally when it is feasible and safe to do so. The South Eastern LCG views our service hubs in the Downe Hospital, the Ards Hospital site and the Lagan Valley Hospital site as key enablers to ensuring good community access to future local services. The Minister has already approved a major new Health and Care Centre in Lisburn .

South Eastern LCG is very focused on the ministerial targets associated with the provision of elective care services. The South Eastern Trust continues to perform consistently across most specialities, however this performance relies on additional capacity provided 'in-house' by clinicians and by the transfer of patients to the independent sector. The provision of care in the independent sector can often be more problematic. The South Eastern LCG would see opportunities in 2014/15 to support additional investment in some speciality area to address shortfalls in capacity.

The South Eastern LCG was unable to lead on the evaluation of the Downe Hospital Midwife Led Unit (MLU) as proposed in 2013/14. While we undertook a procurement exercise to identify an evaluator, we had a disappointing response. However, the South Eastern LCG will re-tender and included in the tender proposal the evaluation of the Lisburn MLU which will in 2014/15 have been operational for three years. This evaluation process will be important both locally and regionally in understanding the contribution that freestanding MLU's provide to new mothers and families. The South Eastern LCG will continue to work with the South Eastern Trust in respect of the general pressures within maternity services and will seek to enhance the recurrent level of baseline funding.

The South Eastern LCG has been in discussion for a prolonged period with the South Eastern Trust regarding the modernisation of acute inpatient mental health provision. The current proposal put forward from the Trust has been assessed and the South Eastern LCG looks forward to finalising arrangements in regard to this important service area in 2014/15

The South Eastern LCG has affirmed its support for the development of new Learning Disability facilities in both Bangor and Newtownards. In addition the South Eastern LCG looks forward to the implementation of improved day opportunities for people with mild to moderate disabilities as part on the reshape of services in North Down and Ards in the next number of years and generally for all clients who can benefit from new community based options.

The South Eastern LCG has systems in place to monitor the overall health and well-being of our population and in this respect we work very closely with our colleagues in the Public Health Agency (PHA). While the overall health and well-being of the population continues to improve and we continue to live longer than previous generations, we are still faced with threats to maintaining this improvement as the number of older people living with more complex long term conditions grows. Strategies are also in place to address the many lifestyle factors which impact on our health and the South Eastern LCG has noted in particular the growing prevalence of obesity within the population and the impact this has on our need to commission additional services right across programmes of care. The South Eastern LCG has brought this issue to the fore in discussion with our local councils and our voluntary providers with a view to addressing the issue collaboratively.

8.3 Ensuring Financial Stability & Effective Use of Resources

Use of Resources

The South Eastern LCG's baseline funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £507m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 48 Baseline investment by Service Area in 2014/15

Programme of Care	£m	%
Acute Services	185.2	36.6
Maternity & Child Health	28.4	5.6
Family & Child Care	38.9	7.7
Older People	120.1	23.7
Mental Health	37.0	7.3
Learning Disability	46.3	9.1
Physical and Sensory Disability	18.1	3.6
Health Promotion	14.8	2.9
Primary Health & Adult Community	17.9	3.5
POC Total	**506.7**	**100.0**

This investment will be made through a range of service providers as follows:

ICP budgets 2014/15

Table 49

Provider	£m	%
BHSST	122.0	24.1
NHSST	1.0	0.2
SEHSST	346.8	68.4
SHSST	5.5	1.1
WHSST	0.6	0.1
Non-Trust	30.8	6.1
Provider Total	**506.7**	**100.0**

Whilst emergency department (ED) services have not been assigned to LCGs as these are regional services, the planned investment in 2014/15 in respect of Emergency Care by the South Eastern Trust is £17.7m.
The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

The Commissioning Plan for 2014/15 indicated a significant range of service pressures/developments and other additional pressures most notably inescapable pressures such as pay and price inflation as well as additional investment to take account of the demographic changes in the population. The South Eastern LCG share of these indicative investments areas is noted below:

South Eastern LCG share of indicative investments 2014/15
Table 50

Pressures	**£m Full Year Effect**
Pay & Non Pay	7.9
Demography	7.5
NICE Drugs	3.7
Revenue Consequences of Capital Expenditure	0.8
Mental Health Resettlements	0.4
Learning Disability Resettlements	1.6
Service Pressures/Developments	13.8
Public Health Agency	0.6
Total	**36.3**

8.4 Commissioning Priorities and Requirements 2014/15 by Programme of Care (POC)

This section of the Local Commissioning Plan provides an overview of the South Eastern LCGs commissioning priorities for 2014/15 and beyond and is set out to address the nine programmes of care area as follows:

8.4.1 POC 1 – Acute

This programme covers both specialist and non-specialist services. In the main, non-specialist acute services are the focus for provision for the LCG in respect of our population. Specialist services are mostly provided outside the south eastern locality, by the Belfast Trust as N Ireland's regional service provider, although some regional services are provided by the South Eastern Trust, for example plastic surgery.

SET is currently managing five hospital sites: Ulster Hospital, Dundonald, (this facility is in the Belfast LGD and provides services to a significant proportion of the Belfast LCG population living in East Belfast and Castlereagh); Lagan Valley Hospital which services the Lisburn population; the Downe Hospital, services the Down population and two community hospitals in Bangor and Newtownards.

Introduction
In respect to non-specialist services, the LCG commissions both unscheduled (or emergency) and elective (or planned) acute care.

In regard to **unscheduled care**, there are a range of issues that need to be addressed in 2014/15 to improve services for our population – specifically the performance of emergency departments, the management of the patient flow through the hospital care system and general access to urgent care services. A revised service model and clear information to the public about where, when and how emergency and urgent care can be accessed is required.

In regard to elective or planned services (as they relate to outpatients, inpatient, day-case treatments and access to diagnostics and Allied Health Professionals services), there have been improvements in the waiting time performance in the south east in several speciality areas. However there remain a number of speciality or services areas where there are gaps in the current capacity when measured against the service demand. While additional non-recurrent investment, in additional in-house capacity and with the independent sector has alleviated waiting time pressures, specific gaps still need to be addressed in general surgery, gynaecology and rheumatology among others. The LCG also acknowledges that there are emerging pressures in regard to the provision of some aspects of cancer care and improvements required in the patient pathway associated with sleep disorders.

The LCG, as part of its engagement processes, has received clear feedback on elective care both directly from patients, from general practice on behalf of their patients and from elected representatives. Comments reflect the need to continue to improve waiting times and reduce the reliance on independent sector services. In addition, the potential to improve access to elective services (specifically outpatient services) is one that has been noted in the context of an increasing number of Trust services now being provided on a busy Ulster Hospital site, located in east Belfast.

Overview of Local Needs

In terms of addressing future needs, the following statements highlight the current challenges in the south eastern locality:

- Attendances at SET's Emergency Departments increased to 148,655 in 2012/13 from 146,380 in 2008/09 (up 1.6%). Whilst attendances at Downe, Lagan Valley, Ards and Bangor fell (-8,900), more people attended the Ulster Hospital (+10,300).
- Non-elective admissions increased across all localities and there was a 9% increase from 2008/09 to 2012/13, most notably from the Ards

locality which has seen a 16% increase in non-elective admissions during this period.

- In the last five years the number of occupied bed days has decreased, however in 2012/13 there has been a 1% increase (31,727-32,867).
- GP referrals to elective out-patient services have seen a 4% increase (76,141 to 79,312) over the last two years. The most pronounced increase (23%) has been in red flag (suspected cancer referrals). Urgent referrals increased by 4% and routine by 3%.
- The number of review appointments has risen 9% (131,430-142,897) in the last three years linked to the rise in new outpatient activity.
- Admissions for treatment (in-patients) have reduced by 14.4% (10,749 – 9,222) in the south east area over the last five years. In the last two years this has reduced by 3% reflecting a regional drop of 3%.
- Day case admissions, as a proportion of treatments, have increased as more treatments are delivered as day case rather than inpatient. The SET day case activity has increased by 6.3% (34,035-36,204) in the last two years.

Ministerial Targets

The LCG expects the South Eastern Trust to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The LCG will focus on the following aspects of acute service provision in its dialogue with the Trust and where appropriate the ICP:

- Commissioning additional capacity in a range of elective specialities to address gaps in the demand and capacity for services.
- In line with TYC, reform of the unscheduled care pathway. This will require meaningful discussion with the local population and other stakeholders on options for change.
- The LCG will commission an increasing number of services through the ICP; as such we will look to achieve the requirements identified in TYC of shifting from hospital based services to primary and community based alternatives where this is safe to do so.

- In 2013/14 the LCG invested in additional fracture operating capacity. The LCG/Board will expect the Ministerial target on fractured neck of femur to be achieved and will be closely monitoring it during 2014/15.
- The LCG will continue to work with the Trust in regard to cancer services and will seek to prioritise investment in General Surgery services and other aspects of cancer provision at the Ulster Hospital.

Commissioned Services

During 2013/14 the South Eastern LCG has taken forward initiatives with the ICPs to secure direct access to DEXA (or bone) scanning and explored opportunities to enhance primary care services. These initiatives have provided better local direct access to services for our population. Further opportunities in elective care will be pursued in gynaecology, cardiology, palliative care, psychiatry of older people, sexual health and within community care during 2014/15. The over-arching strategy is to develop initiatives between primary care and the Trust who are provider partners in the ICPs.

The LCG has in recent years has made significant investments in unscheduled care services at the Ulster Hospital in response to changes in demand. In commissioning services in 2014/15 the LCG has prioritised the requirement to commission seven day working to facilitate early discharge and reduce the length of stay for patients in the Ulster Hospital. Extending medical, AHP, social work and pharmacy services to weekends will ensure that patients get timely intervention and support improved health outcomes.

In the recent past the emergency and urgent care arrangements commissioned at other sites by the LCG have been subject to significant change at short notice, due to the challenges for the Trust in the retention and recruitment of junior doctors and specialist nurses to work in their emergency departments. The EDs at the Lagan Valley and Downe Hospitals are now subject to temporary arrangements, curtailing their opening hours to 8am – 8pm weekdays, as opposed to the previous seven day limited opening hours

service. Similarly the Minor Injuries Unit (MIU) at Bangor Community Hospital has moved to weekday only provision on a temporary basis.

In response to this the LCG/HSCB and the SET are developing proposals to support access to urgent care services in Lisburn and Downpatrick and set out a position to support other service provision at both hospitals for the next two to three years. These proposals are likely to seek to maintain the weekday medically led ED service while enhanced arrangements at the weekend are covered by General Practitioners working in the out of hours services. The LCG supports the potential of Emergency Nurse Practitioners (ENPs) to provide a local urgent care response to those patients who will require treatment for ailments of a lower acuity or severity. The LCG is pleased that the SET has already commenced an ENP led service at the Downe Hospital at weekends from early March 2014 and plans to establish similar arrangements at the Lagan Valley Hospital later in 2014/15 upon completion of the co-location of the GP out of hours centre with the current emergency department.

In to the future, we need to ensure that as far as possible we avoid situations which might destabilise our local healthcare system and have potential implications on other LCG areas.

The LCG has made it clear that the emergency and urgent care model in the south east needs reformed. While the Ulster Hospital is the main provider of consultant-led 24/7 emergency care services, new urgent care arrangements in Downpatrick, Lisburn, and North Down and Ards should now begin to evolve. To support this process the LCG will bring forward an Unscheduled Care Improvement Plan in 2014/15 in conjunction with the SET and other stakeholders. In response, the LCG will be seeking the SET to respond with appropriate proposals to ensure that safe, sustainable and clinically appropriate arrangements are in place for the delivery of unscheduled care to the discrete populations in the south east. Relevant consideration in this regard will include - opportunities under TYC to shift services from the hospital

to primary and community care; and in regard to staffing, promoting new roles and skill mix arrangements.

Change in the pattern of use of Emergency Departments in the south east may impact on the provision of acute medicine. The LCG sees opportunities for new service arrangements with medical consultants working both in hospital and in the community, supported by enhanced roles for primary and community care in the management of patients whose profile continues to be older, frailer and often contending with more than one long term condition.

Importantly, the public needs to be assured that services can be accessed when they are required and that the best clinical care will be provided when it is needed. Service transformation will not be easy, but putting off difficult decisions will only exacerbate current difficulties. The LCG, and all HSC organisations, will continue to fully engage and debate, now and into the longer term, on the issues associated with service change with the public. Proposals developed will be in line with TYC and supported by the Integrated Care Partnerships.

Any future subsequent proposals for change will be subject to full public consultation and Ministerial approval.

Specific Commissioning objectives for 2014/15 and 2015/16

POC 1 – Acute (non-specialist)	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to stabilise demand for outpatients, and Emergency Department attendances.	South Eastern Trust already provides direct consultant advice for a limited number of specialties. The South Eastern LCG working with the ICP will seek to commission an extended service across specialties throughout the year and monitor the benefits of such initiatives.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions.	The South Eastern Trust is expected to develop and resource 7 day diagnostics, AHP services and senior clinician decision making service to reduce inpatient length of stay and support early discharge.
Enable district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present	The South Eastern LCG Trust is expected to work with commissioners from the ICPto develop appropriate services in response to the clinical priority areas allowing the shift of services from secondary care to primary care to ensuring that the appropriate infrastructure is in place to support community teams to be responsive.
Review and take forward opportunities to consolidate	The South Eastern Trust is expected to develop alternative

intermediate and acute care beds and the sites on which they are provided	care plans and work with GPs to ensure that community care alternatives are in place which would enable the consolidation of intermediate care beds and sites allowing for improved medical management of patients. This will be part of the hospital reconfiguration programme proposed within the plan.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The South Eastern LCG is expected to work with the South Eastern Trust and Primary Care throughout 2014/15 to develop this Unscheduled Care Improvement Plan. The UCIP will focus on expanding and establishing improved communication between Secondary Care Consultants and GPs, 7 day working practices, direct GP access to, for example, diagnostics, assessments unit and Allied Health Professions, Social Work, Pharmacy and Laboratory Support and enable 7 day discharge.
Local priority	From April 2014, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.
Local priority	From April 2014, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their

	first definitive treatment within 62 days.
Local priority	The South Eastern Trust is expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.
Local priority	The South Eastern Trust is expected to deliver improvements in the LoS associated with stroke patients. Under TYC the LCG will support investment in 2014/15 for early supported discharge.
Local priority	In 2014/15 the South Eastern Trust is expected to deliver comprehensive arrangements for the provision of sleep services.
Local priority	Unscheduled Care Improvement Plan – in response to the pressure on unscheduled care services the South Eastern LCG is expected to work with the South Eastern Trust and Primary Care throughout 2014/15 to develop an Unscheduled Care Improvement Action Plan. The LCG will expect the Trust to implement the out-workings of the plan.
Local priority	The South Eastern LCG will be commissioning increased GP

	direct access to hospital services. The LCG will seek an implementation plan from the ICP.
Local priority	The South Eastern LCG will seek to commission a shift in the number of outpatient clinics (where it is safe to do so) provided at the Ulster Hospital to the Community Hubs or to GP practices where this is feasible. The South Eastern LCG will look to the ICP / Trust to bring forward proposals in this regard.
Local priority	The South Eastern LCG will continue to work with the Trust in respect to the increasing demands on cancer services and will commission to address this demand.
Local priority	The Trust has identified the potential number of beds they can transfer in 2014/15 as a result of their proposed TYC 'shift left' initiatives associated with the Clinical Priorities. The LCG will commission services this year and beyond on the basis of that shift.
Local priority	The South Eastern LCG (supported by the Board) has shared with the Trust opportunities for further service efficiencies which among other things will allow for the Trust to release beds from the Trust's current bed numbers with no impact on service capacity.

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	5,866	113	5,979
	Daycases	28,843	34	28,877
	New Outpatients	207,646	1,953	209,599
	Review Outpatients	118,090	2,237	120,363
Unscheduled	**Non Elective admissions - all**	36,225	1,061	37,286
	ED attendances	137,181	0	137,181
	NIAS Journeys	43,020	406	43,426
	VALUE OF COMMISSIONED ACTIVITY[47]	£185.2m	£12.5m	£197.7m

[47] This includes activity in addition to that set out above.

8.4.2 POC 2 – Maternity and Child Health

Introduction

Maternity and Child Health services cover care and treatment from ante natal to 16 years of age. Maternity services address the needs of women and their babies from pregnancy to post natal stages.

The south eastern locality has two freestanding Midwife Led Units (MLU's). These support the obstetric unit at the Ulster Hospital which also has a stand alongside MLU. The midwife led births in the SET during 2012/13 were 1,158 (over the 3 units) and obstetric births were 3,214. This is the highest number of midwife led births of all Trusts in N. Ireland. There has been an increase in births within the south eastern area within the last number of years and recent changes to services within Belfast (transfer from obstetric led to freestanding MLU at the Mater Hospital) may have a further impact on the number of babies delivered in the south eastern area. The LCG anticipates that the new build maternity unit within Belfast, scheduled to open in late 2016, will offset a volume of the births of Belfast mothers currently being delivered in the Ulster Hospital Maternity Unit.

The regional maternity strategy and the regional commissioning objectives set the direction for the delivery of maternity services in the south east.
To meet these objectives and demands the South Eastern LCG has been working with the SET to build capacity for safe and sustainable maternity services at the Ulster Hospital Maternity Unit. The Trust is currently providing for approximately 200 births above the recurrent capacity commissioned by the South Eastern LCG. The Trust has carried out interim works to develop a six bedded bay for women undergoing induction of labour and two further labour rooms within its obstetric labour ward to improve flow and improve the experience for women.

Of particular concern to both the South Eastern LCG and the Trust is the capacity within the Ulster Hospital Maternity Unit outpatient clinics to deal

with the volume of Gynaecology, fertility and maternity clinics required. The South Eastern LCG continues to work with the Trust to address this concern. Under Child Health services, SET is commissioned to deliver a range of acute and community services for children. Paediatric medicine includes general medical care and treatment for children as well as care for those who have been diagnosed with debilitating or life threatening illnesses, children with special needs, or who are terminally ill and who require palliative care. In addition to these areas of care which may sometimes require admission, the Trust provides outpatients and community care services for allergies and asthma, epilepsy, home intravenous treatment etc.

In November 2013 the initial report on the regional review of paediatric services was issued for consultation. This review covers a wide range of paediatric services across all Trusts. The South Eastern LCG along with colleagues in the HSCB and PHA has contributed to its recommendations. Once the final review is issued in 2014/15 the LCG will work with the Trust and others to implement the recommendations.

Overview of Local Needs

- In 2012 there were 4,526 births to the south eastern resident population. Mothers from the Lisburn area accounted for 39% (1,753) of these births.
- 4,069 births were recorded in 2012/13 at the Ulster Hospital Maternity Unit. 1482 births (36%) were to residents from the Belfast and other LCG areas.
- The number of births in N. Ireland has decreased by 3% in the last three years from 25,273 to 24,429. The number of births in the south eastern locality has remained the same over the last three years (circa 4,500).
- The projected births in Norther Ireland are expected to fall by 5% (24,966 – 23,439 from 2012 to 2023, this trend is also projected in the south eastern locality with a 3% (5,840-5,675) decrease in births.

- The LCG acknowledges the growing demand for paediatric diabetes services.

Ministerial Targets

The South Eastern LCG expects the SET to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of maternal and child health services in its dialogue with the Trust and where appropriate the ICP:

- Address the recurrently funded capacity with the Trust, as births are above the 4,007 births commissioned.
- Assess the requirement for additional midwife provision in the south east in response to on-going analysis of current midwife levels in both the Ulster Hospital Maternity Unit and community services.
- The South Eastern LCG will commission improvements in children's asthma and allergy services and will look to commission appropriate services to address epilepsy as it relates to children.

Commissioned Services

The South Eastern LCG commissions a range of maternity and child health services from SET. Maternity care includes ante-natal, delivery and post-natal care. In the SET this can be midwife led, consultant led or shared depending on the woman's needs and preferences. The Service Budget Agreement 2013/14 is for 4,007 births in the Ulster Hospital Maternity Unit - a volume increased from 3,507 births in 2012/13 with South Eastern LCG investment of £1m recurrent funding. The Ulster hospital maternity unit had 4069 registered births in 2012/13 and as at October 2013 is projecting 4166 by the end of March 2014.

In relation to Paediatric Diabetes, children with diabetes have a lower life expectancy than children without diabetes. Diabetes is more common in

children with learning disability. High quality diabetes care and early detection of complications in diabetes can reduce the frequency of disability. Diabetes can affect people over long period of their lives and requires regular treatment and medication.

Paediatric Asthma and Allergy services

The incidence of asthma and allergies among children has increased in recent years. The South Eastern LCG will work with the Trust during 2014/15 to fully implement a specialist asthma and allergy service that will be delivered by an integrated team. This service led by a consultant with an interest in asthma and allergy and supported by specialist nurses trained in paediatric asthma/allergy, dieticians with paediatric experience and other skill mixes as required.

Specific Commissioning Objectives for 2014/15 and 2015/15

POC 2 Maternal and Child Health	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
The Trust is to develop a sustainable service model for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	The South Eastern Trust has a model of maternity units that is currently in line with the regional maternity strategy. The South Eastern LCG will be taking forward with the Trust and other stakeholders arrangements for the independent evaluation of the two MLU in the south east in 2014/15.
Trust to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	A regional project to develop a pathway for multiple pregnancies is being taken forward by the PHA and South Eastern LCG and SET will take forward actions to meet this recommendation.
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife led antenatal care in the community for women with straightforward pregnancies.	The South Eastern Trust is expected to participate in a regional project being taken forward between the PHA and NIPEC reviewing community maternity care in order to progress these recommendations.
Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce	Trusts are part of the maternity quality improvement collaborative carrying out work regionally to normalise birth

unexplained variation in intervention rates throughout N. Ireland.	and reduce unexplained variation.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The South Eastern LCG will also consider the commissioning implications of the scoping study of the maternity needs of black and minority ethnic (BME) and migrant women in Northern Ireland, highlighting the growing number of births in Northern Ireland to BME and migrant women, and that there are particular sub-groups of very vulnerable migrant pregnant women who have difficulty accessing services and have worse pregnancy outcomes.
Local Priority	The South Eastern Trust is expected to relocate an appropriate number of outpatient clinics from the Ulster Hospital Maternity Unit (or other speciality out patients), where it is safe to do so, to the Community Hubs to alleviate pressure within the current out-patients area and to improve access to maternity outpatient services for the south eastern population. This should be expressed as part of the shift left agenda under TYC.
Local priority	The South Eastern Trust is expected to continue to look for further service efficiencies in 2014/15 which will have an impact on current service capacity.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	**Births**	4,827	0	4,827
	Comm Midwives	**Contacts**	54,200	0	54,200
	Health Visiting	**Contacts**	14,723	0	14,723
	Speech & Lang Therapy	**Contacts**	29,856	0	29,856
		VALUE OF COMMISSIONED ACTIVITY[48]	£28.4m	£1m	£29.4m

[48] This includes activity in addition to that set out above.

8.4.3 POC 3 – Family and Childcare

Introduction

The Children and Families Commissioning remit includes all statutory social work services and as such the functions are prescribed within legislation and remain subject to a high level of monitoring and scrutiny, internal and external to the Health and Social Care Trusts, to be assured that these functions are effectively discharged.

In line with TYC there continues to be a significant focus on early intervention and this agenda is being pursued on a uni-disciplinary, single agency and multiagency basis. There is a strong commitment to partnership working to progress this agenda through vehicles such as the Children and Young People's Strategic Partnership (CYPSP), Childcare Partnerships and Child Development Board. The strategic direction for the statutory social work component is taken forward through the Children's Services Improvement Board with the involvement of senior HSCB and Trust staff.

Overview of local needs

- On 30 September 2013, 3,691 children were identified by the South Eastern Trust as being 'Children in Need' across the Trust's area. Of these 596 were children with a disability. Across NI the 'Children in Need' figure rose from 23,300 to 25,720. Referrals for a 'Child in Need' assessment in the south east rose from 2,741 to 2,905. The Trust reported 17 unallocated cases at the period end out of a NI total of 219.
- The number of children on the Child Protection Register in the south east dropped slightly from 402 to 399 to 30 September 2013 continuing the trend in recent years; however 25% of child protection registrations during the period were re-registrations. The Trust received 602 child protection referrals during the period and undertook child protection investigations involving 571 children.

- Regionally the number of 'Looked after Children' increased from 2,807 on 31 March 2013 to 2,892 on 30 September 2013 continuing the trend in recent years. Regionally the number of 'Looked After Children' increased from 2,807 on 31 March 2013 to 2,892 on 30 Sept 2013 continuing the trend in recent years. The South Eastern Trust LAC population remained fairly consistent (513 on 31 March 2013 and 505 on 30 September 2013) during the same period.

Ministerial targets

The South Eastern LCG expects the SET to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan.

The themes associated with Family and Childcare will all be taken forward regionally in conjunction with LCGs as appropriate.

Commissioned Services

The HSCB commission the full range of services for children across the childcare continuum including early years services such as the registration and inspection of day care facilities; support to families both at an early intervention stage and to children designated as being Children in Need; services for the protection of children; services to children in state care either through voluntary accommodation or Court Order including the full range of care placements to meet assessed need and services to meet the therapeutic needs of LAC; leaving and after care services for young eligible and relevant young people and services for young people who are homeless. Trust services for children are largely considered as Statutory Functions which are delegated to Trusts by the HSCB and are subject to an extensive formal monitoring process.

In 2014/15 Trusts will continue to be required to fulfil their responsibilities under the Delegated Statutory Functions. In addition the Trust will be required to take forward the out workings of a number of regional developments including the Regional Review of Residential Child care; the Regional Review of

Fostering Services; revised Standards in Early Years and Kinship Care; implement the recommendations of the RQIA inspection relating to children with disability service; further developments in relation to Children's Services Planning such as the multi-agency Outcomes Group and Family Support Hubs; and take forward developments in relation to regional services hosted by the Trust such as the regional adolescent forensic service, FACTSNI, and the Regional Secure Centre, Lakewood.

Family Nurse Partnership

Family Nurse Partnership (FNP) is a voluntary preventive programme for teenage mothers, which offers intensive and structured home visiting. It is delivered by specially trained 'family nurses', from early pregnancy until the child is two years of age. The aim of FNP is to improve the health and wellbeing of our most disadvantaged families and children, and to prevent social exclusion.

During 2014/15 the programme will be expanded to the South Eastern Trust.

Specific Commissioning Objectives for 2014/15 and 2015/15

POC 3 Children and Families' Services	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Family Nurse Partnership (Ministerial Target 2) By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust.	It is planned by the Public Health Agency to develop Family Nurse Partnership within the South Eastern LCG area within 2014/15 The South Eastern LCG will seek the Trusts proposals for a FNP in the Lisburn area**.**
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

8.4.4 POC 4 – Older People

Introduction

This Programme of Care applies to people aged 65 years of age and older only.

The population of older people in NI is projected to increase by one third (33.34%) by 2023; however the growth is expected higher than the NI average i.e. 36.6%. As a result of improving health outcomes, both internationally and locally, the older population is living much longer than previous generations. This is to celebrated, however the needs of our ageing population also pose the most significant challenge to the responsiveness of Health and Social Care services.

Older People Population Projections

Table 51

Aged 65+	2011	2023	Change	% Change
BHSCT	52285	58802	6517	12.5%
NHSCT	71527	96386	24859	34.8%
SEHSCT	55220	75419	20199	36.6%
SHSCT	48069	67818	19749	41.1%
WHSCT	39660	57537	17877	45.1%
NI	**266761**	**355962**	**89201**	**33.4%**

South Eastern LCG is clearly set to experience demographic growth in the 65+ and the number of frail elderly people (i.e. those aged over 85 years of age) is projected to increase significantly in the South Eastern LCG area. A variety of flexible and innovative responses will be required ranging from an increased emphasis on promoting healthy ageing, providing tailored support for those who wish to remain at home, developing diversionary services to maintain independence and targeted intensive support for more dependent individuals requiring specialist care.

The South Eastern LCG is cognisant of the Service Framework for Older People and will work with providers to ensure that services are delivered in a person-centred manner, promote health and well-being, provide support for carers,

safeguard vulnerable older people and ensure high quality palliative and end of life care.

Of particular concern for the South Eastern LCG is the potential increase in older people in the local population who may suffer from dementia related conditions in the future.

The South Eastern LCG will continue to focus upon early intervention, including falls prevention and intensive support for those older people at risk of hospitalisation or long term care. Care pathways have been developed that support early intervention, rehabilitation and support, emphasising the avoidance of long term dependence on statutory services or unplanned hospital admission. The South Eastern LCG has issued a range of commissioning specifications to the new Integrated Care Partnerships (ICP) and the LCG will be seeking to evaluate these in 2014/15.

Transforming Your Care (TYC) clearly identifies 'home as the hub of care for older people' – with a corresponding shift away from hospital or other 'institutional' based interventions towards community based services where possible.

Reablement, since its implementation in the South Eastern LCG area, has been vital in promoting and affirming the independence of older people. Reablement has been incrementally 'rolled out' across the SET and is accessible in all 4 sectors; and this has been in partnership with the Voluntary sector i.e. with the funding of a number of Community Navigator posts. The activity has grown incrementally since initiation and has now reached 109 new referrals in October 2013 from 55 new referrals in November 2012 which reflects 100% increase.

Carers continue to play a very significant role in the overall provision of care which enables many people to remain at home. Carers NI have estimated that there are as many as 44,460 carers within the South Eastern LCG; TYC 'recognises the importance of carers' and recommends 'increased provision of respite and short breaks'.

Overview of Local Needs

The largest increase is in the 85+ category which sees a 35% (7,236-11,213) and the area most affected by this rise is Lisburn with a 42% (1,891-3,271) rise in over 85's. NI average life expectancy in 2008/10 is 77.1 for males and 81.5 for females, in the south eastern locality its 78.5 for males and 82 for females.

65+ population change in south eastern locality

Table 52

Population Projections - South Eastern LCG				
Area	**Age Group**	**2012**	**2022**	**% Change**
SE LCG	65-74 yrs	31,800	36,900	16%
	75-84 yrs	18,000	25,700	43%
	Sub total 65-74 yrs	*49,900*	*62,600*	*25%*
	85+	7,200	11,000	53%
	Total aged 65+	57,100	73,500	29%
	Elderly as a % of total Popn	16%	20%	
Ards	Age 65-84 yrs	12,500	15,900	27%
Down		9,200	11,800	28%
Lisburn		15,100	19,000	26%
North Down		13,100	15,900	21%
Ards	Age 85+ yrs	1,600	2,300	44%
Down		1,500	2,300	53%
Lisburn		1,900	3,300	74%
North Down		2,200	3,000	36%

The number of hours of domiciliary care has increased in the past 3 years by 11% to 52,570 in the south eastern locality. There has however been a shift from statutory [Trust provided] (-13%) to independent (+16%) care homes. The average hours offered to clients saw a slight decrease from 11.8 to 11.6 in the last 3 years. The number of clients receiving domiciliary care has increased by 13% in the past 3 years from 3,954 to 4,544 in the south eastern locality.

There has been a slight increase in the number of care packages in effect in the south eastern locality from 2,063 to 2,093 in the last 3 year period. When applying a weighted 65+ population, the South Eastern Trust provides approximately 4% of care packages in effect for older people, above the NI average of 3.6%.

Ministerial Targets

The South Eastern LCG expects the South Eastern Trust to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of older peoples services' in its dialogue with the Trust and where appropriate the ICP:

Domiciliary care packages received an up lift in funds from demography money during the 13/14 year. The table below showing a modest increase in domiciliary care packages is in line with the substantial investment of over £1m in reablement services in 13/14 in the South Eastern LCG locality.

No. of Domiciliary Care Packages Delivered in South Eastern Area
Table 53

Care Packages in place Age 65+	**on 31st March 2012**	**on 31st March 2013**	**Variance**
Domiciliary Care Managed	2144	2199	+55
Domiciliary Non-Care Managed	2365	2283	-82
Domiciliary Total	4509	4482	+27

(Source DSF returns from SET)

Commissioned services

The majority of services in this POC will be commissioned as per 2013/14, however, it should be noted that the following areas are under development:

- In addition to commissioning services to respond to the Ministerial targets, the South Eastern LCG will commission a range of additional activity in 2014/15 to respond to the needs of the growing older population. This will involve working very closely with the ICPs.
- South Eastern LCG will continue to support the Trust in its provision of supported living facilities for Older People vis-a-vis i.e. the re-provision for Ravara House.
- South Eastern LCG will, as part of the ICPs, commission from the Down Integrated Care Partnership a Frail Elderly Integrated Care Pathway to initially target the 85 and over age group in that locality. It should also support the shift toward prevention, self-care, co-ordination and integrated care provided in the home or close to home that is a key part of the Transforming Your Care (TYC) approach and materially reduce demand for acute health services.
- In recognition of the on-going growth in numbers of people with dementia, the South Eastern LCG will work closely with the Trust and others to apply the regional investment was secured to enhance local services for people with dementia. During 2012/13, a total investment of £400k was secured to expand memory clinics and in 2013/14, further investment of £200k was sought to introduce a Navigator role for signposting and provide enhanced access to psychological support.
- The South Eastern LCG continues to recognise the important role played by carers in our community and will continue to place carers at the centre of its future transformation plans.

The table below demonstrates the on-going work within the SET to ensure that Carers are offered assessments; the number of carers offered has dropped marginally but more concerning is the drop of almost 3% in those accepting the offer of assessment - this should be addressed in order to meet the legislative requirement and Ministerial Objective.

Overview of Carers and Direct Payments Made within the South Eastern Area
Table 54

CARERS AND DIRECT PAYMENTS within POC4	2011-12	2012/13	% variance
Number of adult carers offered individual carers assessments during the year	2063	2001	(-) 3%
Number of adult individual carers assessments undertaken during the year	406	340	(-) 16%
Number of adults receiving direct payments @ 31st March	5	87	(+) 1640%
Number of one off Carers Grants made in-year	67	77	(+) 15%

(Source DSF returns from SET)

Care management of older people is a clinical priority for the ICPs and the LCG will be evaluating a range of proposals throughout 2014/15 to deliver more primary and community care support.

Overview of Care Packages Delivered within the South Eastern Area
Table 55

Care Packages in place on 31st March 2013 for Age 65+	2011/12	2012/13	variance
Residential Home Care	667	686	+10
Nursing Home Care	1342	1362	+20
Domiciliary Care Managed	2144	2199	+55
Domiciliary Non-Care Managed	2365	2283	-82
Supported Living	0	36	+36

Specific Commissioning Objectives for 2014/15 and 2015/15

POC4: Older People	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The SEHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The SEHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase uptake of direct payments	The South EasternTrust is expected to achieve this target and will expect the offer of a Direct Payment as an alternative to direct statutory provision to be an integral part of the Trust's standard assessment and service delivery process.
Working with ICPs to improve the care of the frail elderly.	The South Eastern LCG has with the ICP a set of commissioning specifications which include a requirement to develop a Partnership response to the frail elderly population in the south east. The South Eastern LCG expects the ICP to implement this significant proposal when agreed in-year.

Enhancement of dementia services	The South Eastern LCG has prioritised the need to have a responsive dementia and old age psychiatry model in the south east. Significant investment has been made latterly in response to our need assessment. The South Eastern Trust is expected to implement the new model and an overall improvement in the current provision.
Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements.	The South Eastern Trust is expected to develop intermediate care services in line with the delivery of appropriate clinical care for patients in order to meet the 'shift left' objective of TYC.
Continued roll-out of targeted Public Health Agency (PHA) preventative health and well-being improvement programmes.	The South Eastern LCG will support PHA preventative programmes as required.
Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The South Eastern Trust is expected to ensure that reablement is having a positive impact on the independence levels of our older population and the Trust's ability to manage demand for domiciliary care services. The South Eastern Trust is expected to complete the roll out of reablement during 2014/15 to ensure full coverage (7 teams) by 31st March 2015.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The Trust will therefore take forward all opportunities to develop

	primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied Beddays	46,499	0	46,499
	Day Care	Attendances	33,001	0	33,001
	Domiciliary Care	Hours	2,123,382	25,947	2,149,329
	Residential & Nursing Homes	Occupied Beddays	693,949	10,950	704,899
	Community Nursing & AHPs	Face to face contacts	379,058	3476	382,534
	Social Work	Caseload	4,471	0	4,471
		VALUE OF COMMISSIONED ACTIVITY[49]	£120.1m	£4m	£124.1m

[49] This includes activity in addition to that set out above.

8.4.5 POC 5 – Mental Health

Introduction

Mental Health services aim to promote wellbeing and recovery and also provide care and support to those in distress or suffering ill health. Population based initiatives, i.e. mental health promotion, aim to enhance awareness of good mental health and enable people to better deal with day-to-day life stresses; targeted initiatives aim to promote resilience and prevent illness among at risk population groups, self-harm and/or substance misuse. The provision of mental health care and support includes direct care provided within primary care, community mental health and in-patient care settings. A key aim is to promote independence and recovery and the provision of such care within the usual primary/community care setting where possible. The South Eastern LCG area will work with the Regional Commissioning objectives to ensure these translate at local level. The priorities from a regional perspective relate to:

- Addressing the continual high level of suicides in NI and the co-morbidity with substance misuse.
- Stigma associated with Mental Health issues.
- Increase in talking therapies in primary care.
- Improving the patient experience in secondary Mental Health by implementing more recovery focused approaches working in partnership with service users and carers.
- Reduction in hospital beds as resettlement ends.
- Improve the quantity and quality of Crisis Resolution and Home treatment services.

Overview of Local Needs

- The number of mental health patients receiving direct payments in the south east is small (less than ten). This is indicative of the region and there is a need to make further improvements to increase this number.
- The remaining patients for resettlement within 2014/15 are inclusive of a number of patients with a forensic history; SET will need to continue to work towards achieving this target. The Trust is required to resettle eight long stay patients during the next year.
  Over the last three years the number of patients referred for assessment of social care needs with mental health issues has fallen by 37% (9,372 to 5,049).
- There has been a recorded increase in the number and rate of suicide[50] in the last ten years in Northern Ireland. The data for 2010 showed an increase of 6% (Total 290).
- There was some variation in suicide rates by Trust. The highest rate of suicide was in the Eastern area, which includes SET, at 17.8 per 100,000 of population.
- From 2001 until 2011, there were 713 suicides in Northern Ireland identified as mental health patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represented an average of 65 patient suicides per year.
- In Northern Ireland, there were 435 suicides in people with a history of alcohol misuse

Ministerial Targets

The South Eastern LCG expects the SET to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of mental health services in its dialogue with the Trust and where appropriate the ICP:

[50] The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness Annula Report, England, N.Ireland, Scotland, and Wales (July 2013)

- The South Eastern LCG is currently working with the Trust to develop a new model for acute mental health services associated with proposals for a new mental health centre of excellence.
- The South Eastern LCG and Trust will progress proposals for service enhancement of CAMHS in line with Board commissioning requirements and DHSSPS guidance.

Commissioned Services

South Eastern LCG has commissioned a range of services at a local level in line with the regional commissioning objectives and TYC. The investment has been sourced from a range of funding within South Eastern LCG/ HSCB, and the investment has spanned across a number of different services within Mental Health with a particular emphasis upon community teams. Some of the more significant funding streams have focused on investment within:

- Community addictions services
- Psychological therapies
- Care management in Mental Health
- Transition from Children's services (ASD Spectrum)
- ED Psychiatric Assessment
- Mental Health community Teams

Specific Commissioning Objectives for 2014/15 and 2015/16

POC 5: Mental Health	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The SEHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The SEHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
Implementation of the Protect Life Strategy	The South Eastern Trust Protect Life Implementation Group continues to work with the Regional Working Group to progress these areas. MOU-work in progress.
Establishment of integrated care arrangements for the care and treatment of patients with common mental	The South Eastern Trust is in the initial stages of developing their Mental Health and Wellbeing Hub and will link with

health needs	Family Support Hub as a joint initiative.
Implementation of the Crisis Resolution Home Treatment services for CAMHs	Operational within the South Eastern Trust and provided by Belfast Trust.
Further development of specialist community services	Established within the South Eastern Trust and further investment forthcoming 2014/15.
Improved psychiatric liaison services	Work in progress and further investment in 2014/15. This will be reviewed in year.
Local Priority-	The South Eastern Trust is giving consideration to the rationalisation of Acute Inpatient Mental Health Service to a single site adjacent to the Ulster Hospital. The Trust has been asked to deliver a model which is affordable and is working to conclude this process with the South Eastern LCG.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left 'agenda. The Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied Beddays	52,570	0	52,570
	CPN	Contacts	68,137	550	68,687
	Res & Nur Homes + Supported Housing	Occupied Beddays	31,020	0	31,020
	Day Care	Attendances	16,316	0	16,316
	Dom Care	Hours	13,042	0	13,042
		VALUE OF COMMISSIONED ACTIVITY[51]	£37m	£1m	£38m

[51] This includes activity in addition to that set out above.

8.4.6 POC 6 – Learning Disability

Introduction

The Bamford Report estimated that about 9.7 per 1,000 people in N. Ireland had a learning disability, with over 27% of these being severely/profoundly disabled.

The key aims of services are to promote independence for people with a learning disability in inclusive activities in the community which promote their health and wellbeing and to support families who care for the majority of children and adults with a learning disability. These aims should increasingly be met through partnership working with other statutory agencies and with voluntary and community providers.

The South Eastern LCG will work with the regional commissioning objectives to ensure these translate at local level. The priorities relate to;

- Supporting the number of people within learning disability reaching adulthood and requiring day opportunities and community support.
- Supporting older carers.
- Addressing health inequality for people with learning disability.
- Reduce hospital beds as resettlement ends
- Increasing specialist support services within community settings.

Overview of Local Needs

- Whilst SET has improved the numbers of people receiving direct payments, there is a need to continue to strengthen and grow this.
- The number of patients in the south eastern locality with a learning disability has increased by 100% in the last 3 years to 38 patients. These numbers are expected to be low as patients are normally in the system for their lifetime.

- The remaining patients for resettlement within 2014/15 are inclusive of a number of patients with a forensic history. SET is due to resettle 13 patients in 2014/15.

Ministerial Targets

The South Eastern LCG expects the South Eastern Trust to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of learning disability services in its dialogue with the Trust and where appropriate the ICP:

- Implementation of the recommendations from the Day Opportunities consultation will be prioritized by the LCG.
- The South Eastern LCG will seek to see progress (subject to Departmental approval) on the reform of Learning Disability Day Care provision in North Down and Ards.
- The South Eastern LCG will seek to ensure that commissioned services for carer are responsive to their needs.

Commissioned Services

Within learning disability the focus of commissioned services in south eastern area has also been addressed at local level in line with regional commissioning objectives and Transforming Your Care. The investment has been sourced from a range of funding within South Eastern LCG/HSCB, and the investment has spanned across a number of different services within learning disability with a particular emphasis upon community infrastructure teams.

Learning Disability specific investment has focused on;

- Community Infrastructure Accommodation based services in the community (resettlement)
- Autism Spectrum Disorder service delivery model
- Developing capacity within the Trust Learning Disability Teams

Specific Commissioning Objectives for 2014/15 and 2015/16

POC 6: Learning Disability	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The SEHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The SEHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
Delivery of day services in line with the Regional Day Opportunities Model	The South Eastern Trust, working with regional colleagues, is expected to ensure that day services are delivered in line with the Regional Day Opportunities Model.
Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	The South Eastern Trust is expected to work to achieve the regional objectives as specified.

To increase the uptake of direct payments.	The South Eastern LCG Trust is expected to work SEHSCT to monitor achievement of this target and will expect the offer of a Direct Payment as an alternative to direct statutory provision to be an integral part of the South Eastern Trust's standard assessment and service delivery process. From April 12 – March 13, 62 adults were receiving Direct Payments and 18 carers receiving a Direct payment. A significant training programme has been underway following a review and revised guidance for staff relating to Direct payments.
Development and implementation of health promotion initiatives for people with a learning disability.	Annual health checks underway within the South Eastern Trust. Health Promotion regional conference for people with a learning disability organised for march 2014.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. It is expected that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied Beddays	0	0	0
	Day Care	Attendances	133,988	2,125	136,113
	Domiciliary Care	Hours	69,890	0	69,890
	Residential & Nursing Homes	Occupied Beddays	113,135	2,190	115,325
	Community Nursing and AHPs	Face to face contacts	40,696	0	40,696
	Social Work	Active Caseload	1,692	0	1,692
		VALUE OF COMMISSIONED ACTIVITY[52]	£46.3m	£3m	£49.3m

[52] This includes activity in addition to that set out above.

8.4.7 POC 7 – Physical Disability and Sensory Impairment

Introduction
This Programme of Care applies to people aged 18 – 64 years of age only.

According to results from the Northern Ireland Survey of Activity Limitation and Disability conducted by NISRA in 2006/07, 18% of all people living in private households in Northern Ireland have some degree of disability.
By 2023, it is projected that the 0-64 population in NI will be approximately 1.59 million; an estimated increase of 2.7% from 2011.The south eastern area, however, indicates a small projected decrease in population (0.06%) within this age band from 211,908 to 210,457.

Developments in services for people with Physical and Sensory Disabilities have received a renewed impetus with the recent publication of Departmental and OFMDFM strategies. Implementation has benefitted from the involvement of voluntary sector partners and emphasis on the participation of service users. There has been a strong emphasis on the importance of inter-agency working in the fields of housing, transport and employment.

There is also a need to review and reform traditional models of service delivery through an increased emphasis on giving people more control over their support needs through the promotion of personalised budgets, support for carers and advocacy. In terms of specific initiatives there is a need to remain focussed on improving and sustaining performance in the provision of wheelchairs and equipment, reviewing and piloting initiatives to progress the reform of existing day care provision, establishing appropriate links with reablement, building on the recent service enhancements in sensory services and promoting community based accommodation options for people with brain injury.

The TYC recommendations specific to Physical and Sensory Disability are reflected in the commissioning priorities for 2014/15 and 2015/16: promoting

independence and control through self-directed support, advocacy and Direct Payments, support for carers and joint planning across sectors and agencies. The main strategic driver for developments within PoC 7 is the Regional Physical and Sensory Disability Strategy Action Plan (2012-15). In addition, the RQIA report of the Review of Sensory Support Services in NI (2011) is relevant to the development of sensory impairment services and the outstanding recommendations are being addressed alongside the Regional Disability Strategy actions.

The Physical & Sensory Disability Strategy is being implemented via three project-managed work streams; Supporting Independent Living, Information and Training and Sensory Impairment. Trusts, service users and carers and independent sector stakeholders are represented on all work stream groups and the overarching Strategy Implementation Group.

All work streams are prioritising the promotion of independence, reablement and self-directed support. Service redesign is underway across the system involving streamlining care pathways, cross-agency collaboration, improvements in equality of access, focus on prevention and early intervention and improved support for carers.

Capacity and demand gaps continue in respect of the provision of an appropriate range of supported living options for individuals with very complex disabilities including brain injury. Scoping work in relation to the Regional Disability Strategy has highlighted variation across Trusts in the delivery of physical and sensory disability services such as communication support for deaf people, rehabilitation, training and the provision of equipment including wheelchairs and prosthetics.

Overview of Local Needs

- As of June 2013 there were 413 care packages in effect in NI, South Eastern Trust accounts for 60 of these which is a slight decrease over the last 3 years from 64. (Source DSF returns from SET)

- SET had 503 Direct Payments in place at 31 March 2013 which was an increase of 105 from 31 March 2011. During 2012/13 there was an average of 485 Direct payments in place. The amount paid at 31 March 2013 was £675,136 which reflected an increase of £153,414 from 31 March 2011 with a total amount of £2,601,304 being paid out during 2012/13. The number of people receiving direct payments within PoC7 has fallen from 115 to 95. The number of one off Carers Grants made in-year was 91 compared with 67 in the previous year a% increase of 36. (Source DSF returns from SET) In the first 6 months of 2013/14 there have been 194 carers assessments completed throughout SET but this includes all PoCs. In addition there are carers reviews undertaken on an on-going basis.
- There is also a need to review and reform traditional models of service delivery through an increased emphasis on giving people more control over their support needs through the promotion of personalised budgets, support for carers and advocacy.
- In terms of specific initiatives there is a need to remain focussed on improving and sustaining performance in the provision of wheelchairs and equipment. In SET there are 136,698 households and 5.7% (7,792) of the population has had their house adapted to suit wheel chair access (NI census 2011 information). The South Eastern Trust last year had a budget of £593,506 for wheel chair provisions. The actual cost for wheel chairs last year reached £626,522 i.e. over commitment of £32,996 which was 6% of the original budget. Wheel chair provisions received an up lift of funds with an estimated £30,000 of demography monies allocated to the service which equated to the over commitment i.e. demographic pressure.
- The number of people who have complex needs and require significant packages of care is increasing and has been flagged by the trust as a pressure - these packages can cost between £250,000 and £500,000 patients.

Overview of Care Packages Delivered within the South Eastern Area
Table 56

Care Packages in place on 31st March 2013	Age 18 - 65
Residential Home Care	28
Nursing Home Care	47
Domiciliary Care Managed	516
Domiciliary Non-Care Managed	317
Supported Living	2

In SET 5.56% of the population suffer partial or complete hearing loss. This is above the 5.1% regional average. 1.66% (NI average 1.7) of the population suffers blindness or partial sight issues and 11.09% (NI Average 11.4) suffer some form of mobility issue.

Table 57

People in contact with SET	*Category*	*Category*	*Category*	*Category*	*Category*
Age	*Deaf with Speech*	*Deaf without Speech*	*Hard of Hearing*	*Blind*	*Partially sighted*
0-4	*0*	*0*	*8*	*0*	*5*
5-15	*0*	*0*	*27*	*9*	*23*
16-24	*10*	*4*	*7*	*0*	*10*
25-44	*10*	*12*	*15*	*38*	*46*
45-64	*0*	*12*	*45*	*65*	*133*
65-74	*0*	*13*	*71*	*39*	*154*
75+	*0*	*-*	*23*	*153*	*873*
unknown	*1*	*-*	*0*	*0*	*0*
Totals	*47*	*41*	*409*	*304*	*1244*
Deaf Blind Source DSF returns from SET 15 in total aged 18-65(NISRA)					

Ministerial Targets

The South Eastern LCG expects the South Eastern Trust to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan.

Commissioned Services

The majority of services in this POC will be commissioned as per 2013/14 and the South Eastern LCG will continue to commission the provision of a range of services to adults a physical disability or sensory impairment and their carers and families. In addition it should be noted:

- The South Eastern LCG will monitor discharge delays from Specialist Units from within the SELCG area; Regional funding from the P&SD Strategy into the Regional Rehabilitation Services at Musgrave Park Hospital will ensure that there is sufficient medical cover for service continuity on site as well as outreach to local rehabilitation centres and support for Community Rehabilitation teams. Belfast and South Eastern LCGs are working together to ensure that Thompson House is able to accept new patients transferred from the specialist services.
- The South Eastern LCG, in response to the direction of travel signalled in TYC, will continue to support the 'Reform and Modernisation' of day care provision to providing day opportunities.
- The South Eastern LCG welcomes the various new investments into Physical and Sensory Disability Programme of care from the P&SD Strategy Implementation Group:
- Recurrent Funding of Regional (RNIB) Eye Care Liaison Officer Posts
- Recurrent Funding of Regional Additional (BDA)Advocacy Post
- Non- Recurrent Funding of Regional of Tinnitus awareness raising(AoHL)
- Non- Recurrent Funding of (AoHL)Hear 2 Help Pilot
- Recurrent Funding of Regional Wheelchair Therapist Post
- Recurrent Funding of Regional Wheelchair Equipment - Buggy Covers
- Additional Recurrent Funding of Wheelchair Approved Repairer Contract
- Non- Recurrent Funding of E-NISAT roll out within PoC 7

- Non- Recurrent Funding of SET Community Access Pilot Posts within PoC 7 x 2
- Non- Recurrent Funding of Regional Deaf Blind Needs Analysis

The South Eastern LCG continues to recognise the important role played by carers in our community and will continue to place carers at the centre of its future transformation plans.

Specific Commissioning Objectives for 2014/15 and 2015/16

POC 7: Physical Disability and Sensory Impairment	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The SEHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The SEHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase uptake of direct payments	The South Eastern Trust is expected to achieve this target and will expect the offer of a Direct Payment as an alternative to direct statutory provision to be an integral part of the South Eastern Trust's standard assessment and service delivery process.
Review Trust progress in relation to the review and reform of day service opportunities to ensure alignment	The South Eastern Trust is expected to consolidate the on-going reform and modernisation of day opportunities.

with personalisation strategies.	
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability	**Hospital Services**	Occupied Beddays	17,438	0	17,438
	Daycare	Attendances	23,292	0	23,292
	Domiciliary Care	Hours	314,916	0	314,916
	Residential & Nursing Homes	Occupied Beddays	27,192	0	27,192
	Community Nursing & AHPs	Face to face contacts	19,802	0	19,802
	Social Work	Active caseload	1,929	0	1,929
		VALUE OF COMMISSIONED ACTIVITY[53]	£18.1m	£0.5m	£18.6m

[53] This includes activity in addition to that set out above.

8.4.8 POC 8 – Health Improvement

Introduction

Improving health and social wellbeing and reducing the risk of health inequalities is a key priority for the South Eastern Local Commissioning Group and PHA. The priorities focus on four key areas;

- Giving every child and young person the best start in life;
- Ensuring a decent standard of living for all;
- Building sustainable communities; and
- Making healthier choices easier.

In seeking to improve health and social wellbeing there is a need to maximise the contribution of all sectors and to ensure effective collaborative approaches that target both local needs and regional strategic priorities. Addressing the wider social determinants of health together with work to encourage and support individual lifestyle choices is critical to seeing the continued improvements in health that have been realised by those experiencing least disadvantage but not by all.

Within the challenges and opportunities of the "Transforming Your Care" agenda there is a need for all Programmes of Care to embed health and social wellbeing improvement as a key focus within their services and programmes. In adopting a person centred approach all those involved in the delivery of health and social care services need to ensure they consider the totality of need of the individuals and provide effective help and support to ensure these needs are addressed as appropriate.

In addressing the four key building blocks for Health and Social Wellbeing Improvement outlined above there is a need to continue to embed services and programmes within key settings such as communities, schools, early year's settings, workplaces, primary care and acute care that maximise the potential for individual engagement and involvement. Building policies, services and programmes that are conducive to improving health and have a sound

evidence base will continue to provide the foundation for this work within the south eastern locality.

Overview of Local Needs

The south eastern locality shows a mixed profile of prevalence of patients on registers per 1000 of all key QOF measures with the highest rate in the region for hypertension and stroke and the lowest prevalence in mental health.

The SMR for South Eastern LCG has stayed the same over the past decade at 95 making it one of the lowest in the region. The under 75 SMR has moved from 90 to 89.

There were 7 obesity-related deaths in the South Eastern Trust area from 2007 to 2011. The definition of obesity-related deaths is any death where the underlying cause of death is recorded as obesity.

Data on individuals availing of specialist smoking cessation services shows that in the South Eastern Trust area in 2012/13, 55.8% of people who set a quit date had successfully quit (self-report) at 4 weeks.

In the ten years since 2002, there has been an increase in the number of alcohol related deaths in Northern Ireland, and this is also reflected in an increase in deaths from alcohol in the South Eastern Trust, as the table below shows.

Alcohol Related Deaths
Table 58

Registration Year	South Eastern	Total
2002	35	**238**
2003	43	**214**
2004	58	**255**
2005	50	**246**
2006	41	**248**
2007	43	**283**
2008	50	**276**
2009	56	**283**
2010	42	**284**
2011	51	**252**
2012[P]	52	**270**
Total (2002-2012)[P]	**521**	**2,849**

Ministerial Targets
The HSCB/PHA expects the Trust and other commissioned service providers to deliver the targets, objectives and priorities contained within this plan.

Commissioned Services
In relation to Giving every child the best start on-going support has been provided during 2013/14 to develop the two "Early Years Intervention Projects" in the Colin Neighbourhood and Greater Lisburn. These projects represent a very significant investment by a range of partners together with local communities to develop and deliver a shared agenda for children and families. Work has also been taken forward to embed the health and social wellbeing improvement priorities across a range of early years settings such as maternity services, nurseries, playgroups, Sure Starts and schools addressing issues such as maternal smoking, alcohol and drug use, play and development, emotional development, nutrition and accident prevention.

In seeking to ensure a Decent standard of living for all the PHA together with DARD has expanded the provision of the Maximising Access in Rural Areas programme (MARA) to address the needs of rural communities. The service seeks to help individuals and families in rural areas access advice, help and support in areas such as maximising income and benefit uptake. Work has also

been undertaken to support the formation of a poverty network aimed at improving coordination and collaboration across community, statutory and voluntary groups and organisations who are seeking those experiencing the impact of acute poverty.

In seeking to Build sustainable communities there has been an on-going investment in some 15 dedicated Community Health Development Workers working across key areas of disadvantage in the south eastern area to address local health and social wellbeing needs.. A new Healthy Living Community Project has been launched with the Resurgam Community Association in Lisburn and also within the Kilcooley area in Bangor to help address local needs of the communities across the Greater Lisburn area as part of this approach.

The focus on making healthier choices easier aims to get all those groups and organisations that can help improve health and wellbeing to work collaboratively to target their services and support effectively to individuals and communities. Work has continued during the year to increase the provision of a range of evidence based programmes to address issues such as the misuse of alcohol and drugs, the need to reduce the growing levels of obesity, reducing the risk of accidents, improving mental health and reducing the risk of suicide, increasing physical activity levels, improving sexual health and reducing smoking.

The HSCB/PHA will work with partners to support the implementation of the new Regional Public Health Strategic Framework 'Making Life Better' which is expected in 2014/15. This framework will seek to build on the need for effective collaborative working across all sectors and organisations to make a difference in the health and social wellbeing of individuals and communities.

Continuing to build effective interventions in the early years will be a key priority within the south eastern area and there will be significant new investment to deliver evidence based early years programmes such as "Incredible Years," "Parenting UR Teen" and "Strengthening Families" across

the area as well as supporting the growth of the "Early Years networks and communities" approach There will also continue to be a focus on developing the capacity of the five Sure Start programmes across the area to help provide children with a healthy start.

Within the current economic climate there continues to be a challenge to long term health and wellbeing for those individuals affected by poverty and unemployment. The HSCB/PHA will continue to work closely with local groups and organisations to maximise the help and support that can be made available for individuals and families most in need. Critical within this work will be the on-going development of the partnerships with local community groups and networks and the responses that need to be realised from all those who can help address the needs within local areas.

In relation to making healthier choices easier service development priorities in 2014/15 will focus on:

- Reducing the risk of obesity and increasing physical activity across all ages but in particular with children, pregnant mums and adults
- Providing on-going access to a range of drug and alcohol services to address the specific needs of various age groups;
- Improving the opportunities to develop positive mental health and to target help at those at risk of suicide or impacted by suicide;
- Reducing the numbers of people who continue to smoke;
- Improving sexual health and access to family planning and sexual health services; and
- Improving the health and wellbeing of older people by providing targeted health improvement programmes and services, developing mechanisms to improve information and help to access services, working with partners and communities to reduce the risk of isolation and loneliness and delivering services and programmes to reduce the current level of falls amongst those most at risk.

Specific Commissioning Objectives for 2014/15 and 2015/16

POC8 – Health Promotion	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Expansion of the early years intervention programme.	Additional investment will be made within the Trust to ensure the development and delivery of early intervention as a key priority across the area. The South Eastern Outcomes Group will ensure an effective multi-sectorial action plan is implemented in line with the regional strategic programme priorities. The Trust will also deliver the suite of PHA programmes and support the development of locality based "Early Intervention Communities."
Incremental expansion of social economy businesses and community skills development.	The South Eastern Trust is expected to engage with the Public Health Agency and others to reduce the impact of poverty on clients and patients, particularly those with mental health issues, addictions, older people and families with young children. The South Eastern LCG is committed to supporting initiatives which offer opportunities to social economy businesses to participate in public procurement of Health and Social Care services.

Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	A co-ordinated approach should be developed across relevant areas of Trust Business and in conjunction with other statutory, community and voluntary partners. Improved access and uptake of targeted health and wellbeing improvement services and programmes by older people.
LCGs to monitor Trust performance in relation to the HSCB / PHA Community Development strategy	The South Eastern LCG will work with the South Eastern Trust to monitor performance on an ongoing basis.
Implementation of the “Fitter Futures for All Framework”.	Tackling obesity is a pilot project developed by the PHA to reduce obesity in pregnancy. The SE Trust has successfully commenced this project by recruiting the required staff and began to recruit women to the project. New investment has been made within the Trust’s Community Dietetic Services to develop capacity and resource to ensure delivery of the ‘’Fitter Future for All’’ Framework over the next three years. In addition the Trust will lead the development of a new range of programmes and initiatives to address the need to increase levels of physical activity across all ages. o
Implementation of key public health strategies.	The South Eastern LCG will support Public Health Agency colleagues to ensure South Eastern Trust implementation of key public health strategies including tobacco cessation,

	treatment and support for substance misuse and associated mental health, emotional wellbeing and suicide prevention.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	The South Eastern Trust is expected to provide monitoring report outlining range of specialist sexual health services available, numbers and age groups accessing services by the end of March 2015.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The South Eastern LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

8.4.9 POC 9 - Primary Health and Adult Community

Introduction

This programme of care includes all work (except screening) carried out by General Medical Practitioners, Out of Hours, General Ophthalmic Practitioners, and pharmacists as well as community based AHPs and nursing services. There are presently 54 GP practices delivering services across the South Eastern LCG area. The South Eastern LCG resident population is circa. 350,000 with a GP practice registered population of 315,664. The South Eastern LCG area has 90 community pharmacies, 47 optometry practices and 70 dental practices

Primary care and adult community services play a critical role in terms of supporting people in staying well as long as possible.

Integrated Care Partnerships (ICPs) have been established across Northern Ireland as a key recommendation of TYC. There are 4 ICPs in the South Eastern LCG area (17 in total across NI) covering the localities of Ards, Down, Lisburn and North Down and they are responsible for the coordination and provision of patient pathways and improving care, with an early focus on frail elderly, Chronic Obstructive Pulmonary Disease (COPD), stroke, diabetes and end of life care as it relates to those conditions. Each ICP represents a population base of around 100,000 practice based residents. The ICPs are managed by a GP Clinical Lead and are supported by a small business support team. In addition, ICP partnership committees have been established for each locality, to include representation from the primary care, Trust, service users/carers, Northern Ireland Ambulance Service and local community and voluntary sector organisations. Multi-disciplinary teams have also been established for each of the 4 clinical priority areas to redesign patient pathways.

Overview of Local Needs

While primary care is usually the first point of contact for all ages; a higher proportion of the older population will need to access primary care services.

The South Eastern LCG area has a proportionately larger share of Northern Ireland's older population than any other LCG area. There are 59,016 people (17% of the total South Eastern LCG population) who are 65 years and older in the area which accounts for 21% of all people 65 years or older in Northern Ireland. It is inevitable that older people are increasingly more likely to be living with more than one long term chronic conditions. Section 8.1 provides details on demographic change across the south east.

Ministerial Targets

The South Eastern LCG expects the SET to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of Primary Health and Adult Community Services in its dialogue with the Trust and where appropriate the ICP:

- Working with the ICP to ensure that the clinical priority areas are addressed. The ICP has already shared with the South Eastern LCG their initial considerations with the expectation that a substantive proposal in regards to the establishment of a community ward is delivered in 2014/15.
- In regards to end of life care the ICP's will also be contributing to the Transforming Your Palliative and End of Life Care Programme (which is supported by Marie Curie).

Commissioned Services

In addition to the baseline community nursing, AHP, and Family Practitioner Services commissioned in 2013/14 the South Eastern LCG invested in the roll out of primary care based sexual health services. This investment builds on the North Down sexual health pilot which focused on the asymptomatic testing of patients in GP practices for STIs. This service is now being established in the Lisburn locality and in 2014/15 will be rolled out to the rest of the LCG localities. During 2014/15 the South Eastern LCG will, on the basis of an initial scoping exercise carried out this year, develop a plan, in co-operation with SET

and Belfast Trust (which currently provides the majority of family planning services in the South Eastern LCG locality), to integrate family planning and sexual health services within our locality.

The LCG will work with HSCB / PHA colleagues and relevant Trust management to ensure that the recommendations of the 'RQIA Review of Specialist Sexual Health Services in Northern Ireland' are implemented, particularly in relation to Improving access to services and better integration of sexual health and family planning services.

The South Eastern LCG will monitor the roll-out and early audit and evaluation of the re-modelled cataract referral pathways in Belfast & Southern LCG Areas, and the community-based "red eye" service being piloted in Southern LCG. Ophthalmology remains a high-demand specialty, often involving our frail elderly population, and the South Eastern LCG recognises the increasing role high street optometrists play in managing this demand, and delivering safe and accessible services closer to home, in line with TYC and Developing Eye care Partnerships.

The South Eastern LCG is in the process of commissioning a pilot in the North Down locality to provide GP direct access to DEXA scanning. This will use the existing scanner in the Bangor Community Hospital. Currently access to DEXA scanning is via consultant referral; this will allows GP practices to directly refer those patients with appropriate musculoskeletal conditions. As with the pain management service, funding was made available via South Eastern LCG prescribing savings.

Initiatives about to be commissioned from the ICP include:

- An Atrial Fibrillation (AF) pathway to include access to and interpretation of ECG, 24 hour ECG recording, event monitoring, confirmation of diagnosis and decisions about anti-coagulation and management of rate and rhythm available on a 7 day basis

- A diabetes programme to ensure patients/ carers receive a structured education programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to on-going education.
- Health and well-being programmes targeted at the frail elderly in their locality, include a focus on nutrition, falls prevention, social isolation, physical activity, information and medication
- For frail elderly patients, community-based urgent care multi-disciplinary teams with a single point of referral where a same day assessment of need can be carried out.

In order to shift resources from hospital to community a priority will be to review the demand and capacity in the community nursing workforce to ensure the workforce is sufficient and suitably qualified to deal with the complexity of cases that are to be managed at home. The South Eastern LCG will work with the ICPs to improve the care of frail elderly and those with long term conditions to reduce unplanned admissions and provide acute care at home that is supported by robust community nursing and specialist nursing teams

The services in relation to this POC were commissioned as per 2012/13. In response to the shift of services from secondary to primary care, the South Eastern LCG is looking at future infrastructure requirements, under the Primary and Community Infrastructure Development (PCID) programme. During 2013/14 the South Eastern LCG has worked closely with GPs to progress the development of the primary care hub and spoke model in line with HSCB and Departmental policy. The South Eastern LCG aims in the near future to have an agreed prioritisation of hub and spoke developments including service models for each. The hub and spoke service models will provide the catalyst for the shift left agenda involving the transfer of clinically appropriate services, including outpatient diagnostics, from the acute to community settings, thus providing communities with closer to home improved access.

Prescribing

The South Eastern LCG continues to seek efficiencies in the cost of prescribing, both in primary and in secondary care dispensing costs, as well as in GP out-of-hours.

GP Out-of-Hours (GP OOH) Services

In 2014/15 the South Eastern LCG is likely to assume responsibility for directly commissioning GP OOH Services within its locality. As the commissioning priorities and requirements table below shows, the LCG will play a key role in the commissioning and co-ordination of those community based unscheduled care services, in particular nursing, that interface with GP OOH.

Within this programme of care palliative and end of life care is a priority area for the South Eastern LCG and in particular we would seek to ensure that where possible, and if clinically appropriate, people in the final year of life are given the opportunity to remain at home, including nursing homes. We will continue to work with both statutory and community and voluntary providers in this area to ensure that these patients maintain, and where possible, improve the quality of care that they receive.

Direct Referral to AHP services

The Public Health Agency (PHA) with support from Transforming Your Care (TYC) is working to introduce the option of Self-Referral Physiotherapy for patients in the South Eastern area in early 2014/15

The South Eastern area has been selected as an early adopter site for this service which it is hoped can be rolled out to the other Trusts from 2015. The service development means patients will be able to refer themselves to a physiotherapist without first having to see a GP or a healthcare professional.

Similar initiatives in Great Britain have shown that it direct referral can deliver

- High levels of service user satisfaction and confidence

- Improved patient self-care/self-manage to meet needs
- Greater patient compliance
- Better clinical outcomes
- Freeing up GP time
- Reducing in waiting times
- Reducing Did Not Attend

Specific Commissioning Objectives for 2014/15 and 2015/16

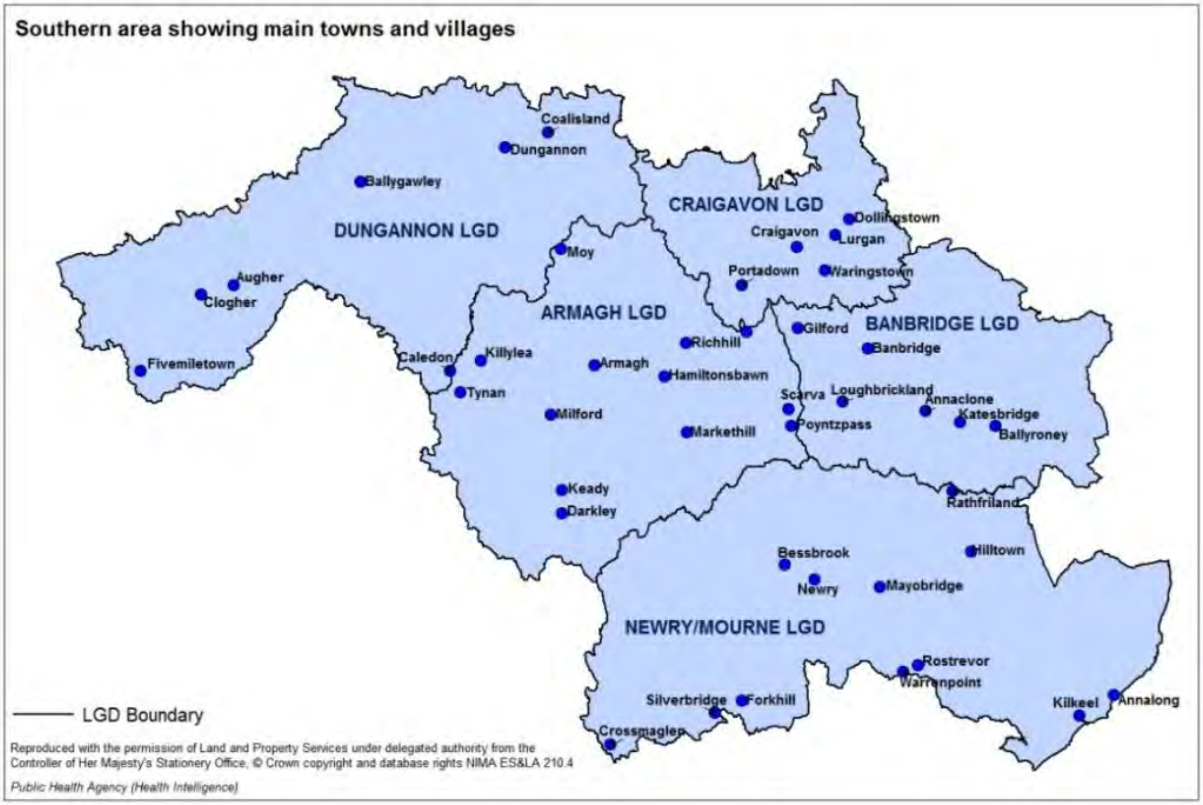
POC 9 - Primary Health and Adult Community	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	The South Eastern LCG will work with regional colleagues and Integrated Care Partnerships to ensure relevant Local Enhanced Services are developed with GPs in line with ICP clinical priorities and LCG commissioning requirements
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility.	The South Eastern Trust is expected to work with the South Eastern LCG to achieve this regional objective.
Local Priority	Ensure roll-out and evaluation of pilot on primary care facing advice and treatment of non-sight-threatening Minor Eye Conditions in South Eastern LCG Area.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.

Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The South Eastern LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

9.0 Southern Local Commissioning Group Plan

This section provides an overview of the assessed needs of the population of the Southern Local Commissioning Group (SLCG). This assessment is based on demographic change, information relating to health inequalities and deprivation and will inform the commissioning of services at local level.
The SLCG is responsible for commissioning local health and social care, in line with strategic and regional direction, across the five local government district areas of Armagh, Dungannon and South Tyrone, Banbridge, Craigavon and Newry and Mourne.

Map of SLCG area showing main towns and villages[54]
Figure 14



[54] Land and Property Services

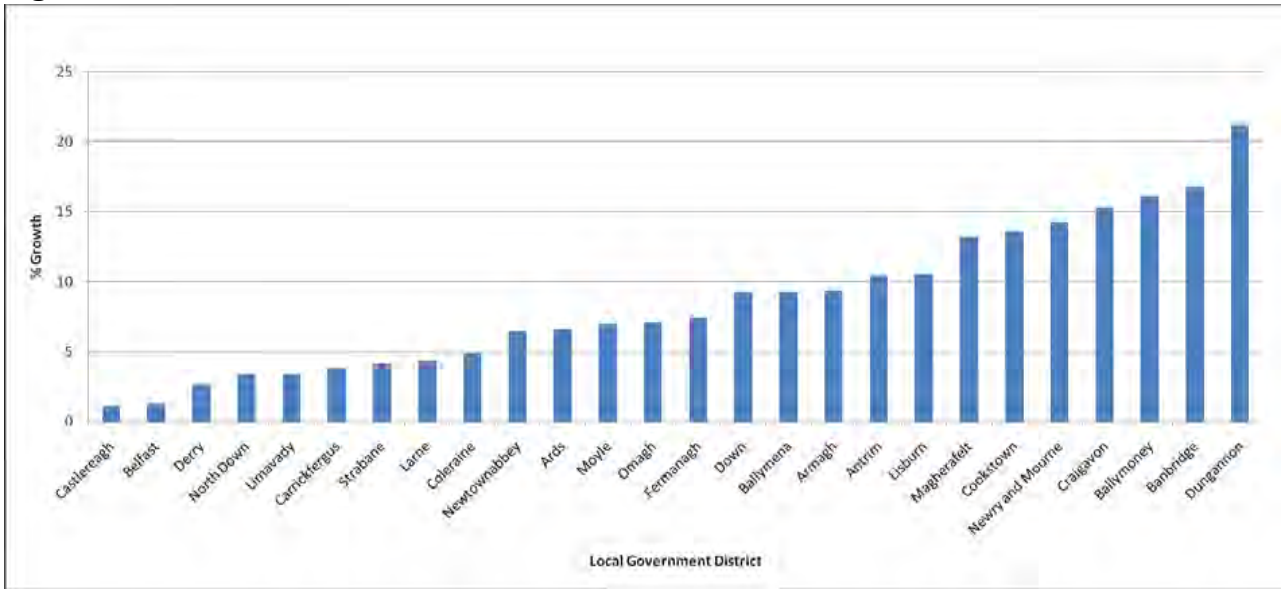
9.1 LCG Population

Demography

The SLCG has a population size of 363,145[55] which represents 20% of Northern Ireland's total population. The SLCG population size has continued to grow steadily each year. Between 1991 and 2012 there has been a 25% increase in the SLCG population size, compared with a 13% increase for Northern Ireland as a whole. Of the 4 fastest growing areas in Northern Ireland, 3 of these (Craigavon, Banbridge and Dungannon/South Tyrone) are in the SLCG area, as illustrated in the Figure 15 below.

Percentage Population Change between the 2001 and 2011 Censuses by Local Government District – All People[56]

Figure 15



The number of children (people aged 0-15 years) in Northern Ireland has in general fallen by 5% between 2001 and 2011. This decrease in the number of children can be seen in 19 of the 26 LGDs. However 7 LGDs have shown increases with the highest growth being recorded in Banbridge (11%) and Dungannon (9%). The LGDs of Banbridge, Dungannon/South Tyrone and

[55] NI Neighbourhood Information Service (NINIS) Population Estimates, 2012

[56] NISRA Statistics Bulletin: Census 2011: Population and Household Estimates for Local Government Districts in Northern Ireland

Craigavon have all seen at least a 25% increase in the number of small children (aged 0-3 years) in the same period.

The number of people aged 85 years and over in Northern Ireland has increased since the 2001 Census in all areas, however the Armagh and Dungannon/South Tyrone districts have seen a higher increase in this age group, recording growth rates in excess of 50%.

Table 59: SLCG Population Growth (2001 – 2023)[57]

Local Government District (LGD)/ SLCG/ NI	Total Population 2001[1]	Total Population, 2012[2]	Population Projection 2023[3]	% increase from 2012 to 2023
Craigavon	81,000	94,600	111,700	18.1%
Banbridge	41,500	48,700	53,600	10.1%
Newry & Mourne	87,600	100,900	118,500	17.4%
Armagh	54,500	60,100	66,700	11.0%
Dungannon/ STyrone	47,800	58,800	69,800	18.7%
SLCG	**312,400**	**363,100**	**420,300**	**15.8%**
Northern Ireland	**1,688,800**	**1,823,600**	**1,945,800**	**6.7%**

Table 59 above shows that the combined Craigavon and Banbridge LGDs population in 2012 equates to 143,300, whilst the combined Armagh and Dungannon/South Tyrone LGDs population is 118,900. The areas of significant growth for 2023 will include Newry and Mourne LGD with a projected growth of 17.4%, followed by Craigavon and Banbridge LGDs which combined have a growth rate of 15.4%. These population projections are significantly higher than the 6.7% predicted growth rate for Northern Ireland as a whole.

[57] Source: NISRA – Mid Year Estimates of Population, 2001; Source[2]: NISRA – Population, 2012 (revised June 2013); Source[3]: NISRA – LGD Pop Projections, based on 2008 Pop.

Table 60 below evidences the much higher proportion of people living in the SLCG area from Central and Eastern European (A8) countries, almost double the Northern Ireland average.

Table 60: Central & Eastern European Migrant Population, 2009[58]

	2009	
HSCT	**A8 Population**	**A8 % of Population**
Northern Ireland	39,000	2.2
Belfast	7,100	2.1
Northern	9,500	2.1
South Eastern	3,400	1.0
Southern	14,700	4.2
Western	4,400	1.5

The SLCG is the highest user of interpreters, during 2012/13 there were 37,880 requests received and dealt with through Northern Ireland Health and Social Care Interpreting Service (NIHSCIS), this represents 50% of the Northern Ireland total number of requests received and dealt with through NIHSCIS as a whole.

Deprivation

Northern Ireland Multiple Deprivation Measure 2010 Summary Measures indicate that 25 of Northern Ireland's top 20% deprived Super Output Areas (SOAs) fall within the SLCG area with ranks of Multiple Deprivation Measure Scores ranging from 31 to 175[59].

Health outcomes are generally worse in the most deprived areas of the Southern area, compared to the overall area. However male life expectancy in the most deprived Southern areas has seen the inequality gap improve from 3.2 years lower in 1999/2001 to 2.3 years lower in 2008-2010. For women however, the inequality gap has widened from 1.9 years lower to 2.1 years

[58] NINIS, Population, 2007-2009

[59] NINIS NIMDM 2010

lower in the same period. Other health outcomes are similarly poorer, for example the proportion of obese children in deprived SLCG areas is 1.5 times that of the LCG as a whole. In addition, the inequality gaps for mood and anxiety disorder rates are around 25% higher in the most deprived Southern areas. Of particular significance is the almost doubling of the inequality gap for standardised death rates for circulatory disease from 26% in 1997-2001 to 49% in 2006-2010[60]

Patient and Public Engagement

The SLCG is fully committed to ensuring that its commissioning decisions are directly informed by the views of patients, service users, their advocates and the community and voluntary sector. At its November 2013 meeting in public, the SLCG outlined its future engagement plan and committing to holding 4-5 engagement events annually, supplemented by specific meetings with users, carers and other key stakeholders as appropriate. This commitment will need to be further developed and refined as we move into the implementation phase of the change projects outlined in the SLCG Locality Population Plan.

During 2013/14, the SLCG engaged directly with elected representatives, held specific issue meetings with MLA's and community and voluntary sector organisations. The SLCG has also had the opportunity to hear at its public meetings the experience and expectation of service users and carers for the services and supports that they would wish to receive. In December 2013, the SLCG hosted a significant engagement event in Armagh to update key stakeholders and members of the public on the changes being taken forward under the TYC agenda. This was extremely well attended and further events are being planned. During 2014/15, the SLCG hopes to establish a forum for local people with physical and/or sensory disabilities the outcome of the discussions of which will help inform our commissioning decisions.

[60] NI Health and Social Care Inequalities Monitoring System: Sub Regional Inequalities – HSC Trusts 2012 (NISRA)

9.2 Key Challenges and Opportunities within the SLCG Area

This section provides an overview of the key challenges faced by the SLCG within 2014/15 and 2015/16 which inform and underpin SLCG commissioning priority for 2014/15 and 2015/16. The challenges described in this section, are, if addressed and responded to, also opportunities for the SLCG and as such have the potential to impact on the health and social care outcomes for all southern residents.

Transforming Your Care (TYC)

The SLCG will continue to work in partnership with the Southern Health and Social Care Trust (Trust) to deliver on the transformation agenda through the local TYC project structure. This will include progressing a number of specific projects including:

- Following regional consultation processes, implement locally the resultant regional TYC recommendations on statutory residential home care and day opportunities in the southern area
- Develop plans for the centralisation / future delivery of non-acute hospital care for older people in the SLCG area
- Develop plans for the future delivery of a centralised model for the care of stroke patients in the SLCG area
- Following establishment of 3 Integrated Care Partnerships (ICPs) in the Southern area during 2013/14, the SLCG will continue to progress a commissioning relationship with these groups to secure appropriate service delivery for the clinical priorities they are to take forward in 2014/2015.

Safety and Quality

The Francis Report highlighted that the fundamental responsibility of the NHS is to provide safe, compassionate care and treatment and it reasserted the importance of commissioning in defining safety and quality specifications and supporting and managing the performance of providers to ensure these standards are met. The DHSSPSNI Quality 2020 Strategic Framework ensures that patients and their experiences remain at the heart of service design and

delivery and they identify 3 specific areas namely – safety, effectiveness and patient/client focus. The SLCG is committed to ensuring all its commissioned services are provided safely, effectively and to the quality standards as identified in Quality 2020, NICE guidance, Service Frameworks, Commissioning Specifications and Departmental Strategies.

Personal and Public Involvement (PPI)

Engagement and user involvement must be at the heart of all that the SLCG does. The SLCG has held significant engagement events across the Southern area in recent months with the public, users, community, voluntary, statutory, local government and independent contractors to consult on the strategic themes in TYC. The SLCG recognises that difficult decisions will have to be taken regarding future service commissioning and engagement with the public, users and their advocates and political representatives will be vital in taking forward these very complex issues.

Demography

A significant challenge for the SLCG locality is our growing and ageing population. The SLCG is the second largest locality population in Northern Ireland and is projected to increase by 14% (compared to 6.5% regionally) by 2020. In addition it has a high number of births, with an anticipated 12.6% increase in our 0-17 population by 2020 (compared to a 2.4% increase regionally). This demographic pressure at both ends of the population scale, combined with our increasing life expectancy, will mean more people, and more people living longer. This has the potential to put strain on already pressurised health and social care services.

Information Systems

Much of the focus over recent years has been on the delivery of acute-based services and significant investments have delivered a series of information systems which support the provision of monitoring and performance information, as well as a picture of capacity within a range of services. There remains a significant deficit in the quality and consistency of the community

information and work will be taken forward in 2014 -2015 to improve the robustness and comparability of data to support the negotiation of service and budget agreements.

Developing the Community

A number of policy direction and procurement challenges still exist which can be barriers to enabling a “shift left” i.e. more care being provided in or as close to a patient’s home as possible and more management of long term conditions available in primary care from HSC provision to development of contracts with community and voluntary sector organisations.

As health is not the sole remit of the health and social care system, collaborative working with other public sector, statutory, community and voluntary and independent sector agencies and organisations will be central to delivering the shift left agenda. There is a clear need to develop the community infrastructure, not just within health and social care, but amongst the community and voluntary sector to support the transformation agenda.

9.3 Ensuring Financial Stability & Effective Use of Resources

Use of Resources

The SLCG's baseline funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £532m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 61: Baseline investment by Service Area in 2014/15

Programme of Care	£m	%
Acute Services	197.6	37.2
Maternity & Child Health	27.1	5.1
Family & Child Care	36.4	6.8
Older People	118.1	22.2
Mental Health	45.2	8.5
Learning Disability	50.6	9.5
Physical and Sensory Disability	18.8	3.5
Health Promotion	17.9	3.4
Primary Health & Adult Community	20.1	3.8
POC Total	**531.8**	**100.0**

This investment will be made through a range of service providers as follows:

Table 62: SLCG Funded Providers 2014/15

Provider	£m	%
BHSST	50.8	9.6
NHSST	0.8	0.1
SEHSST	6.7	1.3
SHSST	436.2	82.0
WHSST	4.2	0.8
Non-Trust	33.1	6.2
Provider Total	**531.8**	**100.0**

Whilst Emergency Department services have not been assigned to LCGs as these are regional services, the planned investment in 2014/15 in respect of Emergency Care by the Southern Trust is £14.8m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

The Commissioning Plan for 2014/15 indicates a significant range of service pressures/developments and other additional pressures most notably inescapable pressures such as Pay and Price Inflation as well as additional investment to take account of the demographic changes in the population. The SLCG share of these indicative investments areas is noted below:

Table 63: Southern LCG share of indicative investments 2014/15

Pressures	£m Full Year Effect
Pay & Non Pay	8.0
Demography	9.7
NICE Drugs	3.4
Revenue Consequences of Capital Expenditure	0.5
Mental Health Resettlements	0.6
Learning Disability Resettlements	2.6
Service Pressures/Developments	14.3
Public Health Agency	0.7
Total	**39.8**

9.4 Commissioning Priorities and Requirements by Programme of Care

9.4.1 POC 1: Acute

Introduction

Acute services are provided on two sites in the SLCG locality, Craigavon Area Hospital (CAH) in Portadown and Daisy Hill Hospital in Newry, with 24 hour emergency departments (EDs) at both sites. Supporting non-acute in-patient services are provided in Lurgan Hospital and in Loane House on the South Tyrone Hospital site. Nurse-led Minor Injury Units are located at South Tyrone Hospital and Armagh Community Hospital. Day case surgery, outpatient clinics, diagnostics and day procedures including endoscopy are provided in South Tyrone Hospital, with outreach clinics provided at Armagh Community Hospital, Banbridge polyclinic and Kilkeel.

Transforming Your Care provides a strategic direction of travel for the commissioning and provision of acute services with a focus on shift left. The process establishment of Integrated Care Partnerships (ICPs) in the SLCG area is central in achieving this. The SLCG will directly commission activity from ICPs in 2014/2015, commencing with the identified four clinical areas, frail elderly, respiratory, diabetes, stroke and including an overarching theme of palliative care across all clinical areas. This will impact on its commissioning from the Trust and of evidencing a shift in commissioning, with a corresponding resource shift from secondary care to primary and community care will be developed in 2014/2015.

Significant regional commissioning direction, as evidenced by Ministerial targets, commissioning specifications, NICE clinical and technical guidance, service frameworks and Departmental strategic direction provides the commissioning context for this section. In broad terms, Trust performance against these strategic and clinical standards and targets is acceptable, but there remains room for improvement. Of significance for the commissioner in 2014/2015 will be Trust performance against the 4 hour ED target, which is

projected to achieve 82.8% by March 2014 (based on April to Nov 2013) and reflects a decrease on the 2011/12 performance against the 4 hour target which was 85.6%.

Overview of Local Needs

The Southern area continues to experience a rising population with challenging and changing health and social care needs and the need to continue to commission responsive, efficient, value for money secondary care services remains a priority for the SLCG.

The SLCG is committed to ensuring that the two acute hospitals within the Southern area i.e. CAH and DHH, continue to provide acute services to the 360,000 people in the population. The SLCG will continue to commission the delivery of unscheduled and elective care at both acute sites and in supporting sites, which are in line with waiting times set by the DHSSPSNI and to the required clinical standards.

In terms of new and unplanned A&E attendances, there were 111,115 in total during 2012/13, with 71,746 presenting to CAH ED and 39,372 presenting at DHH. This represented an increase of 0.3% in CAH and an 8% increase in DHH on the previous year 2011/2012.

In CAH there were 27,504 scheduled and unscheduled inpatient admissions and 15,088 day cases during 2012/2013 representing a 1.5% and 4% increase against the previous year. In DHH there were 11,602 inpatient admissions and 6684 day cases during 2012/2013 representing a 6.5% and 4% increase on the 2011/12 position. In terms of outpatients there were 60,226 new outpatient attendances in CAH during 2012/13 representing a 16% increase on 2011/12 and 84,683 review outpatient attendances reflecting a 3% increase on 2011/12. In DHH there were 17,511 new outpatient attendances representing a 6% increase on 2011/12 and 30,180 review outpatient attendances in 2012/13 representing a 2% increase on 2011/12.

The SLCG recognises the need to work towards the rebalance of elective specialties between the Trust's acute sites in order to reflect the need of interdependent clinical services, such as Intensive care. It also anticipates the need to centralise, where necessary, services such as stroke and non-acute Medical In-patient care currently provided on a range of sites in the in both the acute and non-acute sector. The SLCG would also anticipate that the Trust will need to review the provision of day case surgery across the Southern area and undertake a cost benefit analysis to ascertain if it is preferable to consolidate the provision of day case surgery.

There are clear links between long term conditions, deprivation, lifestyle factors and the wider determinants of health. People living with a long term condition are likely to be more disadvantaged across a range of social indicators, including employment, educational opportunities, home ownership and income. Someone living in a disadvantaged area is more than twice as likely to have a long term condition as someone living in an affluent area, and is more likely to be admitted to hospital because of their condition. Tackling the inequalities in health outcomes for the population will continue to be a focus of the SLCG's commissioning intent. An audit[5] of self-management during 2013 revealed that there are currently 15 different programmes operating for people with long term conditions in the SLCG area, 12 of which are condition-specific and 3 are generic.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Unscheduled Care (Ministerial target 7) – From April 2014, 95% of patients attending any type 1,2 or 3 Emergency Department are either treated and discharged home or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours

- Elective Care (Ministerial Targets 1011 and 12) – From April 2014, at least 80% of patient wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 15 weeks; and From April 2014, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken; and From April 2014, at least 80% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks
- Allied Health Professionals (Ministerial Target 19) – From April 2014, no patient waits longer than nine weeks from referrals to commencement of AHP therapy
- Unplanned admissions (Ministerial target 21) – By March 2015, reduce the number of unplanned admissions to hospital for 5% for adults with specified long term conditions using 2012/2013 data as the baseline
- Unnecessary hospital stays (Ministerial target 29) – By March 2015, reduce the number of excess bed days for the acute programme of care by 10% (using 2012/2013 data as the baseline)

Commissioned Services

In addition to commissioning services to respond to the Ministerial targets, the SLCG will commission a range of additional activity in 2014/2015 to respond to the anticipated increased demand for secondary care services due to the rising population. (See Values and Volumes Tables)

- The SLCG will work with the Trust during 2014/2015 to enhance the Trauma and Orthopaedic service to address the current gap between capacity and demand and enable residents of the Newry and Mourne area to have elective and trauma treatment in their local Trust.
- The SLCG expects the Trust to demonstrate a move toward 7 day working in 2014 / 2015, initially on the CAH site focusing on having enhanced Diagnostic, AHP, Social Work, Pharmacy and Laboratory support. It is anticipated that this will facilitate reduced lengths of stay,

weekend discharge and ensuring that patients get timely intervention and support to improve their outcomes.

- The SLCG will work with the Trust to agree a service model for stroke services which the Trust will implement to deliver on the Ministerial Target for thrombolysis and secure the full range of services locally to support both the rehabilitation of patients in the most appropriate setting and early supported discharge from hospital. The SLCG anticipates that there will be a shift in the balance of services provided on both the CAH and DHH hospital sites to facilitate the most efficient and effective model of care.
- The SLCG believe that there is significant scope for a reduction in hospital bed days linked to long term conditions (specifically diabetes, stroke and COPD). Care and treatment should be provided where possible, in the patient's usual place of residence and the SLCG expects the Trust to evidence a shift of both activity and resources into increased delivery of community services to support people with long term conditions. This includes increased promotion of self- management programmes. As a consequence of this work the SLCG anticipates that there will be opportunities to consolidate beds and sites on which such in-patient care is currently provided.
- Central to achieving these changes will be the work taken forward by ICPs and during 2014 /2015 and beyond the SLCG will work with its three local ICPs to commission services aimed at achieving this TYC direction of travel.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Associated Local Commissioning Requirement
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to reduce/flatten demand for outpatients, and Emergency Department attendances	The SLCG will work with ICPs and Primary and Community Care sectors to develop and implement patient pathways to improve patient outcomes in an appropriate and timely way. This work will be incorporated within the Unscheduled Care Improvement Plan.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions	The Trust is expected to move towards 7 day working, commencing on the CAH site and ensuring appropriate diagnostic provision, AHP, Social Work, Pharmacy and Laboratory provision to facilitate this. The Trust should also evaluate the improvement gained through the implementation of the enhanced recovery model in reducing length of stay, improving outcomes and increasing productivity for the 6 (appropriate for DGHs) identified procedures
Enable district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present	The Trust is expected to explore with GPs and their District Nursing teams appropriate patient pathways in order to respond quickly and flexibly to patient needs.
Review and take forward opportunities to consolidate	The Trust is expected to develop a consultation paper, based on the

intermediate / acute care beds and / or the sites on which they are provided.	discussions with SLCG, on the future of non-acute hospital in-patient service provision, with a view to reconfiguring and consolidating provision.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The SLCG is expected to work with the Trust and Primary Care during 2014 / 2015 to develop this UCIP which will focus on expanding and establishing improved communication between secondary care Consultants and GPs, 7 day working practices, direct GP access to e.g. diagnostics, assessments unit and AHPs, Social Work, Pharmacy and Laboratory support to enable 7 day discharge
Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.	The SLCG will engage with the Southern Trust during 2014/15 to achieve top quartile performance.
Local Priority	In line with TYC direction, during 2014/; 2015 the Trust is expected to further develop its T&O service to address the current demand-capacity gap, thereby improving productivity and ensure a 24/7 fracture service thus enabling residents of Newry & Mourne LGD to

	have access to local treatment
Local Priority	• During 2014/2015, the Trust is expected to work towards achieving peer average LOS across specialities • The SLCG expects the Trust to maximise theatre productivity on both CAH and DHH sites and bring forward proposals to consolidate day surgery • The SLCG anticipate that there may be opportunities to consolidate the provision of non-acute in-patient beds including stroke • The Trust is expected to improve its New : Review Out-patient ratio, to reduce DNA/CNAs and to maintain and where possible improve its pre-operative assessment rate
Local Priority	• During 2014 / 2015 the Trust is expected to work to enhance community service provision to facilitate the implementation of the indicative opportunities above • The Trust is expected to also, as part of ICPs, to develop further patient pathways to achieve a shift left in service provision, with more services moving into primary and community care settings where clinically safe and appropriate to do so. A concomitant level of resource should be identified

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Non-elective	Inpatients			
	ED attendances			
	Non-elective admissions			
	NIAS Journeys			
Elective	Inpatients			
	Daycases			
	New Outpatients			
	Review Outpatients			
	VALUE OF COMMISSIONED ACTIVITY			

9.4.2 POC 2: Maternity and Child Health

Introduction

Maternity services in the southern locality are currently provided in consultant led obstetric units in both CAH and DHH and in the alongside Midwife Unit in CAH since 2000. Following SLCG commissioning direction in the 2013/2014 Commissioning Plan, midwife-led births were commenced in DHH in 2013/ 2014. In response to rising birth numbers, demographic funding was used in 2013 / 2014 to enhance midwifery capacity to ensure the safe delivery of these births. The SBA has been uplifted to reflect these.

A Strategy for Maternity Care in Northern Ireland 2012 / 2018, published in 2012, has provided the strategic framework for the commissioning and provision of Maternity services and the SLCG will both contribute to and be guided by the regional implementation of this strategy, to ensure that safe, high quality maternity services are commissioned on behalf of the SLCG population. Paediatric Services in Northern Ireland have also been the subject of a review by DHSSPSNI, and a consultation document "A Review of Paediatric Health Care Services Provided in Hospitals and in the Community" has been issued along with a supporting consultation document addressing palliative care for children. The recommendations and standards outlined in these documents have been taken into consideration in setting the commissioning priorities for Paediatric services in the SLCG locality.

The SLCG is committed to ensuring that service-users, patients and clients, their advocates and community and voluntary groups have meaningful engagement with the commissioning process. In relation to Maternity and Child Health services, the SLCG has had input at recent meetings in public on neonatal services, child health and child care services and through specific engagement events and opportunities, has heard directly from young people, their carers and parents on their experience of and aspirations for services relevant to them. Specifically in 2013/2014 the SLCG was made aware of the strong views of carers for children on support that they would wish to see in place in the southern area to help them in their caring role and specific

services were commissioned and supported by the SLCG in response. This process of direct engagement will continue in 2014/2015 with specific programme of care events planned.

Overview of Local Needs

The SLCG locality is the second largest locality in Northern Ireland and is projected to continue to see a population growth of 14% by 2020, which is in excess of the Northern Ireland average of 6.5%. This, in combination with a previous increased birth rate during the first decade of the 21st century will result in a 0-17 year old population in the SLCG locality growing at 5 times the Northern Ireland average by 2020.

The birth rate in the SLCG locality continues to rise, with 6098 babies being born in SHSCT maternity Units in 2012 / 2013, 4194 in CAH and 1904 in DHH. Whilst the numbers of births appeared to be stabilising, births in the southern area rose again last year and in response, the SLCG commissioned additional services and will continue to closely monitor demographic trends.

The increasing number of births means a growing child population in the SLCG area, with the full expectation of the need for increased child health service input. Contributing to this increased child population has been the significant inward migration to the SLCG locality over the last decade, with individuals and families from outside UK/ROI choosing to come to live and work in the southern area and establish families here. This has placed increasing demand on all services in the area, including maternity and child health services. The SLCG is aware that national reports and research have indicated that women from certain migrant and minority ethnic groups, including Irish Travellers, are more likely to have maternal ill health and be at higher risk of poorer pregnancy outcomes. The SLCG will carefully monitor these sub-populations within emerging demographic trends.

Ministerial Targets

The SLCG will commission services within this PoC in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Family Nurse Partnership (Ministerial Target 2) – By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site for the Family Nurse Partnership (FNP) Programme within each Trust
- Tackling Obesity (Ministerial target 4) – By March 2015, all eligible pregnant women, aged 18 years or over with a BMI of 40 or more at booking are offered the "Weigh to a Healthy" Pregnancy programme with an uptake of at least 65% of those invited

Commissioned Services

Tackling inequalities in health outcomes for mothers and babies within this programme remains a priority for the SLCG and during 2013 a Family Nurse Partnership (FNP) was established in the southern locality. It is currently working to achieve a registration of 100 first time teenage mothers to the programme.

The SLCG notes the on-going development of an alongside Midwifery Led Unit in DHH and during 2014 / 2015 will work with the Trust to agree a baseline number of Midwife led births to be included in the SBA.
Baseline data (up to 27 November 2013) indicates that there have been 37 referrals to the Weigh to a Healthy Pregnancy programme in the Trust (via CAH and DHH) and the uptake rate is 65%. The continued focus on this programme remains a priority for the SLCG.

Following investment in recent years in both health visiting and midwifery services, the SLCG will continue to ensure it commissions safe and sustainable maternity and child health services at both maternity units and in the community. It will work with the Trust in this regard and ensure that the recommendations of the Maternity strategy continue to be implemented in the southern area over the coming years in a way which responds to local

needs and in line with regional consistency. In particular the SLCG wishes to see:

- The full implementation of the Trust's Normalisation of Birth Action Plan with the resultant reduction in variation in intervention rates within the two local maternity units
- The Trust develop further work to move towards facilitating midwife as the first point of contact
- The SLCG expects the Trust will continue to support the regional work in ensuring a consistent approach to the implementation of the NICE Clinical Guideline 129 on Multiple Pregnancies.
- The SLCG awaits the publication of the Departmental Paediatric strategy, the final recommendations of which will direct its commissioning intent in coming years for paediatric and child health services. However, in the interim the SLCG will continue to work with the Trust to develop paediatric and child health services in the southern area in response to demographic pressures over the last decade resulting in a significantly above Northern Ireland average child population. Of significance within these discussions will be the availability of capital funding to support infrastructure developments on both the CAH and DHH sites.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	• The Trust is expected in 2014/2015 to provide safe and sustainable maternity services in both CAH and DHH Maternity Units. Early indications of any inability to do so must be highlighted to the local commissioner immediately. A SBA level of activity for midwife-led births in DHH will be agreed in year • The Trust is expected to work towards achieving the standards for communication with women and parents on informed choice about place and options for birth • The Trust is expected to demonstrate an increased in referrals for an uptake of midwife-led care, including delivery.
Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	The Trust is expected to fully contribute to the development of a network service model and care pathway for management of multiple pregnancies in line with NICE Clinical Guideline 129, ensuring compliance with this Guideline.
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and	The Trust is expected to work towards facilitating midwife as first point of contact and also in providing more antenatal care in the

providing more midwife-led antenatal care in the community for women with straightforward pregnancies	community for those women for whom this is clinically appropriate. The Trust is to provide evidence of their progress to achieve this.
Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained variation in intervention rates throughout Northern Ireland	The Trust is expected to benchmark their local obstetric intervention rates in both CAH and DHH against peer units, with the aim of reducing the variation in intervention rates between both units and compared to other units in Northern Ireland.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The SLCG will work with the Southern Trust to enhance the experience and outcome for vulnerable groups of pregnant women in the Southern area, focussing initially on the experience of BME women.

***Will be subject to equality screening**

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	6,283	448	6,731
	Daycases	30,262	739	31,001
	New Outpatients	72,952	4,641	77,233
	Review Outpatients	123,054	5,452	128,506
Unscheduled	**Non Elective admissions – all**	33,852	-744	33,108
	ED attendances	129,961	0	129,961
	NIAS Journeys	30,036	1,695	31,738
	VALUE OF COMMISSIONED ACTIVITY[61]	£197.6m	£13m	£210.6m

[61] This includes activity in addition to that set out above.

9.4.2 POC 2: Maternity and Child Health

Introduction

Maternity services in the southern locality are currently provided in consultant led obstetric units in both CAH and DHH and in the alongside Midwife Unit in CAH since 2000. Following SLCG commissioning direction in the 2013/2014 Commissioning Plan, midwife-led births were commenced in DHH in 2013/ 2014. In response to rising birth numbers, demographic funding was used in 2013 / 2014 to enhance midwifery capacity to ensure the safe delivery of these births. The SBA has been uplifted to reflect these.

A Strategy for Maternity Care in Northern Ireland 2012 / 2018, published in 2012, has provided the strategic framework for the commissioning and provision of Maternity services and the SLCG will both contribute to and be guided by the regional implementation of this strategy, to ensure that safe, high quality maternity services are commissioned on behalf of the SLCG population. Paediatric Services in Northern Ireland have also been the subject of a review by DHSSPSNI, and a consultation document "A Review of Paediatric Health Care Services Provided in Hospitals and in the Community" has been issued along with a supporting consultation document addressing palliative care for children. The recommendations and standards outlined in these documents have been taken into consideration in setting the commissioning priorities for Paediatric services in the SLCG locality.

The SLCG is committed to ensuring that service-users, patients and clients, their advocates and community and voluntary groups have meaningful engagement with the commissioning process. In relation to Maternity and Child Health services, the SLCG has had input at recent meetings in public on neonatal services, child health and child care services and through specific engagement events and opportunities, has heard directly from young people, their carers and parents on their experience of and aspirations for services relevant to them. Specifically in 2013/2014 the SLCG was made aware of the strong views of carers for children on support that they would wish to see in

place in the southern area to help them in their caring role and specific services were commissioned and supported by the SLCG in response. This process of direct engagement will continue in 2014/2015 with specific programme of care events planned.

Overview of Local Needs

The SLCG locality is the second largest locality in Northern Ireland and is projected to continue to see a population growth of 14% by 2020, which is in excess of the Northern Ireland average of 6.5%. This, in combination with a previous increased birth rate during the first decade of the 21st century will result in a 0-17 year old population in the SLCG locality growing at 5 times the Northern Ireland average by 2020.

The birth rate in the SLCG locality continues to rise, with 6098 babies being born in SHSCT maternity Units in 2012 / 2013, 4194 in CAH and 1904 in DHH. Whilst the numbers of births appeared to be stabilising, births in the southern area rose again last year and in response, the SLCG commissioned additional services and will continue to closely monitor demographic trends.

The increasing number of births means a growing child population in the SLCG area, with the full expectation of the need for increased child health service input. Contributing to this increased child population has been the significant inward migration to the SLCG locality over the last decade, with individuals and families from outside UK/ROI choosing to come to live and work in the southern area and establish families here. This has placed increasing demand on all services in the area, including maternity and child health services. The SLCG is aware that national reports and research have indicated that women from certain migrant and minority ethnic groups, including Irish Travellers, are more likely to have maternal ill health and be at higher risk of poorer pregnancy outcomes. The SLCG will carefully monitor these sub-populations within emerging demographic trends.

Ministerial Targets

The SLCG will commission services within this PoC in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Family Nurse Partnership (Ministerial Target 2) – By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site for the Family Nurse Partnership (FNP) Programme within each Trust
- Tackling Obesity (Ministerial target 4) – By March 2015, all eligible pregnant women, aged 18 years or over with a BMI of 40 or more at booking are offered the "Weigh to a Healthy" Pregnancy programme with an uptake of at least 65% of those invited

Commissioned Services

Tackling inequalities in health outcomes for mothers and babies within this programme remains a priority for the SLCG and during 2013 a Family Nurse Partnership (FNP) was established in the southern locality. It is currently working to achieve a registration of 100 first time teenage mothers to the programme.

The SLCG notes the on-going development of an alongside Midwifery Led Unit in DHH and during 2014 / 2015 will work with the Trust to agree a baseline number of Midwife led births to be included in the SBA.
Baseline data (up to 27 November 2013) indicates that there have been 37 referrals to the Weigh to a Healthy Pregnancy programme in the Trust (via CAH and DHH) and the uptake rate is 65%. The continued focus on this programme remains a priority for the SLCG.

Following investment in recent years in both health visiting and midwifery services, the SLCG will continue to ensure it commissions safe and sustainable maternity and child health services at both maternity units and in the community. It will work with the Trust in this regard and ensure that the recommendations of the Maternity strategy continue to be implemented in

the southern area over the coming years in a way which responds to local needs and in line with regional consistency. In particular the SLCG wishes to see:

- The full implementation of the Trust's Normalisation of Birth Action Plan with the resultant reduction in variation in intervention rates within the two local maternity units
- The Trust develop further work to move towards facilitating midwife as the first point of contact
- The SLCG expects the Trust will continue to support the regional work in ensuring a consistent approach to the implementation of the NICE Clinical Guideline 129 on Multiple Pregnancies.
- The SLCG awaits the publication of the Departmental Paediatric strategy, the final recommendations of which will direct its commissioning intent in coming years for paediatric and child health services. However, in the interim the SLCG will continue to work with the Trust to develop paediatric and child health services in the southern area in response to demographic pressures over the last decade resulting in a significantly above Northern Ireland average child population. Of significance within these discussions will be the availability of capital funding to support infrastructure developments on both the CAH and DHH sites.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	• The Trust is expected in 2014/2015 to provide safe and sustainable maternity services in both CAH and DHH Maternity Units. Early indications of any inability to do so must be highlighted to the local commissioner immediately. A SBA level of activity for midwife-led births in DHH will be agreed in year • The Trust is expected to work towards achieving the standards for communication with women and parents on informed choice about place and options for birth • The Trust is expected to demonstrate an increased in referrals for an uptake of midwife-led care, including delivery.
Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	The Trust is expected to fully contribute to the development of a network service model and care pathway for management of multiple pregnancies in line with NICE Clinical Guideline 129, ensuring compliance with this Guideline.
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and	The Trust is expected to work towards facilitating midwife as first point of contact and also in providing more antenatal care in the

providing more midwife-led antenatal care in the community for women with straightforward pregnancies	community for those women for whom this is clinically appropriate. The Trust is to provide evidence of their progress to achieve this.
Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained variation in intervention rates throughout Northern Ireland	The Trust is expected to benchmark their local obstetric intervention rates in both CAH and DHH against peer units, with the aim of reducing the variation in intervention rates between both units and compared to other units in Northern Ireland.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The SLCG will work with the Southern Trust to enhance the experience and outcome for vulnerable groups of pregnant women in the Southern area, focussing initially on the experience of BME women.

***Will be subject to equality screening**

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	Births	5,875	120	5,995
	Comm Midwives	Contacts	87,025	0	87,025
	Health Visiting	Contacts	116,073	0	116,073
	Speech and Language Therapy	Contacts	18,099	0	18,099
		VALUE OF COMMISSIONED ACTIVITY[62]	£27.1m	£1.4m	£28.5m

[62] This includes activity in addition to that set out above.

9.4.3 POC 3: Child & Family Care

Introduction

The Families Matter Strategy (DHSSPS, March 2009) is a 10 year strategy which prioritises prevention and early intervention in providing support to families and sets the commissioning intent for this Programme of Care.

The SLCG have been working in partnership with the Trust to deliver on the recommendations of Transforming Your Care in relation to family and child care. In the SLCG area, the focus has been on developing early intervention and prevention services which will provide alternatives to residential care and support families at times of crisis.

Care Matters in Northern Ireland (DHSSPS, 2007) outlines a strategic vision for wide-ranging improvements in services to children and young people in and on the edge of care. It seeks to increase support for vulnerable children and improve outcomes for care-experienced young people through a range of measures including prevention services, support for vulnerable families and improving placement options for children who cannot live at home and improving opportunities in terms of education and extra-curricular activities. The SLCG have already invested significantly in services which offer alternatives to residential care and in early intervention and preventative services.

Enhancing Healthcare Services for Children and Young People in NI: A Review of Paediatric Healthcare Services Provided in Hospitals and in the Community (DHSSPSNI, Nov 2013) and A Review of Children's Palliative and End of Life Care in Northern Ireland (DHSSPSNI, Jan 2014), are both currently out for consultation and the SLCG will await the final recommendations to inform their commissioning intentions for 2014/15 and beyond.

Overview of Local Needs

There are 93,000 children aged 0-17 living in the Southern area, 21.5% of the Northern Ireland total (431,547)[63]. According to the 2011 Census, the SLCG area has the highest percentage of households with dependent children – 37.39%, compared to the Northern Ireland average of 33.86%[64]. The child population of the Southern area is expected to grow by 17.9% between 2008 and 2023. This is significant as the Northern Ireland child population for the same period is expected to increase by only 3.2%. The need to commission the full range of health and social care services for these children, including those with specific and complex needs will continue to increase in line with these demographic changes.

At 31st March 2013, there were 2,807 [65]looked after children in Northern Ireland, about 6 in every 1,000 children (0-17 year olds). This rate is slightly lower in the SLCG area, where there are currently 456 looked after children, about 5 in every 1,000. Two localities in the SLCG area have a higher than NI average percentage of children living in relative low poverty (after housing costs) – Newry and Mourne has 32% of its children living in low income, while Dungannon has 29%. The Northern Ireland average is 27%[66].

The SLCG locality has seen notable inward migration over the last decade with significant numbers of individuals and families choosing to come to live and work in the Southern area. This has placed increasing demand on all services in the area, including health and social services and services have been working hard to adapt to and support their health and social care needs. Craigavon (8.2%) and Dungannon (12.6%) have the highest percentage of children with English as an additional language, well above the Northern Ireland average (3.4%)[67].

[63] NISRA 2012 Mid Year Estimates
[64] Census 2011, KS106NI (administrative geographies)
[65] HSC Corporate Parenting Return
[66] CYPSP Family Resource Survey

Ministerial Targets

The commissioning of services to deliver Ministerial targets is led regionally by the Directorate of Social Care and Children. The SLCG will support their regional direction of travel for commissioning services within this Programme of Care. All communication and monitoring of performance against these targets is led through that directorate.

Commissioned Services

A significant challenge for the SLCG is the overall growth in our child population as discussed in section 1. A key TYC focus for this Programme of Care, is the development and promotion of foster care both within and without families. To support this development, investment was made available in 2013/14 to secure 5 additional front line specialist foster care places for age group 12 plus, and a further 5 additional specialist intensive places for age group 12-17 years with complex needs and require intensive support /wrap-around service.

The SLCG has also developed Therapeutic Services locally though our share of regional funding.

In recognition of the specific needs of children with complex healthcare needs, the SLCG has also invested in the Trust to enhance the existing Community Children's Nursing (CCN) Service by providing dedicated availability of community nurses for children and young people with complex needs at times to include early morning, twilight and weekends.

In the 6 month period March to August 2013, 367 contacts have been made, 93 IV antibiotic doses have been delivered and 29 nasogastric tubes have been replaced, all avoiding hospital admissions/ED attendances. The SLCG expect that this service will continue to support children to be cared for at home and reduce the need for acute admissions.

Supporting carers for children with a disability and complex needs has been a focus of SLCG for a number of years. Given an increasing uptake in carer's assessments, this identified the need to enhance service provision and to ensure continued provision of support for those carers caring for child in transition to adult services up to the age of 20. Regional funding was made available for short breaks for carers support in 2012/13 which was used to support Children with a Disability, Autism and CAMHS. This investment was used to enhance the contract with community and voluntary sector which delivers a programme of social outreach for children and young people.

Regional Commissioning Priority	Local Commissioning Requirement
All Trusts are expected to implement the Crisis Resolution Home Treatment services for CAMHs with associated primary care teams/services including full implementation of the DHSSPSNI strategy for CAMHs.	Should have its Trust Action Plan in place and the full investment deployed for the establishment of PMH and CRHT Teams as agreed leading to reduction in demand for in patient admission and improving access to the service by achieving a reduction to the 9 week target.
Local priority - Children's Palliative and End of Life Care	Pending the outcome of the consultation on the Review of Children's Palliative and End of Life Care in Northern Ireland, the SLCG will undertake an analysis of the existing arrangements in the Southern area which will inform future commissioning intent.
Local priority - Fostercare Places	The SLCG will continue to prioritise the development of additional foster care places as a means of providing alternatives to residential care.
Local priority - High Cost Cases – Children with Complex Needs	The SLCG is aware of the on-going need to support children with highly complex needs. A number of such cases were supported in 2013/14 and the SLCG will continue to be aware of the need to commission services for these children in the future.

9.4.4 POC 4: Older People

Introduction

Transforming Your Care (TYC) sets a clear direction for a range of services required for our older population, with home as the hub of care being at the forefront. The report recommends that steps are taken to ensure that a greater proportion of care is delivered in a home or community setting. It also supports the trend towards independent living, signalling reduced demand for residential home care and a shift of resources to home-based care. TYC references the potentially detrimental effect that an admission to hospital can have on independence and confidence levels of our older population. It endorses models such as reablement, intermediate care which will encourage and protect independence and the establishment of Integrated Care Partnerships which will focus on improving pathways for our frail elderly population, those with long term conditions (initially COPD, stroke and diabetes) and palliative/end of life care.

Three Integrated Care Partnerships (ICPs) have been developed across the Southern area during 2013/14 involving a number of key stakeholders including patients/carers, GPs, secondary care teams, community and voluntary sector organisations, AHPs, social workers and other specialist community staff.

The Dementia Strategy for NI (DHSSPSNI, Nov 2011) sets out actions for a number of organisations focussing on delaying the onset of dementia/reducing risk of development of dementia, raising awareness, promoting early assessment and diagnosis and supporting people with dementia and their carers. It is thought that there could be as many as 3,465[68] people with dementia living in the SLCG area, many may not yet be known to services. According to Alzheimer's Society, about two thirds of those with dementia are females and the proportion of the population with dementia doubles with

[68] http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1667

each 5 year age gap. By the time a person reaches the age of 95, they have a one in three chance of having dementia. In the UK, around 60,000 deaths a year are directly attributable to dementia and if the onset of dementia could be delayed by 5 years, it would reduce deaths directly attributable to dementia by 30,000 a year[69].

Overview of Local Needs

In 2012, there were 48,922 people living in the SLCG aged 65 or over, representing 13% of the total SLCG population and 17.9% of the total 65+ population of Northern Ireland. It is projected that our local 65+ population will rise to 63,000 people (representing 15.5% of the SLCG population) by 2021. Population projections also indicate that by 2021 the SLCG population aged 85 years and over will grow by 69% to reach 9,000.

In 2011, 15.7% of the 228[70] persons aged 100+ living in NI, resided in the SLCG area. Over 40% of our population aged 75+ live alone, with the Armagh Local Government District having a higher percentage of 75 year olds living alone in comparison to other localities in the SLCG area[71]. A wide range of community based services are delivered to our older population across the SLCG area. Currently, 1,707 people are in receipt of a care home package (1,340 nursing and 367 residential) and over 3,538 are in receipt of a domiciliary care package. There are 40,607 unpaid carers in the SLCG area, with a quarter of these providing at least 50 hours of care each week and recent engagement by the SLCG with carers has highlighted the importance of the commissioning and provision of support to them.

In the SLCG area in 2013, 2,215 people were registered with GPs as having dementia. Alzheimer's Society prevalence rates applied to SLCG residents would suggest that there may be as many as 3,465 people with dementia and that this will increase to 4,677 by 2021[72].

[69] http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=341
[70] Census 2011, Usually Resident Population by single year of age and sex (administrative geographies)
[71] Census 2011, Demography, Household Composition - Households
[72] http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1667

In the SLCG area, 18% of Emergency Department/Minor Injuries Unit attenders during 2011/12 were aged 65 and over, whilst 50% of those attenders resulted in a hospital admission. In the SLCG Emergency Departments, during 2012/13, there were 24,537 attendances by people aged 65 and over and there were 10,537 unplanned hospital admissions in the same period for people aged 65+. Currently, there are 96 non-acute assessment and rehabilitation beds based across 2 sites, including a small number for stroke patients. Day hospital and rapid access clinic facilities are also located in a range of sites across the SLCG area.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets.

Commissioned Services

In addition to commissioning services to respond to the Ministerial targets, the SLCG will commission a range of additional activity in 2014/15 to respond to the needs of the growing older population as identified in Section 4.1.2 above. Working closely with the ICPs, the SLCG anticipates the development of patient pathways to enhance care provided to frail older people and promote independence and wellbeing. The SLCG has invested in 2013/14 in 5 reablement teams, with the capacity to deal with 1,000 cases per year (based on an average of 2 weeks reablement per client). The SLCG wishes to see full implementation of the Trust's reablement service in 2014/15, with all 7 teams being in place in year. Each team should deliver services 7 days a week. The SLCG will therefore consider the appropriate balance of new investment across both reablement and domiciliary care, ensuring there is evidence of a shift in provision, including commissioning from other sectors.

The SLCG have over recent years invested significantly in improved and more flexible respite options, such as short breaks and will continue to do this by looking to the potential of other providers and other sectors in delivering this.

In 2013/14, the SLCG invested funding in the Trust to develop a rapid response team and expect this to be operational by April 2014, with a view to further enhancing this across other localities on a phased basis. The first team is expected to take a minimum 5 referrals per day (1,050 per year) to provide timely intervention in either the patients home or a community setting. It is expected that this investment will bring about a reduction in lengths of stay and a reduction in unplanned hospital admission for older people.

The SLCG anticipates that during 2014/15, as a result of investing in community infrastructure, demand for inpatient medical assessment/rehabilitation and statutory residential care will reduce, resulting in a reduction in the number of statutory residential home beds required and opportunities to consolidate the provision of non-acute assessment and rehabilitation beds.

The SLCG recognises that with the increasing population of older people anticipated, including an increase in the number of people with dementia (as discussed in section 4.1.2) a continued commissioning focus is required for this ever growing population and its disease specific sub-populations. During 2012/13 and 2013/14, regional investment was secured to enhance local services for people with dementia. During 2012/13, investment was secured to expand memory clinics and in 2013/14, further investment was sought to introduce a Navigator role for signposting and provide enhanced access to psychological support.

POC4 – Older People	
Regional Commissioning Priority	**Associated Local Commissioning Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The Trust will be expected to increase the number of carers assessments offered by 10% using the 2013/14 outturn as a baseline. According to Carers Matters , 42% of carers surveyed in Northern Ireland said they had missed out on financial support as a result of a lack of advice and information. To support people in meeting unplanned costs of their caring role, the LCG have since 2012/13 allocated funding to the Southern Trust to increase the budget for cash grants to carers. This should continue to be supported by the Trust. The Trust is also expected to fully deliver on the investment made in 2013/14 to provide programmes which focus on prevention and early intervention for people who have a caring role.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The Trust should work towards further innovation in the respite model and actively seek the inputs of other sectors in the delivery of respite care. During 2014/15 the SLCG will take forward a project to develop innovative short breaks for older people.
To increase uptake of direct payments	The Trust is expected to increase the number of direct payments by 5% using the 2013/14 outturn as a baseline. Those programmes of

	care performing less well than others within the Trust should raise their performance beyond the 5% target.
Working with ICPs to improve the care of the frail elderly.	The SLCG will continue to work with our local ICPs and will during 2014/15 commission further pathway development in line with agreed ICP specifications. Monitoring systems will be established to measure the progress that ICPs are making towards improved patient care and shift left.
Enhancement of dementia services	The Trust will be expected to implement investments to date and work with a range of partners to develop proposals against remaining allocations. The focus for 2014/15 will be on training, information and support to carers and people with dementia and respite/ short breaks.
Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements.	During 2014/15, the SLCG will undertake a review of intermediate care service locally and the role it plays in managing demand for a range of services for older people. The Trust will be expected to participate in this.
Continued roll-out of targeted Public Health Agency (PHA) preventative health and well-being improvement programmes.	The Trust is expected to work towards delivering an increased focus on work to promote healthy ageing, individual resilience and independence. In particular the SLCG would wish to support the development of a local programme which tackles the issue of social

	isolation amongst our older population. The "combat loneliness" programme is an exemplar in this regard and the Trust should develop plans to take this forward locally, making particular use of the contribution of community and voluntary sector organisations.
Review of emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The LCG will work with the Trust during 2014/15 to ensure that reablement is having a positive impact on the independence levels of our older population and the Trust's ability to manage demand for domiciliary care services. The Trust is expected to complete the roll out of reablement during 2014/15 to ensure full coverage (7 teams) by 31st March 2015.
Local Priority	• The Trust is expected to put bring forward options for the future provision of non-acute hospital services for older people with a view to consolidating provision, based on an increased community services focussing on prevention of admission and facilitating early discharge. • The Trust is expected to demonstrate the availability of appropriately skilled professionals working across both hospital and community settings on a 7 day basis, to ensure that our older people are able to maximise their potential following a period of ill health.

Local Priority	• The Trust is expected to have the first phase of this service established by 31st March 2014. SLCG expects this team to be in a position to evidence a reduction in unplanned admissions and a reduction in lengths of stay for our older population. • The SLCG will work closely with the Southern Trust during 2014/15 to evaluate the impact of this service model and plan the further implementation across the remaining localities within the SLCG area. The SLCG anticipates this team will be funded through a shift of resources from hospital to community.

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Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied Beddays	64,835	0	64,835
	Day Care	Attendances	51,025	0	51,025
	Domiciliary Care	Hours	2,149,929	110,000	2,259,929
	Residential & Nursing Homes	Occupied Beddays	611,740	0	611,740
	Community Nursing & AHPs	Face to face contacts	462,985	0	462,985
	Social Work	Caseload	6,920	0	6,920
		VALUE OF COMMISSIONED ACTIVITY[73]	£118.1m	£6m	£124.1m

[73] This includes activity in addition to that set out above.

9.4.5 POC 5: Mental Health

Introduction

Inpatient mental health services are provided in the Southern area in the 74-bedded Bluestone Unit, located on the CAH site. The Trust has implemented the stepped care model for mental health and significant investment, both regional and local, continues to see these services developed. A full range of community mental health services are provided by a range of multi-disciplinary teams across the Southern locality, with a focus on prevention and early intervention and maintaining individuals as close to home as possible.

TYC references the higher mental health needs of Northern Ireland in comparison to other parts of the UK and links this to deprivation and the troubled history of the region. Mental health is a key aspect of inequality and is related to both physical health and socio-economic deprivation. Recommendations from TYC include increased focus on suicide prevention and promotion of mental wellbeing, establishment of early intervention programmes, improved pathways for people who require help for a mental health problem, progress with the resettlement programme and increased involvement of community and voluntary sector organisations.

The Northern Ireland Suicide Prevention Strategy – Protect Life: A Shared Vision 2012 – 2014 notes that suicide is now one of the leading causes of death in young adults, with significantly more young men than women taking their own lives. The Mental Health Promotion and Suicide Prevention Action Plan for the SLCG area has seen increased outreach provision, improved communication and joint working with key priority groups including LGBT (Lesbian, Gay, Bisexual and Transgender), Travellers and Black and Minority Ethnic (BME) groups and increased training provided across a range of settings including key employers and sporting organisations. There has also been increased support to communities in the aftermath of suicides and increased access and referral to services for individuals at risk of mental health, suicide and self-harm.

The Bamford Review, Commissioning Plan and TYC requires that there should be no long-stay patients in mental health hospitals by March 2015. The overarching aim of resettlement is to provide suitable alternative community placements in which meet individual need and an improved quality of life.

The Health Minister launched his Department's Service Framework for Mental Health and Wellbeing on World Mental Health Day, Monday, 10 October 2011. The Framework takes forward the values and principles of the Bamford Review. It sets out clearly the key standards in services that mental health patients and clients can expect and that service commissioners and providers must seek to deliver. The Framework provides standards of care that are underpinned by robust evidence, regional/national Policy, the findings of regional Inquiries, the experience of service users and also relevant legislative requirements.

The Framework sets out performance standards and targets in respect of day-to-day service delivery across the HPSS. This includes reference to the desired clinical and social care outcomes and timeframes across a range of service sectors and settings. The Framework will therefore provide a potential vehicle against which the quality of services/service provision may be judged by members of the public, Commissioners and other organisations which are required to report on the performance and quality of services and care.

Overview of Local Needs

There are 2,979 [74] people currently registered with the Southern LCG GPs as having mental illness including Schizophrenia, Bipolar Disorder or other psychoses. This equates to approximately 7.6 people in every 1,000.

In terms of hospital services, the SLCG have been experiencing higher than average levels of admissions. During the period April 2010 to March 2013 the Trust had the highest average number of all mental health monthly ward

[74] NINIS Health & Social Care, Health of the Population, Disease Prevalence, 2013

admissions in comparison to the other 4 HSC Trusts, seeing an average number of 130 admissions per month , representing 29% of the NI average number of 442 monthly admissions. In the same period, the Trust experienced the highest number of mental health admissions to acute wards and represented 27% of the NI total in 2012/2013[75]. During 2009 the SLCG area saw the highest level of hospital admissions related to mood or anxiety disorder which represented 31% of 709 total admissions for N. Ireland[76]. The SLCG area also experienced the second highest number of self-harm hospital admissions in 2009 which accounted for 19% of the total Northern Ireland self-harm hospital admissions[77]. During 2012, within the SLCG there were 308 mental health compulsory admissions which represented the highest number across Northern Ireland and accounted for 28.6% of the total for N. Ireland[78].

The Trust's community addictions service experience demand of around 42 new patients every week, who will require either 1:1 therapy or group sessions. In 2011/12, the Trust primary mental health care service received 5,022 referrals. At this stage, a waiting list for assessment and treatment was developing and in 2012/13, the SLCG invested significantly to enhance this team to cope with demand, securing an additional 7,340 contacts per year. As referenced below, The SLCG has also recently invested to secure independent sector input to assist with demand pressures.

In the SLCG area, there are 46 people with mental health difficulties living in residential care, 121 living in nursing home care and 87 living in supported living arrangements. 117 people were in receipt of day care (all sectors) and 285 people were in receipt of domiciliary care [79].

Suicide continues to be a major source of concern to all agencies and organisations committed to promoting positive mental health and developing

[75] HSCB Mental Health and Learning Disability Monthly Information Bulletin 2012-13, March 2013
[76] NINIS Health & Social Care, Health of the Population, Hospital Admission due to Mood or Anxiety Disorder, 2009
[77] NINIS Health and Social Care, Social Care, Hospital Admissions due to Self Harm, 2005-2009
[78] NINIS Health & Social Care, Health of the Population, Mental Health – Compulsory Admissions, 2012
[79] SHSCT Delegated Statutory Functions Return 2012/13

resilience and individuals and communities to cope with the challenges and changes of life. Within Northern Ireland, of the top 10 LGDs with the highest suicide rates (i.e. deaths per 100,000 population), 3 of these are in the SLCG area, namely Dungannon (17.1), Newry and Mourne (17.0) and Armagh (16.8), compared to a NI average of 14.7[80]

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Direct Payments (Ministerial Target 23) – By March 2015 secure a 5% increase in the number of direct payments across all programmes of care.
- Carers Assessments (Ministerial Target 22) – by March 2015, secure a 10% increase in the number of carers' assessments offered.
- Substance misuse (Ministerial Target 3) - By March 2015, services should be commissioned and in place that provide seven day integrated and coordinated substance misuse liaison services within all appropriate HSC acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention programmes.

Commissioned Services

During 2013/14, a consultation on the regional review of Tier 4 addictions service was carried out. Pending the outcome of the consultation, it is likely that the Southern area will lose inpatient addictions beds in the near future. As a consequence, the SLCG will commission arrangements to ensure that our residents have equitable access to beds provided regionally. During 2014/15 and beyond, the SLCG in partnership with the PHA, will work with the Trust to consider the supports needed across a range of sectors to enable the development of community services (tier 1-3), focussing on prevention, early intervention and community based treatment.

[80] The NI Suicide Prevention Strategy – Protect Life: A Shared Vision 2012 – 2014

Following significant investment in 2012/13, the SLCG continued in 2013/14 to invest in primary mental health care services in the Trust to increase capacity by an additional 150 initial assessments and 600 review appointments to improve access to mental health assessment and treatment services.
The SLCG also invested in specialist staffing to support individuals with an eating disorder to avail of local inpatient treatment and is pleased to note that in 2013/14, no patient required an extra contractual referral for such treatment outside Northern Ireland. In addition, the SLCG invested non-recurrently in inpatient mental health nursing services (bank nurses) during 2013/14, to respond to the Trust's identification of increased pressure.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	Transforming your Care (2011) recognizes the need for more practical support for carers through improved access to respite, which should become more community based, provided largely through the independent sector. The Trust will be expected to increase the number of carers assessments offered by 10% using the 2013/14 outturn as a baseline. The Trust should continue to support the local carer's forum in ensuring that their voices are heard and that they are involved in service development within the Trust. Information around respite and short breaks services should be made available in accessible formats to ensure it reaches all carers and service users. The Trust is also expected to fully deliver on the investment made in 2013/14 to provide programmes which focus on prevention and early intervention for people who have a caring role.
Access to more options for carers in the provision or	The provision or arrangements to improve support to

arrangement of their respite/short breaks.	carers of Short breaks is intended to achieve some of the following: • Minimise the risk of possible breakdown in the carer support to the service user • Help the carer to deal with crisis situations which might prevent them from continuing in the caring role • Prevent the social isolation of the carer • Enable the carer to sustain family/social relationships • Provide positive benefits for both carer and service user. The Trust should work towards further innovation in the respite model and actively seek the inputs of other sectors in the delivery of respite care.
Increase uptake of direct payments.	The Trust will increase the number of direct payments by 5% using the 2013/14 outturn as a baseline. The SLCG would wish to see the mental health Programme of Care increase their performance beyond the 5% target.
Implementation of the Protect Life strategy	The Trust should ensure that the "Protect Life Strategy is both refreshed and fully implemented to include: • Contributing to the development of an improved model

	of support for those who self-harm. • Specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. Supporting the on-going delivery of the Lifeline Service and implement the regionally agreed memorandum of understanding.
Establishment of integrated care arrangements for the care and treatment of patients with common mental health needs	• During 2014/15, the Southern Trust should ensure the roll out of the model and further training. • The Trust should provide a monitoring report to the SLCG by the end of March 2015, outlining the numbers trained and how numbers of Psychological Therapy Sessions in primary care have been increased. During 2013/14, the SLCG established a talking therapies project team and it is anticipated that a consortium comprising a range of representatives will be underway by 2014/15. This structure will inform how investment is made locally to support the development of a primary care talking therapies service.

Further development of specialist community services	The Trust should report on current funded WTE ASD Services in Adults. The Trust should continue to ensure that all patients with Eating Disorders are treated locally and report at the end of March 2014 on the numbers of local ED admissions with Trust facilities.
Improved Psychiatric Liaison Services	The Trust will ensure a maximum 2 hours response time in Emergency Departments. The Regional Commissioning Team is currently developing this model for implementation in 14/15.
Local Priority	• The Trust will ensure that waiting time targets for assessment and treatment in adult mental health, dementia and psychological therapies services are met. • Following on from non-recurrent investment during 2013/14, by 30th April 2014, the Southern Trust should provide the SLCG with evidence to support their nursing pressures created through increased demand for inpatient mental health services.

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Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied Beddays	36,100	0	36,100
	CPN	Contacts	26,908	0	26,908
	Res & Nur Homes + Supported Housing	Occupied Beddays	58,400	0	58,400
	Day Care	Attendances	31,745	0	31,745
	Dom Care	Hours	120,505	0	120,505
		VALUE OF COMMISSIONED ACTIVITY[81]	£45.2m	£2m	£47.2m

[81] This includes activity in addition to that set out above.

9.4.6 POC 6: Learning Disability

Introduction

Within the Southern Area, there are 16 inpatient assessment and treatment beds currently located on the Longstone site in Armagh. A capital build programme is currently underway adjacent to the Bluestone Unit on the CAH site, which will provide 10 beds. The transfer of these beds will provide an integrated approach to the care of patients with Learning Disabilities. IN addition, a range of support services are provided, including day care, day opportunities, respite and domiciliary care are provided across the Southern area.

The Bamford Review of Mental Health & Learning Disability for Northern Ireland (August 2007), sets the vision for services for people with mental health problems and learning disability. Central to the Bamford vision is valuing people with mental health needs or a learning disability, ensuring their right to full citizenship, equality of opportunity and self-determination. To make the Bamford vision a reality for people with learning disability, Trusts need to ensure that they provide a person-centred, seamless community-based service, informed by the views of service users and their carers, making early intervention a key priority and protecting and promoting people's mental health.

By the end of March 2014, all remaining long stay patients with Learning Disability in the SLCG will have been resettled into the community. This represents a significant step forward in the long term care of people with a Learning Disability and has been completed a year ahead of schedule. During 2013/14, 30 people have been resettled within the Trust with a total of 31 planned by the end of March 2014. The priority for the Trust in the years ahead is to start identifying those individuals who live in the community with parents and or families and support then to live independently with the right support.

TYC builds on the Bamford Review, by recommending further development of a more diverse range of age appropriate day support and respite/short break services. Recently the HSCB consulted on a Regional Review of Day Opportunities. The consultation document considers a regional model which sets out the need to both improve day centres for people with complex healthcare and behavioural support needs, and community based day opportunities. This consultation comes to an end on Friday the 10th of January 2014. It is anticipated that the post consultation report will be presented to the Regional Bamford Board in March 2014 with a view of developing a regional implementation group in early April 2014.

The Service Framework for Learning Disability standards has been developed over the past 3 years. The standards were widely consulted on during this time led by the 'Association For Real Change' (ARC). The Framework was launched by the Minister on the 27th of September 2012. Each standard has Performance Indicators along with quantifiable measures that assess/measure the extent that each standard is implemented.

The Framework aims to set out clear standards of health and social care that are both evidence based and measurable. They set out the standard of care that service users and their carers can expect, and are also to be used by health and social care organisations to drive performance improvement through the commissioning process.

People with Learning Disabilities have a variable range of health and social care needs. In general, people with learning disabilities experience greater health and wellbeing inequalities than the general population. In general they have poorer health but have difficulties accessing the services they need. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. A Direct Enhanced Service (DES) for learning disability service has been in place for a number of years to facilitate access to primary health care services for people

with a learning disability and 67 of the 77 GP practices in the Southern area are currently registered to provide this service.
Health problems which are more common in people with Learning Disability include: respiratory disease epilepsy, mental health problems, communication problems, visual and dental problems and coronary heart disease. Life expectancy is shortest for those with the greatest support needs and the most complex and/or multiple (co-morbid) conditions. This change in demographics referenced above and improvements in treatment and care not only means that there will be a growth in the population of people with Learning disabilities but an increase in the numbers of those with more severe disabilities.

Overview of Local Needs
In 2005, the Bamford Report estimated that about 9.7 per 1000 people in Northern Ireland had a Learning Disability, with over 27% of these being severe or profound. Increased life expectancy, added to the significant increase in births in the SLCG area over recent years will cause this to increase further.

The Trust report contact with 1,627 people with learning disabilities at end of March 2013, 1,201 of these were aged 16+. The adult population in the Southern area has increased by 24% between 2001 and 2012 and is expected to increase by a further 12% over the next ten years. Bamford estimates, that there may be approximately 2580 people with Learning Disability in the SLCG area, an increase of over 500 during the last 10 years and an increase of 300 during the next ten years.

Currently, 126 people with Learning Disabilities in the SLCG area live in residential care and 180 people live in nursing care. 466 people are regular users of day care, the vast majority through Social Education Centres[82].
There are currently 232 individual Supported Living placements in the Trust locality provided by a range of providers and housing associations. The Trust

[82] DHSSPSNI/NISRA Statistics on Community Care for Adults in NI 2012-13 (Dec 2013)

has recently undertaken a further piece of work to start identifying future need as well as the care and support needed to maintain the placements.

There are currently 167 individuals receiving Day Opportunities from total weekly available places of 405. There are also an additional 157 individuals availing of community access which includes college courses and community services.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Direct Payments (Ministerial Target 23) – By March 2015 secure a 5% increase in the number of direct payments across all programmes of care.
- Carers Assessments (Ministerial Target 22) – by March 2015, secure a 10% increase in the number of carers' assessments offered.

Commissioned Services

During 2013/14, the SLCG through its engagement processes was made clearly aware of the challenge facing carers of individuals with Learning Disability in providing care for their loved ones. The SLCG is committed to ensuring that carers have access to adequate short break and respite services.

In order to support individuals with Learning Disability in the community, the SLCG anticipates that the Trust will work closely with other sectors to develop a range of age appropriate, meaningful and developmental day opportunities and short break/respite services which meet the needs of individuals. In addition, the SLCG wish to see a further increase in the uptake of direct payments within this programme of care, enabling individuals to have more control over the services which they require to meet their needs.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The Trust will be expected to increase the number of carers assessments offered by 10% using the 2013/14 outturn as a baseline. The Trust is also expected to fully deliver on the investment made in 2013/14 to provide programmes which focus on prevention and early intervention for people who have a caring role. The Trust should continue to support the local carer's forum in ensuring that their voices are heard and that they are involved in service development within the Trust. Information around respite and short breaks services should be made available in accessible formats to ensure it reaches all carers and service users.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The provision or arrangements to improve support to carers of Short breaks is intended to achieve some of the following: • Minimise the risk of possible breakdown in the carer support to the service user • Help the carer to deal with crisis situations which might prevent them from continuing in the caring role • Prevent the social isolation of the carer

	• Enable the carer to sustain family/social relationships • Provide positive benefits for both carer and service user. The Trust should work towards further innovation in the respite model and actively seek the inputs of other sectors in the delivery of respite care.
Delivery of day services in line with the Regional Day Opportunities Model	The Trust is expected to specify the percentage of community based services available/uptake figures.
Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	The Trust is expected to develop their specialist community services to respond to the needs of people whose behaviours challenge services and those with offending behaviours including 2 hour response 7 days per week and high support beds in the community. This will be measured through 28 day breaches monitoring systems.
Increase uptake of direct payments	The Trust is expected to increase the number of direct payments by 5% using the 2013/14 outturn as a baseline. The SLCG expects to see Programmes which are performing less well raise their performance beyond the 5% target.
Development and implementation of health promotion	The Trust is expected to ensure continued development and

initiatives for people with a learning disability.	implementation of Learning Disability specific Health Promotion initiatives within their overall Health Promotion Strategy.

***Will be subject to equality screening**

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied Beddays	17,440	0	4,672
	Day Care	Attendances	95,905	0	95,905
	Domiciliary Care	Hours	213,638	4,800	218,438
	Residential & Nursing Homes	Occupied Beddays	98,915	0	98,915
	Community Nursing and AHPs	Face to face contacts	47,274	0	47,274
	Social Work	Active Caseload	2,122	0	2,122
		VALUE OF COMMISSIONED ACTIVITY[83]	£50.6m	£4.6m	£55.2m

[83] This includes activity in addition to that set out above.

9.4.7 POC 7: Physical Disability & Sensory Impairment

Introduction

The DHSSPS Physical Disability & Sensory Impairment Strategy (2010) brings forward a number of recommendations to improve the range of services available for people with a disability. The Strategy sets out a number of actions for commissioners and providers, through a multi-agency approach, to ensure a range of opportunities and supports are available to individuals to enable them to maintain independent lifestyles, by providing flexible budgets (e.g. self-directed support) using person centred approaches.

TYC builds on this and sets the themes of personalisation and independence, with more control for service users over budgets and health and social care organisations taking on the role of enabler and information provider. TYC also recommends a greater availability of respite and short break options for people with disabilities and sensory impairments.

The Northern Ireland Survey of Activity Limitation and Disability conducted by NISRA in 2006/07 identifies that 18% of all people living in private households in Northern Ireland have some degree of disability. The prevalence rate is 21% for adults and 6% for children (NISRA, 2007). The 2011 Census also tells us that in the SLCG area, 7.87% of households have been adapted to accommodate a wheelchair user, above the NI average of 6.4% and 5.92% of households have been adapted to accommodate other physical or mobility difficulties.

Estimates for Northern Ireland show that in 2010 there was approximately 8,900 people who are deaf blind equating to a prevalence rate of 0.5% of the population. Using population projections extrapolations indicate that this will rise to 14,700 people or a prevalence rate of 0.75% of the population by 2030.

Overview of Local Needs

The Physical Disability & Sensory Impairment Strategy suggests that 21% of adults in Northern Ireland, or 322,000 people, have some form of disability

(based on NISRA 2007 data), an increase on the estimated rate for 1992 (18%). The SLCG population aged 20+ has grown by 40% in the past twenty years and is projected to increase by a further 12% by 2021. This growing adult population added to the increasing numbers of children with disabilities progressing to into adult services is and will continue to place increasing pressure on adult disability services.

During 2012/13, 2,141 adults were in receipt of a range of social care services for people with disabilities. 156 people with a physical disability were registered in day care placements in the Southern area provided in a range of facilities. A further 100 individuals were availing of day opportunities, 2 people with a physical disability were living in a supported living facility, 5 living in an independent residential care home and 52 living in an independent nursing home[84]. In total, 700 people with a physical or sensory disability were in receipt of over 300,000 hours of domiciliary care.

Engagement with people with physical and sensory disability is central to developing the SLCG commissioning intent. At a recent event held in Armagh in December 2013, SLCG members had an opportunity to engage with a group of young adults with a physical disability and hear their views on the services currently provided to them and those they would wish to see in the future. During 2014/15, the SLCG plan to establish a forum for individuals with physical and sensory disabilities, to empower them to contribute to the commissioning agenda.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Direct Payments (Ministerial Target 23) – By March 2015 secure a 5% increase in the number of direct payments across all programmes of care.

[84] SHSCT DSF Return 2012/13

- Carers Assessments (Ministerial Target 22) – by March 2015, secure a 10% increase in the number of carers' assessments offered.

Commissioned Services

In addition to commissioning services to respond to the Ministerial targets, the SLCG will commission a range of additional activity in 2014/15 to respond to the needs of individuals with physical and sensory disability and their carers. In particular, the SLCG continues to expect the Trust to increase the uptake of direct payments in this programme.

The SLCG in response to the direction of travel signalled in TYC continues to support the move from day care to providing day opportunities, with the vision for the future to ensure that individuals with a disability will have appropriate support to enable them to be as independent and socially active as possible. The SLCG anticipates that the Trust will work closely with other sectors to develop a range of age appropriate, meaningful and developmental day opportunities which meet the needs of individuals.

During 2014/15 the SLCG anticipates carrying out a review of services to individuals with brain injury in the Southern locality. This will inform commissioning intent and future investment in this service area in 2015/16.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The Trust will be expected to increase the number of carers assessments offered by 10% using the 2013/14 outturn as a baseline. According to Carers Matters, 42% of carers surveyed in Northern Ireland said they had missed out on financial support as a result of a lack of advice and information. To support people in meeting unplanned costs of their caring role, the LCG have since 2012/13 allocated funding to the Southern Trust to increase the budget for cash grants to carers. This should continue to be supported by the Trust. The Trust is also expected to fully deliver on the investment made in 2013/14 to provide programmes which focus on prevention and early intervention for people who have a caring role.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The Trust should work towards further innovation in the respite model and actively seek the inputs of other sectors in the delivery of respite care. Information around respite and

	short breaks services should be made available in accessible formats to ensure it reaches all carers and service users.
To increase uptake of direct payments	The Trust will be expected to increase the number of direct payments by 5% using the 2013/14 outturn as a baseline. The LCG would wish to see Programmes which are performing less well raise their performance beyond the 5% target
Review Trust progress in relation to the review and reform of day opportunities in alignment with personalisation initiatives in line with both TYC and the Physical and Sensory Disability Strategy.	During 2014/15, the Trust should review existing availability and uptake of day opportunities within this programme and ensure the continued development of community access team to focus on building relationships and creating an environment where day opportunities can be realised.
Local Priority	During 2014/15 the SLCG will undertake a review of local service provision (all sectors) for people with a brain injury, with a view to ensuring equity of access and improved provision throughout the statutory and non-statutory sector.

***Will be subject to equality screening**

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability	**Hospital Services**	Occupied Beddays	0	0	0
	Daycare	Attendances	21,993	0	21,993
	Domiciliary Care	Hours	348,092	17,000	365,092
	Residential & Nursing Homes	Occupied Beddays	17,520	0	17,520
	Community Nursing & AHPs	Face to face contacts	26,978	0	26,978
	Social Work	Active caseload	2,526	0	2,526
		VALUE OF COMMISSIONED ACTIVITY[85]	£18.8m	£1m	£19.8m

[85] This includes activity in addition to that set out above.

9.4.8 POC 8: Health Promotion & Disease Prevention

Introduction

Health and wellbeing improvement refers to any activity which aims to prevent ill health and improve the health and wellbeing of our population. Prevention, early intervention and tackling health inequalities continues to be a key focus of the work of the SLCG and all programmes and interventions in this programme will adopt a proportionate universalism approach, i.e. where actions must be proportionate to the scale and intensity of disadvantage, to tackle rising rates of obesity, smoking and promoting positive mental health and wellbeing. The primary focus of this programme is to reduce health inequalities, with emphasis placed on services commissioned within health and social care, as well as the development of effective partnerships with other sectors, including communities, in order to influence the wider determinants of health.

The Public Health Agency for Northern Ireland is the overarching body that takes forward the regional and local implementation of departmental health improvement and disease prevention work. The SLCG, through its local commissioning intent can support and where appropriate enhance services delivered within this programme and is represented on the local Strategic Health Improvement Partnership forum, which includes all 5 District Council Chief Executives.

Overview of Local Needs

Within the SLCG locality, life expectancy has risen over the last decade. A male aged 65 years would have been expected to live for a further 16.6 years in 2001-03 and this had risen to 17.2 years by 2008-10. A female aged 65 years would have been expected to live for a further 19.3 years in 2001-03 and this had increased to a further 20.2 years by 2008-10[86]. However, there is continued need for improvement. For example, the Southern area has 40% of

[86] Source: Office for National Statistics via NISRA – http://www.nisra.gov.uk/demography/default.asp130.htm

the Traveller population for Northern Ireland resident in its area. For male Travellers, life expectancy at birth is 61.7 years and for females it is 70.1 years, both markedly less than the settled population.

However, in terms of general health and wellbeing, indictors taken from data from the Northern Ireland Health Survey 2011/2012,it is evident that the population in the Southern area shows more positive results than other areas i.e. 18% drink above the recommended weekly limit compared to 25% in Northern Ireland.

The increasing child population in the SLCG area, already noted, provides both challenges and opportunities to ensure every child is given the best start in life. A particular emphasis needs to be put on supporting parents in their role and to assist them in acquiring skills and knowledge for infant and child mental wellbeing, breastfeeding, healthy eating and smoking cessation. Programmes such as the Family Nurse Partnership (4.2) will play an important role in helping young mothers in this respect.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Bowel cancer screening (Ministerial Target 1) - the HSC will extend the bowel cancer screening programme from April 2014 to invite, by March 2015, 50% of all eligible men and women aged 60-74, with an uptake of at least 55% of those invited.
- Tackling obesity (Ministerial Target 4) - by March 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.

Commissioned Services

During 2013/14, the SLCG commissioned a range of services focusing on prevention and early interventions to address the demographic pressures across a range of programmes.

In 2014/15 and beyond the SLCG will continue to promote the earliest possible intervention in individuals and families and will continue to support the Family Nurse Partnership in the Southern area and the Roots of Empathy infant mental health training and parenting support.

The SLCG is fully committed to the empowerment of local communities, community and voluntary organisations to contribute to the delivery of support and community based services. It therefore continues to work towards supporting social enterprise approaches and community development.

Central to this will be tackling health and social wellbeing inequalities and ensuring that by the actions of the SLCG, these are not exacerbated but rather that the outcomes for all residents of the Southern area are equalised, regardless of geographical location, deprivation, education, poverty and housing. The SLCG is committed to ensuring that every individual in the Southern area is supported to reach their full potential, regardless of ability/inability, social, racial and equality status and would want every person to feel valued, of worth and supported to fulfil their hopes and expectations for life.

The SLCG will be guided in its commissioning intent by the range of key Departmental public health strategies in 2014/15. The SLCG will particularly focus on Tobacco Control, The NI Suicide Prevention Strategy – Protect Life: A Shared Vision 2012 – 2014 and the Breastfeeding Strategy. However, in terms of the overall strategic direction for this programme, the SLCG looks forward to the publication of the forthcoming Public Health Strategic Framework and will be guided by its recommendations in the future commissioning of services and

interventions in this programme. The SLCG remains fully committed to exploring the best practice in prevention and early intervention at European and world level in health and wellbeing interventions and programmes.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Expansion of the early years intervention programme.	By 31st March 2015, the Trust is expected to have demonstrated: • A coordinated approach has been developed across relevant service areas of Trust activity in this programme • An extension of the Roots of Empathy programme • Achievement of FNP targets • Delivery of infant mental health training as per agreed action plan. • Implementation of 5 new Early Intervention programmes to support parents.
Incremental expansion of social economy businesses and community skills development.	The Trust is expected to provide a report to the SLCG which details numbers of social economy businesses engaged by the end of 2014/15.
Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	The LCG will work with the PHA to develop a monitoring report, which will be sought by the end of 2014/15 in regard to this. A coordinated approach should be developed across relevant

	areas of Trust business and in conjunction with other statutory, community and voluntary partners. The Trust will be expected to produce a full year report demonstrating how funding provided during 2013/14 for health improvement for carers and children with disabilities has been used and what outcomes were delivered. The Trust is expected to provide a report which evidences improved access and uptake of targeted health and wellbeing improvement services and programmes by older people by the end of March 2015, using 2013/14 as a baseline. Community Navigator services funded by both the PHA and LCG in 2013/14 should be fully operational by 1st April 2014 and an evaluation of year 1 to be provided by the end of March 2015. Local health action plans relevant to this service should be produced during 2014/15 and shared with the LCG.
LCGs to monitor Trust performance in relation to the HSCB /	The Southern PHA office will liaise with the Trust in relation

PHA Community Development strategy	to this regional priority
Implementation of the "Fitter Futures for All Framework".	The Trust is expected to ensure that by 31 March 2015 they: • Can demonstrate full implementation of the Weigh to a Healthy Pregnancy Programme for women with BMI >40 • Report on the implementation of new 'Baby Friendly' standards. • Report on provision of weight loss programmes for adults and children as appropriate. • Report on contribution to implementation of new standardised Regional Activity Referral Programme • Report from regional working group on progress towards healthier catering and vending provision in all HSC facilities.
Implementation of key public health strategies	By 31 March 2015, the Trust is expected to: • Ensure that smoking Cessation services available with identified group. Brief Intervention training should be delivered to key staff working with priority groups. • Ensure the use of carbon monoxide monitors in ante-natal and pre-operative assessments. • Provide a progress report on smoke free campuses.

	• Have in place a new service model for substance misuse liaison service • Update of Registry and new service model should be developed and delivered.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	The Trust is expected to provide monitoring report outlining range of specialist sexual health services available, numbers and age groups accessing services by the end of March 2015.

***Will be subject to equality screening**

9.4.9 POC9: Primary Health & Adult Community

Introduction

There are presently 77 GP Practices delivering services across SLCG area. The total geographical area of SLCG is 3,188 km^2. As referenced in Section 1.1, NINIS population estimates for 2012 indicate the SLCG population as 363,145. An average GP Practice within the SLCG area will cover an area of 41 km^2 and have an average list size of 4,716[87]. The SLCG area is home to 72 community pharmacies, 37 optometry practices and 58 dental practices.

Out of hours GP services are provided at a range of sites across the Southern area and these are commissioned regionally by the HSCB Directorate of Integrated Care. Demand for these services continues to rise.

Integrated Care Partnerships (ICPs) have been established across Northern Ireland as a recommendation of TYC. These groups each cover populations of c.100,000 people and will be responsible for the coordination of patient pathways and improving care, with an early focus on frail elderly, Chronic Obstructive Pulmonary Disease (COPD), stroke and diabetes. Three ICPs have been developed in the SLCG area – covering the localities of Craigavon & Banbridge, Armagh & Dungannon and Newry & Mourne. The ICPs are managed by a GP Clinical Lead and are supported by a small business support team. In addition, ICP partnership committees have been established for each locality, to include representation from the primary care, Local Medical Committee (LMC), Trust, service users/carers, Northern Ireland Ambulance Service and local community and voluntary sector organisations. Multi-disciplinary teams have also been established for each of the 4 clinical priority areas.

The HSCB tasked the SLCG to take forward work in 2013 /2104 to identify Primary and Community Care infrastructure needs (Hub and Spoke developments) for the delivery of an integrated serviced model to reflect the

[87] Business Services Organisation (BSO)

commissioning direction outlined in TYC and in line with Ministerial direction to HSCB.

Overview of Local Needs

Table 59 illustrated the population sizes of the combined Local Government Districts of our 3 ICP populations. The areas of significant growth for 2023 will include Newry and Mourne LGD with a projected growth of 17.4%, followed by Craigavon and Banbridge LGDs which combined have a growth rate of 15.4%. The SLCG will take account of these growing populations in commissioning decisions, to ensure it is able to meet the primary care needs of this changing population in the future.

The SLCG has completed a detailed locality profile for Armagh, Dungannon and Lurgan in order to inform the prioritization of future hub and spoke developments in the Southern area. This profile has highlighted a range of pressures across the SLCG area including demographic pressure on list sizes, inward migration and infrastructure inadequacies. An integrated primary and community care hub is operational in Portadown and a community hub is currently being built in Banbridge and the Newry City primary and community care hub is at the procurement stage. During 2014/15, the SLCG hopes to work with local stakeholders to prioritise and develop proposals in other localities.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Integrated Care Partnerships (Ministerial Target 26) - By March 2015, 95% of patients within the four ICP priority areas [frail elderly, diabetes, stroke, respiratory] will have been identified and will be actively managed on the agreed Care Pathway.
- Unplanned admissions (Ministerial Target 21) - By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions (using 2012/13 data as the baseline).

Commissioned Services

During 2013/14, the SLCG has worked closely with GPs in all localities of the Southern area, in particular with Newry GPs, to progress the development of the primary care hub and spoke developments in line with HSCB and DHSSPSNI direction. In 2014/15, the SLCG looks forward to having an agreed prioritisation order for future hub and spoke developments including the development of detailed service models for each.

These service models will outline the shift left of activity from secondary to primary and community care with associated shift of resource and the impact of this on services currently provided in inpatient facilities and sites across the Southern area. Central to the success of this approach will be the provision of increased GP access to diagnostics, 7 day community support, improved access to district and community nursing, AHPs, pharmacy and social work and the ability to support individuals in their own homes to prevent unnecessary admissions to hospitals.

Within the Southern area, a number of specialist teams are in place to support people with long term conditions, including heart failure, stroke, diabetes and COPD. The SLCG has also previously invested in an Intra Venous at home service aimed at avoiding the need for admission. However, increasing levels of unplanned admissions over recent years is concerning and commissioning community based services to address this will be a key focus for the SLCG and ICPs. The SLCG has bridge-funded the development of a rapid response model of care for frail elderly and will during 2014/15 be considering how this and other community based models can impact on reducing unplanned admissions and reducing lengths of stay.

During 2013/14, the SLCG invested in additional hours for the local COPD service, to ensure a presence over weekends, this will increase capacity by another 460 referrals (936 contacts) per year. This investment should deliver reduced levels of unplanned admissions/ED attendances and facilitate earlier discharge from hospital.

The SLCG will continue to support, through allocation of its prescribing savings, funding to enhance GP capacity in Primary Care to enable patients to be managed closer to home in line with the direction signalled in TYC and the DHSSPSNI's Commissioning Plan Direction. In addition, opportunities to support Independent Contractors to implement patient pathways that will facilitate early intervention or the management of disease specific conditions for patients will continue to be explored.

The SLCG looks forward to the full implementation and evaluation of the Southern Primary Eye-care Assessment and Referral (SPEARS) pilot currently being implemented by Community Optometrists in one locality for patients with acute eye problems. A report will be presented to the SLCG in 2014 / 2015 enabling it to consider the future commissioning of this pathway.

The SLCG recognises the need to continue engagement with community pharmacists and community dentists to ensure their participation in the development of relevant patient pathways.

Commissioning Priorities and Requirements

POC9: Primary Health & Adult Community	
Regional Commissioning Priority	**Local Commissioning Requirement**
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	The SLCG through its use of prescribing savings will continue to commission in 2014/15, the GP capacity LES, based on £1 per patient registered, to enhance Practices' ability to provide services for patients closer to home and appropriately manage long term conditions in the community.
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility.	The SLCG will work with SHSCT to agree baseline information and bring this service into line with future regional direction for the delivery of 24/7 community nursing services.

10.0 Western Local Commissioning Group Plan

10.1 LCG Population

Demographic Drivers

On Census Day (27 March 2011), the resident population of the Western LCG area was 294,417 persons accounting for 16.26% of the NI total. Mid-Year Estimates show projected increase in population to 296,610 persons.

The age profile on Census Day includes:

- 22.1% were aged under 16 years and 13.1% were aged 65 and over;
- 49.6% of the usually resident population were male and 50.4% were female; and
- 36 years was the average (median) age of the population.

The older people population is lower proportionately than the NI average (13.1% and 14.6% respectively) although the Western area is projected to see the greatest increase in 65+ persons in the next ten years, i.e. 40.1% increase compared to 29.7% for NI as a whole. There were 4,268 births to Western families during 2011.

Mortality and Morbidity

In total, 2,188 people died in 2012 in the Western area, of these 851 (38.9%) were under 75 years old. Of all deaths, 628 (28.7%) were to malignant neoplasms; 335 (15.3%) were to respiratory disease; and 581 (26.6%) were to circulatory disease. (Note: Deaths data for 2012 are provisional.) The median age at death was 78 in 2011.

Potential Years of Life Lost (PYLL) is a measure of premature death, measured as the number of years of life 'lost' from a death when a person dies before the age of 75. A death at age 25, for example, has lost 50 potential years of life. In the Western area, the PYLL per year per 100 population for 2006 to 2008 was 8.0 years for males and 4.3 years for females.

The Standardised Mortality Ratio is a method of comparing mortality in different populations, while allowing for differences in the age structure of these populations. The Northern Ireland rate is set equal to 100 and a value greater than 100 indicates above average mortality. In the West, the Standardised Mortality Ratio from 2008-2010 for all ages was 99.8. The SMR (all ages) for Western LCG area has improved from 106 to 102 over the past decade. The Under 75s SMR has moved from 105 to 103.

Average death rates are available from 2004-2008 standardised for age to the 2004-2008 Mid- Year Population Estimates. In the Western area, the standardised death rate (per 100,000 population) for the population under 75 years of age was 438.5 for males and 283.7 for females.

There were 7,282 incidences of all cancers (excluding non-melanoma skin cancer) in the West in the 5 year period 2007-2011.

The NI Cancer Registry provides a five-year standardised cancer incidence ratio. The Northern Ireland rate is set equal to 100 and a value greater than 100 indicates above average incidence of cancer. The latest dataset available is for 2007-2011 and the standardised cancer incidence rate for all persons in the Western HSCT was 97.9.

On Census Day 2011, the population in the West reported that 21.85% or 64,330 of people had a long-term health problem or disability that limited their day-to-day activities and 11.04% or 32,386 of people stated that they provided unpaid care to family, friends, neighbours or others.

Life expectancy in the West is slightly below the NI average for both men and women (76.7 years for Western men compared to 77.1 years for NI and 81.4 years for Western women compared to 81.5 years for NI) (Source: Life Expectancy, DHSSPSNI).

It is of concern that the West remains among the highest rates for deaths for smoking related causes, above the NI average standardised death rates.

Notably the rate has reduced in recent years by 4% to 141.2 deaths per 100,000 population (Source: PSAB, DHSSPS). Standardised alcohol-related admissions in the West has risen by 41% from 476 admissions in 2000/01-2002/03 to 670 admissions in 2008/09-2010/11. Standardised death rates due to alcohol are also above the NI average.

There were 272 admissions as a result of injuries due to road traffic collisions in 2009/10. This represents 12.3% of all hospital admissions due to accidents and is higher than the NI average of 10.6%. There were 620 admissions as a result of injuries in the home in 2009/10 which represents 27.9% of all hospital admissions due to accidents, again higher than NI average of 22.9%. There were 69 admissions to hospital due to accidental injuries occurring at school, 3.1% of all hospital admissions due to accidents in 2010. There were 860 road traffic collisions in Western LGD in 2012 which resulted in 9 people being killed. In total there was a rate of 45 road traffic casualties per 10,000 population in 2012.

Raw prevalence of patients (per 1,000) on the Obesity register age 16 and over in 2012 was 119.3 which is considerably higher than the NI rate of 110.3. (Source: Health Survey NI, DHSSPSNI, 2012).

Deprivation

The Western area, and particularly Derry City and Strabane Council areas, experiences some of the highest rates of multiple deprivation. Only Belfast has more people living in the highest deprivation decile than the Western area. Derry City and Strabane Council areas are most deprived in terms of income and employment rates. In 2012/13, 24.2% of post-primary school pupils were entitled to free school meals (a rise on the previous year of 23.9%) and 12,940 people over 16 years were claiming income support with a further 4,880 (16-64 years) receiving Incapacity Benefit. Based on 2011 Census figures, 6.4% of the population was unemployed of which almost half were long-term unemployed (two years or more).

Rurality

DHSSPSNI strategy *Fit and Well - Changing Lives 2012-2022* notes that health outcomes in rural areas tend to be better than in NI overall but that "evidence suggests that health inequalities have a significant impact on people living in rural communities". In particular, the strategy identifies key challenges faced by many people living in rural areas, including:

- Deprivation and fuel poverty;
- Social isolation and social exclusion;
- A growing ageing population and changing population patterns; and
- Adequate access to services.

Patient and Public Involvement

The LCG flagship engagement programme, *Voice of Older People*, seeks to engage 1,000 older people between January and March 2014. With support from Public Health Agency, the LCG is committed to working with a range of Community Networks, asking them to undertake PPI work with the aim to carry out an engagement exercise, working with constituent community and voluntary groups, that provides service users with the opportunity to talk about their experiences of using Primary Care, Secondary Care and Community Care, and their views on Transforming Your Care, to ascertain their expectations of future services. Each network, covering its respective council area, will engage at least 200 older people and draw together views on a series of questions set by the LCG. The LCG will receive a report in Spring 2014 and consider the implications for HSC services. The Networks will convene a feedback session in each of the 5 Council areas in October 2014 to inform and discuss with participants the outcomes and findings of the engagement process. In terms of future planning the LCG will take into consideration these outcomes and recommendations when developing the Local Commissioning Plan for 2015/16 in relation to commissioning of Older People's Services.

During 2013, the LCG received presentations from each Community Network and has reflected on the range of issues raised in relation to HSC services. A strong theme across the presentations was the issue of rurality and the LCG is

planning a workshop with key interests, including community and voluntary groups, patient representatives, ICPs, GP representatives and Western Trust to develop a deeper understanding of the challenges facing people in rural areas in accessing and receiving services.

The LCG is very supportive of the development of self-directed support and the increasing emphasis on the role of carers. In recognition of this the LCG has executive representation on the Board's Self Directed Support Programme Board, the Regional Carers Strategy Implementation Group (CSIG) and the Western Trust's Carers steering group. The LCG initiated a Western area Carers Short Breaks Group involving a range of local carers to respond locally to a regional commissioning specification in attempting to create more choice, control and flexibility for aging carers (aged over 50 years) of learning disabled clients.

LCG staff attended WHSCT respite review meetings across all 5 district council localities and input was secured to the Western LCG short breaks break group which met on a number of occasions in 2013. The LCG considered and approved a Trust Investment proposal which took account of discussions and broad agreement at the short breaks group. This short breaks pilot is now being implemented by the WHSCT and ongoing evaluation will be reported through to the LCG as appropriate in addition to local and regional short breaks groups.

10.2 Key Challenges and Opportunities 2014/15

Delivery of successful outcomes in Health and Social Care is underpinned by collaboration among key stakeholders – commissioners, providers, patients/clients and carers/families. In recent years, the Western area has consistently delivered success through collaboration: in Primary Care Partnerships; in Primary Care prescribing efficiency; in integrated pathway development; and in progressing service transformation. It is my view that with these foundations the Western area is well-placed to continue to reform services, in line with *Transforming Your Care,* in the face of increasing financial constraints and in support of local people.

Integration is the key, recognising that patients will have better outcomes where GPs can plan care with social workers, community nurses, community pharmacists, community and voluntary groups, and so on with a focus on promoting independence and maintaining people at home for as long as possible. The LCG has placed a great emphasis on growing the community nursing service; investing in Reablement; and supporting initiatives such as community falls prevention programmes and carers respite.

The LCG has maintained a focus on driving efficiency. The LCG continues to promote efficiency in Primary Care prescribing and through the efforts of Western GPs has realised a release of almost £1 million for reinvestment in local services, such as GP services, GUM services and neurology diagnostics. During 2013, the LCG has encouraged GPs to review requests for laboratory tests to ensure compliance with guidance and hopes to see a reduction in requests in 2014/15. The LCG is also investing in placing centrifuges in Southern Sector practices in an effort to reduce blood contamination that can lead to the need to re-test and/or unnecessary Emergency Department attendance.

The coming year will bring challenges but also important developments. The introduction of Primary Percutaneous Coronary Intervention at Altnagelvin Hospital; commencement of building work on both Omagh Local Enhanced Hospital and Altnagelvin Radiotherapy Unit; and emerging plans for a number

of primary care hubs and related improvement to existing primary care accommodation together clearly signal considerable investment in local services. The LCG is determined to maximise these opportunities, both to improve services in line with *Transforming Your Care* and to deliver efficiencies through savings in running costs and improved productivity.

Key challenges for the LCG in 2014/15 include:

- Fulfilling the potential of Western Integrated Care Partnerships in driving the *Transforming Your Care* agenda through integrated care pathways based on multi-disciplinary collaboration and an ethos of self-reliance and share responsibility;
- Driving further primary care prescribing savings leading to additional reinvestment in primary care services;
- Delivering the proposed Primary Care Infrastructure programme for the Western area in line with agreed priorities;
- Developing the healthy ageing agenda;
- Further enhancing carers support and respite services;
- Progressing plans towards having in place appropriate 24-hour community nursing services, including acute care at home;
- Meeting domiciliary long-term care demand supported by the roll-out of reablement model;
- Introducing of a comprehensive fall prevention services with appropriate integrated care pathways, building on PHA Community Falls Prevention Pilot;
- Tackling impact of alcohol on HSC services, particularly Emergency Services;
- Putting in place across key acute specialties processes to allow GPs to gain consultant and specialist professional advice which might prevent the need for referrals and improve management of patients in primary care;
- Achieving Ministerial waiting times for outpatient and treatment;
- Ensuring 4-hour and 12-hour Emergency Department performance is achieved;

- Maximising utilisation of hospital theatres and in-patient beds;
- Securing a way forward in the delivery of acute mental health services; and
- Identification of opportunities to consolidate the provision of intermediate and acute beds and/or sites.

10.3 Ensuring Financial Stability & Effective Use of Resources

The Western LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £487.1m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Baseline investment by Service Area in 2014/15

Table 64

Programme of Care	£m	%
Acute Services	189.3	38.9
Maternity & Child Health	25.1	5.2
Family & Child Care	38.8	8.0
Older People	106.9	21.9
Mental Health	44.0	9.0
Learning Disability	34.3	6.9
Physical and Sensory Disability	15.7	3.2
Health Promotion	14.1	2.9
Primary Health & Adult Community	19.4	4.0
POC Total	**487.6**	**100.0**

This investment will be made through a range of service providers as follows:

WLCG Funded Providers 2014/15

Table 65

Provider	£m	%
BHSCT	27.0	5.5
NHSCT	1.7	0.3
SEHSCT	1.8	0.4
SHSCT	2.3	0.5
WHSCT	425.2	87.2
Non-Trust	29.6	6.1
Provider Total	**487.6**	**100.0**

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2014/15 in respect of Emergency Care by the Western Trust is £12.2m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2014/15 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation and additional funding to take account of the demographic changes in the population of the Northern area. It should be noted that the Learning Disability and Mental Health funds are indicative only at this stage.

Western LCG share of indicative investments 2014/15

Table 66

Pressures	**£m**
Demography – Acute Elective > 55 yrs	0.781
Demography NonElective > 55 years	1.024
Demography General	4.084
Learning Disability	0.487
Mental Health	0.287
Non Pay	4.528
Pay	3.420
PHA	0.567
RCCE	1.756
Service Pressures	13.378
NICE Drugs	3.172
Total	**33.484**

10.4 Commissioning Priorities 2014/15 – 2015/16 by Programme of Care (POC)

10.4.1 POC 1 - Acute Care

Introduction

Acute care is provided at Altnagelvin Hospital and South-West Acute Hospital with a range of specialties available on both sites. Altnagelvin provides a number of key regional specialties to patients in the Western and Northern areas, including Trauma & Orthopaedics and Oral Maxillofacial. In the past year has also seen the development of hospital care and treatment undertaken by the Independent Sector in the South-West Acute Hospital in order to address waiting times challenges.

Overview of local needs

Elective Demand

GP referrals to Consultant Led outpatient services account for the majority of the demand to acute services. Over the two years, 2011/12 to 2012/13, there has been approximately an 8% increase in demand across the LCG (from 62,323 to 67,599). Routine referrals increased by 7%, Urgent by 8% and red flags by 43%.

The number of new outpatient appointments held for Western residents has increased significantly, by 19%, (62,000 to 73,716) from 2008/09 to 2012/13. The average increase across NI Northern Ireland between 2008/09 to 2012/13 was 14%. Between 2011/12 and 2012/13 there was a 3% increase in new outpatient activity.

Due to identified gaps in capacity and demand the HSCB has purchased additional activity over the last few years. This additionality has been provided by both in-house initiatives and also additional activity purchased within the Independent Sector. All activity delivered regardless of the how it was purchased has been included here as this constitutes the demand upon the service.

Demand for Outpatient services will impact on elective admissions and day case activity carried out. As with outpatients above, additional activity has been purchased either via additional in house activity or activity being purchased from the Independent Sector and all activity has been included here. The move to meet efficiency targets, such as improved day case rates should have an impact on the admission / day case splits.

Between 2008/09 and 2012/13 there has been a 12% increase in review appointments held by Western residents, with an 11% increase between 2010/11 and 2011/2012. The average increase across NI Northern Ireland between 2008/09 to 2012/13 was 8%.

Over the five years, there has been a 17.2% reduction in elective admissions across the region. At Western LCG level, the change over the last 5 years the reduction in elective admissions represents a 15% reduction. Similarly over the last two years, 2011/12 to 2012/13, there has been a 2.9% decrease in elective admissions across the region and a decrease of less than 1% for the Western LCG.

As well as increased demand in outpatients with improved efficiency targets, there has been an increase in the number of day case admissions. At regional level, over the five year period, there has been a 20.9% increase and over the last two years the increase has been 5.3%. The change for the Western area was 19% over the 5 year period and 4.3% between 2001/12 and 2012/13.

Non-Elective Demand

Over the last five years Emergency Department attendances (new and unplanned review) have reduced across the region by 2.1% (from 696,832 to 683,386). There has been an increase in the number of ED attendances for Western residents from 94,017 to 94,623 equating to an increase of 0.6%. ED attendances at Western Trust hospital have increased by 3.6% over the 5 year period and by 1.8% over the two year period 11/12-12/13.

Over the last five years there has been an increase in non-elective admissions of approximately 16% (29,623 to 34,257). At LGD level within the LCG area, the greatest % increase was for Omagh LGD (27%) and Limavady LGD (16%) residents. All other LGDs (Derry, Fermanagh and Strabane) increased by 13%.

The greatest % change was over the last year (2011/12 to 2012/13) when the overall increase for the LCG was 5% and at LGD level it was 8% and 4% for Limavady, 6% for Derry, 5% for Omagh, and 3% for Fermanagh and Strabane.

While the number of non-elective admissions has increased, the corresponding number of occupied bed days has decreased, possibly suggesting either an improvement in length of stay or an increase in zero day lengths of stay. Over the five years, the number of occupied bed days have decreased by less than 1% for the LCG. At LGD level within the area, there has been an overall increase in the non-elective bed days for residents of Fermanagh (13%) and Omagh (20%).

Ministerial Targets

Western LCG will commission acute services in line with Ministerial targets set out in the Commissioning Plan Direction 2014/15.

In particular, the LCG is keen to ensure the development of alcohol liaison services in both acute hospitals, building on investment in 2013/14 with additional investment in alcohol liaison nursing to support Emergency Departments (ED).

The LCG continues to work closely with Western Trust to ensure the delivery of the Western share of the TYC transfer from secondary care. The LCG is leading the Primary Care Infrastructure Western Programme and is actively driving opportunities to reprovision acute services in these community settings. Efforts to put in place Acute Care at Home and 24-hour community nursing model will also deliver a significant element of re-provisioned service. Bed reductions in acute hospitals due to, for example, introduction of Day of

Surgery Unit and the roll-out of Older People's Assessment and Liaison Service will be pivotal in realising the shift.

Commissioned services

Western LCG will continue to commission the provision of a broad range of acute services, in the main at Altnagelvin and South-West Acute Hospitals with some outreach to Tyrone County Hospital and primary care locations, as appropriate. More specialist services are provided at Belfast acute hospitals and patient requiring care and treatment for more complex conditions will receive this further afield, whenever deemed necessary.

The opening of the South-West Acute Hospital has presented unforeseen difficulties, not least the challenge of nursing care in a hospital made up entirely of single rooms. The scale of the hospital compared to the Erne Hospital has also presented staff the need to work differently.

Driving the *Transforming Your Care* agenda, including delivering the shift of services and resources, remains the priority and the LCG has promoted the development of 24-hour integrated community nursing services; the establishment of the first Clinical Intervention Centre with more planned at key primary care locations across the area; the introduction of an elective Day of Surgery Unit and Short-Stay Paediatric Assessment Unit; an integrated Musculoskeletal Pathway in place with full support from all GP practices; and the establishment of outreach chemotherapy service at Tyrone County Hospital as examples of the evident 'shift' taking place in the West. Moreover the considerable enthusiasm for Integrated Care Partnerships and for the Primary Care Infrastructure programme provides considerable opportunities to achieve the TYC vision.

Hospital performance, while among the best in Northern Ireland, nonetheless falls short of Ministerial targets, particularly in unscheduled care. Breaches of the 12-hour target to complete treatment in an Emergency Department has been a more frequent occurrence at Altnagelvin Hospital in the past year and,

more significantly, 4-hour performance has fallen yet further below the 95% target.

In Elective Care, the Trust has continued to reduce waiting times for initial outpatient assessment and treatment in most specialities, and whilst Ministerial targets for assessment and treatment have been met in many areas, there are still a number of areas where this is proving problematic.

The commissioner continues to work with the Trust to increase core capacity to meet demand for services through recurring investment, service redesign, or improved productivity. Recurring investment has been made in 2013/14 in Pain Management, Gynaecology and MSK Physiotherapy, with further plans to invest in General Surgery and Orthopaedics in 2014/15. Redesign of ophthalmology ICATS services to implement the Glaucoma model has already increased core capacity within the service by over 10% with no investment. The introduction of revised care pathways within Primary Care in a number of areas including General Surgery and Gastroenterology has already had an impact on reducing demand in secondary care. Within General Surgery and Orthopaedics work is progressing to shift the treatment of varicose veins and dupuytrens contracture from day case theatres to treatment rooms. There is also significant work on-going with the Trust to improve productivity across a range of areas, by reducing cancellations, increasing pre-operative assessment, increasing day case rates and reducing length of stay.

As well as changes to systems and processes to deliver improved productivity, the introduction of planning assumptions for a range of specialities has been an important factor in increasing capacity. In line with the work done in other areas, the PHA has developed a Job Planning Toolkit for Clinical Nurse Specialists which sets out agreed activity levels for Nurse Led activity and MDT contribution. Where appropriate these should be added or reflected within current service SBAs.

Western Trust continues to have challenges in recruitment and retention of senior medical staff and in attracting junior doctors to take up training posts

across a number of acute specialties. While the Trust has been fortunate to attract locum doctors in some cases, cost and clinical limitations have proven problematic in maintaining services.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioner Requirement
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to reduce/flatten demand for outpatients, and Emergency Department attendances	The LCG is committed to improving working practices which enable GPs to appropriately manage patients in Primary Care. To date, the LCG has sponsored a series of care pathways which enhance GP direct access to imaging; support efficient Primary Care use of laboratory tests; and extend 'virtual clinics' approach in key specialties. The LCG, working with ICPs, will seek to go further across a broader range of acute specialties and in line with TYC. Key examples will include respiratory virtual clinic; GP-led head pain clinics with direct access to radiology; and Primary Care management of suspected DVT.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions	The commissioner has committed to invest funds to allow an additional two Emergency Care consultants can be recruited which will extend hours of senior decision making at Altnagelvin Emergency Department. Additional investment in radiology during 2013/14 will also underpin efforts to deliver radiology services 7-days per week. The LCG is committed to developing the Unscheduled Care Improvement Plan (as outlined) and will work collaboratively

	with Western Trust, ICPs, GPs and other interests to ensure this a comprehensive response in line with Ministerial priorities. The LCG will give consideration to the recommendations of the Western Trust review of its Emergency Care pathway which reported in December 2013. The LCG recognises the significant importance of the introduction of Primary Percutaneous Coronary Intervention in supporting the 7-day response.
Enable district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present	The LCG has invested in additional capacity of district and community nursing services for the past three years and is committed to putting in place 24-hour community nursing services in line with TYC timeframe. As an integral part of this, the LCG recognises that GP referral to district nursing should be as straightforward as making a referral to an Emergency Department. The LCG will work with Western Trust, ICPs and GPs to develop a model during 2014/15 which supports effective GP referral to district nursing in order to avoid unnecessary hospital admissions and to support earlier discharge, including district nursing in-reach to acute hospitals.
Review and take forward opportunities to consolidate the provision of intermediate care beds/acute beds and/or	The LCG, working with ICPs and Western Trust, will seek to ensure acute and intermediate care beds are maximised in line

sites.	with IPOP assumptions and in light of developments in community services, such as acute care at home and Reablement. The LCG will seek proposals from Western Trust on consolidation of bed provision and opportunities to reduce bed numbers.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The LCG is committed to developing collaboratively the Western Unscheduled Care Implementation Plan, building on its work on integrated care pathways; promotion of 7-day working; commissioning of GP out-of-hours services; and Western Trust recent review of Emergency Care at Altnagelvin Hospital.
Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.	The LCG notes IPOP comparisons which highlight significant opportunities to reduce beds, particularly through reducing average length of stay; extend day surgery procedures; reduce 'Did Not Attend' rates in outpatients and day surgery across a range of acute specialties, including reducing cancelled operations. Reduction in excess bed days to reach the peer average would equate to requiring approximately 70 fewer beds in the Western area. Going beyond this to be a high performing Trust, i.e. 75th percentile performance compared to peers, would mean requiring more than 100 acute beds less. Cancelled elective procedures is also an area for attention.

	Cancelled operations exceed 10% and the LCG would wish to a reduction to 5% in line with Audit Commission 2002 recommendations. The LCG also wishes to continue the drive to maximise acute elective capacity in line with HSCB direction. It is essential that consultant job plans seek to give priority to clinical activity.

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	15,975	422	16,397
	Daycases	24,155	389	24,544
	New Outpatients	74,699	5,300	79,999
	Review Outpatients	137,503	12,661	150,164
Unscheduled	**Non Elective admissions - all**	34,983	1,034	36,017
	ED attendances	101,700	1,473	103,173
	NIAS Journeys	26,644	1,354	27,998
	VALUE OF COMMISSIONED ACTIVITY[88]	£189.3m	£14m	£203.3m

[88] This includes activity in addition to that set out above.

10.4.2 POC 2 – Maternity and Child Health

Introduction

Maternity services are provided at both Western acute hospitals with appropriate neo-natal support on site and outreach to ensure access to ante-natal care. Health visiting remains at the heart of Child Health services, underpinned by specialist services, such as Family Nurse Partnership.

Overview of local needs

Across NI, the Western LCG has seen the smallest increase with 4,168 births in 2012, a 7% increase from the 3,911 births in 2002.

Births data for 2012 shows that the teenage birth rate per 1,000 of the female population aged 13-19 was 11.2 (provisional figure) in the Western area. The teenage birth rate per 1,000 of the female population aged 13-19 in the Western HSCT decreased by 4.9 between 2001 to 2012 from 16.1 to 11.2. The Northern Ireland teenage birth rate per 1,000 of the female population aged 13-19 decreased by 3.9 for the same period, from 16.9 to 13.0.

In 2012 (NISRA projected), there were 2,741 births in Altnagelvin Hospital and 1,226 births in Erne and South-West Acute Hospitals (combined)

The number of births in Northern Ireland is projected to continue decreasing. Estimated figures published by NISRA indicate that up until mid-2017, around 24,500 births are projected. After this 5-year period, the number of births is projected to fall steadily to 22,600 births in the year ending mid-2027, 11% below the number of births that occurred in the year ending mid-2012 (NISRA, 2013).

It is anticipated that the Western area will see a reduction in births from 4,268 births in 2008 to 3,692 births projected for 2023, i.e. 13.5% reduction over the 15 year period.

There are 74,200 persons under 18 years living in the Western area of whom 21,300 are under five years. (Census 2011, NISRA)

Ministerial targets

The LCG continues to support the Western HSC Trust-led. Family Nurse Partnership programme running in the North-West. The programme has shown considerable success, recently graduating its first intake following babies reaching the age of 2 years. The LCG Commissioning Lead is the chair of the Western FNP Advisory Board and the LCG is looking at opportunities to extend the programme across the Western area in the next three years.

Commissioned services

Western LCG will continue to commission the provision of Maternity and Child Health Services in line with current services.

Challenges in staffing maternity units in the face of difficulties in attracting junior doctors to Western hospitals continue to affect delivery of services. In South-West Acute Hospital in particular, where delivery numbers are lower and senior medical staffing limited, it has been necessary to consider if the Unit can deliver higher risk babies, particularly given neo-natal care is for the lowest risk newborns. The commissioner remains committed to maintaining the Unit but continues to review with Western Trust specific exclusions due to patient safety concerns. The Local Commissioning Group, working with regional colleagues and Western Trust, will ensure that maternity services here are endorsed in line with the requirements outlined within the Maternity Strategy.

The LCG recognises the need to ensure adequate medical cover in provision of services and is mindful of the challenges facing Western Trust in attracting and retaining senior and junior doctors which have put women and children's acute services under pressure in recent years. Moreover, specialisms within paediatric services are proving more difficult to provide locally and it has become necessary to increasing look at networked provision from regional hospitals which has reduced access to some degree.

The LCG has welcomed Western Trust efforts to test and introduce a short-stay paediatric assessment unit at Altnagelvin Hospital. The pilot initiative has shown considerable potential to reduce in-patient admissions and to shorten lengths of stay and the LCG will work with Western Trust to see the unit established, supporting the delivery of quality and efficient services.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioner Requirement
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	The LCG, working with regional colleagues, will seek assurance from Western Trust that it is putting in place the necessary arrangements to meet standards of the Maternity Strategy.
Trusts are expected to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	The LCG, working with regional colleagues, has agreed a protocol for the management of multiple pregnancies and will keep under review its implementation.
Trusts are expected to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife led antenatal care in the community for women with straightforward pregnancies	The LCG, working with regional colleagues, will seek assurance from Western Trust that midwife is 'first point of contact' and proposals to deliver more midwife-led antenatal care in the community for women with straightforward pregnancies.
Trusts are expected to continue to benchmark their local obstetric intervention rates against peer units and to	The LCG will work with regional colleagues and Western Trust to ensure the reduction of unexplained variation in

reduce unexplained variation in intervention rates throughout Northern Ireland	intervention rates.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The LCG, working with regional colleagues, will seek to commission targeted responses to meet the needs of vulnerable groups of pregnant women, in line with available evidence and drawing on best practice.

Values and Volumes

Programme of Care	**Service Description**	**Currency**	**2013/14 Baseline**	**Indicative Additionality 2014/15**	**Total indicative commissioned Volumes 2014/15**
Maternity and Child Health	**Obstetrics**	Births	4009	0	4009
	Comm Midwives	Contacts	72,576	581	73,157
	Health Visiting	Contacts	62,253	0	62,253
	Speech and Language Therapy	Contacts	26,015	0	26,015
		VALUE OF COMMISSIONED ACTIVITY[89]	£25.1m	£1.2m	£26.3m

[89] This includes activity in addition to that set out above.

10.4.3 POC 3 – Family and Childcare

Introduction

Family and Childcare Services are commissioned regionally and Western LCG has a limited role in relation to commissioning of these services locally.

Overview of local needs

Based on NI Statistics and Research Agency publication of outputs of the 2011 Census the total child (aged 0-17) population in Northern Ireland is 430,763. The Western Trust has a population of 74,354 or 17.3% of the child population which is the second lowest of the five HSC Trusts. Based on Discharge of Statutory Functions Report 31 March 2013 the Western Trust had 6,422 children in need, the highest number in the region. The majority of these children were in the 0-11 age range. Regionally there was a total of 1,961 children on the Child Protection Register, 297 of these children were in the Western Trust. There were 468 children in care in the Western Trust which represents 16.7% of the total number of children in care. The number of children in care in the Trust has increased by 68 since March 2011.
The Trust reports significant pressure on the Children Services programme in the current economic climate with the requirement for substantial savings against a backdrop of increasing demand. Compared to September 2012 there has been an increase of 215 in the number of children in need, an increase of 31 on the Child Protection Register and an increase of 24 in the number of children who are looked after.

Particular areas of Children and Families identified as posing particular challenges include:

- Unallocated cases arising from increased demand and complexity of cases
- Growth in kinship care and compliance with recently issued kinship standards

- Late care entrants arising from older adolescents who present as homeless being admitted to care
- Meeting the needs of children with high and complex health care needs through the provision of substantial and intensive support home care packages

Key policy directions include the development of early intervention and family support to prevent family breakdown and admissions to care. For children who are looked after the emphasis is on promoting the more extensive use of foster care and minimising the use of residential care. Recruiting specialist carers for looked after children with complex needs will be an integral part of this.

Ministerial Targets

The LCG continues to support the Western HSC Trust-led Family Nurse Partnership programme running in the North-West. The programme has shown considerable success, recently graduating its first intake following babies reaching the age of 2 years. The LCG Commissioning Lead is the chair of the Western FNP Advisory Board and the LCG is looking at opportunities to extend the programme across the Western area in the next three years.

Commissioned Services

In line with regional and ministerial priorities for Children and Families and aligned to statutory functions contained within the Children (NI) Order 1995 and direction of TYC commissioning emphasis will be on:

- The development of early intervention and family support to strengthen parenting, prevent family breakdown and admissions of children to care including development and delivery of the Early Intervention Transformation Programme
- The promotion of foster care for children looked after within their kinship network where appropriate as a first consideration
- The recruitment of professional / specialist foster carers for children with complex needs

- Responses to concerns pertaining to child sexual exploitation, including joint working arrangements as well as protective and therapeutic services for these children
- Robust needs assessment and delivery of localised service for children with complex needs including those with learning disabilities or challenging behaviour

Commissioning Priorities and Requirements

Enhance the Health Visiting workforce to provide the full Core Universal Service as set out in *Healthy Child Health Future*.	The LCG recognises the significant role of Health Visiting and has provided additional resources in 2013/14 to extend capacity in the face of rising caseloads. The LCG is keen to ensure that it maximises the health visiting resource to deliver *Healthy Child, Healthy Future* requirement in coming years.

10.4.4 POC 4 – Older People Services

Introduction

In the face of rapid growth of the older population and in light of *Transforming Your Care*, it is imperative that services for older people change and grow. The priority will be to provide support to enable all older people to remain independent and living in their own home for as long as possible. This will require social support with important roles played by community and voluntary groups. Home-base care will be key with an increasing emphasis on 24-hour support and support and respite for carers. Traditional acute geriatric medicine services will increasingly underpin community services and, in particular, General Practice and community nursing. As Integrated Care Partnerships (ICPs) roll out their programmes to support frail elderly; clinical priorities of diabetes, respiratory and stroke conditions; and end of life care, the LCG recognises the need to give greater emphasis to transforming older people's services in line with health and wellbeing goals.

Overview of local needs

The older person population has been increasing year-on-year for the past two decades. In the West, the rise has been 15.8% in the past five years (2007-2012 MYE); 28.3% in the past 11 years (2001-2012 MYE); and 40.3% in the past 21 years (1991-2012 MYE).

Projecting forward, the rise in older people will continue. The rise in over 65 years will be 38% in the next decade and 42% in total for the next two decades. The rise in the over 75s and 85s is also marked in the coming 20 years.

Average life expectancy measures the expected years of life at birth based on the mortality rates of the period in question. The Northern Ireland average life expectancy for 2008-2010 is 77.1 years for males and 81.5 years for females. Life expectancy for males in the Western HSCT for 2008-2010 is 76.7 years, and for females is 81.4 years.

Ministerial targets

The LCG recognises the potential to further develop telecare and telehealth in line with ministerial targets and will seek to ensure that Western Trust maximises potential in collaboration with ICPs.

Commissioned services

Western LCG will continue to commission the provision of a broad range of services for older people, with a particular emphasis on providing Primary and Community Care which minimises the necessity for acute hospital care. Crucial in this will be commissioning initiatives with Integrated Care Partnerships which offer opportunities to transform care pathways through collaboration between General Practice, Western Trust, community and voluntary bodies, and service users and carers.

The LCG has placed considerable effort on addressing the impact of demographic change on HSC services and has deployed Demographic funding to both meet the demand of traditional services and to drive transformation. In the face of considerable pressures in Trust domiciliary care services, the LCG allocated a large proportion of funding to buy more than 100,000 additional domiciliary hours thereby closing the capacity/demand gap in respect of older people's services. Moreover the LCG, for a second year, invested in the development of Reablement services, emphasising the Occupational Therapy approach which seeks to return older people to independence following a period of illness or hospitalisation. There has been considerable benefits of Reablement to date but it has not been roll-out beyond Derry/Londonderry and the LCG is working with Western Trust to ensure this happens in the next year. An important aspect will be involvement of the community and voluntary sector who can provide considerable support to maintain independence beyond the period of Reablement.

In hospital services, the LCG has recognised the importance of taking a holistic approach to meeting the needs of older people and has commissioned the Older People's Assessment and Liaison (OPAL) service which is now in place in Altnagelvin Hospital and will shortly be introduced to South-West Acute

Hospital. The service provides a comprehensive assessment for all older people on admission with a view to provide more joined up service in response, thereby shorten lengths of stay and improving health outcomes.

The LCG is aware of challenges facing Western Trust to recruiting and retaining senior medical staff in both geriatrics and older people's psychiatry. The LCG intends to work with Western Trust to put in place alternative models of care in order to overcome service vulnerabilities.

As the focus of our service model moves towards supporting people to remain healthier for longer and, when they become unwell, providing as much of their care as close to home as possible, we should see opportunities to consolidate the provision of intermediate and acute care beds and / or sites.

The LCG has also piloted greater involvement in nursing home care and has supported the appointment of 2 dieticians to link with nursing homes across the Western area to advise on nutrition and the use of supplements. Another initiative to review medication of nursing home patients took place in Limavady. Pharmacy prescribers reviewed medication of nursing home patients, identifying clinical issues of multi-prescribed drugs and opportunities to switch to generic alternatives. The LCG will roll this initiative out further in 2014/15.

A key area for work has been falls prevention and the LCG has been fortunate that Public Health Agency has developed and pilotted locally a community-based programme to identify older patients who have previously had a fall and offer them education and physiotherapy intervention at a community setting. The LCG hopes to link this programme with efforts to develop a dedicated Osteoporosis Clinic linked to fracture liaison services in both hospitals.

The LCG, with regional colleagues, has commissioned a significant development in adult safeguarding and has provided additional funding to enable Western Trust to put in place an Adult Safeguarding Gateway Team

which will screening referrals and put in place adult protection plans as required.

Building on investment in the previous year, the LCG has extended the Early Support Discharge Team to South West Acute Hospital which will provide dedicated support to patients following a stroke to assist them to return home and to independent living. Success is evident in the service in place in Altnagelvin Hospital and the LCG Is optimistic that similar benefits will be delivered in the Southern sector.

The LCG will continue to consolidate palliative and end of life care with an emphasis on development of home-based care and Hospice care in line with the Delivering Choice programme.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioner Requirement
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The LCG has sought to improve support for carers through increased access to carer assessments and respite options. The LCG will seek proposals from Western Trust on approaches to earlier identification of carers and assurance of provision of necessary carer assessment as appropriate.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The LCG is promoting carers' short breaks and is working closely with carers' representatives and voluntary providers to ensure additional resources provide maximum benefit for service users and families. The LCG is working with regional colleagues to ensure short breaks approach continues to develop in coming years.
To increase uptake of direct payments	The LCG, working with regional colleagues, will seek proposals from Western Trust on how an increased uptake of direct payments can be achieved.
Working with ICPs to improve the care of the frail elderly.	The LCG is commissioning Western ICPs to improve the care of frail elderly. Risk stratification will underpin the development of integrated care pathways which seek to support independence and home-base care and to improve care planning and management and reduction of unscheduled hospital attendances and admissions. In particular, ICPs will take forward: • A range of targeted health and wellbeing programmes;

	• Extended medicines review by community pharmacists; • Improvements to discharge letters; • Coordinated falls prevention programmes; • A range of initiatives to overcome social isolation, led by local community and voluntary organisations; • Improved intermediate care; • Additional carers short breaks and carers personal development programmes; and • Establishment of multi-disciplinary groups to look at best practice in the care of frail elderly.
Enhancement of dementia services	The LCG has worked closely with regional colleagues to ensure the recommendations of the Dementia Strategy are realised in the West. A full memory service has now been established, Monday to Friday, 9am to 5pm in the Southern sector of the Western area to facilitate early detection and intervention in cases of dementia. The funding will also enhance the current service within the Northern sector, providing dedicated occupational therapy input. It will enhance the current SLA with Alzheimer's Society to provide a 'navigator' type role for signposting to help clients and their families access the full range of services available when required.
Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements.	The LCG, working with Western ICPs and Western Trust, will seek to improve intermediate care provision in the context of efforts to put in place 24-hour community nursing.

Continued roll-out of targeted Public Health Agency (PHA) preventative health and well-being improvement programmes.	The LCG will support PHA preventative programmes as required.
Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The LCG will seek to build on progress in Western Trust towards rolling out Reablement across the Western area in line with agreed regional model.

Values and Volumes

Programme of Care	**Service Description**	**Currency**	**2013/14 Baseline**	**Indicative Additionality 2014/15**	**Total indicative commissioned Volumes 2014/15**
Older People	**Geriatric Hospital Services**	Occupied Beddays	36,088	-3822	32,266
	Day Care	Attendances	72,991	0	72,991
	Domiciliary Care	Hours	1,606,331	103,020	1,709,351
	Residential & Nursing Homes	Occupied Beddays	549,248	0	549,248
	Community Nursing & AHPs	Face to face contacts	314,912	5,826	320,738
	Social Work	Caseload	9934	0	9934
		VALUE OF COMMISSIONED ACTIVITY[90]	£106.9m	£5m	£111.9m

[90] This includes activity in addition to that set out above.

10.4.5 POC 5 – Mental Health

Introduction

Mental Health Services in the Western area have seen considerable reform in recent years with a marked shift from acute care to Primary Care services with a significant reduction in acute in-patient beds across the area. The opening of Grangewood Hospital in Derry has seen a step change in acute care. Consideration of providing a similar facility, either in Omagh or Enniskillen, continues in line with TYC recommendations.

Child and Adolescent Mental Health Services have also seen considerable reform and the drive to provide CAMH Services to young people up to their 18th birthday are in line with regional requirements.

Overview of local needs

The Quality and Outcomes Framework (QOF) measures general practice achievement against a range of evidence-based indicators and provides raw disease prevalence data by a total of 17 clinical areas. In 2013, the raw prevalence of patients (per 1,000 patients) on the Mental Health Register was 9.0 and on the Dementia Register was 5.9 for the Western area.

Information collected via the GMS Quality and Outcomes Framework, highlight that there are 2,843 patients on the Mental Health register maintained within GP Practices. In 2011/12 there were 1,203 in-patients to Gransha (583) and Tyrone & Fermanagh (620) Hospitals, with occupancy of approximately 90.8% and average length of stay of 46.7 days.

In Western Trust, there were 93 admissions to hospital as a result of mood or anxiety disorder in 2009/10. The data is extracted from the NI Hospital Inpatients System (HIS), but excludes mental health specialities as not all mental health information is recorded on the Patient Administration System. More than half of these were by residents of Derry.

Aggregated hospital admissions data is also available for the age standardised rate of admissions due to self-harm. The Northern Ireland rate is set equal to 100 and a value greater than 100 indicates an above average admission rate. From 2005/06-2009/10 the admission rate was 89.0 in Western Trust.

Data is recorded on the number of deaths due to suicide and undetermined intent from 1999 to 2012. In the West, there were 46 such deaths in 2012 (provisional figure).

All deaths data supplied by Demography and Methodology Branch is based on the year of registration rather than the year of occurrence unless otherwise stated. Events such as suicide are likely to be referred to the coroner. This can take some time; therefore deaths recorded each year may have occurred prior to the registration year.

In 2011, there were 1,402 self-harm presentations to Emergency Departments (ED) in the Western Trust, an increase of 11% from the 2009 figure.

Information collected as part of the Health Inequalities Monitoring System (2010) on Mood & Anxiety Disorders estimate that 159 persons per 1,000 population in the West are receiving drugs for mood and anxiety disorders.

Addiction and mental health are also interrelated phenomena in Northern Ireland. Drug and alcohol abuse often coexist with poor mental health. The majority of users take sedatives, tranquillisers or anti-depressants daily or mostly daily. Benzodiazepines are the second most common substance of referral for people with addictions in Northern Ireland.

Ministerial targets

The LCG is committed to securing a 10% increase in the number of carers' assessments offered within the Mental Health programme and will seek assurances from Western Trust that this will be delivered during 2014/15 in line with Ministerial requirements.

Commissioned services

Western LCG, supported by regional colleagues, will continue to commission the provision of the range of mental health services for adults and children across the Western area.

In line with the *Transforming Your Care, Bamford Review* and *New Strategic Direction for Drugs and Alcohol*, it is evident of the importance to intervene earlier where alcohol abuse is concerned and to reduce hazardous and harmful drinking with associated targets such as reducing attendances at Emergency Departments. The LCG has commissioned the expansion of alcohol liaison services within Emergency Departments, particularly to reduce impact on in-patient beds, and to drive the use of appropriate short-term therapeutic intervention which seeks to reduce alcohol abuse. This investment will build on previous investment in both Emergency Depts.

The LCG has also commissioned Western Trust to begin to implement Recovery Approaches in line with *Transforming Your Care* which states that "At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives." Additional investment in 13/14 will deliver additional capacity in the Trust Recovery Team to meet growing demand due to demographic change.

Transforming Your Care places a particular emphasis on support for carers and families. It states that "There will be a need to provide more respite care and short breaks in the community, to support individuals and carers… All of this intervention is designed to respond to the patient's and carer's needs." TYC recognises the need for more investment in respite care services in Mental Health Services in line with the *Bamford Review* recommendations. The LCG has committed additional funds to provide more respite care within the Adult Mental Health Programme.

Commissioning Priorities and Requirements

Regional Commissioning Priority	**Local Commissioner Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The LCG has sought to improve support for carers through increased access to carer assessments and respite options. The LCG will seek proposals from Western Trust on approaches to earlier identification of carers and assurance of provision of necessary carer assessment as appropriate.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The LCG is promoting carers' short breaks and is working closely with carers' representatives and voluntary providers to ensure additional resources provide maximum benefit for service users and families. The LCG is working with regional colleagues to ensure short breaks approach continues to develop in coming years.
Increase uptake of direct payments.	The LCG, working with regional colleagues, will seek proposals from Western Trust on how an increased uptake of direct payments can be achieved.
Implementation of the Protect Life Strategy	The LCG will support PHA colleagues to ensure Western Trust provides the necessary actions to fully implement the refreshed *Protect Life* strategy.
Establishment of integrated care arrangements for the	The LCG has been central in the establishment of a

care and treatment of patients with common mental health needs	collaborative to take forward Primary Care Talking Therapies, drawing together existing HSC services, such as GP-commissioned therapies through voluntary providers, and seeking to commission additional capacity from the community and voluntary sector going forward. Initially, the LCG has directed Western Trust to undertake scoping which will provide clarity on opportunities and constraints and it is hoped to develop the service in 2014 with a single point of contact and clear referral pathways.
Implementation of the Crisis Resolution Home Treatment services for CAMHs	The LCG will support regional colleagues to ensure the implementation by Western Trust of Crisis Resolution Home Treatment Mental Health services for children and young people.
Further development of specialist community services	The LCG, with regional colleagues, will seek to further develop adult autism services, including supporting transition for young people with ASD. The LCG will also ensure further enhancement of adult and children's mental health services in line with *Transforming Your Care* and the *Bamford Review*.
Improved psychiatric liaison services	The LCG will support regional colleagues to ensure timely response of Psychiatric Liaison Services in both Western

	Emergency Departments.
Consolidation of inpatient mental health beds to single sites in Belfast Trust and Southern Trusts and to two sites within Western Trust.	The LCG will take forward the outcome of the Board's review of acute mental health in the southern part of the Western area as required.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied Beddays	38759	0	38759
	CPN	Contacts	49349	0	49349
	Res & Nur Homes + Supported Housing	Occupied Beddays	326	0	326
	Day Care	Attendances	78418	0	78418
	Domiciliary Care	Hours	29294	0	29294
		VALUE OF COMMISSIONED ACTIVITY	£44m	£1.5m	£45.5m

10.4.6 POC 6 – Learning Disability

Introduction

Learning Disability Services are provided across the Western area and include support services in schools and adult day opportunity services, ranging from traditional day care to vocational opportunities. In-patient services, provided in Lakeview Hospital, focus on assessment and treatment.

Overview of local needs

The Quality and Outcomes Framework (QOF) measures general practice achievement against a range of evidence-based indicators and provides raw disease prevalence data by a total of 17 clinical areas. In 2013, the raw prevalence of patients aged 18 plus (per 1,000 patients) on the Learning Disabilities Register was 6.17 for the Western LCG which is the highest prevalence in Northern Ireland (NI average – 5.16).

There were approximately 2,260 people with a learning disability on the informal register held by the Western Trust in 2010. The number of people with a severe learning disability is rising and there has been an increase of almost 30% since 2000.

Ministerial Targets

The LCG recognises the importance of providing timely carer's assessments and will work with regional colleagues to ensure Western Trust increases assessments undertaken in line with Ministerial targets.

Commissioned services

Western LCG, working with regional colleagues, will continue to commission the provision of a range of services to adults and children with a learning disability and their carers and families.

While resettlement of adults who had been living inappropriately in hospital for many years is largely complete in the Western area, challenges exist due to

people coming into hospital for assessment and treatment who, following a period in hospital, are unable to return home and experience lengthy stays in hospital. Work to develop community teams to prevent caring arrangements breaking down has shown some benefit in recent years.

The shift from centre-based day care to person-centred day opportunities has been a feature of services for adults with a learning disability in the West for a number of years. However centre-based services have nonetheless come under pressure due to growing demand and extended life expectancy among service users. Western Trust has faced challenges to provide day opportunities for school leavers and has worked with the LCG to maximise capacity, including seeking alternative provision for older people. Similarly, providing community support as an alternative to admission to hospital remains of great importance.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioner Requirement
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The LCG has sought to improve support for carers through increased access to carer assessments and respite options. The LCG will seek proposals from Western Trust on approaches to earlier identification of carers and assurance of provision of necessary carer assessment as appropriate.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The LCG is promoting carers' short breaks and is working closely with carers' representatives and voluntary providers to ensure additional resources provide maximum benefit for service users and families. The LCG is working with regional colleagues to ensure short breaks approach continues to develop in coming years.
Delivery of day services in line with the Regional Day Opportunities Model	The LCG, working with regional colleagues, will seek to ensure that Western Trust day services are delivered in line with the Regional Day Opportunities Model.
Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	The LCG, working with regional colleagues, will seek to ensure that Western Trust specialist community services respond to the needs of people whose behaviours challenge services and those with offending behaviours, including 2-hour response 7-days per

	week and high support beds in the community.
Increase uptake of direct payments	The LCG, working with regional colleagues, will seek proposals from Western Trust on how an increased uptake of direct payments can be achieved.
Development and implementation of health promotion initiatives for people with a learning disability.	The LCG will support regional colleagues in taking forward health promotion initiatives for people with a learning disability.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied Beddays	16187	-6570	9617
	Day Care	Attendances	162564	0	162564
	Domiciliary Care	Hours	107510	0	107510
	Residential & Nursing Homes	Occupied Beddays	100719	4044	104763
	Community Nursing and AHPs	Face to face contacts	18233	0	18233
	Social Work	Active Caseload	1278	0	1278
		VALUE OF COMMISSIONED ACTIVITY[91]	£34.3m	£1.2m	£35.5m

[91] This includes activity in addition to that set out above.

10.4.7 POC 7 – Physical and Sensory Disability

Introduction

The LCG has recognised the importance of investing in the development of

Overview of local needs

The 2011 Census notes that almost 22% of residents reported a long-term health problem or disability which limited their day-to-day lives, a figure above the NI average of under 21%. At June 2011, there were 75 people with a physical and sensory disability being cared for in residential/nursing facilities, of this 87% live in nursing homes.

Prevalence of a range of physical and sensory disabilities for the Western LCG (from 2011 Census information) includes:

- Deafness and partial hearing – 4.8 compared to NI average of 5.1
- Blindness or partial sight loss – 1.72 compared to NO average of 1.7
- Communication difficulty – 1.76 compared to NI average of 1.7
- Mobility or dexterity difficulty – 11.85 compared to NI average of 11.4

Ministerial targets

The LCG will seek to ensure that Western Trust provides a 10% increase in the number of carers' assessments during 2014/15.

Commissioned services

Western LCG will continue to commission the provision of a range of services to adults and children with a physical disability or sensory impairment and their carers and families.

In recent years, the LCG has invested additional funds to support community-based services, such as dedicated sensory support services for deafblind people. In 2013/14, The LCG has recognised the considerable value of the pilot Community Access project, funded through CAWT and has invested Demographics funding to ensure the continuation and development of the

project which is providing day opportunities for adults with a physical and sensory disability as an alternative to centred-based daycare. The LCG, in response to the direction signalled in TYC, will continue to support the Reform and Modernisation of day care provision to providing day opportunities As well as improved choice for service users directly engaged in the Community Access service, the model has freed up places in day centres, allowing service users with more complex needs to engage in more beneficial activities.

The LCG will monitor discharge delays from Specialist Units from within the Western area. Board funding, from the P&SD Strategy into the Regional Rehabilitation Services, to support Spruce House, Altnagelvin Hospital will ensure that there is sufficient consultant and medical cover for service continuity on site as well as outreach to local rehabilitation centres and support for Community Rehabilitation teams.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioner Requirement
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The LCG has sought to improve support for carers through increased access to carer assessments and respite options. The LCG will seek proposals from Western Trust on approaches to earlier identification of carers and assurance of provision of necessary carer assessment as appropriate.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The LCG is promoting carers' short breaks and is working closely with carers' representatives and voluntary providers to ensure additional resources provide maximum benefit for service users and families. The LCG is working with regional colleagues to ensure short breaks approach continues to develop in coming years.
To increase uptake of direct payments	The LCG, working with regional colleagues, will seek proposals from Western Trust on how an increased uptake of direct payments can be achieved.
Review Trust progress in relation to the review and reform of day service opportunities to ensure alignment with personalisation strategies.	The LCG, working with regional colleagues, will seek to ensure that Western Trust day services are delivered in line with personalisation strategies.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability & Sensory Impairment	**Hospital Services**	Occupied Beddays	9800	0	9800
	Daycare	Attendances	24420	0	24420
	Domiciliary Care	Hours	298781	0	298781
	Residential & Nursing Homes	Occupied Beddays	25692	0	25692
	Community Nursing & AHPs	Face to face contacts	18529	0	18529
	Social Work	Active caseload	1700	0	1700
		VALUE OF COMMISSIONED ACTIVITY[92]	£15.7m	£1m	£16.7m

[92] This includes activity in addition to that set out above.

10.4.8 POC 8 – Health Protection

Introduction

Pressures on Health and Social Care services are exacerbated by choices made by local people which can have detrimental impact on their health and wellbeing. The impact of alcohol is now recognises as being a major societal issue requiring multi-agency response. Obesity is also recognised as contributing the rising long-term conditions, such as diabetes and heart disease. Smoking cessation remains a high priority.

Overview of local needs

Western area shows a mixed profile of prevalence of patients on registers per 1000 of all the key QOF measures. Mental health, learning disability, obesity and COPD showing higher prevalence, with lower than average in heart disease and stroke.

Another key indicator showing deaths amenable to intervention shows that in 2001-05 West had a higher than average indicator of 104.6 deaths per 100,000 population whereas in 2006-10 it has dropped to 77.2, below the NI average, 77.9.

There were 3 obesity-related deaths in the Western HSCT from 2007 to 2011. The definition of obesity-related deaths is any death where the underlying cause of death is recorded as obesity. The Quality and Outcomes Framework (QOF) measures general practice achievement against a range of evidence-based indicators and provides raw disease prevalence data by a total of 17 clinical areas. In 2013, the raw prevalence of patients aged 16 plus (per 1,000 patients) on the Obesity Register was 118.6 for the Western area.

Data on individuals availing of specialist smoking cessation services shows that in the Western HSCT in 2012/13, 60.9% of people who set a quit date had successfully quit (self-report) at 4 weeks.

Ministerial targets

The LCG will support regional colleagues in implementing the Ministerial target that all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme.

The LCG continues to support the Western HSC Trust-led. Family Nurse Partnership programme running in the North-West. The programme has shown considerable success, recently graduating its first intake following babies reaching the age of 2 years. The LCG Commissioning Lead is the chair of the Western FNP Advisory Board and the LCG is looking at opportunities to extend the programme across the Western area in the next three years.

Commissioned services

Western LCG will continue to support PHA colleagues to commission the provision of a range of Health Protection services.

The LCG has placed an emphasis on ensuring the implementation of the TB Action Plan in the Western area. The Group has invested Demographics funding in providing additional nurse capacity to support the setting up of a community team, linking with secondary care, which will support patients to manage the condition. The service will provide screening, treatment, HIV risk assessment, and advice and information to patients.

The emergence of Integrated Care Partnerships offers an opportunity to enhance preventative initiatives involving the range of interests who provide Health and Social Care services. With a greater emphasis on self-reliance and self-care, the LCG is committed to ensuring that ICPs place prevention and wellbeing centrally in its programme.

Commissioning Priorities and Requirements

Regional Commissioning Priority	**Local Commissioner Requirement**
Expansion of the early years intervention programme.	The LCG will support regional colleagues to implement the Early Years Intervention Programme. In particular, the LCG will continue to play an active role in the delivery of the Family Nurse Partnership in the North-West.
Incremental expansion of social economy businesses and community skills development.	The LCG is committed to supporting initiatives which offer opportunities to social economy businesses to participate in public procurement of Health and Social Care services.
Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	The LCG will continue to ensure tailored service provision to meet the needs of vulnerable groups. In particular, the LCG is committed to extending support to Travellers through multi-agency collaboration, applying prescribing savings to fund health and social care initiatives to meet the needs of Travellers in the Western area.
LCGs to monitor Trust performance in relation to the HSCB / PHA Community Development strategy	The LCG will continue to monitor Western Trust performance in relation to the HSCB / PHA Community Development strategy.
Implementation of the “Fitter Futures for All Framework”.	The LCG will work with regional colleagues to ensure Western Trust delivers the implementation of *Fitter Futures for All*

	framework
• Implementation of key public health strategies.	The LCG will support PHA colleagues to ensure Western Trust implementation of key public health strategies including: • Tobacco cessation services and BIT in particular for pregnant women and other vulnerable groups; e.g. Looked After Children; • Working towards smoke free campuses and sites; • 7 days services which prioritise individuals presenting to Emergency Departments, acute medical/ surgical admission wards and other settings within the acute sector for identification/ health improvement (screening/ brief intervention), treatment and support for substance misuse and associated mental health; • Trust should continue to support the delivery of emotional wellbeing and suicide prevention strategy including continuing to collect data for attendances at ED related to self-harm and contributing to the development of an improved model of support for those who self-harm. • Specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME

	communities and Travellers. • Supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed memorandum of understanding.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	The LCG is committed to maintaining current sexual health services provided by Western Trust and GPs. In particular, the LCG will ensure the maintenance of sexual health clinics for young people. Moreover the LCG has invested in the continuation of additional Genitourinary Medicine (GUM) services at Altnagelvin and Tyrone County Hospitals, previously piloted with EU funding from CAWT.

10.4.9 POC 9 – Primary Health and Adult Community

Introduction

Opportunities to develop Primary Care services and, in particular, enhanced services provided by General Practice have been evident across the Western area for some years. Western GPs have embraced integrated care pathways and shown considerable commitment in driving down the cost of primary care prescribing enabling a significant release of resources to enable the LCG to commission additional local services. Similarly, Western Trust has working collaboratively with the LCG to improve community nursing services with a view to having in place 24-hour services in coming years and the context of improving Primary Care accommodation in line with *Transforming Your Care* recommendations.

Overview of local needs

Based on GP data, the Western area has below average rates for key long-term conditions except COPD which is among the highest rates in NI. Moreover, based on Census 2011, almost 22% of the population reported they had a long-term condition of whom 78% reported they felt in good or very good health. It is also notable that across those key long-term conditions (asthma, COPD, Diabetes, heart failure and stroke) Western patients had lower than average rates of emergency admissions with heart failure and stroke emergency admissions where the lowest rate across the 5 LCG areas. The West also has slightly lower than average incidence rates for cancer.

Ministerial targets

The LCG is developing effective working relationships with the Western Integrated Care Partnerships and has constructively developed a programme of work which reflects the ICP Clinical Priorities Commissioning Specifications. The LCG recognises considerable progress locally in developing a shared agenda among primary and secondary care and community and voluntary

providers. Involvement of service users and carers is also taking place and will be an important focus for the next year.

During 2013/14, the two ICPs in the Western area have established multi-disciplinary groups to identify the best pathways to care for frail elderly, diabetes, stroke, respiratory service users. The development and implementation of these pathways will be supported by the commissioner in 2014/15 within available resources.

Identification of the patients in these service areas will be achieved by working closely with the General Medical Practitioners and taking a top down, bottom up approach to Risk Stratification. General Practice will be provided with tools and support to extract data from practice systems. This data will be analysed to proactively identify the patients most at risk within these groups, and the information provided back to the individual practices so that they can ensure patients are placed on the appropriate part of the pathway, shifting left. In addition, at local level, practices will continue to develop advanced care planning based on extended practice meetings.

The LCG has set the following objectives for Western ICPs in line with regional commissioning specifications and has received a comprehensive response within the ICP programme proposals:

Care for People with Diabetes

1. ICPs will undertake an education campaign with General Practitioners and Practice Nurses on best practice in diabetes care and proposed integrated care pathways in place to support patient self-management and primary care condition management.
2. ICPs will raise awareness among Primary Care practitioners re. early diagnosis of diabetic ketoacidosis among children leading to a reduction of emergency admissions, ICU care, and shorten lengths of stay.
3. ICPs will give consideration to extending access to insulin pumps among young people and seek to have in place the necessary staff to support new and ongoing patients using pumps.

4. Following the successful CAWT project providing pre-pregnancy support to women with diabetes, ICPs will ensure that Primary Care practitioners are aware of this important service which is likely to be mainstreamed by the commissioner.
5. ICPs will have in place processes for engaging with people with diabetes who are non-compliant, including those who fail to attend for planned condition review.
6. ICPs will ensure the provision of an ongoing programme of courses for adults deemed at risk of developing diabetes in the near future.
7. ICPs will have in place Diabetes Foot Pathway, ensuring resources necessary coordinate this are available and raising GP awareness of its contribution to patient care.

Care for People who are Frail Elderly

1. ICPs, working with Health Improvement Teams, will ensure the provision of a range of targeted health and wellbeing programmes, delivered across the Western area.
2. ICPs will coordinate and lead local initiatives to improve medicine compliance, including linking secondary care and community pharmacy and focusing on compliance among patients in nursing homes.
3. ICPs will improve communication between secondary care and General Practice, including focused work to improve hospital discharge letters to GPs.
4. Working with Western LCG, ICPs will describe current falls services and seeks to have in place an integrated falls prevention pathway.
5. ICPs will bring forward an action plan to put in place a consortium to overcome social isolation among older people living independently, building on the work of community and voluntary organisations and on Flexicare, aimed at measurably reducing social isolation.
6. ICPs will consider the need for additional intermediate care provision in the community, taking account of plans to establish acute care at home services in the context of 24-hour community nursing provision, providing an assessment to the commissioner.

7. ICPs will bring forward plans to extend carers' support services, including respite care, putting in place up to six initiatives.
8. ICPs will consider how carers could benefit from plans to introduce a consortium to deliver Primary Care Talking Therapies collaboratively between GPs, Western HSC Trust and community and voluntary organisations.

Care for People with COPD

1. ICPs will ensure the provision of home oxygen for appropriate patients with COPD in order to maintain home-based care.
2. ICPs will consider enhancing existing Community Respiratory Teams in support of integrated respiratory care pathways.
3. ICPs will bring forward proposals to put in place a pulmonary rehabilitation programme across the Western area to support patients with COPD.
4. ICPs will consider physiotherapy requirement of COPD patients supported by the Respiratory Early Supported Discharge Team and extend the service as required.

Care for People who have had a Stroke

1. ICPs will ensure patients who have had a stroke receive optimal medication to manage their condition in line with the Medicines Management Programme with a process of medicines review in place.
2. ICPs will ensure patients at most risk who have modifiable risk factors for stroke are given lifestyle advice by Primary Care practitioners.

Care for People who are receiving End of Life Care

1. ICPs will extend the GP-based palliative care register to include non-cancer conditions relating to respiratory, diabetes and stroke conditions.
2. ICPs will make available resources to support GPs to coordinate advanced care planning in line with ICP clinical priorities with Practices developing action plans and commencing practice-based palliative care planning meetings with appropriate input from Western Trust professionals.

3. ICPs will seek to build on Western Trust GP Facilitation initiative, providing support to GPs in advance care planning and training on palliative and end of life care.
4. ICPs will give consideration to the role of community pharmacy in supporting palliative care, including urgent response out-of-hours.
5. ICPs will provide advanced communication skills training for relevant Primary Care staff, including General Practice, offering a programme of events across the Western area.

Commissioned services

Western LCG, in line with regional colleagues as appropriate, will continue to commission the provision of a range of Primary Care services in line with *Transforming Your Care* and underpinned by Western Integrated Care Partnerships.

The emergence of Integrated Care Partnerships during 2013/14 has marked an important development in driving the shift of services from secondary to primary care. The LCG had successfully built integrated pathways on its Primary Care Partnerships and has made considerable strides supporting effective patient management in Primary Care through GP direct access to diagnostics (i.e. MRI, CT and ultrasound); application of clinical guidelines; and improved communication between primary and secondary care clinicians. Moreover the LCG has been keen to put in place practical solutions in the face of unnecessary pathways to secondary care, e.g. extending GP minor surgery to patients whose own GP practice did not provide the service. This practical approach has yielded considerable dividends and has been buoyed up by the LCG having additional funding to deploy in light of successful reductions in Primary Care Prescribing following an LCG-led campaign supported by Western GPs.

The LCG has sought to develop community nursing in recent years, investing additional funds in District Nursing and Rapid Response Nursing and initiating work to develop a model of 24-hour community nursing which seeks to prevent hospital admissions and aid timely hospital discharge. The LCG has

also encourage the development of ambulatory care which maximises Rapid Response Nursing capacity through bringing patients to Primary Care centres to receive treatments previously delivered at home. The first centre, opened in Omagh, has proven popular with patients who receive IV infusions, etc in recliner chairs and in the company of other patients with added social benefits.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioner Requirement
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	The LCG will work with regional colleagues and ICPs to ensure relevant Local Enhanced Services are developed with GPs in line with ICP clinical priorities and LCG commissioning requirements.
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing, to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility. A Regional Commissioning Framework for Community Nursing will be developed.	The LCG has sought to develop community nursing in recent years, investing additional funds in District Nursing and Rapid Response Nursing and initiating work to develop a model of 24-hour community nursing which seeks to prevent hospital admissions and aid timely hospital discharge. The LCG has also encouraged the development of ambulatory care which maximises Rapid Response Nursing capacity through bringing patients to Primary Care centres to receive treatments previously delivered at home. The first centre, opened in Omagh, has proven popular with patients who receive IV infusions, etc in recliner chairs and in the company of other patients with added social benefits. Plans for similar centres aligned with planned Primary Care hubs are progressing.

10.5 Other Commissioning Priorities 2014/15 – 2015/16

The LCG remains committed to driving efficiency in HSC in the Western area. An incentivised approach is under way in ensuring GP demand on laboratories is in line with NICE guidelines and the LCG is keen to ensure that the outcome of this project leads to reduction in demand.

The LCG has provided funding to Western Trust during 2013/14 to place centrifuges in each GP practice in the Western area to reduce deterioration of blood tests and prevent unnecessary hospital attendances. Practices will receive training and support and it is anticipated that there will be a reduction in repeat blood tests and unreliable results.

The LCG will seek to extend the successful LCG Extended GP Minor Surgery Scheme to include additional appropriate procedures based on the competence of GP providers.

The LCG continues to seek efficiencies in the cost of prescribing in the West. Following a successful drive to reduce GP prescribing costs, the LCG recognises that other drivers must be addressed, such as secondary care prescribing, dispensing costs, and prescribing in GP out-of-hours. A plan is being developed as part of the Medicines Management Partnership Initiative. This includes further protected time for GPs, a focus on mental health prescribing and up-scaling reviews of medication prescribed to nursing home patients.

The LCG is now responsible for the commissioning of GP Out-of-Hours and will work with Western Urgent Care to ensure it maximises its resources in the delivery of GP services. The LCG recognises opportunities to integrate out-of-hours services, linking GPs, community nursing, social services, etc. and will work with providers to develop plans, drawing on opportunities inherent in the Primary Care Infrastructure programme.

The LCG has developed its programme to take forward the Western Primary Care Infrastructure Programme in line with *Transforming Your Care* recommendations. The LCG programme is overseen by a steering group involving a range of stakeholders, including Western Trust and Local Medical Committee. The LCG will continue to work with local stakeholders to develop combined health and wellbeing hubs which provide the opportunity to provide services as locally as possible, optimising integrated working and support health improvement in areas of greatest need.

11.0 Opportunities & Enablers

There are a range of areas and issues which create opportunities for us to improve how we deliver services to the benefit of service users and carers. These are outlined below.

11.1 Integrated Care Partnerships

Significant progress has been made throughout 2013/14 in the establishment of Integrated Care Partnerships (ICPs) as laid out in the DHSSPS Policy Implementation Framework. Seventeen Integrated Care partnership committees have been established. A number of multidisciplinary task and finish groups have been set up within the ICP structures to review existing pathways for the clinical priority conditions and to design integrated approaches to care and identify opportunities for service improvement. In 2014/15 ICPs will focus on delivering integrated care for the clinical condition areas through the ICP committees.

A clinical leadership development programme is being delivered by the HSC Leadership Centre to enable leaders of ICPs to effectively develop and implement ICP working (see Section 11.4). There will also be a considerable emphasis on carrying out risk stratification activity at primary care level in line with the CPD target that; 'By March 2015, 95% of patients within the four ICP priority areas (frail elderly, diabetes, stroke, respiratory) will have been identified and will be actively managed on the agreed care pathway'. It is envisaged that this risk stratification at primary care level will be delivered via an enhanced service which will allow ICPs to put targeted case management approaches in place for those patients where appropriate interventions can prevent development of or exacerbation of chronic conditions.

11.2 Capital Investment

Key to the effective delivery of reform will be the HSC's ability to invest capital in a range of projects from refurbishing existing hospital and community facilities to developing new infrastructure and investing in new equipment such as ambulances and diagnostic scanners.

A total £247m capital investment is required during 2014/15 to support planned reforms. Table 67 summarises the capital schemes approved for 2014/15 under a number of reform banners. During the period 2015/16 to 2020/21 capital schemes requiring a total expenditure of £1,084m are planned.

Summary of Contractually Committed, Approved and Annual Recurring Capital Costs

Table 67

Banner Heading	**2014/15 Planned Capital Spend** **£m**	**Planned Spend 15/16 – 20/21** **£m**
Hospital and related services	150	362
Children	19	236
Diagnostics	9	2
Home as hub	30	234
ICT	30	220
Mental Health & Learning Disability	5	30
Primary PCI	4	0
TOTAL	**247**	**1,084**

In addition to the projects summarised in Table 67 above there are a number of projects identified by HSCB as being a key enabler to reform. These projects are not yet approved or funding agreed. Planned spend for them would likely commence in 2015/16 or 2016/17.

Hospital & Related Services

Key reform projects within hospital and related services that have been committed to in 2014/15 include the renewal of the ambulance fleet and eleven major building projects; these include the redevelopment of a number of

existing hospital sites (RVH Maternity; the Ulster Hospital; Tyrone County Hospital and Altnagelvin) and the development of a new radiotherapy suite within Altnagelvin.

In addition, the HSCB has identified three hospital infrastructure schemes which would require investment from 2015/16 (one scheme in Craigavon, one in Antrim and Causeway and one at Altnagelvin) and further three requiring investment from 2016/17 (one in Antrim and Causeway, one at Altnagelvin and one at Belfast City Hospital Laboratories). These schemes, totalling £362m, do not yet have DHSSPS approval to proceed and are not included in the costs outlined in Table 67.

Children's Services

Schemes in relation to Children's services that have already been committed during 2014/15 include the development of a new Regional Children's Hospital at the Royal Victoria Hospital site at total cost of £237m (funding of £15m is required for this in 2014/15).

In addition, the following schemes are assessed as essential to support the commissioning agenda in the short to medium term - the development of a Respite Centre for Children with Disabilities within the Northern HSC Trust) and the refurbishment of two children's homes (Glenmona, BHSCT and Ballee, NHSCT). These schemes have not yet been approved for funding, and their costs are not included in Table 67.

Diagnostics

Key projects already committed to within diagnostic services during 2014/15 include the purchase of MRI Scanners for BHSCT, NHSCT and SHSCT and the roll out of Regional Digital Mammography (total cost £9m).

In addition, the HSCB has identified the need to invest in direct access to diagnostics by GPs through further investment in CT and MRI scanner purchases

beyond 2014/15. Capital funding for these scanners has not yet been approved and is not included in the funds identified in Table 67.

Home as the Hub

To facilitate patient care closer to home Primary Care Infrastructure development is essential across the whole of Northern Ireland. £138m of capital investment is planned to support the development of primary care hubs and spokes in the period 2014/15 to 2020/21. These costs are included in Table 67. There is also a planned commitment of £65m of through the provision of loan capital for Primary Care.

In addition, a further £61m may be required to commence a number of projects that would come on line in 2015/16 or 2016/17. This includes the refurbishment of statutory residential homes across the province. Confirmation of this requirement will be made following completion of the 'Making Choices' consultation.

Information and Communication Technologies (ICT)

Key capital priorities within ICT already committed to during 2014/15 include the roll out of Electronic Care Records, implementation of E-prescribing and employee hardware updates.

Mental Health & Learning Disability

A key part of the mental health reform programme is the development of new mental health inpatient facilities. Three schemes have already been committed to (Gransha in WHSCT, Bluestone in SHSCT and a further one at BCH).

Three further units in SET, NHSCT and a second facility in WHSCT are HSCB priority areas for investment to fulfil the reform programme but do not have DHSSPS approval to proceed at the time of writing. These three units would require further capital investment (over and above that stated in Table 67) in the region of £100m over the period 2015/16 to 2020/21.

Finally there are two projects, considered to be priority areas for investment by the HSCB, but which would not come on line until 2016/17. These are a Mental Health Inpatient Addictions unit in SEHSCT and a new Adult Centre in NHSCT with associated total costs of £8m. At the time of writing they do not have DHSSPS approval to proceed and are excluded from the figures included in Table 67.

Percutaneous Coronary Intervention (PCI)
2014/15 will see the completion of expansion works to two Catheterisation Laboratories, one in BHSCT and one in WHSCT, with no further capital requirement beyond this year.

11.3 Cross-sector collaboration

The pressures and evolving nature of our HSC system mean that we must seek to continually challenge and improve our ways of working. Effective partnership working has always been a critical part of effective commissioning, but never more so than now, as we plan and implement the recommendations arising from *Transforming Your Care.* The development of more responsive and innovative models of care, closer to people's homes requires effective collaboration across statutory, independent and voluntary and community practitioners and organisations. ICPs provide a valuable mechanism for this cross sector and cross care settings collaboration and innovation to take place. The HSCB and PHA are committed to reflecting this same approach in relation to the commissioning of services.

11.4 Personal and Public Involvement

The HSCB and PHA recognise that Personal and Public Involvement (PPI) is core to the effective and efficient commissioning, design, delivery and evaluation of Health and Social Care services. PPI is about the active and meaningful involvement of service users, carers and the public in those processes. PPI operates at different levels, from information provision through to joint decision making. It is underpinned by a set of values and principles (PPI Circular HSC (SQSD) 29/07) and at its' core it is about changing culture and improving quality.

The legislative requirements for Health and Social Care organisations in regard to PPI are outlined within the HSC (Reform) NI Act 2009. Departmental Guidance issued in 2007 and further updated in 2012, details the value and benefits to be accrued from effective PPI, and outlines roles and responsibilities of Health and Social Care organisations in this regard. The concept of Involvement is also regarded as a Ministerial Priority.

As Commissioners, we are committed to embedding PPI into our culture and practice. To this end, all commissioning teams and Local Commissioning Groups actively consider PPI in all aspects of their work, from ensuring that input and feedback from service users and carers underpins the identification of their commissioning priorities, to involving service users and carers in the development of service models and service planning, and in the evaluation and monitoring of service changes or improvements. There are many examples of good practice:-

- Lifeline is a project led by the PHA to provide crisis support to people who are at risk of suicide. Service users and carers have been recruited to sit on the Lifeline Clinical and Social Care Governance Group contributing to their decision making process.
- Integrated Care Partnerships (ICPs) - recruitment of service users and carers has been undertaken. A minimum of two service users will be actively involved on the partnership committees and the working groups.
- Children and Young Peoples Strategic Partnership (CYPSP) 40 young people involved in the design and content of new web pages for CYPSP web site, P6 and P7 school children involved in making a DVD explaining in their words about CYPSP and how it helps children and young people. The Northern Outcomes Group has over the past 18 months involved over 1200 young people in the planning process.
- Promoting the Needs of Looked After Children through the active participation of young people and carers of looked after young people, in the development of a personal health journal called “About Me” which has helped to shape the development of services.

- Personalisation – Service users and carers have told us they want more control of who, how, when their services are delivered. Self - Directed Support (SDS) and Direct Payments are the main vehicles to enable this to happen. Both the SDS Programme Board and the direct payments working groups have service users and carers actively promoting and advancing the individualisation agenda.
- NI Formulary Pharmacy and Medicines Management - The HSCB has run a series of public workshops in relation to medicines. Feedback from service users and carers has shaped the production of a number of patient leaflets aimed at improving medicines safety and compliance and reducing waste: Your Child's Medicines; Medication Reviews; Your Medicines – Your Responsibility (adult); Your Medicines (partners in care).

However, we also acknowledge that there are still areas where we can strengthen what we do. In this context the PHA and HSCB are currently implementing a joint PPI Strategy (produced in 2012 and aligned to the aims of the Regional Health and Social Care PPI Forum). Delivery of our complementary PPI action plans is underway, with opportunities for joint working between the two organisations being taken forward through our Joint Implementation Group.

Increasing our capacity to engage with service users, carers and the public
In its capacity as regional lead for PPI for the HSC, the PHA has secured Ministerial permission to commission the design and development of a PPI awareness raising and training programme for all HSC staff. We will be working with service users and carers as part of this initiative and aim to have it completed in 2014.

The PHA has also, since 2010/11, committed almost £350,000 to initiatives which aim to advance and promote PPI across the HSC. After evaluation, best practice is identified and shared across the HSC, with a view to embedding it into normal culture and practice.

As individual organisations the HSCB and PHA are fully committed to involving its staff, service user, carers and the wider public, in the commissioning process and recognise that staff may need additional skills to engage with service users and carers in a meaningful and productive way. In an attempt to do this, the HSCB and PHA have made significant recurrent investment in training initiatives for staff and service users, including the Involving People Programme (an in-depth PPI and community development training programme) and an E-Learning programme for PPI. This investment in training will continue in 2014/15.

Both organisations have also established groups of staff across the respective Directorates who act as leads for PPI, helping to embed the concept and practice of Involvement into our ethos. In May 2013, the HSCB group held an event to allow service users and carers who have been involved in service planning with the HSCB to share with the senior management team their experiences of that involvement. The event, attended by around 80 service users and carers has resulted in the HSCB making six commitments aimed at improving the experience of involvement. These ranged from simple measures, such a producing a simplified form and guidance to make it easier for service users and carers to claim back expenses (now completed) to a commitment to using plain English in all its communications (a new communications policy is due to be issued in January 2014 and the HSCB is looking at options around provision of plain English training for staff [DN update prior to publication]).

Involving service users and carers in the development of standards and mechanisms for monitoring and evaluation

The PHA working with HSC partners through the Regional PPI Forum, has developed a set of Indicative Standards and Key Performance Indicators for PPI. These have been considered by the DHSSPS and subsequently endorsed by them as policy leads. These initial process based standards, will be followed by the development of more outcome focussed standards in 2014/15.

The PHA and HSCB will continue to work collaboratively to take forward the development of arrangements for the monitoring and evaluation of progress in

PPI. Service users and carers played a major part in the design of the pilot arrangements that were introduced with Trusts in terms of PPI monitoring in late 2013. They will be instrumental in evaluating the pilot and in further developing these monitoring arrangements for Involvement as we move forward. The learning from this will be key to informing the development and operation of performance management arrangements, which look at how well we are discharging our responsibilities in relation to PPI.

We will also continue to work collectively across related areas such as patient experience, safety, advocacy, complaints and community development and in partnership with other HSC organisations including the PCC, to share learning and insights, to improve processes and systems and most importantly, to improve outcomes for service users and carers.

11.5 Clinical engagement

The ability to influence, manage and drive change in health care to achieve improved health outcomes is central to the transformational change envisaged in TYC. Change is a constant in today's unpredictable and dynamic health care work environment and the barriers to implementation of health service change can at times seem too great to overcome. The development of ICPs places clinicians at the centre of that change.

The Transformation Programme Board, recognising this challenge, have commissioned a Leadership Support Programme aimed at developing the leadership skills of clinicians leading change within ICPs. The programme, which commenced in November 2013, runs through to September 2014 and provides support to GPs, community pharmacy leads and to a group of hospital consultants who are working with ICPs to deliver integration and transformation. It provides four modules over 7 days:

- Personal Effectiveness Module
- Leading Integrated Care Partnerships Module
- Engaging Leadership Skills Workshop
- Personal Leadership, Presence and Impact Module

HSCB would envisage the development of clinical networking through ICPs as a real opportunity for these inspirational leaders to grow and support each other. ICPs, through the united goal of improving health outcomes through evidence informed approaches to care delivery will facilitate and nurture this engagement.

11.6 eHealth & Care and External Collaboration

11.6.1 Introduction

The World Health Organisation defines eHealth as follows:
'eHealth is the use of information and communication technologies (ICT) for health.'

N Ireland has the particular advantage of integrated health and social care, and the descriptor has therefore been extended to include social care. This broad definition encompasses all aspects of technology and information management, including remote telecommunications to support patients and clients. Following the appointment of a Director of eHealth and External Collaboration, DHSSPS have agreed the need to devise a new 5-year strategy for eHealth & Care. The development of the strategy is being led by the HSCB and PHA, supported by other HSC organisations.

In progressing external collaboration, the objective of engaging with Europe and further afield is to secure support for the adoption of best practice and the development of innovative solutions to meet our current service challenges. In addition to these benefits, in pursuing EU engagement the HSC should aim to attract additional funding from European competitive funding streams. The strategies to be pursued are set out in Transforming Your Care (TYC), Quality 2020, and other regional policies and strategies; these strategies are broadly consistent with key EU strategies including the European Innovation Partnership for Active & Healthy Ageing. The HSCB and PHA will support the development of partnerships across Europe, and promote an integrated response from the HSC in NI to maximise the opportunity for success in bidding, and the impact of those

successes by promoting alignment with the agenda set out in TYC and Quality 2020.

11.6.2 eHealth & Care and External Collaboration - Priorities 2014/15

There are five key priorities areas to be taken forward during 2014/15 which will carry forward into 2015/16.

1. Implementation of the eHealth Strategy.
2. Electronic care records.
3. Electronic care communications.
4. Development of Telemonitoring NI.
5. Implementation of the priorities within the Connected Health and Prosperity Memorandum of Understanding.

Detail regarding each of these priorities is provided below. The ICT Programme Board is currently reviewing its priorities so the information below may be subject to amendment.

1. Implementation of eHealth Strategy

The development of the strategy is underway, and is due for completion by June 2014, with implementation commencing in 2014/15. The strategy will outline the substantial role that eHealth & Care can play in supporting the transformation of service delivery and quality improvement agendas set out in Transforming Your Care, Quality 2020, and other regional strategies and policies. Amongst other aspects, the strategy will address the leadership and governance arrangements needed to ensure that the potential benefits of eHealth and Care investment may be fully realized. The implementation of the strategy will require significant associated revenue support.

Work to date on engaging stakeholders in the development of the eHealth & Care strategy highlights that across Northern Ireland there are many examples of excellent, innovative practice in the eHealth & Care sector, however much remains to be done in terms of making such initiatives available ubiquitously. Progressing these developments provide a pathway for improvement across the

HSC in N Ireland. The following paragraphs highlight the major new projects already underway or planned to start during 2014-2015, under the headings of Electronic Care Records and Electronic Care Communications.

2. Electronic Care Records

The Electronic Care Record (ECR) is now live in all Trusts. During 2014/2015 we will continue the rollout of the ECRsolution across the HSCNI exploiting opportunities to better co-ordinate patient care. The ECR Clinical Content Group will continue to prioritise data from other systems on an ongoing basis including summary Community Information System data, for inclusion in the ECR. Community summary information will be available in the ECR from Soscare, LCID (Nothern and South Eastern Trusts) and from the Belfast instance pf PARIS by the end 2014/2015. The ECR is now available to clinicians working in the newly formed Integrated Care Partnerships and will provide new functionality to assist with care planning.

The implementation of Bed Management and Patient flow systems in Trusts is underway and will be further rolled out during 2014/15. Information to support End of Life care will be enhanced with the development of a Key Information Summary (KIS) populated for selected patients with data extracted from GP systems. Rollout of KIS will begin in 2014/2015 and will be fully implemented by the end 2015/2016.

Significant resources will be made available to provide care information at the point of care in both Acute and Community settings through the use of mobile technology. This will involve investment in both the wired and wireless network infrastructure, also in technology to ensure that mobile devices are both secure and easy to use. Mobile devices to support staff working by in the community staff will be important in delivering the “shift left” agenda and will allow better use of staff resources.

The deployment of mobile devices will continue during 2014/2015 and 2015/2016.

The regional Medicines Management initiative will complete a business case to initiate the procurement of a HSCNI system to introduce ICT support for electronic prescribing and drugs administration in hospitals. The Business Case for this system will be developed during 2014/2015 and a procurement initiated. A system will be procured during 2015/2016 and implementation will commence in 2015/2016. A website to support the N. Ireland formulary has now been developed and will go live early in 2014. The new RISOH system will be implemented in all Trusts by the end of 2014/15. These initiatives will support safer and more effective prescribing.

The implementation of Community Information Systems (CIS) will continue with BHSCT completing the implementation of PARIS, by the end of 2014/2015, the SHSCT continuing with its rollout of PARIS, and the WHSCT commencing the implementation of PARIS during 2014/2015 with an expected 3 year rollout. The Northern and South-Eastern Trust have built modern community information systems through investment in legacy systems, and during 2014/2015 will bring forward a business case that considers the further development of these systems and alternatives, to deliver a Community ECR.

An enhanced data quality tool will be delivered by the end of 2014/2015 to support the Data Quality Dispute Network allowing faster and more accurate resolution of data quality issues in the HSC

Work will continue to enhance the HSCNI single Master Patient Index, and a business case will be developed to replace the Health + Care Number Index during 2014/2015.

A project to review options for replacement of the existing PAS systems will commence during 2014.

3. Electronic Care Communications

A project has been established to develop a HSC Web Portal to provide a HSC-equivalent of the NHS Choices website for England. The Web Portal will provide comprehensive information on symptoms, possible diagnoses, investigations, treatment and services. It will enable people to self-treat minor conditions and manage long term conditions more effectively. A Business Case for this development will be developed during 2014/2015.

The Electronic Referrals project has now developed the capability of this system to support electronic requests for advice. The HSCB and BSO will continue to work with GP practices and other practitioners to increase the use the electronic referrals system. The HSCB will fund further developments in this area to improve referrals workflow required to triage referrals. These developments will be trialled by the NHSCT during 2014/2015 with regional rollout complete by the end of 2015/2016.

Implementation of a new Primary Care ICT network will commence in early 2014/2015 providing higher bandwidth to GP Practices and will introduce wireless network access to staff working in and from GP practices. Further scoping will be undertaken during 2014/2015 to determine the most appropriate technical architecture to allow community pharmacists, optometrists, and dentists to the HSC network. An interim solution will be in place by the end of 2014These developments will support initiatives such as Project Echo and Developing Eyecare Partnerships.

In order to facilitate the faster transfer of documents such as Discharge Letters, the HSCB will fund a project to implement an ICT solution that will manage the electronic transfer of these documents. The technical work ill be complete by the end of 2014 with full rollout by the end of 2015.

Telemonitoring NI already incorporates a patient portal which enables patients to view and keep a track of their vital sign data. During 2014/15, this concept will be extended to enable, on a pilot basis, a small number of patients to have

access to their own records held on the ECR. This pilot will help inform future developments in this area.

The Directorate of Integrated Care will complete the business case for the DQiP project in 2014/15 and will initiate a project to procure the necessary ICT tools and support. The Data Warehouse will continue to be developed in line with the priorities set by the Regional Information Group (RIG).

Many of the above initiatives will contribute to removal of paper from care communications. A pilot Electronic Document Management project in the Western Trust is currently being evaluated and the lessons learned from this pilot project help inform any future developments in this area.

4. Expansion of Telemonitoring NI

Since commencement of the service in December 2011, 2609 patients (as at 30th Nov 2013) have been referred to the service, across the different condition groups such as heart failure, COPD, diabetes, post-stroke management. During 2013/14, healthcare professionals expanded the use of Telemonitoring NI to weight management as well as management of renal disease. Telecare services which can be used to manage and reduce risk for people in their own homes, has also been deployed across all the 5 Trusts. Individual targets for service levels and priorities for 2014/15 are set out at section 10.

5. Connected Health & Prosperity – Memorandum of Understanding between DHSSPSNI and Invest NI.

During 2012, a memorandum of understanding between DHSSPS and Invest NI highlighting the potential for growth in Life and Health Sciences to support NI's economic strategy, including the potential for jobs growth. The implementation plan has four key priorities:

- Priority Area 1 - Targeted Connected Health R&D and innovation funding, including optimising assets across the various organisations

- Priority Area 2 – The development of the NI Connected Health Eco System, along with international linkages
- Priority Area 3 - Collaboration with international regions, particularly within Europe and North America, for mutual gain
- Priority Area 4 – Promoting the Connected Health agenda internationally, particularly within Europe and North America

Priority Area 1

A core funding source in relation to Priority Area 1 is the European Commission (EC), through Horizon 2020, AAL, Health for Growth and other funding programmes. Success in this arena requires investment in reputation building, and in the development of active partnerships with partners across Europe, reflecting the requirement for collaborative working to achieve success in EC competitive bidding calls. See commentary under Priority 4 below.

Priority Area 2

The NI Connected Health Ecosystem has been strongly supported from right across the HSC, this forum has strong support from academia and industry.

Priority Area 3

The eHealth and Connected Health teams within HSCB and PHA have worked alongside DHSSPS to develop and support collaboration for care improvement with international partners. Formal memoranda of understanding are now in place with Basque Country, and with Oulu, Finland. Similar commitments are under discussion with Catalonia and Galicia. These partnerships will support collaboration on improvement work that will include application for EU funds during 2014 in response to calls from the EU.

Priority Area 4

Northern Ireland achieved accreditation as a 3* reference site as part of the European Innovation Partnership (EIP), on Active and healthy ageing (AHA) in September. Most recently, public reference to achievements in NI by European Commissioners for DG Sanco (Health) and for DG Connect (IT) reinforced this.

There has been some early success that has seen NI draw down funds for EU funded 'integration' projects.

The investment in awareness of NI achievements in the European Commission has been led by the Minister, supported by the Permanent Secretary, and by Ministerial colleagues, by OFMDFM, and by the Dept for Enterprise Trade and Investment (DETI), through Invest NI. The Horizon 2020 programme will be launched in January 2014; additional intelligence on 'competitive calls' is beginning to emerge. Other funding opportunities including the Health programme and 'Interreg 5' will launch in the first half of 2014.

During 2013/14, a work programme with the New York Department of Health on interoperability of health records is under discussion, with a view to capitalizing on NI's progress on the ECR, and to act as an exemplar for EU – US agreed strategic objective of improving interoperability across the two domains. This work will continue during 2014/2015.

In addition to these projects, teams from across the HSC have supported the work streams that arose from the Economy: Task & Finish report, which reports to the Connected Health & Prosperity Board.

By June2014, an External Collaboration engagement workplan will be submitted to the Boards of the HSCB and PHA, setting out the work ahead, the investment required to deliver on this agenda, and the expected benefits. The workplan will include activities in 2014/15/16 that should support each of the above-mentioned Priority Areas, shared learning from current EU projects for future funding opportunities, future cross-border initiatives and implementation of Task and Finish Group report for example progressing work on International Health Analytics Centre (IHAC).

11.7 Workforce Planning & Development

This Commissioning Plan and the transformation and reform agenda it sets out will reshape our service provision across health and social care over the coming

years. It is recognised that this will have implications for our workforce – and we are committed to supporting and enabling our workforce to take forward transformation and new ways of working. We need to ensure that we have the rights skills in the right place to deliver our services.

Three of the 99 TYC recommendations relate directly to workforce:

- Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated, and at home or close to home.
- More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.
- Re-allocation of resources estimated to equate to a 5% shift of funds from hospitals into the community.

In addition, the Francis Report made specific recommendations impacting on workforce:

- Enhancing recruitment, education, training and support for all the key contributors to healthcare, in particular nursing and leadership positions
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for patients, the public and stakeholders in the system

HSCB and PHA are taking forward a number of initiatives and strands of work to support our workforce:

Integrated Service and Workforce Planning

In order to meet the challenge of workforce/service remodelling the HSCB, in conjunction with the DHSSPS and the Trusts through Regional Workforce Planning Group, are taking forward a project to procure a regional workforce/service planning tool which can triangulate finance, activity (service) and workforce data to support service planning.

Capability Development Initiatives to support the implementation of TYC

The HSCB will invest in a range development initiatives designed to increase the wider HSC's capacity and capability to deliver the transformation agenda. These include:

- A Leadership Development programme for those leading TYC or transformation initiatives
- Change Management and core skills programme for those involved in TYC or transformation projects
- Leadership development and Effective Partnership Working and core skills programmes for those on Integrated Care Partnership Committees, or those supporting their successful operation
- The establishment of a Knowledge Exchange open to all those involved in the design, commission or provision of health and social care services across N Ireland

Profession specific workforce planning and development

Each of the key professions is looking at their workforce planning and development including the impact of the transformation agenda set out in TYC and the Commissioning Plan. This includes:

- the introduction of normative staffing levels in nursing as set out in the Commissioning Plan Direction;
- investment in nursing and midwifery re-skilling and development to support the shift into more community / primary care settings;
- increased introduction of 7 day working practices; and
- the establishment of a medical workforce planning sub-group to develop a suite of medical workforce plans for primary and secondary care for the 5-year period 2013/14 to 2018/19, taking into account increased 7 day working. This will include an incremental assessment of each sub-speciality to quantify current staffing levels by grade, and anticipated flows into and out of the specialty to 2018/19, and model future workforce needs.

11.8 Equality Good Relations & Human Rights

Promoting equality and equity are at the heart of the HSCB's and PHA's values – ensuring that both organisations exercise fairness in all that they do and that no community or group is left behind in the improvements that will be made to health outcomes across N Ireland.

We recognise that to deliver equality we need to understand diversity and that diversity exists even within and between equality groups. We believe that it is important that decisions are informed by human rights standards and principles with attention to those areas of commissioning that have a higher risk of raising human rights issues such as older people, mental health and children.

To support this work the HSCB/PHA has published our Equality Scheme and our Audit of Inequalities Action Plan, both of which are intended to promote and disseminate an understanding of what we need to do corporately and as a commissioning organisation to better address inequalities in outcomes and access to services.

The Inequalities Action plan makes a number of commitments which are aimed at reducing inequalities. These include:

- Production of an information policy which will ensure that any communications issued by the HSCB can be accessed by all 9 equality groups.
- Maintaining and developing staff awareness, skills and confidence in relation to Section 75 equality duties.
- Looking at ways to expand our information base in relation to equality groups / issues – This has involved a review of all information systems within the HSCB and has resulted in additional information fields which relate to the 9 equality groups being added to a number of information systems including.
- Mainstreaming equality within commissioning – as part of this process a number of commissioning teams have identified specific inequalities actions. These range from trying to improve the information base within

their area of work to delivery of services which aim to target known inequalities. Some examples include:

- The maternity and child health team is currently undertaking a scoping exercise to determine the experience and issues of mothers from outside the UK who have given birth in N Ireland.
- Educational outcomes are known to be poorer for Looked After Children (LAC) than for the general population. HSCB is currently working with the Education sector to ensure that all LAC receive a Personal Education Plan. These plans are designed to establish clear targets and actions to respond effectively to each child's needs and provide a continuous record of their achievements with the aim of improving educational outcomes.
- Health outcomes are generally known to be poorer for people with a learning disability. Annual health checks have been shown to be an effective way of improving health outcomes in this group Last year the HCSB commissioned a Local Enhanced Service to provide annual health checks for people with a learning disability. This LES has been successfully evaluated and is being extended in 2014/15.

One of the other ways we can seek to enhance the impact of our commissioning on people and communities, including those living in disadvantaged areas and population groups who require additional or more specific support such as Travellers, migrants, Lesbian, Gay, Bisexual and Transgender (LGBT), Looked After Children, those with Disability, and Homeless people, is by engaging and promoting supportive and sustainable communities. The health promotion and prevention approach utilised by the PHA is underpinned partnership models which include the active engagement of those most affected alongside other agencies that can influence the determinants of health. Similarly, LCGs, seek to engage directly with communities in the identification of their health needs, working in partnership with the community to address them.

We have also embedded equality and diversity and human rights into the mainstream commissioning cycle. This is to ensure that, in the developmental

stage, commissioning decisions are informed by an explicit consideration of the needs, experiences of, and impacts on, those across the 9 categories protected by the equality duties.

An equality screening template detailing the overarching screening outcomes and the screening outcomes from each service team area accompanies this Commissioning Plan, which can be found on the HSCB website (www.hscboard.hscni.net/publications/Commissioning%20Plans). It is also published as part of the HSCB's screening outcome report as is required as part of the equality duties. In addition, you will note the each of the POC sections highlights those decisions where we intend to undertake a screening or EQIA during 2014/15.

The HSCB and PHA will continue to work internally, and in partnership with colleagues within the DHSS&PS, to ensure that advancing equality and diversity is central to how we conduct our business as an organisation.

11.9 Primary Care Infrastructure

In 2011/12 the Minister has indicated that he wishes to invest in the development of the primary and community care infrastructure as part of the strategy for improving the overall health and well-being of the community and for improving the delivery of integrated primary, community and secondary care services.

Primary and community care is considered to be the appropriate setting to meet up to 90-95% of all health and social service's needs. The services and resources available within primary and community care have the potential to prevent the development of conditions which might later require hospitalisation. They can also facilitate earlier discharge from hospital and in many instances assist with the management of conditions and provide appropriate support to prevent hospitalisation.

The development, therefore, of an integrated primary and community care service that is closely linked with secondary care provision could lead to better outcomes, improved health status and improved cost effectiveness.

It is anticipated that a hub and spoke model would be most effective in delivering a full range of services locally. Each hub would be a 'one stop shop' for a wide range of services including GP and Trust led primary care services. Larger centres should, where appropriate, also act as the 'local hub' for a network of services that could include GPs, community pharmacy, general dental services, or ophthalmic services.

Each spoke would have a defined level of services, depending on economies of scale, and will draw on the services of the hub as required. Each spoke will as a minimum contain GP services.
This model is intended to be the basis upon which Trusts, in conjunction with Local Commissioning Groups (LCGs,) can structure the local delivery of services to reflect the requirements of each area's hubs/spokes and best meet the needs of the population. This will include agreement on the appropriate physical infrastructure and its configuration required for the delivery of services.

The details of the model will vary in each area, depending on how best the existing infrastructure and service model can be augmented. While it may not be appropriate or possible to have all the services listed below in each facility, they form the basis of a model which will maximise the range of services and improve access to, and responsiveness of, primary and community care services, particularly making available more specialised services nearer to where people live and work. This includes provision of an enhanced diagnostic and treatment capability where appropriate. The proposed service model may include some or all of the services outlined in the table below.

The proposed hub and spoke configuration will also create opportunities for the wider independent contractor network (GPs, dentists, pharmacists etc), supporting practitioners to work collectively through appropriate linkages, with

access to community services provided in shared facilities. This approach should create the opportunity for greater efficiencies within integrated care pathways.

Over the coming years there will be a need for significant investment in primary care infrastructure to ensure that the physical capacity required to deliver the service model and the changes in the patterns of delivery, can be facilitated.

List of services which might be provided through hubs and spokes

Nurse Treatment	Parenting Support
Speech and Language Therapy	Diagnostics
Health & Well Being	Podiatry
Dental Services	Family and Childcare
District Nursing	Pharmaceutical Services
Social Work	Point of Care Testing
Long-term Condition Clinics	Family planning
Physiotherapy	Minor Injuries
Health Visiting	Advocacy
Services for Older People	Dietetics
Maternity Services	Sports Injury
Paediatrics	Mental Health
Occupational Therapy	GPs
Urgent Care	Audiology
Bookable Clinical Rooms	ECG
Out of Hours	Counselling
Minor Surgical Procedures	Population Screening Programmes
"Special Interest" Clinics	Community Space
Integrated Clinical Assessment and Treatment Services (ICATS).	Commercial Activities

During 2013/14 there has been significant progress in identifying the most appropriate configuration of hubs and spoke to deliver improved services to patients and support the 'shift left'. Work on the first 5 hubs commenced in

2013/14. Three schemes are in construction Banbridge, Ballymena and Omagh and two further schemes, at Lisburn and Newry, are in the procurement phase.

There are also 35 spokes associated with the 5 hubs and work commenced in 2013/14 on identifying their requirements in terms of their physical capacity and future ability to deliver services to patients.

During 2014/15 the key priorities are as follows:

- LCGs/Trusts and GPs should agree the hub and spoke configuration for each area
- LCGs/Trusts and GPs should agree the priority for implementation of each of the hubs within their area taking account of the shift left of services and how the reduced demand for hospital beds will impact on the commissioning of new facilities and the decommissioning of others
- Develop details of the impact of the proposed hub and spoke configuration on the commissioning of services and the existing delivery model.

Appendix 1 – Programme of Care Definitions

Acute Services (POC 1)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in an acute specialty. It also includes all activity, and resources used, by a hospital consultant in an acute specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

Acute specialties are all hospital specialties with the exception of the following (specialty codes in brackets); Geriatric Medicine (430), Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), GP Maternity (610) and mental health specialties (710 to 715).

Maternity and Child Health (POC 2)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), and GP Maternity (610). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts by any health professional where the primary reason for the contact was maternity or child health reasons. All community contacts to children under 16 are included as long as the contact was not in relation to mental health, learning disability or physical and sensory disability.

Family and Child Care (POC 3)
This programme is mainly concerned with activity and resources relating to the provision of social services support for families and/or children. This includes

Children in Care; Child Protection; Child Abuse; Adoption; Fostering; Day Care; Women's Hostels/Shelters and Family Centres. This is not a definitive list of the type of support which may be offered under this programme. This programme includes community contacts by any health professional where the primary reason for the contact is because of family or child care issues.

Elderly Care (POC 4)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Geriatric Medicine (430), Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts with those aged 65 and over except where the reason for the contact was because of mental illness or learning disability. All community contacts where the reason for the contact was dementia are also included, regardless of the patient's age, as well as all work relating to homes for the elderly, including those for the Elderly Mentally Infirm.

Mental Health (POC 5)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Mental Illness (710), Child & Adolescent Psychiatry (711), Forensic Psychiatry (712) and Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to mental health. If the reason for contact is that

the patient has dementia, the activity is allocated to the Elderly Care programme of care.

Learning Disability (POC 6)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in the Learning Disability specialty (710). It also includes all activity, and resources used, by a hospital consultant in this specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to learning disability. All community contacts with Down's Syndrome patients who develop dementia, for any dementia related care or treatment are included as are all contacts in learning disability homes and units.

Physical and Sensory Disability (POC 7)
This programme includes all community contacts by any health professional where the primary reason for the contact is physical and/or sensory disability. All patients and clients aged 65 and over are excluded. These contacts should be allocated to the Elderly Care programme.

Health Promotion and Disease Prevention (POC 8)
This programme includes all community and GP based activity relating to health promotion and disease prevention. This includes all screening, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisation and community dental screening and prevention work.

Primary Health and Adult Community (POC 9)
This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic

Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability.

Appendix 2 – Quality Assurance Framework 2014/15

The PHA and HSCB have a duty under Article 34 of the Health and Personal Social Services (Quality Improvement and Regulation) (N Ireland) Order 2003 to establish and maintain arrangements for the purpose of monitoring and improving the quality of the Health and Personal Social Services provided to individuals, and the environment in which services are provided. Information and intelligence is received from a wide range of sources in relation to safety, quality and patient experience and the HSCB and PHA have established an overarching Quality Safety Experience group to strengthen existing arrangements. Consideration will be given to learning identified through existing arrangements for SAI's, Complaints, Patient Experience and medicines safety and agree appropriate actions and follow-up arrangements.

The PHA and HSCB have in place a comprehensive Quality Assurance Programme which encompasses the following priorities:

(1) Quality Improvement Plans

In line with Commissioning requirements, Health and Social Care Trusts are required to submit for approval their Quality Improvement Plan (QIP). The plan focuses on those key priority areas that lead to improved quality in services and better outcomes for patients and clients through the provision of safe, effective and sustainable services. It will take account of quality improvement indicators and priorities required by the Commissioner in response to DHSSPS Commissioning Plan Direction. HSC Trusts are required to submit quarterly progress updates to the PHA which should include local quality improvement priorities in addition to the core commissioning requirements.

The core commissioning quality improvement plan priorities for 2014/15 are:

(i) Reduction of Harm from Falls in Hospital:

- Trusts will continue, in pilot areas, to improve compliance with Part B of the "Fallsafe" Bundle.

- Trusts will spread Part A of the "Fallsafe" Bundle and demonstrate an increase each quarter in the % of adult impatient ward/areas in which "Fallsafe" Bundle has been implemented.

PHA will monitor:

- compliance with Part A and B in pilot and spread areas
- % of all adult wards in which the "Fallsafe" Bundle has been implemented
- total number of falls and the number of these causing moderate or more severe harm
- rate of falls per 1000 occupied bed days

(ii) Pressure Ulcers: By March 2015 all Trusts will secure a 10% reduction in pressure ulcers. PHA will monitor:

- sustained spread of the SKIN Bundle to all adult inpatient areas / wards
- 95% compliance with SKIN bundle
- the rate of pressure ulcers per 1,000 occupied bed days

(iii) Preventing harm from Venous Thromboembolism (VTE): Trusts will achieve 95% compliance with VTE risk assessment across all adult inpatient hospital wards by March 2015

(iv) Sepsis6: The HSC Safety Forum will work with Trusts to implement and spread Quality Improvement in the Early Management of Sepsis (e.g. use of the Sepsis6) in medical assessment units (or in other pilot wards by agreement) by March 2015.

(2) Patient and Client Experience: Implementing the Standards

The DHSSPS Patient Client Standards highlights that patients are entitled to be treated with compassion, dignity and respect throughout their entire experience. The HSCB / PHA will work collaboratively with Trusts to undertake a comprehensive programme to engage patients and ensure that service improvements are patient focused; including the implementation of the regional

priorities identified in the PHA annual report (2012/13) on the Patient Experience Standards.

During 2014/15 the Patient and Client Experience Steering Group will provide strategic direction for the implementation of the DHSSPS Patient and Client Experience Standards and agree the annual work plan which will include the following:

- The PHA, in liaison with the HSCB and HSC Trusts will assist the DHSSPS to deliver a regional survey of inpatient and A&E patient experience during 2014/15, in order to baseline the position and put in place a programme of work to secure improvement.
- Trusts will be required to submit quarterly monitoring reports and detailed action plans to the PHA for approval on regionally agreed areas.
- In the final quarter of 2014/15, i.e. January-March 2015, Trusts will be required to undertake an evaluation of improvements achieved throughout the year and identify priorities for the following year. Reports on progress will be submitted to the DHSSPS and Boards of PHA/HSCB bi-annually.
- Through 2014/15 a planned programme of work will continue for the independent collection of patient stories. Each HSC Trust will continue to collect patient stories using an agreed methodology.
- The PHA will continue to lead the experience led commissioning project: **10,000 Voices** to shape and influence commissioning. The focus during 2014/15 will be to respond to some of the issues raised by Phase 1 of the project which focused on unscheduled care and nursing key performance indicators and to commence Phase 2, which will focus on patient experience of primary care and nursing key performance indicators.
- By March 2015 the PHA will work with HSC Trusts to establish a baseline of the number of wards where patients are cared for in Mixed Gender Accommodation. The PHA will develop regional guidance, definitions and work with HSC Trusts to implement and sustain improvements.

- The PHA will develop a schedule for monthly monitoring of Vacant Nursing Posts (registered and unregistered) within the HSC Trusts which will inform workforce planning.
- 'Promoting Good Nutrition Guidance' has been published in 2013 and The PHA will work in partnership with HSC Trusts to ensure that all * patients, in adult in-patient wards have nutritional screening. (* see Promoting Good Nutrition Guidance 2013 for groups of patients exempt from MUST screening)

(3) The HSC Safety Forum

During 2014/15, the Patient Safety Forum will develop a comprehensive work plan to provide mutually agreed support to providers to include the following:

- Promoting the concepts and clinical practices which underpin Normalising Childbirth in line with the 2012 Regional Maternity Strategy through a regional Maternity Quality Improvement collaborative
- A regional approach to improving the care of the deteriorating adult patient – to consolidate use of NEWS including Trust plan for audit of appropriate escalation.
- To continue the regional collaborative in Emergency Medicine, building on the agreed quality indicators and extending the work to promote enhanced patient flow.
- To continue the regional collaborative in Nursing Homes, sustaining the progress on falls prevention and spreading this across the system. Also to promote improvement in other areas of practice as identified in the themes for inspection by RQIA (Jan –Feb 2014)
- To facilitate a regional Quality Improvement collaborative for Mental Health following agreement from the Mental Health Advisory Group, on key areas of focus for improvement. Initial areas currently under discussion include crisis management and physical health.
- To facilitate a regional Quality Improvement Collaborative for paediatrics which will initially focus on:

- The improved identification and rescue of deteriorating children in acute care. This will include the development of an agreed regional, age appropriate, physiological early warning score tool and the use of enhanced communication models
- The prescription and administration of high risk paediatric medications
- To continue to build capacity and capability within HSC on patient safety and improvement science.

- HSC Safety Forum will work with Trusts to develop Quality improvement in Leadership for Safety within theatres and procedural areas.
- In addition, on request (capacity permitting) the HSC Safety Forum will support Trusts with small projects tailored for their prioritised needs.

(4) Regional Learning System

The PHA will continue to work with the DHSSPS in reviewing the most appropriate methodology for a Regional Learning System.

(5) Key Performance Indicators for Nursing and Midwifery

In 2013/14 Phase 1 of the project was completed with an initial regional set of high level key performance indicators for nursing and midwifery agreed. Definitions, reporting and monitoring arrangements have been developed.

In 2014/15 Trusts will measure and report on the agreed initial 4 Key Performance Indicators for Nursing (KPIs) which are:

- Reduction of hospital acquired pressure ulcers
- Reduction of harm from falls in hospital
- Reduction of omitted and delayed medicines in hospital
- Reduction of bank and agency use in areas that have implemented the normative staffing framework

These Indicators will lead to improved Patient and Client Experience outcomes and will provide evidence of the quality of Nursing and Midwifery care in N

Ireland. Phase 2 of the project will be taken forward by The Public Health Agency (PHA) in collaboration with the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), in partnership with key stakeholders. It will include the development and implementation of further indicators of nursing performance and the development of a regionally agreed electronic dashboard.

(6) Workforce planning within Nursing and Midwifery Services

Improving the quality of nursing services to the public in Northern Ireland: *'the right nurse, with the right skills, at the right time in the right place'.*

At the request of the Minister in July2013 the Public Health Agency (PHA) will continue to lead on the implementation, monitoring and development of The Normative Nurse Staffing framework "Delivering care" for N. Ireland. Delivering care sets out the principles for commissioners and providers of health and Social care services for planning nursing and midwifery workforce requirements.

- From April 2014, the Normative Nurse Staffing Tool should be applied to all inpatient general and specialist adult hospital medical and surgical care settings. A range of key performance indicators will be developed to monitor the implementation process. In addition E- rostering will be in place across all HSCT settings.
- By March 2015 normative staffing ranges will be developed and introduced for Community nursing and Health Visiting within a range which secures the delivery of the service model detailed with the Departmental Strategy including 'Healthy Futures'.

During 2014/15, work will also continue on the implementation of Specialist Nurse Job planning. This work is aimed at delivering on Safety Quality and Patient Experience outcomes within hospital services. Work will commence on the development of similar plans for Specialist Community Nursing services.

Appendix 3 – Breakdown of pressures 2014/15

Inescapable Funding Areas:

(i) Pay

The pay pressure £22m 2014/15 (£22m 2015/16) is based on a financial model which identifies pay expenditure and uplifts the cost by the nationally planned increase of 1% in both years.

(ii) Non-Pay

This pressure of £30m is to cover inflationary increases for goods and services. The pressure is based on a financial model which identifies non-pay expenditure and uplifts the cost by an average uplift factor of 2.5%. This was originally estimated at 3%. This figure may be subject to review when inflation indices are released in September this year.

(iii) Demography

The demography pressures identified in the plan take account of projected additional costs for each programme of care resulting from increases in population projections (see table below). This includes £3.97m pressures of re-ablement covered in *Transforming Your Care*.

Demography by POC 1

	Demography - Elective	Demography - Non-Elective	Demography - General
	14/15 £m	14/15 £m	14/15 £m
POC 1	4.3	5.7	
POC 2			0.3
POC 3			0.4
POC 4			19.1
POC 5			2.5
POC 6			1.1
POC 7			0.7
POC 8			0.7
POC 9			0.3
TOTAL	4.3	5.7	25.0

(iv) Specialist Hospital Services

The identified need for Specialist Hospital Services is currently estimated at £6m in year (£7m full year) including taking account of significant investment requirements with regard to Paediatric Congenital Cardiac Surgery, vulnerable specialties, specialist cancer developments (e.g. Brachytherapy) and ongoing development of Primary PCI. The detailed investment figures will be subject to the normal arrangements.

Specialist Hospital Services – Detail

The identified need for Specialist Hospital Services is currently estimated at £6m in year (£7m full year) including taking account of significant investment requirements with regard to Paediatric Congenital Cardiac Surgery, vulnerable specialties, specialist cancer developments (e.g. Brachytherapy) and ongoing development of Primary PCI. The detailed investment figures will be subject to the normal arrangements.

Specialist Hospital Services – Detail

Specialist Hospital Services	14/15 £m CYE	14/15 £m FYE
Apheresis	0.050	0.100
Cath labs	3.655	4.515
Rare Disease	0.025	0.050
Paediatric Oncology / Haematology	0.200	0.300
Air Ambulance additional costs from tender, provision	0.200	0.200
Neuromuscular Services to include CNS and Care Advisors	0.060	0.080
Adult and Paediatric Clinical Networks – delivering resilience	0.100	0.150
Brachytherapy	0.150	0.150
Stereotactic Radiotherapy	0.300	0.300
Paediatric Congenital Cardiac Surgery Services	1.500	1.500
Total	**6.240**	**7.345**

(v) NICE Approved Drugs

This funding requirement identified to enable the continued implementation of relevant NICE approved treatments in NI has been increased to £19m in 2014/15. This increase from previous estimates reflects pressures as a result of latest estimates of new and continuing drugs. Examples of this pressure are:

- ivacaftor £3.9m - the first of a new class of medicines, called CFTR potentiators that target the underlying cause of Cystic Fibrosis rather than simply treat its complications;
- continuing growth in patients numbers on macular, rheumatoid arthritis, multiple sclerosis, cancer, psoriasis, crohns and HIV account for an estimated additional cost of £13m;

- new drugs due to be approved by NICE in 2014/15 such as ipilumunab with recurrent costs of £4.3m - for previously untreated unresectable stage III or IV malignant melanoma and vintafolide £1.4m – for the treatment of ovarian cancer.

(vi) RCCE

The RCCE pressure (£7m) is to address those revenue costs arising from capital projects committed to, and planned to be committed to, over the Spending Review period including radiotherapy provision in the Belfast City and Altnagelvin hospitals, RVH energy centre and BHSCT theatre modernisation. This figure is largely unavoidable without significant impact on new schemes or the timing of others.

(vii) Mental Health Resettlements

This funding (£4m) will be used for the resettlement of mental health patients from hospital to a community setting. Further work is ongoing with Trusts to validate total client numbers over the Spending Review period. However there is specific detail on resettlement and this is targeted towards achieving the 2015 timetable.

(viii) Learning Disability Resettlements

This funding (£13m) will be used for the resettlement of learning disability patients from hospital to a community setting. HSCB has instigated a community integration programme to oversee the resettlement process, comprising representatives from DHSSPS, HSCB, Trusts and other stakeholders. The £13m includes £6m pressures in respect of DSD funding.

(ix) Service pressures/Service Developments

The funding under the service pressures heading has increased significantly to £77m. See table below.

The plan recognises that despite the tight financial restraints it is important to reflect a level of investment of new service developments in the final year of the Spending Review period.

Service Pressures

PoC	Pressure Area Recommended	14/15 FYE £m
Acute	Consultants to support acute oncology service	**0.3**
Acute	Oncology service gaps equating to 30 PAs or 3 WTE	**0.3**
Acute	Implementation of Cancer Care Framework	**1.5**
Acute	Fractures	**0.4**
Acute	Hospice funding	**0.4**
Acute	Introduction of FET to women who have had a cycle of IVF/ICSI since April 2012 and who have frozen embryos	**0.3**
Acute	IVF	**1.9**
Acute	LTC policy implementation	**1.0**
Acute	ED capacity planning	**5.0**
Acute	Elective	**15.0**
Acute	Radiology diagnostics	**2.0**
Acute	24/7 blood sciences	**3.3**
Acute	Regional perinatal & pediatric pathology service	**0.1**
Acute	Sleep apneoa	**0.4**
Acute	GUM SE & N	**0.2**
Acute	GMC reconition of trainers	**3.5**
Acute	Specialist nurse for neuromuscular disease	**0.1**
Acute	Workforce review of SW Hospital - 19.3 WTE nurses	**0.7**
Acute	Alcohol/substance liason services	**0.4**
Acute	Epilepsy nurses	**0.2**
Acute	Palliative care pressures	**1.0**
Acute	Tumour specific CNS	**0.2**
Acute	SAI reporting	**0.0**
Acute	Idiopathic Pulmonary Fibrosis	**0.5**
Acute	Haematology - 2 training posts	**0.2**
Acute/HP/FCC	24/7 acute & community working	**5.0**
Acute/Comm	Secure professional project support	**0.1**
Acute/Comm	Other	**2.1**
All	Normative Nursing	**12.0**
All Community	Community nursing access to clinical records	**0.0**

Elderly	Dementia strategy	0.3
Elderly	NIV service	0.1
Elderly	Fallsafe	0.2
Family & Child Care	CHOICE	0.2
Family & Child Care	Lakewood secure provision	0.4
Family & Child Care	Availability of personal advisers as required under the Leaving Care Act	0.3
Family & Child Care	Funding for Extended Fostercare Scheme	0.3
Family & Child Care	Supported accommodation (Young Homeless and Care Leavers).	0.6
Family & Child Care	Safeguarding child sexual exploitation	1.0
Family & Child Care	Assessment & approval support kinship foster carers	0.3
Family & Child Care	Therapeutic requirements for children within the child protection and looked after children systems (legislative and procedural requirements	0.5
Family & Child Care	Health visiting	1.5
Family & Child Care	Expansion of FNP to SEHSCT & NHSCT	0.8
Family & Child Care	School nurses for LAC	1.0
Family & Child Care	Safeguarding Children nurse specialists	0.2
Family & Child Care	NHSCT LAC specialist nurse	0.0
Primary Health & Adult Community	Infrastructure for GP's(Hub/Spokes)	0.4
Primary Health & Adult Community	OOH(GMS)	1.9
Health Promotion	Weight management programmes	0.2
Health Promotion	Support for families of patients in addiction services	0.6
Health Promotion	Community based Obesity Treatment Intervention Programme	0.5
Health Promotion	PHA Promoting Good Nutrition strategy/Living Matters	0.1
Health Promotion	Promoting Good Nutrition implementation	0.5
Health Promotion	Patient care experience	0.2
Learning Disability	Community forensic teams	0.6
Maternity & Child Health	Perinatal parent infant mental health service	0.3
Maternity & Child Health	Foetal medicine	0.3
Maternity & Child Health	Maternity support workers	0.2
Maternity & Child Health	Midwife for new immigrants	0.1
Mental Health	ASD	0.5
Mental Health	Pyschological therapies	2.5
Mental Health	Tier 4 addiction services	0.8
Mental Health	Psychological support for adult/kids with LTC	0.4
Mental Health	Specialist nurse - Domestic & sexual violence	0.2
Primary Health & Adult Community	Supervised swallowing (Prisons)	0.2

Acute	Major Trauma Network	**0.2**
Acute	EU cross border directive	**0.3**
Primary Health & Adult Community	Revalidation - Medical/GMS	**0.2**
Health Promotion	Diabetes network	**0.1**
Health Promotion	10,000 voices	**0.3**
Learning Disability	Review of AHP services in special needs schools	**0.1**
Maternity & Child Health	Implementation of paediatric stategy	**0.1**
Total		**77.2**

(x) Family Health Services (FHS)

The pressures identified for FHS are primarily to cover anticipated increased costs in Prescribing, Dental, General Medical and Ophthalmic Services including demography, residual demand, pay and non-pay inflation.

(xi) Public Health Agency (PHA)

The total pressure for PHA is £6.1m. After taking account of pay and price costs of circa £2.1m there are additional pressures of £4.0m.

(xii) *Transforming Your Care* (TYC) Gross Costs

The financial analysis of Transforming Your Care is addressed in detail in Section 3.4 – Shifting Financial Resources Through Transforming Your Care. The table below details the £21m pressures in 2014/15 (£29m 2015/16).

TYC Reforms

Year	12/13 - 15/16 Net	12/13 - 15/16 Gross	2014/15 Gross	2015/16 Gross
	£m	£m	£m	£m
ICPs	21	28	7	14
Service Change: Stroke	10	10	4	4
Service Change: PCCI/Cardiac Catheterisation	1	12	4	4
Service Change: Reablement	3	17	4	6
TYC Implementation	13	13	6	2
Telecare	0	0	0	0
Prevention	0	0	0	0
Carers Respite	1	1	0	0
Bamford	2	2	1	1
Child Development	0	0	0	0
111 Urgent Care	0	0	0	0
NIAS 'See, Treat, Leave'	1	1	0	1
Self Directed Support	1	3	1	1
Workforce Reskilling	1	1	1	0
Marie Curie - Delivering Choices	0	0	0	0
Home Oxygen Services	1	1	1	0
ICT Enablers	1	1	0	0
Web Portal	1	1	0	0
Medicines Mgt Review of Care Home Clients	0	0	0	0
ICP Leadership Development Additional Costs	0	0	0	0
Local Trust Service Reforms	1	1	0	1
Application of balance of reprofiled 14-15 funds still to be confirmed	5	5	0	5
TYC VR/VER	7	8	0	8
TYC REFORMS ONLY	**70**	**105**	**29**	**48**
QICR VR/VER	15	15	0	
TOTAL TYC COSTS	**85**	**120**	**29**	**48**
Less Funded by HSCB				
PPCI from Elective			4	4
Reablement from Demography			4	6
Self Directed Support from Demography			1	1
Local Trust Service Reforms from Demography				0
TYC Benefits Realised				7
TOTAL DHSSPS FUNDING SOUGHT 14/15			**21**	**29**

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the Department of Health in N Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / longterm conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the HSCB and PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction – A document published by the Minister on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not publicly funded. Also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

Cord blood is blood that remains in the placenta and in the attached umbilical cord after childbirth. Cord blood is collected from the umbilical cord because it contains cells called stem cells, which can be used to treat some blood and genetic disorders.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Directed cord blood donations - These are collected from the umbilical cord of new born siblings of children with a condition such as acute leukaemia (sometimes referred to as saviour sibling donations). They are arranged with the haematologist treating the affected child.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a

range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector.

Lesbian, Gay, Bisexual & Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the Board arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Neoplasm – Any new and abnormal growth of tissue. Usually a cancer.

Palliative Care – The active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of N Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) – these pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Reablement - range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Service Framework - a document which contains explicit standards underpinned by evidence and legislative requirements. Service Frameworks set standards, specific timeframes and expected outcomes

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Transforming Your Care – This is a strategic assessment across all aspects of health and social care services examining the present quality and accessibility of services.

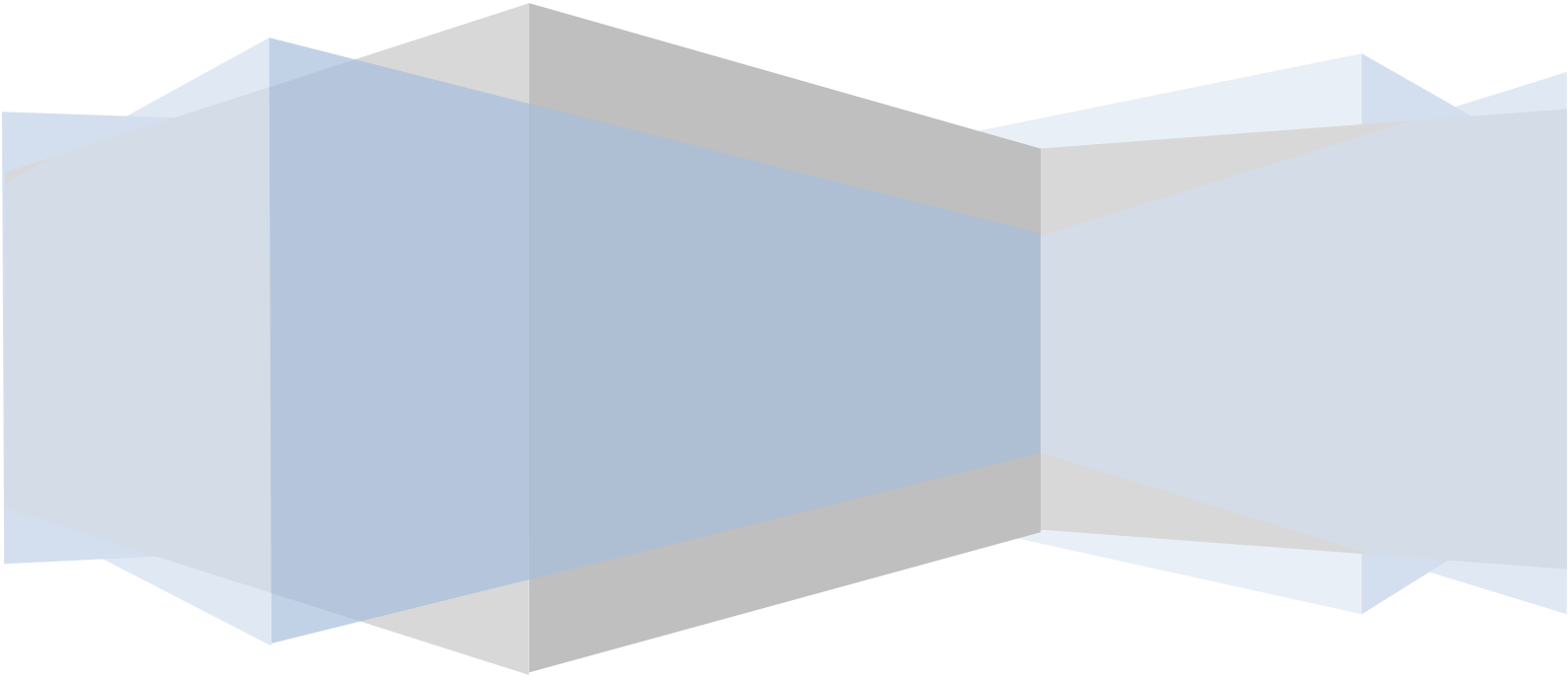
Trust Delivery Plans – In response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Ministerial targets, key themes and objectives outlined for the year ahead.

Unrelated cord blood donations - Also known as undirected or public donations, these are altruistic donations of blood taken from volunteers' umbilical cords at the time of delivery. They are processed and typed for storage in a public cord bank. Registers of public cord banks can be searched internationally to provide the best match for a stem cell transplant.

Health and Social Care Board

Public Health Agency

Commissioning Plan 2015/16



Contents

Foreword

This Commissioning Plan describes the actions that will be taken across health and social care during 2015/16 to ensure continued improvement in the health and wellbeing of the people of Northern Ireland within the available resources. The Plan has been developed in partnership by the Health and Social Care Board and the Public Health Agency, and responds to the Commissioning Plan Direction published by the Minister for Health, Social Services and Public Safety on the 6 March 2015. In doing so, it includes the underpinning financial plan and outlines how the commissioning decisions planned in 2015/16 will deliver the planned transformation of services outlined in *Transforming Your Care*. It outlines a range of actions that have been developed in partnership with patients and the public which are driven by need, clear goals and financial transparency.

The plan also highlights areas of unmet need and service developments which cannot be progressed within currently available resources, or can only be progressed at a significantly reduced scale and/or pace. Steps are being taken, where possible, to mitigate risk and HSCB will continuously review commitments to ensure best use of all available resources. In addition the HSCB have supported the DHSSPS in preparing bids for June Monitoring amounting to £89m – the bids remain subject to approval.

Improvements in the quality of care for our population in recent years mean that people are living longer than ever before. With an increase in the age of the population comes an increasing burden of chronic disease, increased demand for health and care services and a greater reliance on hospital-based care. This increase in demand comes at a time when the Northern Ireland Executive budget has been reduced by 1.6% in real terms.

The only way to have sustainable, safe and high quality services is to transform how we plan and deliver our care. This plan focuses on the transformation agenda which is committed to improving patient experience and outcomes of care by placing the patient, carer and community at the heart of care and by thinking more innovatively about our ways of working. A consistent theme is the need to reduce our reliance on hospital and institutional care while focusing investment on the development of more responsive and individualised care closer

to home and the promotion of early intervention, prevention and greater choice and independence. This means that the way in which we deliver care will change; patients will be able to access new services in different places.

Both the Ministerial and TYC themes highlight the need to redesign and refocus services in order to:

- Enhance primary prevention to improve the way we live and look after our health;
- Supporting people to live independently for as long as possible;
- Providing more care closer to home – home as hub of care;
- Focussing on the provision of high quality, safe and effective care, which may require concentration of some services to ensure minimum clinical critical mass and maximum efficiency;
- Safeguarding the most vulnerable; and
- Ensuring efficiency and value for money.

The HSCB/PHA commits to supporting the delivery of the actions outlined in the Plan by:

- Listening to Patient and Client experience and learning from Personal and Public Involvement;
- Supporting our staff through training and development;
- Working with clinicians to ensure delivery of best practice;
- Working in partnership with providers, including the private and voluntary sector to support greater choice and innovation;
- Embracing innovation and technology;
- Use eHealth (technology) to improve citizens' experience of interacting with health and social care and to improve care by making it easier for staff to get the information they need to provide that care; and
- Through a continued focus on reducing health inequalities.

1.0 Introduction

1.1 The Purpose of the Plan

This Commissioning Plan is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Services and Public Safety for 2015/16. It includes the underpinning financial plan and outlines how commissioning will serve to deliver the planned transformation of services consistent with Transforming Your Care. Consequently, a key area of focus within the plan is the shift left of services from hospital into primary and community.

The commissioning priorities and decisions outlined within the Commissioning Plan have been identified through regional and local assessment of needs and inequalities and with reference to evidence-based or agreed best practice. In particular, they aim to respond to the three strategic themes and statutory obligations identified by the Minister in the Commissioning Plan Direction:

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

In line with established commissioning arrangements, the plan provides an overview of regional commissioning themes and priorities for 2015/16 (Sections 6 and 7) together with information on the priorities and decisions being taken forward at local level by the five Local Commissioning Groups (LCGs; Sections 9-14).

The regional themes and priorities outlined in Section 7 are closely aligned to the Ministerial priorities and the key themes within *Transforming Your Care*. The transformation agenda is therefore integrated throughout the plan. In addition to outlining how we intend to deliver on the transformation agenda, the document will also outline how commissioning will support the implementation of a range of Government and Departmental strategies, standards and initiatives including:

- Achievement of Ministerial standards / targets 2015/16 (see Section 8)
- The Executive's Programme for Government, Economic strategy and Investment Strategy (Section 3)
- Quality 2020 (Section 3.2)
- 10,000 Voices and Patient and Client Experience Standards (Section 5)
- Personal and Public Involvement (Section 5)
- Public Health Strategic Framework: Making Life Better 2013-23 (Section 6.1)
- Delivering Care: Nurse Staffing in N Ireland (Section 3.6)
- Other Departmental guidance and guidelines such as (e.g. Service Framework documents, NICE, Maternity Strategy). (Section 3)

Key actions in relation to a number of these strategies are addressed separately in Section 3, *Delivering on Key Strategies*. Others are embedded within the regional commissioning themes and priorities.

Finally, the Plan makes explicit those areas of service development and delivery that providers will be expected to respond to in their development plans for 2015/16 and against which they will be monitored.

It is important to note that the Plan does not attempt to encompass all of the many strands of work that HSCB and PHA will continue to progress with providers during 2015/16. Rather it provides focus on a discrete number of key strategic and service priorities which we feel will have the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level, and those which represent a step change in how we deliver our services.

1.2 Placing communities at the centre of commissioning

The HSCB and PHA are committed to ensuring that commissioning priorities are focused upon known need and inequalities, are locally responsive and reflect the aspirations of local communities and their representatives.

There are five Local Commissioning Groups (LCGs) and each is a committee of the HSCB: Belfast; Northern; South Eastern; Southern; and Western. LCGs are

responsible for assessing local health and social care needs; planning health and social care to meet current and emerging needs; and supporting the HSCB to secure the delivery of health and social care to meet assessed needs.

Local commissioning priorities, reflect the regional themes, but are presented by Programme of Care (PoC). PoCs are divisions of health care, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. In total, there are nine PoCs. Definitions of each PoC are provided in Appendix 1.

The plan also outlines how we will meet our Equality duties under the Northern Ireland Act 1998(b) and how we have sought to embed Personal and Public Involvement (PPI) in our commissioning processes. The equality screening template that accompanies this document can be found on the HSCB website.

Commissioning priorities and decisions also seek to take account of opportunities for and the benefits of partnership working with other Departments and agencies whose policy; strategy and service provision impinges on health and social care.

1.3 Monitoring Performance

The priorities and targets detailed in the *Commissioning Plan Direction* are complemented by a number of indicators of performance indicated in a separate *Indicators of Performance Direction* for 2014/15.

The *Indicators of Performance Direction* has been produced to ensure that the Health and Social Care sector has a core set of indicators in place, on common definitions across the sector, which enable us to track trends and performance. The HSCB, PHA and Trusts monitor the trends in indicators, taking early and appropriate action to address any variations / deterioration in unit costs or performance or in order to ensure achievement of the Ministerial targets.

2.0 Summary of Key Demographic Changes

This section provides an overview of key demographic changes of the NI population and outlines information relating to lifestyle and health inequalities. Consideration has been given to these within the needs assessments outlined within sections 7 and 9-13 in order to inform the commissioning of services at both regional and local level.

N Ireland Resident Populations by Local Commissioning Group

Table 1

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	67,000	96,000	71,000	83,000	65,000	383,000
16-39	124,000	143,000	104,000	118,000	95,000	584,000
40-64	105,000	153,000	117,000	114,000	96,000	584,000
65+	53,000	75,000	59,000	50,000	42,000	279,000
All ages	350,000	467,000	366,000	366,000	297,000	1,830,000
%	19%	26%	19%	20%	16%	100%

Source: NISRA, 2013 MYEs

Some of the key demographic changes which will have an impact on the demand for health and care services in Northern Ireland are noted below:

- Recently published Mid-Year Estimates for 2013 indicate that there are approximately 1.83m people living in N Ireland (NI). Current population projections anticipate the population will rise to 1.927m by 2023.
- Belfast Trust has the lowest proportion of younger people aged 0-15 years, in comparison to other Trusts (19% or 67,000) and the Southern Trust has the highest percentage at (23% or 83,000).
- The Northern Trust however has the highest number of younger people within its population at 96,000 or 21% of its population.
- Persons of working age (persons aged 16-64) account for the highest proportions across all Trusts, ranging from 66% of the population in Belfast to 63% in the South Eastern Trust.
- There are a total of 279,000 older people (65+ years) in N Ireland, equating to 15% of the NI population.

- 19% of these or 53,000 persons are in Belfast Trust, 27% or 75,000 are in Northern Trust; 21% or 59,000 reside in South Eastern; 18% or 50,000 are in Southern Trust, and the remaining 15% or 42,000 live in Western Trust.
- The anticipated population increase is characterised by a marked rise in the proportion of older people. From 2015-2023 the number of people aged 65+ is estimated to increase by 74,000 to 353,000 – a rise of 26%. The number of older people will represent 18% of the total population compared with 15% currently.
- At sub-regional levels, the areas with the highest projected growth overall is the Southern Trust (+10%), for the aged 65+ and 75+ cohorts of the population is in the Western Trust at +32% and South Eastern Trust at +49%. For aged 85+ years, the highest projected growth is in the Southern Trust (+58%).
- Births in N Ireland have fallen from 25,300 in 2012 to 24,300 in 2013 – a decrease of 4%
- 14,968 deaths were registered in N Ireland during 2013, which is a slight increase of 212 or 1.4% since 2012.
- The main cause of death was cancer accounting for 28% of deaths in N Ireland (4,230).
- Life expectancy across the region has improved by 7 years for females and 9 years for males since 1980/82. In 2011/13 males could expect to live to the age of 78 years and females to the age of 82 years. Males living in the 10% least deprived areas in NI could expect to live on average approximately 9 years longer and females, approximately 6 years longer than their counterparts living in the 10% most deprived areas.
- The prevalence of long term conditions such as COPD, diabetes, stroke, asthma and hypertension is increasing. In conjunction the number of people coping with co-morbidities is increasing.
- Deprivation has an impact on health and wellbeing in many ways resulting in the lack of social support, low self-esteem unhealthy life style choices, risk taking behaviour and poor access to health information and quality services.

3.0 Delivering on Key Policies, Strategies and Initiatives

The Plan attempts to outline how Commissioning will deliver across a number of key Government and Departmental policies and strategies. As noted in the introduction, Transforming Your Care is integrated throughout the document and will therefore not be addressed separately within this section. Other policies and strategies are also encompassed within the regional themes and priorities (e.g. the Public Health Strategic Framework – 'Making Life Better', is addressed under the first of the regional themes). This section therefore outlines our commitments in relation to a small number of policies, strategies or initiatives which are not covered elsewhere in the plan. These include:

- Programme for Government
- Quality 2020
- Delivering Care: Nurse Staffing in Northern Ireland
- Service Frameworks
- Living Matters Dying Matters
- Maternity Strategy
- Physical and Sensory Disability Strategy
- Community planning

3.1 Programme for Government

The Programme for Government (PFG), launched March 2012, sets the strategic context for the Budget, Investment Strategy and Economic Strategy for Northern Ireland. It identifies the actions the Executive will take to deliver its number one priority – a vibrant economy which can transform our society while dealing with the deprivation and poverty which has affected some of our communities for generations.

3.2 Quality 2020

The DHSSPS Quality 2020 is the strategic framework that ensures patients and their experiences remain at the heart of service design and delivery.

During 2015/16 the HSC Quality 2020 Implementation Team will complete work to:

- Develop HSC Trust Annual Quality Reports

- Develop professional leadership via implementation of the Attributes Framework to develop HSC staff skills in Quality Improvement and Safety.
- Introduction of the WHO patient safety curriculum in undergraduate and post graduate training programmes.

In 2014 the DHSSPS, Patient Client Council and RQIA held a successful Stakeholder Forum and the findings from this event will inform the development of an annual Quality 2020 Stakeholder forum and will feed into the future work of Quality 2020.

3.3 Institute of Healthcare Improvement Liaison

The HSCB is working with the Institute of Healthcare Improvement (IHI) to build capacity and develop expertise, across the HSC, in quality improvement skills.

The focus of this work is on trialling and adopting the 'Triple Aim' framework - the term Triple Aim refers to the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health.

East Belfast Integrated Care Partnership and the South Eastern Trust have been selected to act as prototype sites for this approach. Both sites are working to develop and test new models of care at home for frail older people.

As part of the regional Outpatient and Care Pathway reform projects the HSCB are working in partnership with the NI Safety Forum to bring Institute of Healthcare Improvement science expertise to the identification of priority pathways for regional implementation and the design of same.

3.4 HSC Safety Forum

The role of the HSC Safety Forum is to provide leadership for Safety and Quality Improvement across Health and Social Care.

During 2015/2016 the key deliverables will include:

- Recruiting and funding key individuals to the role of Safety Forum Scottish Fellows, receiving high-level training on Improvement and Leadership.

- Linking with the Health Foundation to recruit HSC staff to the 1st Cohort of the *Q. Initiative*Develop a business case for further Quality Improvement training on an All-Ireland basis via Interregnum V funding via Co-operating and Working Together (CaWT).
- Create and deliver the first regional learning event to share and learn from Serious Adverse Events
- Continue the work to embed use of the Attributes Framework, developed under the leadership of the Safety Forum in staff development and appraisal.
- Follow-up the very successful Delivering Safer Care Conference in 2014 with a similar event in early 2016.
- Promote judge and award the first Safety Forum Awards to recognise and reward the efforts of staff to progress Quality Improvement and Safety.
- Complete the Lessons from Berwick series in partnership with the HSC Leadership centre
- Partner with RQIA to inform the development of its new programme of inspection Develop a regional bundle for the prevention and care of delirium as part of the Regional Dementia Strategy
- Support the development of a network of improvers across Health & Social Care – the Improvement Network- Northern Ireland (INNI)
- Develop and introduce a regional Early Warning Score for Paediatrics
- Continue to lead on the Quality Improvement Collaboratives and develop new areas of work as needed

3.5 Workforce Planning & Development

This Commissioning Plan and the reform agenda it sets out will reshape our service provision across health and social care over the coming years which will be underpinned by workforce planning and development. The movement towards model of care which deliver more services in primary or community care settings and the consequent re-allocation of resources and funds has significant implications for our workforce in terms of its roles, location and skills mix.

HSCB and PHA are taking forward a number of initiatives and strands of work with regard to workforce planning and development:

Integrated Service and Workforce Planning
The DHSSPS will soon publish the regional workforce planning framework, which will set out the relative roles of the HSC organisations, and this will drive the practical implementation and improvement of workforce planning at all levels across the HSC. The HSCB and PHA will led and participate in workforce reviews, as appropriate.

Profession specific workforce planning and development
There will continue to be consideration of workforce planning and development through profession specific activities, including the impact of the transformation agenda set out in the Commissioning Plan.

This includes:

- a comprehensive workforce planning review for Nursing and Midwifery services in Northern Ireland - *Delivering Care: Nurse Staffing in Northern Ireland* (see section 3.6)
- work with Trusts on increased introduction of working practices which support 7 day services, as reflected in this Commissioning Plan.
- a suite of workforce plans across different specialties have a been developed or are underway. It is anticipated that Trauma & Orthopaedics and Occupational Medicine will be complete early in 2015/16, and the next group of specialties to be reviewed in 2015/16 has been agreed with DHSSPS and Trusts.
- working with partners on the implementation of the Social Work Strategy, which includes workstreams focussed on First Line Managers, Workload Management in Adult Services, Job Rotation, Extended Hours & Flexible Working, and Promoting Leadership.

Capability Development Initiatives to support our reform agenda
The HSCB has invested in a range of development initiatives designed to increase the wider HSC's capacity and capability to deliver the transformation agenda.

These include:

- Change Management and core skills programme for those involved in TYC or transformation projects.
- Effective Partnership Working and bespoke skills programmes for those on Integrated Care Partnership Committees, or those supporting their successful operation.
- The establishment and on-going development of a HSC Knowledge Exchange open to all those involved in the design, commissioning or provision of health and social care services across N Ireland. During 2015/16, the HSCB will be investing in Organisation Workforce Development and Service Improvement skills to support staff in their roles, including promoting innovation, reform and change.

3.6 Delivering Care: Nurse Staffing in Northern Ireland

The aim of the *Delivering Care: Nurse Staffing in Northern Ireland* Project is to support the provision of quality care which is safe and effective in hospital and community settings through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities.

Phase one sets out the nursing workforce required for all general and specialist medical and surgical hospital services. The HSCB has agreed a detailed implementation plan to support the delivery of Phase One. Three further phases are at developmental stage. Phase two focuses on nurse staffing within Emergency Departments, Phase Three focuses on District Nursing and Phase Four is focused on Health Visiting. Once a regional approach for the implementation of these further phases has been agreed by DHSSPS, the HSCB, supported by the PHA, will agree implementation plans.

3.7 Service Frameworks

Service frameworks and strategies set clear quality requirements for care. These are based on the best available evidence of the treatments and services that work most effectively for patients.

Many of the standards contained in the Frameworks do not require additional resources as they are focused on quality improvement and are capable of delivery by optimising the use of existing funding. Where there are additional costs associated with specific standards, these will be sought through existing financial planning, service development and commissioning processes.

There are currently a total of six Service Frameworks (Respiratory, Cancer, Mental Health, Learning Disability, Cardiovascular and Older People) and a seventh for Children and Young People currently under development.
During 2015/2016 the key deliverables will include:

- Following formal publication of the Respiratory and Children and Young People Service Frameworks, the HSCB/PHA will develop implementation plans to take forward the standards and Key Performance Indicators (KPIs) set out in the frameworks.
- Fundamental reviews for Cancer and Mental Health Frameworks to be completed by HSCB/PHA by September 2015.
- Implementation of remaining three frameworks to be taken forward in line with implementation plans agreed with the DHSSPS.

3.8 Primary & Community Care Infrastructure

In 2011/12, the then Minister indicated that he wished to invest in the development of the primary and community care infrastructure as part of the strategy for improving the overall health and well-being of the community and for improving the delivery of integrated primary, community and secondary care services.

In 2014/15 a Strategic Implementation Plan was developed based on the hub and spoke model which sets out the regional plan for investment in primary care infrastructure. It includes an outline of the prioritised hub projects within the programme and proposed funding plan. Each hub will be a ‘one stop shop’ for a

wide range of services including GP and Trust led primary care services. This model will improve access to, and responsiveness of, primary and community care services, particularly making available more specialised services nearer to where people live and work. This includes provision of an enhanced diagnostic and treatment capability where appropriate.
The priority for 2015/16 is to continue to take forward the hub and spoke model. The key tasks will be to:

- Gain ministerial approval of the Strategic Implementation Plan;
- Complete construction of 3 Hubs in Banbridge, Ballymena and Omagh;
- Conclude on Value for Money of procurement approach for two 3PD pilot projects (Lisburn & Newry);
- Appoint the preferred bidder for the hubs in Lisburn and Newry;
- Commence detailed needs assessment of next tranche of hub projects including impact on commissioning and delivery model;
- Complete Tranche 1 of GP Loan Scheme and launch Tranche 2; and
- Continue detailed assessment of need for investment in spoke projects and prioritisation of investment in spoke practices.

3.9 Palliative and End of Life Care

The Transforming Your Palliative and End of Life Care Programme is supporting the redesign and delivery of coordinated services, in line with the *Living Matters: Dying Matters Strategy (2010),* to enable people across Northern Ireland with palliative and end of life care needs to have choice in their preferred place of care. The Programme is being delivered by the HSCB/PHA in partnership with Marie Curie, working with statutory, voluntary and independent sector providers.

During 2015/2016 the key deliverables will include:

- Agreement and implementation of regional advance care planning across the region for those with identified palliative and end of life care needs
- Implementation of the key worker function for those identified palliative and end of life care needs
- Development of a Transforming Your Palliative and End of Life Care business case to support the agreed regional palliative care model with implementation in 2016, subject to funding.

3.10 Maternity Strategy

The Maternity Strategy for Northern Ireland, published in July 2012, promotes improvements in care and outcomes for women and babies from before conception right through to the postnatal period. The Strategy focuses on the need to improve pre-conceptual health, promote antenatal care appropriate to the individual woman's needs, support midwife-led care for women with a straightforward pregnancy and ensure consultant-led care for women with a complex pregnancy. During 2015/2016 the key deliverables will include:

- Finalisation of a regional core pathway for antenatal care
- Development of a standard electronic referral letter for primary care referrals for maternity care
- Development of guidelines for admission to and transfer from midwife-led care in Northern Ireland
- Achieving an improvement in the uptake of Folic Acid by women pre-conceptually to reduce the incidence of Neural Tube Defects
- Continued improvement of the quality of clinical data collected
- The Maternity Quality Improvement Collaborative will continue to work to improve safety and quality of maternity care services
- Continued improvement of the quality of online information available about local care options for women and their partners
- Full implementation of the regional pathway for multiple pregnancy
- Developing services for women with epilepsy to help them have an optimum pregnancy outcome.

The funding position in 2015/16 will however impact on the ability of commissioners to take forward a range of maternity health service developments including:

- establishment of specialist midwifery service for the care of vulnerable groups of migrant and minority ethnic pregnant women
- establishment of specialist joint diabetic antenatal clinics for women with gestational diabetes mellitus, Type 1 and Type 2 diabetes to allow for the redesign of antenatal care for all diagnosed diabetes in the antenatal period

- ability to address additional pressures which may emerge from the current review of neonatology, for example, need to further expand medical capacity

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

3.11 Physical and Sensory Disability Strategy

The Physical and Sensory Disability Strategy 2012/15 has a number of overarching themes:

- Promoting Positive Health, Wellbeing and Early Intervention
- Providing better Services to Support Independent Lives
- Supporting Carers and Families

Significant effort has been expended over the past two years in the implementation of the Physical and Sensory Disability Action Plan which identifies 34 Actions to address the above themes. On-going improvements are required to ensure that people with physical and/or sensory disabilities are enabled to lead independent lives. By continuing to implement the Strategy, the HSCB will promote choice and independence as well as support carers. This will require further investment in:

- Wheelchair services
- Services to people with sensory loss (Deafblind, Visual, and Hearing loss)
- Community Access and Social Networking
- Implementation of neuro-rehabilitation pathways including people with neurological conditions.

The funding position in 2015/16 will impact on the ability of commissioners to maintain effective services for people with a physical or sensory disability. In particular, it is anticipated that complex care package and transitional care costs will exceed available resources.

3.12 Community planning

1 April 2015 heralds significant changes to Local Government with the number of councils reducing from 26 to 11 and a transfer of powers for central to local government. The new council boundaries are not co-terminus with the LCG/Trust areas but there will be enhanced opportunities for more effective working with local government under the auspices of Community Planning.
As a new statutory function, councils will be required to initiate, maintain and facilitate community planning. A corresponding duty will be placed on other statutory partners, including HSC, to participate in this process. Community planning will be a process, led by councils in collaboration with partners and communities, to develop and implement a shared vision for their area which will involve people working together to plan and deliver better services.

Building relationships across the sectors will be crucial to the success of community planning. Health and Social care has long worked in partnership with local government and other statutory and community partners. Learning from these partnerships will provide a solid foundation for HSC participation in the community planning processes. HSCB, PHA and LCG officers have already been involved in the exploratory community planning processes at local level and there will be further opportunities for engagement with local government in 2015/16 to build on progress and develop community plans.

3.13 E–Health

An eHealth & Care strategy has been developed by the HSCB, supported by the PHA and by other HSC organisations. Commissioning key priorities include;

- Working with NI Direct to further develop web portal access to support citizens for self-care; defining and building ways for citizens to access their health and care records to support independence; evaluating the NI investment in Remote Telemonitoring solutions to inform future design and deployment of remote health and care solutions to support citizens.
- Building on successes to date in sharing information to support improved care and wellbeing. This includes the implementation of care pathway support and the development of a shared key information summary for individuals with higher risk of health & wellbeing crises;

- Further developing risk management processes commenced in 2014/15 with General Practice to support improved care planning and intervention for individuals at risk of health and wellbeing deterioration; and agreeing an information development plan for HSCNI;
- Building on the development of electronic referrals by making available electronic triage of referral and electronic discharge support to Trusts to speed care decision making and reduce the delays and risks associated with paper based processes.
- Supporting re-design of processes for the provision of advice and guidance including outpatient consultation, to increase the timeliness of advice provision, and to reduce the cost of individual interventions.
- During 2015/16, the business case for e-prescribing and medicines administration will be finalized and the procurement process for medicines administration agreed. This will also support reducing the cost of these processes.

4.0 Ensuring Financial Stability & Effective Use of Resources

4.1 Introduction

The HSCB has a statutory duty to break even and operational responsibility for ensuring financial stability across the HSC. Following consultation on its draft budget for 2015-16 the DHSSPS latest assessment of its financial position shows an unresolved gap of £31m. This assessment takes account of significant opening pressures in all organisations which have occurred as a result of demand led expenditure levels in the HSC rising in prior years above funding allocations.

The 2014/15 initial Commissioning Plan identified a funding gap of £160m which was resolved through £80m non recurrent in-monitoring funding and one off savings opportunities within the HSC. The full year impact of these pressures is now carried forward into the 2015/16 plan.

The assessment of the financial gap has been arrived at following detailed engagement between the HSCB, PHA, Trusts and the DHSSPS to agree income sources, inescapable/discretionary cost pressures, savings opportunities and new funding requirements. During this engagement a significant range of service development and service pressure areas were identified, which given current assessment of the financial position, have not been included in this plan. These pressures, however, have been further prioritised and submitted to the DHSSPS for inclusion in the June Monitoring bids. The HSCB will also continuously review commitments to ensure best use of all available resources.

The HSCB and PHA are continuing to work closely with the DHSSPS in seeking urgent solutions to resolve the funding gap as early as possible. However, in the absence of any firm solutions the £31m gap will remain primarily the responsibility of the HSCB to address. In order not to breach the key financial target to break even the HSCB will be required to live within available resources. The DHSSPS will be submitting a range of bids in the forthcoming June monitoring round to address the funding gap and the need to fund service developments.

In the interim, following discussions with the DHSSPS, the HSCB will delay the implementation of a number of key projects and delay the investment in elective care at this stage. Whilst this will help manage the financial position in the short term, this decision will be revisited after the June monitoring round.

Table 2 summarises the current planning position in respect of HSCB and PHA.

Summary of 2015/16 Financial Plan

Table 2

2015/16		**£m**	**£m**	**£m**
PRESSURES	C/Fwd Service Commitments 14/15 HSCB		73	
	Trust CFwd Recurrent Pressures		131	
	Full Pay Award 2014/15	23		
	Less saving on implementation of pay award	(13)		
	Net Non-Recurrent cost of pay award		10	
	Non Pay		27	
	Demography		26	
	FHS		23	
	Primary Care		5	
	Inescapable service pressures		8	
				303
SOURCES				
	Addition allocation from DHSSPS		150	
	Trust Savings*		85	
	Regional Prescribing / FHS opportunities*		22	
	Regional Projects not being commenced		6	
	Reduction in baseline expenditure		9	
				272
	DHSSPS Unresolved Gap			**(31)**
	HSCB Options to resolve:			
	Slippage with in year consequences		9	
	Elective		22	
	Total Options			**31**

* includes savings from Pharmaceutical Price Regulation Scheme (PPRS)

4.2 Producing the Financial Plan

This section sets out an overview of key elements of the HSCB/PHA financial plan for 2015/16 covering:

- An assessment of opening positions across the HSC 2014/15;
- An overview of the additional inescapable pressures of HSCB and PHA in 2014/15 and indicative 2015/16;
- A summary of income sources available to HSC;
- Potential options to address funding shortfalls;
- An analysis of total planned investments by POC, LCG and Provider; and
- An equity analysis across Local Commissioning Group area.
- An update on progress in shifting resources through Transforming Your Care.

4.2.1 Assessment of opening financial positions across the HSC 2015/16

In recent years the HSC has experienced annual financial pressures significantly in excess of the annual recurrent funding allocations from the DHSSPS. This has meant substantial savings from within the system which, together with additional in year income sources such as the Executive in year monitoring monies, have been necessary to address service needs and deliver financial balance. Where these additional sources are not repeatable in the next year they result in opening shortfalls both within the HSCB itself and within local Trusts.

HSCB – Opening Position

The Commissioning Plan 2014/15 identified a range of inescapable service pressures for which there was no recurrent funding source available at that time. These service pressure areas have been carried forward into the 2015/16 Financial Plan and identified for priority funding as per Table 3.

These developments were commissioned in 2014/15 with only in-year funding.

2014/15 Carried Forward Service Commitments

Table 3

Carried Forward Service Developments	£m
Elective	15.80
Radiology Diagnostics	2.00
Implementation of Cancer Care Framework	0.80
Hospice funding	0.40
ED capacity planning	4.00
Haematology - 2 training posts	0.12
24/7 blood sciences	2.30
GMC recognition of trainers	1.13
24/7 acute & community working	4.00
Dementia strategy	0.25
CHOICE	0.18
Lakewood secure provision	0.42
Availability of personal advisers as required under the Leaving Care Act	0.30
Funding for Extended Fostercare Scheme	0.30
Supported accommodation (Young Homeless and Care Leavers).	0.55
Safeguarding child sexual exploitation	1.00
Assessment & approval support kinship foster carers	0.26
Health visiting	1.50
Expansion of FNP to SEHSCT & NHSCT	0.85
NHSCT LAC specialist nurse	0.05
Infrastructure for GP's(Hub/Spokes)	0.37
Alcohol/substance liason services	0.40
Supervised swallowing (Prisons)	0.08
Revalidation - Medical/GMS	0.16
10,000 voices	0.31
Review of AHP services in special needs schools	0.10
Normative Nursing	10.40
TYC	15.62
2014/15 Growth in existing NICE drug/therapies	9.00
TOTAL	**72.64**

Trust Opening Position - Carried Forward Pressures

The HSCB has worked closely with the Trusts in the identification and review of Trusts recurrent pressures brought forward from previous years. As a result the HSCB has recognised £131m in the 2015/16.

4.2.2 Planned additional investment 2015/16

Due to the overall constrained financial position only a limited number of inescapable pressures have been recognised in the 2015/16 financial plan to date which will need to be addressed. These are set out in Table 4 below. The financial plan has made provision for a limited number of inescapable service pressures.

Total new pressures 2015/16

Table 4

New Pressures	£m
Net Non Recurrent cost of pay award	10.0
Non Pay	27.0
Demography	25.6
FHS	22.8
Primary Care investment	5.1
Inescapable Service Pressures	7.7
TOTAL	**98.2**

Whilst there has been agreement in NHS England on the 2015/16 pay award, there is not yet an agreed position for the 2015/16 HSC pay award.

Therefore at this time, the financial plan has assumed that the 2015/16 pay award will cost the same as in 2014/15 and that it will be a non-recurrent award.

The 2014/15 pay award was projected to cost £23m on the basis of a 1% non-recurrent pay award for all staff but was implemented at a cost of £10m, hence the 2015/16 pay award has been projected to cost the same.

Non pay pressure of £27m will arise due to inflationary increases for goods and services and independent sector care. Non-pay expenditure has been modelled to increase by an average of 2%. This is to cover general inflationary uplifts and areas such as increased independent sector costs e.g. care homes.
The demography pressures identified in the plan take account of projected additional costs for each programme of care resulting from increases in population projections. The table below shows this by Programme of Care.

Demography by Programme of Care

Table 5

Programme of Care	£m
Acute Non Elective 1	8.91
Maternity 2	0.04
Family 3	0.35
Elderly 4	13.39
Mental 5	1.43
Learning Disability 6	0.47
Physical and Sensory Disability 7	0.48
Health Promotion and Disease Prevention 8	0.36
Primary Health and Adult Community 9	0.14
TOTAL CYE	**25.56**

The pressures identified for FHS are primarily to cover anticipated increased costs in Prescribing, Dental, General Medical and Ophthalmic Services including demography, residual demand, pay and non-pay inflation. See Table 6 below.

FHS Pressures

Table 6

FHS	£m
General Medical Services	1.0
General Pharmaceutical Services	18.0
General Opthalmic Services	0.5
General Dental Services	3.3
TOTAL	**22.8**

Table 7 below reflects revisions to the General Medical Services contract 2015/16 as agreed with the DHSSPS.

Primary care investment

Table 7

Primary Care	£m
Out of Hours	3.10
Diagnostic Work	1.20
GP development scheme	0.10
GP retention scheme	0.10
GP transfer	0.10
Sessional GP for apprasials	0.13
GP premises	0.35
TOTAL	**5.08**

There are a number of service developments that are a critical requirement in 2015/16 and must proceed because of statutory or other reasons. These are listed in Table 8 below.

Inescapable Service Pressures

Table 8

Inescapable Service Pressures	£m
Paediatric Congenital Cardiac Surgery Services	0.50
Virology	0.03
Paediatrics Transitional Care	0.08
Improving care for Multiple Preganacies	0.04
Neonatal Nursing (RJMS)	0.35
Looked After Children	0.25
High Cost cases	2.50
LD Community Forensic teams	0.28
LD Care Costs for adults living with older adults	1.00
LD Young people transitioning to adult services	2.50
Health Visiting	0.23
TOTAL	**7.73**

Pressures for which no funding is available

Over £100m of additional key service pressures were identified during the commissioning plan process. Only £8m of which have been included in the financial plan as these were deemed fully inescapable. The residual balances have been further reviewed and prioritised, and essential pressures will feed into the DHSSPS June monitoring bids. In the interim a comprehensive assessment has been undertaken by Local and Regional Commissioning Leads to identify any significant risk associated with these unfunded service pressures (see Appendix 3).

4.2.3 A summary of income sources and options to address identified funding gap

This section sets out the assumed additional income for 2015/16 (Table 9).

Income 2015/16

Table 9

	£m
HSCB Opening Allocation	4,114.8
PHA Opening Allocation	95.4
DHSSPS Additional funding to HSCB	148.3
DHSSPS Additional funding to PHA	1.4
TOTAL	**4,360.0**

The 2015/16 allocation letter from the DHSSPS also includes a number of other allocations/ retractions which are not included in the table above.
These are listed below:

- **15% reduction to HSCB admin budget** of £5.4m. The HSCB is currently developing plans to address this reduction.
- **15% reduction to PHA admin budget** of £2.771m. The PHA is currently developing plans to address this reduction.
- **Retraction of Conditions Management Programme** of £1m. This investment has historically been provided to help people get back to employment. Reduction in investment may affect funded posts in Trusts.
- **Clinical Negligence and other provisions settlements transfer** from DHSSPS of £39.5m. The devolvement of clinical negligence may come with associated risks to the HSCB given the difficulties in managing and predicting the resource and accounting implications.
- **Change Fund £1.46m.** The NI Executive final budget included a change fund which is for reform orientated projects that are innovative, involve collaboration between departments and agencies or focus on prevention. Funding of £4m has been identified to DHSSPS to take forward 5 projects 3 of which have been allocated to the HSCB for Extension for Community Healthcare Outcomes (ECHO), Rapid Assessment Interface Discharge

(RAID) and BHSCT outpatient modernisation. The DHSSPS has planned for a further £2.5m to be allocated later in the year to the HSCB for Congenital Cardiac Service model and NI Strategic Innovation in Medicines Management Programme.

It should be noted that in 2014/15 DSD provided £6.0m non recurrent funding to be used to help meet the care costs of people resettled from hospital to supported living schemes in the community. The £6.0m in 2014/15 was the third year of this funding (£2.0m was given non-recurrently in 2012/13 and £4.0m was given non-recurrently in 2013/14). It was understood that the £6.0m funding would be made recurrent in 2015/16, but this is now uncertain. The DHSSPS is endeavouring to secure confirmation from DSD for this funding. As this has not yet been agreed the £6.0m recurrent cost has been reflected in this plan as having to be met by the HSCB.

Efficiency Savings 2015/16

Since 2012/13 the HSC has delivered £550m as part of a comprehensive cash and productivity savings programme and in the context of annual targets by the HSCB to support financial breakeven.

Table 10 below shows additional income sources which will contribute towards the additional funding pressures identified for 2015/16. These comprise cash targets for Trusts and the HSCB totalling £122m.

There is a significant challenge for the HSC to breakeven in 2015/16 and the HSCB continues to work with Trusts and to review FHS services to identify all potential savings opportunities that could be achieved in 2015/16. To date the level of savings opportunities identified are £107m, which together with a further £15m of reduced expenditure identified from within existing baselines and from deferring investment in a number of regional projects, enables delivery of £122m.

Efficiency Savings 2015/16

Table 10

	Cash £m
Belfast HSC Trust	20.4
Northern HSC Trust	12.0
South Eastern HSC Trust	8.4
Southern HSC Trust	12.6
Western HSC Trust	11.4
NI Ambulance Service	1.2
Total Trusts	**66.0**
FHS	20.0
PPRS - Primary Care2	2.0
PPRS – Secondary Care	19.0
Sub Total	**107.0**
Regional projects not being commenced	6.0
Reductions in baseline expenditure	9.0
TOTAL	**122.0**

Trusts and Commissioners will work together to establish local plans to summarise how the cash release element will be achieved. They include a wide range of initiatives which include:

Staff Productivity

Within Trusts, savings opportunities for 2015/16 include vacancy control (scrutiny of permanent and temporary vacancies), absence management, reductions in agency costs and the management of skill mix, overtime and additional hours. There will also be a focus on securing savings from management and administration expenditure across the Trusts.

Non Pay Opportunities

Trusts are expected to target a range of areas to reduce expenditure on goods and services and discretionary spend as well as maximise the opportunities for procurement savings. This will include reviewing expenditure on items such as travel, courses and conferences, non-clinical equipment, management of minor work schemes and contract renegotiations.

Acute opportunities
Trust will continue to seek opportunities, including benchmarking with appropriate peers, to improve throughput and reduce the length of stay in order to reduce the number of beds required.

Social Care Opportunities
Trust opportunities within social care will focus on the review of the provision of domiciliary care, residential and day care and the continued implementation of reablement.

FHS Prescribing Efficiency and PPRS
The HSCB is committed to maximising efficiency across FHS services and significant savings in this area have been delivered in recent years.

Detailed project plans have been developed aimed at delivering £20m prescribing efficiency for Family Health Services in 2015-16. Achieving this scale of savings will depend upon a number of factors which may require policy and clinical support in the area of prescribing.

A further £21m savings target has been included in the plan to reflect savings from the national Pharmaceutical Price Regulation Scheme (PPRS) in both Primary Care and Secondary Care whereby a rebate is allocated to HSCNI by the pharmaceutical industry when spend on branded medicines goes above an agreed growth rate. However predicting accurately the scale of the rebate is complex and must also reflect any planned reduction in spend on branded drugs achieved as part of the general HSCNI prescribing efficiency highlighted above.

The £21m receipt is on top of a £15m estimated receipt from 2014/15, i.e. cumulative position of £36m.

4.2.4 Options to Ensure Financial Stability

The HSCB and PHA are continuing to work closely with the DHSSPS in seeking urgent solutions to resolve the funding gap which will have minimal impact on services.

However, in order to provide a balanced financial plan the HSCB has in addition identified a number of potential in year funding solutions these are listed below (Table 11). It is important to note that these will provide a temporary solution only.

Potential in year funding solutions

Table 11

		£m
RCCE	Royal Phase 2B	3.0
	Implementation of Regional Decontamination Strategy (BHSCT)	1.0
	Implementation of Regional Decontamination Strategy (NHSCT & SEHSCT)	0.9
	2nd MRI SHSCT	0.5
	Ballymena HCC	0.3
	RCCE other	1.4
Residual Demand	Residual Demand Other	1.1
	Community Resuscitation	0.1
	BHSCT Neonatal nursing	0.5
	Molecular Pathology	0.4
	Sub Total	**9**
	Elective	**22**
	TOTAL	**31**

4.2.5 Analysis of total planned investments by POC, LCG and Provider

The HSCB and PHA will receive some £4.4bn for commissioning health and social care on behalf of Northern Ireland 1.8m resident population for 2015/16.

Of the total received, over£3.2bn is spent in the six provider Trusts and other providers of care such as Family Health Services and voluntary organisations. Figure 1 illustrates this for both the HSCB and PHA.

Total Planned Spend by Organisation

Figure 1

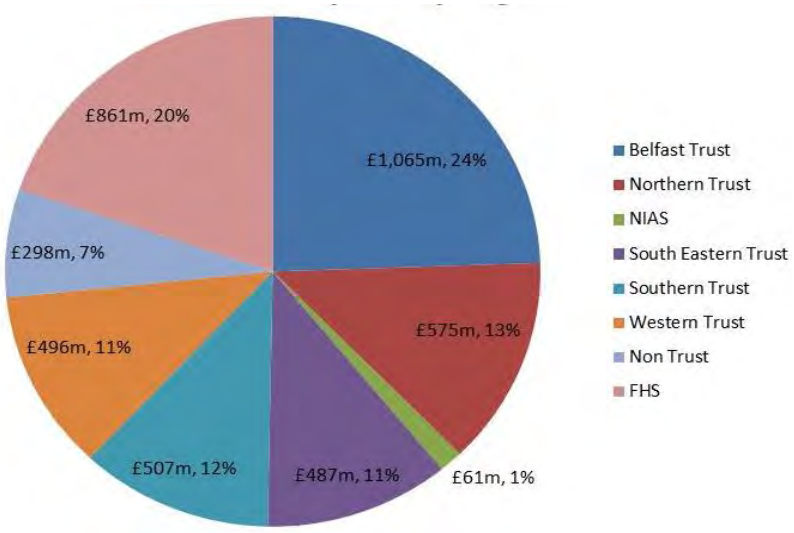


Table 12 sets out how the total resources are planned to be spent across the Programmes of Care and Family Health Services.

Planned Expenditure by Programme of Care

Table 12

Programme of Care	PHA		HSCB		TOTAL	
	£m	%	£m	%	£m	%
Acute Services	8	10.42%	1,419	42.62%	1,427	41.89%
Maternal & Child Health	0	0.06%	137	4.12%	137	4.03%
Family & Child care	1	1.02%	219	6.58%	220	6.45%
Older People	0	0.10%	681	20.47%	682	20.01%
Mental Health	13	16.28%	242	7.28%	255	7.48%
Learning Disability	0	0.00%	264	7.93%	264	7.75%
Physical & Sensory Disability	0	0.00%	108	3.23%	108	3.16%
Health Promotion	56	71.43%	47	1.42%	103	3.03%
Primary Health & Adult Community	1	0.70%	211	6.34%	212	6.21%
Sub Total	*78*		*3,328*		*3,406*	
FHS			861		861	
Not allocated to PoC*	16		68		84	
Total	**94**		**4,257**		**4,351**	
* BSO, DIS, Management &Admin						

Ensuring resources are fairly distributed across local populations is a core objective in the Commissioning process. The HSCB commissions by LCG population. Table 13 shows how the HSCB resources are planned to be spent across localities. This reflects the different population sizes and need profiles within each locality (e.g. the Northern LCG crude resident population is the largest with 25.50% and the Western LCG the smallest with 16.35%). Family Health Services (FHS) are not assigned to LCG as these are managed on a different population base. A&E, prisons and other regional services have not been assigned to LCG.

Resources by LCG

Table 13

Trust	Local Commissioning Group								
	A&E £m	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Regional £m	FHS £m	Total £m
BHSCT	21	531	125	117	49	26	196	0	1,065
NHSCT	17	2	539	0	0	1	15	0	575
NIAS	61	0	0	0	0	0	0	0	61
SEHSCT	28	39	3	372	5	0	40	0	487
SHSCT	16	1	5	6	463	2	15	0	507
WHSCT	13	0	6	0	4	450	23	0	496
Non Trust/Funds to be attributed**	0	47	50	36	41	39	1	861	1,075
Sub Total	**156**	**620**	**728**	**532**	**562**	**519**	**290**	**861**	**4,267**
Not Assigned to LCG*									84
TOTAL									**4,351**

* Includes Mgmt & Admin, BSO, DIS

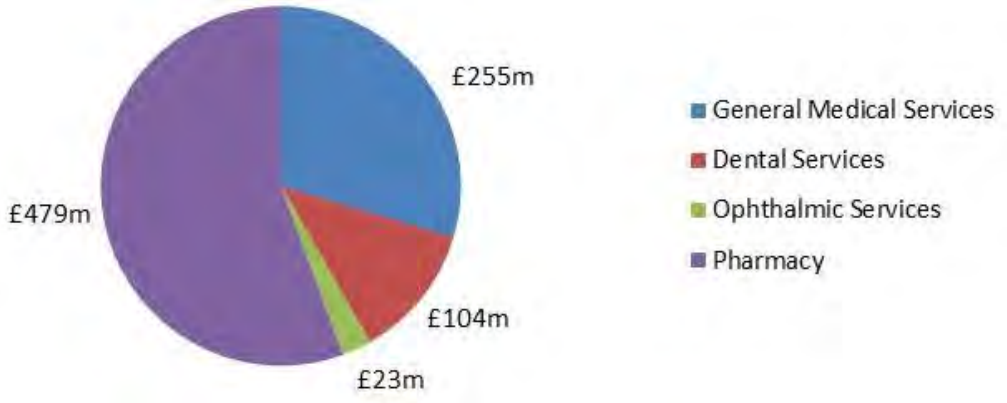
** Non Trust includes voluntaries and Extra Contractual Referrals

Total £4,351m reconciles to Table 9 total allocation £4,360m less HSCB admin reduction £5.4m, PHA admin reduction 2.8m and Condition Management Programme £1m.

The HSCB commissions services from a range of Family Health Services. Figure 2 below shows the breakdown of planned spend across these services.

Planned Spend for Family Health Services

Figure 2



4.2.6 Equity

Achieving equity in commissioning health and social care for its local population is a key objective of the HSCB. This involves comparing expenditure, access to services and quality of care received across local populations. The HSCB continuously reviews these as part of their on-going equity strategy. Part of this involves comparing at the start of each financial year the planned investment by

LCG with the capitation formula which provides a statistical assessment of the fair shares of total resources across population areas.

Capitation Formula

The Capitation Formula has been developed over the past two decades to measure the relative health and social care needs of local populations and to provide resource allocation fair shares for local populations. It takes account of factors which differentiate one population's need from another including age, socio economic factors and the cost of rural versus urban living. For this exercise updated Capitation Formula shares have been calculated to reflect the Census 2011 population.

Expenditure

The expenditure analysis identifies planned investment on local populations. This is compared to the capitation fair shares. FHS (£856m), Management and admin (£84m) and PFI unitary payment (£11m) included in Table 13 above have been excluded from the equity LCG analysis Table 14 below.

Impact of 2015/16 Plan Compared to Capitation Share

Table 14

	Local Commissioning Group					
Year	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Total £m
Capitation Shares 2015/16	20.947%	24.368%	17.910%	19.808%	16.967%	100.00%
Planned Spend - Adj for PFI	**711**	**836**	**610**	**650**	**587**	**3,395**
Capitation share	**711**	**827**	**608**	**672**	**576**	**3,395**
Equity gap (adj for PFI)	**0.22**	**8.59**	**2.41**	**(22.68)**	**11.47**	**0.00**
% from Capitation share	**0.0%**	**1.0%**	**0.4%**	**(3.4%)**	**2.0%**	**0.0%**

In percentage terms the variances are all relatively small. The largest relative underspend is in the Southern LCG. Residents in this area however benefit from the fact that their local Trust, SHSCT, is one of the most efficient Trusts in the region and therefore services will cost less than similar services in other Trusts.

The financial plan in recent years has been skewing additional resources with the specific aim of reducing capitation variances within a manageable process. In 2015/16 for example the Southern LCG will receive over £5m more than its capitation share of the additional 2015-16 funds. More material adjustments would potentially destabilise services, however it is recognised that the best strategy would therefore ensure increased access to local populations within the existing infrastructure.

4.3 Shifting Financial Resources through Transforming Your Care (Based on Gross Costs)

The Commissioning Plan Direction for 2015/16 contains a target by March 2016 to transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. An early indication for 2015/16 is that shift left delivered by the end of 2015/16 will cumulatively total a minimum of £45m.

4.3.1 Effecting the shift

The Commissioning Plan Direction for 2015/16 contains a target by March 2016 to transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. An early indication for 2015/16 is that shift left delivered by the end of 2015/16 will cumulatively total a minimum of at least £45m; however as the TYC programme and the projects therein are subject to continual change the value of shift left is likely to increase.

In order to affect this shift of care and funding, the HSCB will continue to commission services to be delivered in a different way. There will be a number of strands to this work including:

Integrated Care Partnerships (ICPs)

Integrated Care Partnerships are central to engaging clinicians and other health and social care professionals in leading reform and improve health outcomes. Each ICP has representation from general practice, pharmacy, acute medicine, nursing, allied health professions, social care and ambulance staff as well as

service users, carers and representatives from the voluntary and community sectors.

Built into the day to day work of ICPs, and to the supporting development initiatives put in place by the HSCB, is the development of new pathways and ways of working as well as opportunities for sharing across professional boundaries and across the clinical priorities of frail elderly, respiratory stroke, diabetes and end of life care. This is delivered through ICP working groups, committee meetings, and regular regional events including a regional workshop each year with all ICP committee members, and regular cross-ICP chairperson meetings, the majority of which are clinicians.
HSCB would envisage the development of clinical networking through ICPs as a real opportunity for these inspirational leaders to grow and support each other.

A variety of initiatives will either be introduced or expanded. These include:

- Acute/Enhanced Care at Home
- Falls Prevention
- Rapid Response Nursing
- Advanced Access to Diagnostic Tests
- Community & Hospital Pharmacy Lead Reviews
- Access to Community Specialist Respiratory Teams
- Home Oxygen Service
- Stroke Early Supported Discharge
- Diabetes management including comprehensive foot care

The HSCB does not anticipate that any of the above projects will achieve any material shift in funding before 2016/17.

Acute care
It is envisaged that a number of reform initiatives will be undertaken specifically within acute care, which ultimately will shift care out of hospital settings or reduce the hospital activity that would otherwise have occurred. Examples of potential initiatives where shift left from acute care could be delivered in

2015/16 and beyond are listed below. These will be confirmed via the Trusts response to this Commissioning Plan.

- Patients being admitted to an acute stroke unit as the ward of first admission
- Community Mental Health (Dementia) Teams
- Increased hyper acute care post thrombolysis treatment
- Increased Stroke Community Infrastructure to support Early Supported Discharges from hospital
- Increased use of Rapid Response Nursing Teams
- Increased use of Community Mental Health Teams
- Primary Percutaneous Coronary Intervention services
- Sepsis Screening, Early Detection and Intervention
- Virtual respiratory clinics
- Implementation of Day of Surgery Units
- New Ambulance Response Models
- Ambulatory Wards
- Increased Access to Renal Home Therapies
- Increased review by Community Pharmacists of Medicines Prescribed to Nursing Home Clients
- Home Based Diabetes Management Systems
- Outpatient Reform
- Reform of Hospital based Care Pathways.

Calculation of 'shift left' associated with hospital activity avoided is complex. At the time of writing it is expected that the above initiatives will contribute a value of £1m that can be delivered by the end of 2015/16.

Learning disability & mental health resettlement programmes

The resettlement programmes, which have are not yet complete, have contributed £28m to the £45m of shift left that can be delivered by the end of 2015/16.

Recurrent Investment in Reform

Since 2012/13, LCGs have been investing funds recurrently in a number of reform areas. These include Glaucoma Services in Primary Care, Community Nursing to Support Early Discharge, Telemedicine, Palliative Care Services in the Community and Reablement. By the end of 2015/16, it is estimated that £16m will have been invested by LCGs to commission new services from Primary Care, Secondary Care and the Third Sector. This has formed a significant contribution to the achievement of the £45m of Shift Left. Further investment in 2015/16 is likely following finalisation of the financial plan.

A summary of the service changes that will contribute to £45m of Shift Left by the end of 2015/16 is outlined in the table below.

Overview of financial resources to be shifted into primary/community setting
Table 15

	2012/13	2013/14	2014/15	2015/16	Total
	£m	£m	£m	£m	£m
	Actual	Actual	Actual	Estimated	Cumulative
ICPs	0	0	0	0	0
Acute Care	0	0	1	0	1
MH Resettlement	4	7	0	0	11
LD Resettlement	7	7	3	0	17
Recurrent Investment in Reform	6	8	2	0	16
Total	17	22	6	0	45

Further work is underway to provide a more robust assessment of the financial impact of all shift left initiatives and their associated timescales.

The HSCB will continue to investigate all opportunities to commission services in a different way to ensure that more services are provided either outside a hospital setting or moved along the care continuum. In that context, the shift left plan will continue to be refined and updated throughout the year informed by the HSCB.

4.3.2 Monitoring the Delivery of Financial Shift Left

The delivery of this shift in resources will be monitored and measured on a monthly basis by the HSCB and reported through the TYC Transformation Programme Board and associated governance structures. It is anticipated that this will be demonstrated both through a review of key activity levels/metrics as well as an analysis of the associated financial resources.

The funding position in 2015/16 will impact on the pace and scale of key regional reform initiatives. Particular service developments impacted include:

- Further expansion and roll out of reablement
- Acceleration and expansion of work in relation to redesign and implementation of care pathways
- Reform and modernisation of outpatient services
- Expansion of ICP initiatives in relation to frail elderly, diabetes, respiratory and end of life care
- GP Practices proactive management of the care of those at greatest risk of deterioration to reduce unplanned admissions
- Pilot of the Atrial Fibrillation Enhanced Service
- Elements of the Primary Care Infrastructure Development Strategic Implementation Plan.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow many of these priority reforms to be taken forward.

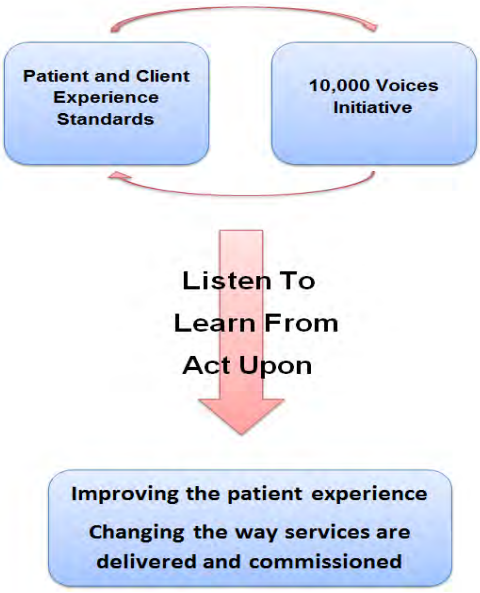
5.0 Listening to Patient and Client experience and learning from Personal and Public Involvement

The HSCB / PHA are focused on ensuring that our services are truly person centred; that they address need; that service users and carers have a voice in the commissioning, planning and delivery of services and that patient and client experience informs and shapes culture and practice. It does this in two key ways. Firstly through the implementation of DHSSPS Patient Client Experience Standards and the 10,000 Voices programme and secondly through compliance with the Statutory Duty to Involve and Consult, as set out in the HSCB and PHA's Personal and Public Involvement responsibilities.

5.1 Patient Client Experience Standards & 10,000 Voices

The PHA and HSCB lead on the monitoring and implementation of the DHSSPS Patient Client Experience Standards through a regional comprehensive work-programme with HSC Trusts. In 2014/15 the HSCB/PHA led the implementation of Experience Led Commissioning through 10,000 Voices and established a system which was responsive to 'real time improvements' ensuring that the 'patient/carer' voice was central to and informed local changes to practice. Throughout 2015/16 the HSCB/PHA will integrate the Patient Client Experience work programme and 10,000 Voices in order to further develop and improve systems to listen to, learn from and act upon patient and client experience.

Figure 3



Based on the outcomes from the audit of the five Standards of Patient Experience and 10,000 Voices the HSCB/PHA is committing to the following key priorities in 2015/16:

- Ensuring that patient experiences from patients on hospital wards is effectively communicated to all staff involved in the commissioning of services via the provision of updates and briefings to the Local Commissioning Groups (LCGs) and to the Boards of the HSCB and PHA.
- Undertaking a comprehensive work programme using 10,000 Voices surveys (patient and staff) in a range of other settings (e.g. Emergency Departments), with a particular focus on patients/carers and families in 'hard to reach groups' e.g. autism and CAMHS services
- Engaging other key stakeholders in 'listening to and learning from patients/carers/families' experience. For example, engaging with RQIA to undertake work to gain experience from residents in nursing and residential homes.
- Engaging with education providers to ensure that findings inform training for pre and post registration staff in medical, nursing, midwifery and Mental Health and Dementia teams.
- Raising the profile of "Hello my Name is…" in the primary care setting.
- Looking at ways of reducing 'Noise at Night' in hospital wards.

5.2 Patient Client Council (PCC) Peoples' Priorities 2014

Each year, the PCC ask the population of Northern Ireland to identify their top ten priorities for the coming year. The HSCB and PHA take account when deciding how to prioritise how they will invest available resources. The table below outlines the top 10 priorities and which section of the plan each priority is addressed.

Table 16

Priorities	Commissioner Response
1. Frontline health and social care staff	See section 3.5
2. Waiting times	See 6.3 & 8.0
3. Quality of care	See section 3.2, 3.4 & 6.3
4. Care of older people	See sections 6.2 through to 6.5 & POC 4 in LCG Plans
5. A&E services	See section 6.3.2

6. Funding, management, and cost-effectiveness	See section 6.6
7. GP services	See section 7.5.1
8. Access to a full range of health and social care services locally	See LCG Plans sections 9.0 through to 13.0
9. Cancer services	See section 6.3.6
10. Health and social care for children and young people	See sections 6.4.4 & 6.5

5.3 Personal and Public Involvement

The HSCB and PHA recognise that Personal and Public Involvement (PPI) is core to the effective and efficient design, delivery and evaluation of Health and Social Care (HSC) services. PPI is about the active and meaningful involvement of service users, carers and the public in those processes. The legislative requirements for HSC organisations in regard to PPI are outlined within the HSC (Reform) NI Act 2009. The concept of Involvement is also regarded as a Ministerial Priority.

Standards for PPI

A set of standards and Key Performance Indicators for PPI which were developed under the leadership of the PHA have been agreed with the DHSSPS, were endorsed by the Minister and launched in March 2015. The standards aim to embed PPI into HSC culture and practice, ensuring that the design, development and delivery of services is informed and influenced by the active involvement and input of those who are in receipt of them.

Involving Patients and Clients in the Commissioning of Services

All commissioning teams and Local Commissioning Groups actively consider PPI in all aspects of their work throughout the year, from ensuring that input and feedback from service users and carers underpins the identification of their commissioning priorities, to involving service users and carers in the development of service models and service planning, and in the evaluation and monitoring of service changes or improvements.

Each LCG has consulted on the local commissioning priorities contained within this document and has taken account of the feedback received. In addition, the HSCB / PHA have hosted a workshop of service users and carers to consult

on the regional themes and priorities included within the plan. The workshop, which was attended by 75 people, brought together individuals from across the nine equality groupings and generated useful feedback which has been incorporated within this document and helped to inform the accompanying screening document.

The PHA and HSCB have recently worked with staff, service users and carers, to take forward the development of PPI Action Plans for 2015-18. These plans outline our key commitments in relation to PPI and what we intend to do over the next three years in order to deliver on those commitments.

ICPs are another vehicle for effective involvement of service users and carers. Each ICP has a service user and a carer representative who fulfil a vital role in helping to ensure that ICPs plans for greater integration of services are person centred and meet the needs of those who use services.

Increasing our capacity to engage with service users, carers and the public.
In its capacity as regional lead for PPI for the HSC, the PHA has led on the design and development of a PPI awareness raising and training programme for all HSC staff. This will provide a comprehensive PPI training programme for staff which is responsive to and accessible by the diverse range of staff across HSC organisations.

The HSCB has:

- Jointly funded a training programme specifically for service user's and carers in partnership with the Patient Client Council;
- Funded accredited training (ILM level 3) for service users and carers who work with the HSCB; and
- Invested in the Involving People Programme, an in-depth PPI and community development training programme for staff.

6.0 Regional Commissioning – Overarching Themes

6.1 Improving & Protecting Population Health & Reducing Inequalities

Improving health and reducing health inequalities requires coordinated action across health and social care, government departments and a range of delivery organisations in the statutory, community, voluntary and private sectors. DHSSPS published Making Life Better in 2014, a whole systematic strategic framework for public health which sets out key actions to address the determinants of health. Investment in prevention is a key contributor to reducing future demand for health and social care. A healthy population also contributes to economic prosperity, high educational attainment, and reduced reliance on welfare.

In Northern Ireland between 2002 and 2012 more than 41,000 people died prematurely of disease which was potentially avoidable or potentially treatable. Nearly 700,000 life years were lost. In 2012, 3,756 people died of illness which could either have been prevented in the first place (84%) or if detected early enough could have been treated successfully. Some, but not all, preventable deaths are directly related to healthcare and many reflect lifestyle and underlying social and environmental influences or what are referred to as the 'social determinants'.

Those most likely to die prematurely included men (61% for 2012), reflecting the four and a half year gap in life expectancy between men and women, and those living in our most deprived areas. Residents of most deprived areas are two and a half times as likely to die prematurely of preventable things as those in least deprived areas. This increases to a factor of four for drug and alcohol related deaths and three times for suicide, respiratory problems and lung cancer[1] .

The DHSSPS disaggregation of life expectancy differentials in Northern Ireland[2] highlighted the reducing impact of circulatory disease on premature mortality with the increased contribution of cancers and accidental injuries and suicide amongst

[1] http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-and-age-65-in-the-united-kingdom/2008-10/index.html
[2] http://www.dhsspsni.gov.uk/life-expectancy-decomposition

the younger age groups, particularly in more deprived areas. Known inequalities in health have been identified across a range of groups including:

- Travellers
- Young men
- Ethnic minorities
- Lesbian, Gay, Bisexual and Transgender (LGB&T)
- Migrants
- Carers
- Prisoners
- Homeless
- Disabled
- People living in more deprived areas

In producing local action plans, the LCGs have taken consideration of these groups and where appropriate how they may be targeted. Likewise any health improvement programmes, information and support services will assess any necessary additional requirements in order to enable full engagement or access for these groupings.

While the work programme for 2015/16 is likely to be impacted upon by the reduction in the administration budget within the PHA, improving and protecting population health and reducing health inequalities remain priorities across the HSC. The following paragraphs provide details of the specific commissioning intentions for 2015/16 to achieve these aims.

6.1.1 Giving every child the best start

The PHA will continue to prioritise investment in early years' interventions. Commissioning intentions during 2015/16 will include:

- Expansion of the Family Nurse Partnership Programme to the Northern and South Eastern Trusts, thereby providing N Ireland wide coverage, and developments in health visiting, early intervention services and family support hubs.

- Expansion of evidence based parenting support programmes which will support the development of the infant mental health action plan; the implementation of the Early Years Transformation Programme
- Implementation of the breast feeding strategy across all trust areas with specific attention to the training of staff, peer support and accreditation of facilities to meet the World Health Organisation UNICEF Baby Friendly standards.

6.1.2 Tackling poverty

Specific Commissioning Intentions for 2015/16 will include:

- Delivery of the MARA programme funded by the Department of Agriculture and Rural Development; this programme reduces rural isolation and poverty and achieves a 9-fold return on investment.
- Support through community networks for a range of local programmes
- Keep Warm initiatives with vulnerable populations

6.1.3 Sustainable communities

The PHA will continue work with a range of partners to use sports, arts and other leisure opportunities to improve the health and wellbeing of local populations. Specific Commissioning Intentions for 2015/16 include:

- Implementation of the Action Plan of the Regional Travellers Health Forum
- Expansion of the NI New Entrants service; and a support to a range of community development and health programmes.

6.1.4 Supporting healthier choices

The PHA will continue to implement a range of public health strategies to support people in making healthier choices. Specific Commissioning Intentions for 2015/16 include:

- Implementation of the obesity prevention strategy [*Obesity is one of the most important public health challenges in N Ireland today; the prevalence of obesity has been rising over the past number of decades. Projections suggest that half of the UK will be obese by 2030 – a rise of 73%. Research has shown that obesity can reduce life expectancy by up*

to 9 years, increasing the risk of coronary heart disease, cancer, type II diabetes and impacting mental health, self-esteem and quality of life (CMO, 2010)]

- Roll out of the 'Weigh to a Healthy Pregnancy'; (In accordance with Ministerial Target 2, appendix 2)
- Implementation of the tobacco control strategy including smoking cessation services [*First results published from the Health Survey, Northern Ireland (2013/14) reveal that around one-fifth of respondents (22%) were current smokers, a reduction in the proportion of overall smoking prevalence from 24% in 2012/13. There was no difference in smoking prevalence for males (23%) and females (21%) in 2013/14 and no change from 2012/13*];
- Promoting mental and emotional wellbeing and implementation of the suicide prevention strategy including procurement of new services and development of the Self-Harm Registry;
- Implementation of the sexual health strategy including improving access to public information and sexual health services –to include the development of a service specification which will enable closer integration of sexual and reproduction health services;
- Implementation of the New Strategic Direction for alcohol and drugs and the procurement of new services including the a priority to work toward a seven day integrated and coordinated substance misuse liaison service in acute hospital settings using agreed Structured Brief Advice or Intervention programmes. These services will be rolled out during 2015/16. (In accordance with Ministerial Target 3, appendix 2) [*Alcohol and drugs misuse have been a significant issue in N Ireland for many years. Alcohol related admission rates have also been on the increase in N Ireland over the past 5 years, see table below. In general admission rates have increased for all Trusts with the exception of Northern. Alcohol related standardised admission rates and death rates for Belfast Trust residents are significantly higher than all other Trusts*].

Certain population areas/groupings are also key priorities including disadvantaged areas, older people, homeless people, black minority ethnic groups, prisoners, Travellers, LGB&T, looked after children, and those with disability.

6.1.5 Screening & Health Protection

Screening

Screening is an important public health function that involves inviting members of the public, who have no symptoms of a particular disease, to be tested to see if they might have the disease, or are at risk of getting it. Population screening allows certain diseases and conditions to be identified at an early stage when they are more amenable to treatment. The PHA is the lead organisation for commissioning and for quality assuring population screening programmes.

During 2015/2016 the key deliverables will include:

- The bowel cancer screening programme has been fully rolled out to include the population aged 60-74. Work will be ongoing to attain the 55% uptake and ensure that standards and relevant accreditation are attained and maintained. (In accordance with Ministerial Target 7, appendix 2)
- Develop a business case for an IT system to support the new-born hearing screening programme (NHSP) in N Ireland in order to eliminate many manual processes Increase the number of Joint Advisory Groups on GI Endoscopy accredited units within Northern Ireland by one in 2015/16 in order to ease the pressure on endoscopy services whilst also offering more choice for patients.

Health Protection

The Health Protection Service is a multidisciplinary service in the Public Health Directorate in the PHA. It comprises Consultants in health protection, nurses in health protection, epidemiology and surveillance staff, and emergency planning staff. The health protection service delivers on statutory responsibilities of the

Director of Public Health, with respect to protecting the health of the NI population from threats due to communicable diseases and environmental hazards. It provides the acute response function to major issues, such as outbreaks of infection and major incidents. The PHA Health Protection Duty room is the first point of call for all acute issues in relation to infectious disease incidents and for notifications of infectious diseases.

The funding position in 2015/16 will impact on the ability of commissioners to take forward the introduction of a surveillance system for antimicrobial resistant organisms and a region wide programme on antimicrobial stewardship.

Communicable diseases disproportionally affect certain groups in the population including those at social disadvantage, living in poor housing conditions, migrants from countries that have higher prevalence of infectious diseases, and those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities. Healthcare Associated Infections (HCAIs) are an important cause of morbidity and mortality. Levels of infections are increasing.

Commissioning priorities for 2015/16 include:

- *Healthcare Associated Infections (HCAIs)*
  - Trusts, supported by PHA will develop and deliver improvement plans to reduce infection rates. This will be monitored via PHA surveillance programmes for HCAIs. (In accordance with Ministerial Target 20, appendix 2)

- *Flu immunisation*
  - Trusts and Primary care to implement the flu immunisation programme for all pre-school children aged two and over, and all primary school children, increasing uptake to the required level (75%)
  - Trusts and Primary Care to increase uptake of flu immunisation among healthcare workers.

- *Meningitis B immunisation programme*
  - PHA will oversee the introduction of the programme, with the vaccine being offered from September 2015 onwards to infants at 2, 4 & 12 months of age. Primary care and Trusts should implement the programme ensuring that uptake is similar to that achieved for other vaccines given at these ages.

    The funding position in 2015/16 will impact on the ability of commissioners to take forward this programme. The PHA has supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow this and other public health priority service developments to be taken forward. The PHA will also continuously review commitments to ensure best use of all available resources.

- *Hazardous Area Response Team*
  - HART in NI is a well-established specialist response team in NIAS that provides essential paramedic level care to casualties within the hazardous area of a CBRN:HAZMAT incident. PHA works closely with HART in training for and responding to CBRN:HAZMAT incidents and as such will continue to work with HSCB colleagues to ensure that the present capability of this vital service is maintained

6.2 Providing care closer to home

Providing care closer to home, often in primary and community care settings means that people can access and receive services in the most appropriate place for them. By viewing home or the community as the 'hub of care', there is also potential to reduce the need for avoidable visits to hospital. The focus is on the patient and providing alternative options to admission to hospital, and creating the opportunity to prevent such occurrences whenever possible.

Multi-disciplinary teams provide the primary source of intervention, allowing quick response and effective treatment to be delivered locally. Community teams also help individuals to prevent their condition from worsening, with regular contact (particularly with those with long-term conditions) along with practical support and education.

Technology is also a key enabler to providing care closer to home. Greater support can be given to individuals and health care professionals through telehealth monitoring. Individuals can also have the ability to better manage their own condition through a combination of technology and access to information. The eHealth and Care Strategy implementation plan provides a framework for the introduction of technology enabled services.

The following service developments have been prioritised during 2015/16.

6.2.1 Commission acute care closer to home

During 2015/16, the HSCB will continue to implement their acute care at home commissioning framework. 'Acute care at home' is 'a service that provides active treatment by health care professionals in the persons own home for a condition that would otherwise require acute hospital in-patient care and always for a limited time'. The main components of the model moving forward in Northern Ireland are:

- Community Geriatrician led through a single point of referral with access to an ambulatory assessment facility, same day diagnostics, community Geriatrician-led inpatient beds and Speciality or Medical Admission Unit beds through direct discussion with the relevant Consultant. Other members include Medical Officers including those with General Practice skills, Nursing, Physiotherapy, Occupational Therapy, Social Work and Pharmacy.
- The team provides direct clinical care and will treat and manage the frail older person in the acute phase of illness i.e. 24 – 72 hours before formally returning the management of care to the GP and other community/ specialist teams.
- The team will cover 24/7 over 7 days although it is accepted that this will happen over a period of time.
- The team will be supported by 24/7 district nursing and GP in and out of hours service.

The HSCB, through the LCGs, will work with ICPs to implement the Framework as described.

6.2.2 Ensure effective community nursing and AHP interventions

The District Nursing service is the main provider of nursing care for patients in the community. The rising challenges and demands of an aging population with more complex and multiple health and social care needs, means that the need to prevent hospital admissions and reduce length of hospital stays is increasing and that the role of the District Nursing service is more highly valued than ever.

The District Nurse works autonomously and has a central and decisive role in the assessment, planning and delivery of care in the community. This includes the patient's home, or that of a family carer/informal carer, a residential/nursing home and a clinic/outpatient setting. Simultaneously the role also requires that the District Nurse works collaboratively and in partnership with statutory and non-statutory colleagues to coordinate care. This includes public health, self-management / teaching, provision of a range of treatments and interventions, palliative and end of life care.

Investment in District Nursing will be fundamental to the successful delivery of the integrated care pathways that are being implemented by ICPs across the clinical priority areas during 2015/16, such as long term conditions and frail elderly

AHPs will also play a fundamental role in the transformation of care through the use of preventative upstream approaches which enable people to live well and for as long as possible in their own homes and communities:

- undertaking roles in health promotion, health improvement, diagnosis, early detection and early interventions
- supporting service users to avoid illnesses and complications through enhanced rehabilitation and re-ablement to maximise independence; and
- supporting people of all ages to manage long term conditions.

Investment in community nursing and AHP provision will be fundamental to the successful delivery of the integrated care pathways and the new models of care (e.g. community wards, rapid response teams) that will be developed and implemented by ICPs across the clinical priority areas during 2015/16.

Commissioning priorities to be taken forward at regional level during 2015/16 include:

- Implement the DHSSPS District Nursing framework when approved
- Continued expansion of the district nursing service which includes a 24/7 service
- To commence the implementation of the community indicators for community nursing including District Nursing
- To ensure the electronic caseload analysis tool is functioning consistently in all HSC Trusts
- Increased roll out/implementation of radiography led plain film reporting
- Capacity building in ultrasound/sonography services for direct access from primary care, early detection and obstetrics
- Implementation of a Direct Access Physiotherapy pilot within South Eastern Trust, to commence May 2015 for a period of 9 months
- Continued delivery of the joint HSCB/PHA Regional Medicines Management Dietitian initiative to ensure the appropriate use of Oral Nutritional Supplements (ONS)
- Implementation of the AHP Strategy - Improving Health & Wellbeing through positive partnerships 2012/2017.

6.2.3 More appropriate targeting of domiciliary care services

The HSCB is committed to providing a range of health and social care services close to, or in, people's own homes and communities. Receiving services locally is typically people's first preference so wherever possible the HSCB will deliver care that is locally accessible and addresses individual need.

Domiciliary care is an important service that ensures people can remain in their own homes for as long as possible with the greatest possible level of independence. Regionally, approximately 24,000 people are supported by domiciliary care services; this equates to delivery of nearly 250,000 hours of care per week. Some of this support is provided directly by Trusts and some via a network of independent sector providers.

Domiciliary care is most effective when targeted at key client needs enabling it to respond quickly and flexibly to any changes in client circumstances. This means that the level of domiciliary care provided may increase or decrease over time.

Key actions during 2015/16 will include:

- Prioritising client need to allow domiciliary care to be targeted at those with higher level needs thus ensuring that flexibility and capacity are maintained within the service as a whole
- Ensuring care packages are kept under review and revised to meet changing client needs
- Implementation of the recommendations associated with the HSCB led Regional Review of Domiciliary Care.
- Improved interfaces with other services such as re-ablement to ensure that people receive focused and intensive packages of support when required
- Developing formal and informal arrangements with the community and voluntary sector to enable people to access a range of alternative community services such as befriending services or luncheon clubs
- Engagement with the independent sector to ensure providers are able to respond to the changing profile of user need (i.e. frail elderly, more highly complex needs).

The funding position in 2015/16 will impact on the ability of commissioners to maintain effective domiciliary services for older people with providers expressing concern regarding the increasing costs and their ability to provide these services within existing funding. It is becoming an increasing challenge to source independent provision in some parts of Northern Ireland, particularly in the remoter rural areas. Some providers are also finding it increasingly difficult to attract workers at the rates per hour currently being paid. Depending on the outcome of forthcoming Trust tendering processes, the funding available for demographic increases this year may not be sufficient to cover both the needs of an increasing number of older people as well as an increase in the cost per hour.

6.2.4 Statutory Residential Homes

The HSCB was asked by the former Minister, Edwin Poots, in 2013 to lead a consultation to determine criteria to assess the future role and function of statutory residential homes across the five Health and Social Care Trusts. A thorough and robust consultation was led by the HSCB in conjunction with the Trusts and a post consultation report on the agreed criteria for the evaluation of statutory residential homes was approved at its public HSCB meeting in June 2014.

The final criteria was used by Trusts to assist decision making about the role and function of statutory residential care homes in the context of planning suitable services for older people in the future. Trusts were then required to subsequently submit their proposals for change to statutory residential homes, following their evaluation of each home, to the five Local Commissioning Groups and the HSCB for consideration.

Following HSCB challenge and review of Trust proposals for change in late 2014, the HSCB project team summarised the regional proposals for change to statutory residential care for older people. Subject to DHSSPS approval the proposals contained in the report will be subject to consultations by individual Trusts in 2015/16.

The Department of Health, Social Services and Public Safety has now requested the HSCB to pause in considering the Trusts' proposals on the future of each home at this stage, whilst it considers the outcome of the Dalriada judicial review and the potential impact this may have on any future consultations. Having taking cognisance of public consultation on the proposed changes to residential homes, individual Trusts will commence their programme of change in 2015/16.

6.3 High quality, safe & effective care

The HSCB and PHA place the quality of patient care, in particular patient safety, above all other issues, and are continually working to monitor and review services. This is more important than ever in the context of the current unprecedented resource difficulties. While health and social care is both complex and pressurised, the HSCB and PHA are focused on ensuring that the experiences of patients, clients

and carers are shared, understood and acted upon, appropriately influencing commissioning.

At the beginning of this year the Minister published for consultation the Donaldson Review (The Right Time, the Right Place). The majority of the findings and recommendations within the Review Report centre on the quality and safety of services and arrangements in place to learn from incidents and complaints.

While it is reassuring that the Review concluded that services in Northern Ireland are likely to be no more or less safe than those in any other part of the UK or comparable country globally, it did identify areas where improvements can be made. The HSCB and PHA will work with the Department, Trusts and other organisations to take these forward during the next year and beyond.

Key priorities for the HSCB and PHA in 2015/16 in relation to the safety and quality agenda are outlined below.

6.3.1 Quality Improvement Plans (QIPs)

The HSCB/PHA is required through the HSC framework (DHSSPS, 2011) to provide professional expertise to the commissioning of health and social care services that meet established safety and quality standards and support innovation.

The HSCB/PHA gain assurances on progress with regional safety and quality priorities through Quality Improvement Plans (QIPS). These consider the safety and quality indicators of performance which must be included in QIPS developed by Trusts. HSC Trusts are required to submit to PHA, an annual Quality Improvement Plan which includes the indicators identified in the HSCB/PHA Commissioning Plan. QIPs for 2015/16 include:

- Falls: - Trusts will continue to improve compliance with Part B of the 'Fallsafe' Bundle. Trusts will spread Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented.

- Pressure Ulcers: 'From April 2015 establish a baseline for the Incidents of pressure ulcers (grade 3 & 4) occurring in all adult inpatient wards & the number of those which were unavoidable.'
- Venous Thrombosis Embolism: Trusts will sustain 95% compliance with VTE risk assessment across all inpatient hospital wards throughout 2015/2016.
- Sepsis6: The HSC Safety Forum will monitor the Sepsis6 bundle compliance in the pilot areas and establish a spread plan.
- The 'Malnutrition Universal Screening Tool' (MUST) tool: % compliance of the completed MUST tool within 24 hours admission to hospital in all Adult Inpatient Wards by March 2016.
- Early Warning Scores (EWS): % compliance with accurately completed EWS charts.

6.3.2 Unscheduled Care Services

The ensuring of safe and effective unscheduled care services continues to present a particular challenge for both commissioners and providers. This matter has been given the very highest priority, including the establishment by the Department of a regional Unscheduled Care Task Group chaired by the Chief Medical and Nursing officers. However patients at a number of larger hospital sites continue routinely to have to endure long waiting times in Emergency Departments for assessment, treatment and, where appropriate, admission to hospital.

Regionally the Unscheduled Care Task Group identified five priorities to be addressed to improve patient flow, with a focus on seven day working. Three of these priorities will be progressed in year; however the priorities relating to medical workforce (to ensure twice – daily decision making) is likely to have significant resource implications which cannot be fully addressed within available funding for 2015/16. However, work will continue to be taken forward with Trusts to review and address outstanding medical workforce issues with a view to delivering twice-daily Senior Decision making for inpatients and more generally improving the effectiveness of ward rounds.

A further issue is that, when patients are admitted to hospital, it is often by necessity to a bed in a ward area other than that which would be most appropriate for their healthcare needs. This is very challenging for both patients and staff and compromises the patient experience, quality of care and presenting risks in terms of patient safety. It has also impacted materially on the provision of key regional services such as cardiac surgery, due to specialist beds being occupied by general unscheduled care patients necessitating the frequent cancellation of planned surgical procedures.

Levels of demand for unscheduled care services have continued to increase with sustained pressures on services throughout the winter and into the springtime.

Against this exceptionally challenging background, the key objectives and actions to be progressed by the HSCB and PHA in 2015/16 include the following:

- The continued roll out of a range of measures to identify earlier and better meet patients' needs in community settings and to avoid the need for patients to attend hospital. These measures include:
  - The establishment of Acute Care at Home models and other rapid response arrangements.
  - The establishment of a range of alternative care pathways, linked to the NI Ambulance Service, to provide alternatives for both patients and staff to hospital attendance.
  - The establishment on a pilot basis of an alcohol recovery centre in Belfast.
  - The reform of palliative care services, facilitating people to die in their place of choice – typically their own home - rather than a hospital bed. During 2015/16 this will include:
    - The implementation of advance care planning arrangements across Northern Ireland to allow the needs and wishes of palliative care patients to be identified and planned for.
    - The implementation of a key worker function – typically the District Nurse to oversee care planning arrangements.

The above measures will take time to embed, and the pace and scale of service change will be impacted upon by the availability of resources. In parallel with the above "out of hospital" initiatives, arrangements will be taken forward to further improve the flow of patients through hospital and back into community settings, with a particular focus on moving towards seven-day working. Key initiatives in this regard to be taken forward in 2015/16 at the five larger hospital sites include:

- Establishment of radiology services seven days a week to support same day/next morning investigation and reporting (to include CT, MRI and non-obstetric ultrasound scans).
- Establishment of dedicated minor injury stream in EDs (9am to 9pm, 7 days a week).
- Embedding of physiotherapy, occupational therapy, pharmacy and social work support within EDs and short-stay wards (9am to 5pm, 7 days a week).

During 2015/16 the HSCB will continue to progress with Trusts and primary care directly (including through the newly established GP Federations) and through ICPs a range of other initiatives to improve hospital flows and the patient experience:

- The roll out of same day/next day ambulatory care models, providing an appropriate alternative for many patients to admission to hospital (as well as providing a key vehicle to transform outpatient services more generally).
- The roll out of alternative care pathways for frail elderly patients, avoiding as far as possible the need for them to wait in Emergency Departments.
- Appropriate and early planning for winter 2015/16 informed by the findings and recommendations of the recent external stock-take commissioned by the HSCB in relation to planning arrangements for the winter of 2014/15.

More generally, local discussions between LCGs and Trusts have highlighted particular ED and acute care pressures that are currently impacting on performance against the 12 hour and 4 hour standard. A number of these will require additional investment which is unlikely to be available in 2015/16. The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS to make a bid through June monitoring for additional in-year resources to enhance unscheduled care services

and improve patient flow, and will consider any other opportunities to provide additional funding in-year.

6.3.3 Acute reform

Transforming Your Care set out the strategic direction of travel for acute services to be based around 5-7 hospital networks within which services would be configured to secure the sustainability of services and care pathways to ensure patients have the best possible outcomes by being able to access the right service from the right clinical team as rapidly as possible. The function of each hospital within a network is becoming more specialised with some offering mainly acute emergency treatment and others focusing on care for the frail elderly and those with long term conditions.

The RQIA highlighted the importance of care pathways for acute care within each hospital network as well as between local networks and regional specialties. The review supported the development of direct admission arrangements, with patients avoiding Emergency Departments where appropriate, and recommended a collaborative approach to the development of care pathways across the health and social care system both within each hospital network and at regional level.

The HSCB will establish a regional workstream to further develop care pathways. Developments currently underway will be extended. GPs will increasingly able to contact specialists directly, for example through a single phone number in Belfast, to discuss the most appropriate care plan for their patient which may mean receiving acute care at home delivered by specialist community teams or being transported directly to hospital-based assessment and admission if required. As referred to above, protocols are being introduced for the NI Ambulance Service to enable paramedics to make decisions in the patient's home about their care pathway with specialist advice.

Care pathways are being agreed jointly between regional specialists, local networks and primary care. Regional specialties such as Neurology will continue to extend their support to local networks and groups of GP through tele-medical links, referral for advice and peer education sessions.

Key initiatives to be taken forward in 2015/16 include:

- The completion, by September 2015, of a public consultation on the delivery of vascular services on a regional, networked basis
- The development, by December 2015, of a networked urology services on a safe, sustainable basis
- The development of a long term plan for the delivery of networked neurology services on a safe, sustainable basis.

6.3.4 Delivering Care

As referred to in Section 3 of this Plan, *Delivering Care: Nurse Staffing in Northern Ireland* is a key quality initiative in terms of identifying minimum nurse staffing requirements in a range of hospital and community settings, and ensuring these requirements are met.

To date the key focus of the HSCB and PHA working with the Department, Trusts and RCN, has been in relation to nurse staffing levels in medical and surgical hospital wards. During 2014/15 required nurse staffing levels for each medical and surgical ward across Northern Ireland have been developed and agreed with Trusts, and implementation plans are now being finalised. In total some £12m will be invested in additional permanent nursing staff during 2015/16. The HSCB and PHA will continue to work closely with Trusts to ensure timely and effective implementation and ongoing monitoring (in order to support the delivery of Ministerial Target 26, appendix 2)

During 2015/16 the HSCB and PHA will continue to support the regional work being taken forward in relation to the other areas of the nursing workforce that have been identified, specifically emergency department district nursing and health visiting.

6.3.5 Managing Long-Term Conditions

The prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation. Across N Ireland the most

prevalent LTCs are hypertension (131 per 1000 patients; 250,000 people), asthma (60 per 1000 patients) and diabetes (54 per 1000 patients; 82,000 people).

Emergency Admissions to hospital for Long Term Conditions

In each of the years from 2010/11 to 2014/15 (Full Year Effect projected based on activity between April and September) the number of emergency admissions to hospital ranged from approximately 11,500 to 12,900 for those aged 18 years and over (see Table 17). COPD accounts for the majority of these admissions at approximately 40% of the total, with Asthma having the lowest percentage of admissions at approximately 8%.

Number of Emergency Admissions by condition (relevant ICD-10 codes were coded as primary diagnosis or main condition treated on the admission episode)
Table 17

Emergency Admissions	Asthma		Diabetes		Heart Failure		COPD		Stroke	
	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000
2010/11	886	64	1017	74	2341	170	4716	343	2537	185
2011/12	834	60	1010	73	2373	172	4700	340	2848	206
2012/13	995	71	1098	79	2600	187	5404	388	2820	203
2013/14	960	69	1076	77	2630	188	5355	383	2833	203
2014/15 FYE	868	62	1038	74	2652	190	4756	340	2532	181

Source: PAS Data Warehouse

During 2014/15, there has been a 10% increase in the number of self-management programmes for people with long term conditions. The funding position in 2015/16 will impact on the ability of commissioners to maintain and deliver additional accessible self-management programmes.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow priority service developments to be taken forward.

6.3.6 Addressing known shortfalls in capacity/quality concerns

Improving Cancer Services

According to NISRA, cancer now accounts for the largest number of deaths attributable to a single cause. The proportion of deaths due to cancer in N Ireland has increased from 20% in 1983 to 28% of all deaths in 2013. By way of contrast, deaths in 2013 due to ischemic heart disease decreased by 60% since 1983 from 4,786 to 1,916.

The HSCB will continue to monitor Trust progress against best practice and suspect cancer/red flag pathways.

More people are living with cancer as a chronic illness. New models of follow up have been introduced to address the needs of cancer survivors. The learning from the 3 year transforming cancer follow-up (TCFU) programme evaluation will help shape the future of patient follow up. The HSCB and PHA will progress a number of key areas, including building on the successes of the TCFU programme, specifically;

- Commitment to continuation of the TCFU approach, which now has a sound evidence base.
- Consolidation of the approach and the learning such that it becomes best practice for all eligible patients with cancer, while recognising that each site specific tumour area may have differing requirements.
- Extension of the TCFU approach to all other cancer service areas where it is potentially applicable and continue to demonstrate the clinical and cost effectiveness of the TCFU approach.

The introduction of Acute Oncology teams at the Cancer Centre and Cancer Units during 2015 will enhance the quality of services for patients with complications of cancer or cancer treatment, advanced cancer or those admitted to hospital with a newly diagnosed cancer. National evidence has shown that these teams can aid in admission avoidance, reducing unnecessary diagnostic investigations, reduce length of stay and aid in the co-ordination of care and end of life support. The teams and the supporting infrastructure will be instrumental in implementing NICE guidance on Neutropenic Sepsis (CG 151) and management of Metastatic Malignant Disease of Unknown Primary Origin (CG 104). Neither set of guidance can be implemented without the establishment of a multidisciplinary acute oncology team.

The expansion of the National Peer Review Programme to cancer Multidisciplinary Teams (MDTs) in Northern Ireland is being utilised as a mechanism to ensure services are as safe as possible, that quality and effective care is provided and that the experience of the patient and carer is positive. Over the three year cycle all MDTs will be assessed against national measures and benchmarked against equivalent MDTs in Northern Ireland and at a nation level. A robust mechanism has been put in place to ensure the production of appropriate Trust action plans and for HSCB monitoring of required service improvements.

The findings of the first rollout of National Cancer Patient Experience Survey (CPES) in Northern Ireland will provide a patient assessment of the quality of care and support provided by Cancer Services across Northern Ireland. Over 2,800 submissions will be analysed by HSCB and Trusts and appropriate actions plans will be produced in order to continuously improve the quality of patient care and experience.

Current consideration of chemotherapy services for oncology and haematology patients indicates an opportunity to improve skills mix by which chemotherapy is delivered. Recommendations expected from the regional chemotherapy review will create an opportunity to improve skills mix and consequently improve quality and timeliness of treatment. Subject to consultation HSCB anticipate introduction of skills mix in late 2015.

Implementation of the recommendations from the 2014/15 Teenage and Young Adult Cancer Scoping Exercise of Service Provision will lead to streamlining of pathways and increased access to support for this cohort of patients who have complex care and pyscho-social needs.

Work is currently underway to develop a robust and sustainable plan for specialising nursing expertise to support people with cancer. This work is in direct response to peer review findings, CPES findings and feedback from patients, members of the public and cancer organisations.

Standardised clinical management guidelines and regimen prescribing will be facilitated by the introduction of the Regional Information System for Oncology and Haematology (RISOH) during 2015/16.

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of service developments for patients with cancer including:

- centralisation of Upper GI Cancer Surgery in BHSCT and associated pre and post-operative care by a specialist multidisciplinary team (MDT)
- development of skills mix approach to prescribing and delivering of chemotherapy services across NI
- access to cancer clinical nurse specialists throughout patient pathway for cancer patients across NI
- access to fully constituted MDT for discussion on diagnosis and treatment options for all patients with a suspected and/or confirmed cancer
- ability to provide timely access to molecular pathology tests that inform most appropriate treatment choices
- ability to ensure a resilient and sustainable radiotherapy medical physics service is restricted by limited resourcing for workforce planning
- ability to respond to cancer MDT peer review findings.

Improving Fracture Services

The changing demographic profile of the population, coupled with changes to clinical practice and training has put an increasing demand on the fracture service. Patients who previously would have had their fracture managed within the Emergency Department are increasing being referred to a fracture clinic. This has had a direct impact on the number of patients seen in fracture clinic, increasing the waiting times at those clinics and generating unnecessary clinic visits for patients.

A redesign of the non-operative fracture pathway, modelled on the work previously undertaken in the Glasgow Royal Infirmary, has resulted in a standardised treatment pathway for a range of stable fractures, supported by patient discharge leaflets. Patients with minor, stable fractures are now being discharged with no further follow-up arranged.

This new pathway has already been piloted across a number of Trusts with significant quality benefits including better clinical decision making via the use of agreed ED fracture pathways, addressed the issue of over booked clinics and helped reduce the waiting times for patients attending fracture clinic. The new pathways have also reduced unnecessary attendances for patients at fracture clinics and allowed consultants to spend more clinical time on those patients with moderate to severe fractures

Improving Imaging Services

Diagnostic imaging is an integral part of modern healthcare. It plays a role in diagnosing and screening for virtually all major illnesses and contributes to the planning of treatment. There is increasing recognition of the need to place imaging early in care pathways to reduce the time to diagnosis and treatment and to improve efficiency and effectiveness.

Traditionally, each hospital has its own imaging service employing its own radiologists to support its own service, providing a variable level of local primary care imaging access. In the current NI radiology service model, the overall activity within the services is limited by reporting capacity rather than the capacity for image acquisition.

The accurate and timely interpretation and reporting of all radiological images is fundamental for patient care. Mostly, image reporting is done by radiologists, although some images are viewed by other medical practitioners by formal local arrangements. Although, some images are reported by advanced practitioner radiographers e.g. ultrasound, breast screening and some plain film examinations, radiologists are required for more complex and time consuming examination e.g. CT and MRI scans.

Each HSC Trust manages the reporting of the scans undertaken for their patients. In addition, work may be either outsourced to the Independent Sector or undertaken as in-house additionality. There are number of hidden drawbacks to the outsourcing model which are increasingly apparent with greater use. Most

work is reported in-hours, but the level of reporting undertaken out of hours has increased significantly, not least because there are approximately 21 vacant radiologist posts across the region.

Following discussion of a reporting-related SAI, and through discussion at the Radiology Network, the concept of combining the resources of radiologists and reporting radiographers across the region has emerged. In the first instance, it is proposed that a regional reporting network will serve to bring back plain film reporting from the Independent Sector through formation of networks staffed by HSC staff. This could further develop to support specialist networks to better utilise scare, valuable resources.

6.4 Promoting independence and choice

Personalisation, independence and choice are at the heart of a more person-centred model in which statutory health and social care acts as an enabler, working in partnership with each individual, their carers and organisations outside the statutory sector, to help people access the support that meets their individual needs. This signals a move from a "service led" system to one which promotes peoples' autonomy and independence. .

Voluntary and community sector organisations play a vital role in providing this much wider range of support and promoting individual control and independence. The priorities referred to under this theme are key to enabling independence and choice.

6.4.1 Reablement

Reablement is a short term service to help people perform their necessary daily living skills such as personal care, walking and preparing meals so that they can regain their confidence and independence within their own home and avoid remaining in hospital, as well as reduce further hospital admissions. Reablement helps people to do things for themselves rather than having to rely on others.

The Regional Reablement Model was originally issued in 2012/13 as a guide for Trusts in their work to establish the Reablement service model, with the intention

to review in the light of Trusts' experiences of embedding the key components of the model. To determine the progress and effectiveness of the Reablement service across the Health and Social Care Trusts, the Reablement Project Board approved a Regional Audit in 2014 which was conducted by the HSCB. This Audit demonstrated that there was a divergence in how the Trusts interpreted the model and its roll-out. However, it also clearly highlighted the essential components which should be considered for adoption within a Northern Ireland model. Therefore, to ensure a convergence across the region the HSCB has revised the model to reflect key essential elements which will underpin a consistent and effective model which will allow more effective measurement of outcomes, planning investment and will set out a "road map" for further improvement.

During 2015/16, the HSCB will seek to implement the revised regional model for reablement. This will be aided through a number of key actions:

- Finalise the standardisation of the access criteria for the service across Trusts and further reductions in the number of access points so that there is greater consistency and fairness.
- Continuing development of partnership arrangements with non-statutory services. The range of services will be increased and additional IT solutions explored to improve accessibility to existing directories.
- Investment in additional Reablement Occupational Therapists and the establishment of a Clinical Forum for these specialists to standardise best practice including the development of standards for governance and practice, and production of regional practice tools to assist in assessment and independence planning.
- Enhancing the role of Reablement Support Workers (RSW) through the development of a regional framework to support learning and development in conjunction with NISCC. The framework should become the benchmark for all aligning all RSW training and mentoring needs.
- Review and develop the existing Key Performance Indicator (KPI) - number of service users discharged with no statutory service needed – as it is now largely being met. Other indicators of effectiveness (such as longer term impact of the service) should be developed.

6.4.2 Promotion of direct payments / self-directed support

This Self Directed Support initiative is in response to what people have overwhelmingly requested. Third sector groups representing those who use the service and their Carers have raised the importance of having greater choice and control for a long time. In response to this, and in reviewing the development of Self Directed Support in England and Scotland, social care in Northern Ireland has begun to work towards the implementation of our own Self Directed Support.

Self-Directed support allows people to choose how their care is provided, and gives them as much control as they want over their personal budget. Self-Directed Support includes a number or combination of options for getting support, namely:

- Direct Payment (a cash payment); (to support the delivery of Ministerial Target 8, appendix 2)
- Managed budgets (where the Trust holds the budget, but the person is in control of how it is spent);
- Trust co-ordination of services on behalf of the client.

The Self Directed Support initiative is a key element of the Transforming Your Care reform agenda and is fundamental to social care services moving forward to that extent it is important that Trusts maintain an active commitment to the implementation of SDS.

A regional and local project has been established over the past months with a three-year plan (2015-18) to mainstream Self Directed Support within social care. Implementation plans have been developed and agreed with all the Trusts and the HSCB is currently undertaking a region-wide Equality Impact Assessment with a range of key stakeholders prior to implementation (end of May).

6.4.3 Carer support

Approximately one in eight adults is a carer; a person who, without payment, provides support to a family member or neighbour who is older, infirm or disabled, so that they can remain at home. Many will be able to do this without assistance, but many make a substantial weekly commitment, and may be lone

carers and have been doing this for some time. HSC has been prioritising support to this group.

Key priorities for 2015/16 include:

- *Increasing uptake of carer's assessments* - In any quarter, trusts identify approximately 2500 "new" carers and offered them their legal entitlement of a carers assessment. (In accordance with Ministerial Target 7, appendix 2) But there are numbers who are not recognised and we need to improve performance here. This will include better information directly available to all who might be carers; and working with GP Practices who increase numbers referred at the point of GP consultation.
- *Improving the carer experience of the carer assessment* - Carer feedback has sometimes been that carers assessments experienced as a test of their eligibility rather than an opportunity to acknowledge their contribution and the emotional pressures on them. As part of the updating of NISAT carers assessment, Trusts should participate in the HSCB service improvement focus on carer experience. Trusts should also adhere to the carer support parts of the Service Framework for Older People.
- *Creating more community-based short break options* - Trust provision of short break support is now more than one million hours in each quarter; but more than half of this is in an institutional setting and we need to offer carers home-based alternatives where that is feasible or by offering more carers some form of self-directed support so that they can arrange their own support. HSCB also expects trusts to respond to the findings of the TYC report on short break pilot projects and cooperate with the HSCB review of home-based short break support currently underway and implement service improvement measures which emerge.

6.4.4 Implementation of Learning Disabilities Day Opportunities Model

Following the endorsement of the Learning Disability Day Opportunities Model in 2014, implementation has now begun. The number of young people leaving school with a learning disability who require either a buildings-based or community based day support service has been identified. The appropriate additional services required to meet these needs will be delivered by HSC

alongside other statutory providers with responsibility for further education, vocational training, supported employment, travel and leisure.

The HSC services to meet the young peoples' needs who are leaving school in 2015/16 are divided approximately 50/50 between day care and community activities. The range of services to be provided must support young people with complex physical and behavioural needs. These services will also play a vital role in supporting families and carers with whom the vast majority of these young people live.

6.5 Safeguarding the most vulnerable

There is a clear requirement to ensure that robust arrangement are in place to protect the most vulnerable in Northern Ireland; specifically those living with dementia, people with learning disability or mental health illness, children and adults in need of protection.

6.5.1 Dementia strategy

It is estimated that at present in Northern Ireland there are 19,000 people living with dementia; fewer than 1000 of these people are under 65. As the population of Northern Ireland ages, dementia will increasingly be a major public health and societal issue, with numbers of people with dementia rising to 23,000 by 2017 and around 60,000 by 2051. The cost to society is also likely to increase dramatically.

During 2015/16 the focus in commissioning care for people with dementia is designed to drive up the quality of care for those with dementia and delirium and their carers which will include the following:

- Implementation of a Public Awareness campaign to improve early diagnosis and information support
- Work with training and care providers and informal carers to complete a training needs analysis and knowledge skills framework in order to drive up workforce skills base and support carers to continue to care.
- Implement a delirium pathway to optimise patient experience
- Development of short breaks offered to people with dementia and their carers.

- A review of outpatient memory services to analyse the barriers to practice, functional and structural integration, identify and reduce all unwarranted service and practice variations.
- Profiling service demand, including an analysis of existing follow up / review models. This will include exploring the opportunities to develop a new risk / need stratified care model for follow on care.
- Benchmark current service capacity including an analysis of how current clinics operate, their respective capacity, the workforce, resources and skills.
- An audit of dementia care in acute hospitals has just finished across NI and recommendations from this audit will be factored into commissioning decisions during 15/16.

6.5.2 Investing in mental health/learning disability community infrastructure

The shift in focus from hospital based services to community services for both Mental Health and for Learning Disability needs to continue. During 2015/16 services which provide community based assessment and treatment 7 days per week should be enhanced. Such services are crucial to preventing inappropriate admissions to hospital, and to facilitating timely discharges in line with discharge targets; including complex discharges.

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of mental health service developments including the delivery of:

- accessible services for patients requiring Tier 2 and 3 addiction service support
- accessible psychiatry services for people presenting at Emergency Departments with self-harm and/or suicidal intentions
- accessible physical health services for people with mental illness
- additional psychological therapy services to meet demand and to address current breaches in access targets.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid

through June monitoring for additional in-year resources to allow many of these priority service developments to be taken forward.

Similarly, the funding position in 2015/16 will impact on the ability of commissioners to take forward a range of learning disability service developments including the delivery of:

- accessible day care/day opportunities for young adults with learning disability who are leaving school
- accessible services for the assessment and treatment of Autism Spectrum Disorder and Attention Deficit Hyperactivity
- short-break/ respite for families caring for adults with a learning disability.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

6.5.3 Safeguarding services

Safeguarding children

There remains a clear requirement to ensure that robust safeguarding arrangements are in place to protect all children. In providing safeguarding services there needs to be a recognition that children who have been exposed to adverse life experiences may be more vulnerable to abuse and exploitation.

There have been a number of high profile Inquiries into Child Sexual Abuse at both a local and national level across the UK. Following a review undertaken by the PSNI the DHSSPS set up a local Inquiry into CSE. The Marshall Inquiry reported its findings in November 2014 and the DHSSPS established a HSC Response Team. The Response Team will oversee progress against the action plan to address the various recommendations.

The PSNI have recently restructured the Public Protection Units which are aligned with Trust boundaries to enhance closer working relationships between HSC and the PSNI. Issues around abuse of alcohol use of legal highs and illegal drugs continue to present as difficulties. The HSCB identified additional investment to

help address issues around CSE and other concerns within both the statutory and voluntary sectors.

A further pressure identified by Trusts relates to children with complex healthcare needs and those children with additional needs and challenging behaviours, some of these children will be in the looked after system. The HSCB is leading on a reform agenda within LAC service provision and Trusts submitted plans to address the commissioning proposals. During 2015/16:

- The HSCB will complete the implementation of the Residential Care review recommendations including a reduction in the size of homes, reviewing statements of Purpose and Function to meet a range of needs and address therapeutic intervention.

  This integrated approach will also address edge of care reduce the need for the placement of children in care by addressing complex need within the community, specialist fostering placements and joint commissioning with NIHE to ensure there is adequate range of placements

There has been a significant rise in the numbers of looked after children over the past number of years. This is consistent with the national picture and has resulted in particular challenges as regards the availability of appropriate care placements to meet the assessed needs of children. During 2015/16:

- The HSCB will continue to recruit additional professional foster carers who will, with the necessary supports, be able to care for some of the young people who present with complex issues – this in line with TYC recommendations.
- The HSCB will commission a range of placements to meet the identified need and have also expanded the number of kinship placements a part of the strategic direction.

As referenced above, there is a cohort of young people who are in contact with a range of services, including the regional acute CAMHS facility, Secure Care which are supported by other statutory services such as Youth Justice. On occasion the demand for secure care will exceed supply for short durations and Trusts put in

place suitable alternative arrangements to manage the presenting risks. Work is progressing on a regional basis to consider the interdependencies across the LAC continuum and with other services to determine how the service can best respond to these complex situations.

The Marshall Inquiry Report made a recommendation that further consideration is given to the concept of "Safe Spaces" and an engagement with young people to ensure their views are factored into any future services. During 2015/16:

- Work will be progressed on the reconfiguration of the regional secure care unit, alongside developments within the residential sector and foster care to provide a more responsive service that provides greater stability and meets the assessed need the young people involved.

Adult Safeguarding

Adult Safeguarding is a developing area of concern and activity continues to increase sharply. The total investment of £1.5m recurrent has been made in adult safeguarding services to date. This investment has provided dedicated specialist staff to improve the prevention, detection and investigation of allegations of abuse. The DHSSPS and Department of Justice will be launching a new Adult Safeguarding Policy in 2015. This will have a significant impact on activity across all sectors and providers and is likely to lead to a further increase in referrals.

Quality of Care is a central theme in adult safeguarding, particularly where the adult in need of protection is in receipt of care services. During 2015/16 HSCB will commission a range of safeguarding activities designed to drive up the quality of care and so prevent / reduce the likelihood of abuse occurring. This will include the following:

- Work with providers to develop innovative ways to prevent abuse and promote a safe environment for the delivery of care. This will include consideration of the use of new or alternative technologies (PoC 4-7)
- Complete move to Gateway approach to respond to all adult safeguarding referrals across all Programmes of Care. This will improve the quality of decision-making, ensure a standard response to all referrals and improve working arrangements with other partner agencies (PoC 4-7)

- Implement generic and specialist safeguarding standards contained in all Service frameworks, with specific reference to the Older Person's Health and Wellbeing Service Framework (PoC 4- 7)
- Work with providers to drive up the quality of services to support people living in residential, nursing or supported living environments (PoC 5)

The majority of referrals to adult safeguarding are made by or on behalf of older people. It is therefore important that adult safeguarding commissioning priorities reflect the particular needs of older people. In 2015/16 the HSCB will:

- Ensure early detection of abuse through full implementation of the NISAT
- Deliver local prevention plans to prevent abuse with particular reference to Community Safety Strategy priorities in relation to Fear of Crime in Older People and the role of the Police and Community Safety Partnerships
- Roll out Peer Educator Programmes to increase the capacity of older people, local and community groups to keep themselves safe from all types of harm.

6.6 Efficiency & Value for Money

In the context of the financial challenges facing the health and social care system in 2015/16 and beyond it is essential that all appropriate opportunities to improve productivity and cost effectiveness are identified and taken.

For several years the HSCB has produced a range of indicative measures to support Trusts in identifying the partial areas to target further efficiency and productivity gains. This work has included benchmarking Trust to Trust performance locally, and comparing Trust performance against equivalent healthcare providers in GB. During 2015/16, the methodology used to benchmark Trust performance will be reviewed and refined, taking account of input from Trusts and the Department and changes to service models. In addition, it is planned to broaden the scope of the benchmarking indicators to include a wider range of performance measures for community-based services.

These indicators will be used to support ongoing work with HSC Trusts to improve the efficiency and effectiveness of service delivery; as appropriate they will also be used to support the case for commissioning from alternative providers.

Key productivity and cost effectiveness initiatives underway or to be progressed in 2015/16 include the following:

- *Pathology services* – the HSCB will complete by December 2015 a public consultation process on the future delivery arrangements for blood sciences, microbiology and cellular pathology
- *Effective use of resources* – the HSCB will complete by September 2015 a public consultation process in relation to the range of elective surgery procedures which are routinely available to patients in Northern Ireland, to ensure that scarce services are targeted towards those procedures with greatest patient benefit
- *Patient transport services* – the HSCB will, in partnership with the Department and NIAS, complete by December 2015 a public consultation on the future provision in non-urgent patient transport services
- *Pharmacy expenditure* – the HSCB will work to secure further reductions in pharmacy expenditure with a target saving of [£30m] to be delivered during 2014/15
- *Hospital bed days* – the HSCB will support the delivery of further reduction in hospital length of stay and associated bed requirements through improved arrangements for managing patient flow
- *Outpatient reform* – as one of four agreed regional workstreams, the HSCB will lead a process to implement outpatient reform. A key element of this process will be the development and implementation of a 21st century care model for patients requiring specialist assessment – whether following a GP consultation or an ED attendance – with patients being seen same day/next day in an ambulatory care model rather than being added to a more traditional waiting list.
- *Regional service delivery opportunities* – in the context of both financial pressures and issues of sustainability and resilience, there are opportunities

to deliver particular services in a more consolidated fashion, potentially with a single provider for the whole of NI. In this regard, the HSCB will during 2015/16 establish regional arrangements for the delivery of out of hours radiology reporting and stroke lysis advice. Opportunities for regionalisation will also be explored through the outpatient reform initiative referred to above with proposals already being worked up in relation to neurology and urology.

- *Interpreting services* – the HSC's expenditure on interpreting services is increasing annually with an annual spend of over £3m. Following a public consultation in 2014/15 the HSCB is working with BSO to support the provision of telephone interpreting services where appropriate, as a more cost effective alternative to face to face interpreting.

6.6.1 Procurement from Alternative Providers

The majority of health and social care services for the NI population are purchased by LCGs from their 'local' Trust. The size of NI, the limited number of statutory providers and the need to maintain financial stability both at individual provider and system level means that, in practice, the opportunities to establish a truly competitive provider market locally are limited. Nonetheless the HSCB will in 2015/16 continue to pursue opportunities in this regard in the context of the need to secure improved value for money.

Specifically, the HSCB will seek to respond to existing and new patient demands by commissioning services where appropriate from a provider other than the local HSC Trust to include:

- Commissioning from another HSC Trust in NI
- Commissioning from the community/voluntary sector
- Commissioning from partnership of providers e.g.GP Federations
- Community from the Independent Sector or the Statutory Sector in GB or RoI.

This approach will be adopted across a range of service areas. In each case the over-riding priority will be to identify opportunities for more patient-focused,

sustainable and cost effective delivery while at the same time seeking to maintain the integrity of other related services commissioned from existing providers.

GP Federations

All GP practices in Northern Ireland are set to form not-for-profit provider companies by September 2015. The practices will form federations covering 100,000 patients, each including around 20 practices, which together will own and manage a not-for-profit social enterprise.

Under the plans, practices will maintain their current GMS work and the social enterprises will be able to employ staff to carry out the extra work that will result from the shift of care from secondary to primary care, as detailed in Transforming Your Care. Federations will also co-ordinate and empower the work of practices enabling them to work in a more effective and integrated manner and enable GPs to provide a better service for their patients.

It is hoped that the development of Federations can contribute to the delivery of the objectives of TYC working alongside Trusts and integrated-care partnerships.

6.6.2 Delivery of Contracted Volumes

During 2014/15 there have been instances where the volume of services delivered by providers has fallen considerably short of the level of service commissioned – impacting directly on patient care. In some instances performance difficulties have arisen as a result of ongoing operational difficulties, in others they may have arisen directly as a result of vacancy controls.

While the HSCB will continue to work with Trusts and other providers to support improved performance, during 2015/16 the HSCB will in addition, remove funding in full in targeted service areas where there have been performance difficulties with the funds being used to secure services from another provider.

It is recognised by the HSCB that this intervention will present challenges for Trusts and other provider organisations, particularly in the current financial context. However at the same time it is essential that the scarce commissioning resources which are available in 2015/16 are used to best effect to deliver commissioned services for patients.

7.0 Regional Commissioning

There are a small number of services which are commissioned at regional level. These include:

- Family & childcare services
- Regional specialist services
- Prisoner health
- NI Ambulance Service
- Family Practitioner Services

Commissioning priorities for 2015/16 for these areas are outlined below.

7.1 Family & Childcare Services

It is acknowledged that the Children and Families programme is heavily prescribed within legislation and thus there is an imperative for Trusts in their role as Corporate Parent to assist children and young people who are looked after to realise their aspirations and ambitions to their maximum potential.
Current strategic drivers within Children and Families Services include:

- Responding to the Marshall Inquiry on Child Sexual Exploitation, whilst also remaining cognisant of the wider safeguarding agenda
- Continuation of the Transforming Your Care (TYC) plans relating to the reviews of Residential Child Care and Fostercare
- Progression of the various proposals within the Early Intervention Transformation Programme (EITP) and development of Family Nurse Partnerships in the NHSCT and SEHSCT (The latter is in accordance with Ministerial Target 4 , appendix 2)
- Pursuance of key actions emanating from the Acute CAMHS Review
- To continue to take forward the Review of AHP support for children with statements of special educational needs in special and mainstream schools
- There are increasing demands arising from the growing number of children with complex healthcare needs and those with challenging behaviours. The HSCB and PHA are reviewing the position to inform future actions.

Family and Childcare– Key Commissioning Priorities 2015/16

Needs and Assessment

1. The Marshall Inquiry identified that Child Sexual Exploitation (CSE) is a growing threat in Northern Ireland
2. There is an increasing number of LAC coming into the system.
3. There is an increase in demand for CAMHs service and a recognised need to improve the interface between acute and community CAMHs teams as well as working arrangements with secure care and the regional Youth Justice Centre.
4. There are an increasing number of children with complex health care needs and challenging behaviour.
5. Inequity of access to AHP provision for children with statements of educational needs (SEN)

Services to be commissioned

1. HSCB will commission specialist teams within Trusts to co-ordinate responses to CSE and Alcohol and Drug Support Workers to work with LAC across Trusts
2. HSCB will commission:
   - a range of appropriate LAC/16+ placements to meet the projected demand detailed in the Residential and Fostercare Reviews
   - additional early intervention programmes to include and extension of the Family Nurse Partnership to South Eastern and Northern Trusts.
3. HSCB to progress the recommendations of the Regional Acute CAMHS Review.
4. HSCB will commission required care packages to enable these children to be looked after at home where appropriate
5. HSCB/PHA to progress review of AHP provision within mainstream and special schools for children with statements of SEN

Securing Service Delivery

1. Regional action plan to be monitored by DHSSPS led HSC Response Team with mechanisms in place for Trusts to provide regular updates to HSCB
2. Trusts will provide placements in line with agreed investments. The availability of placements will be monitored through DHSSPS Strategic Framework reporting arrangements and meetings with Commissioning Leads.

   FNP monitoring arrangements are in place.
3. Local Implementation Teams will progress the Acute CAMHs Review Action Plan and report into the regional HSCB steering group.
4. LCGs will monitor number of care packages made available in each locality

Regional Priorities (see appendix A): Allied Health (MT9), Mental Health Services (MT22), Family Nurse Partnership (MT4)
Key Strategies: Marshall Enquiry recommendations, Regional Acute CAMHS Review, Residential Child Care Review, Fostercare Review

Family and Childcare– Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 18

Programme of Care	Service Description	Currency (no. of children)	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Family and Childcare	**Looked After Children**	Residential Care	194	0	194
		Foster Care	2,189	0	2,189
		Other (placed at home, specialist facility etc.)	493	0	493
		Planned investment in 2015-16		£0.48m	

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of services relating to the need for assessment of children for Autism Spectrum Disorders/ Attention Deficit Hyperactivity Disorder and treatment/support services for children and their families.

In addition, the overall pressures within Children's Services indicate a likely rise in unallocated cases. The securing of appropriate placements for the increased number of looked after children will present particular challenges and will take longer to achieve.

7.2 Specialist Services

Specialist acute services include specialist tertiary or quarternary level services delivered through a single provider in Northern Ireland or designated centres in Great Britain / ROI. High cost specialist drugs also fall within the remit of this branch of commissioning.

Due to our small population the more specialist services are proving increasingly difficult to sustain through the traditional service models. Services which fall within this branch of commissioning include rare diseases, renal services, genetics, specialised services for children, specialist ophthalmology services; specialist neurology services and cardiac surgery. There are some 30-40 sub-specialist or small specialist areas within specialist services.

The 2015/16 priorities set out on the next page are subject to available funding.

Specialist Services – Key Commissioning Priorities 2015/16

Needs and Assessment

1. Transforming Your Care established the commitment of the HSC in supporting the delivery of more specialist care in the local setting where it is safe and effective to do so. In 2015/16 services will be configured to support improvements in local access across the region to highly specialist drugs and diagnostics.

2. A number of specialist services are delivered by one or two person teams in Northern Ireland. This can create difficulties in consistently delivering access times and securing resilience in the provision of the service locally.

3. The availability of specialist drug therapies for a range of conditions has improved the care available for a significant number of patients. Each year there is an increase in the number of patients accessing existing therapies and an increase in the number of new NICE approved therapies available.

Services to be Commissioned

1. SSCT will commission:
   - Increased local access to Tysabri for MS patients
   - Increased local access in the community setting to general support services such as phlebotomy to reduce the need for hospital attendances to support the ongoing clinical management of patients undergoing specialist treatment
   - The roll out of diagnostic capacity for imaging associated with ophthalmology macular services.

2. SSCT will commission:
   - A programme of in-reach and networked services through formal alliances with tertiary and quarternary providers outside NI
   - Models to further support the work of small specialist teams to cascade learning and expertise through local acute and community services
   - The implementation of the NI Rare Disease Plan

3. SSCT will work with Trusts to increase the number o patients on existing treatments and introduce NICE approved therapies approved in 2015/16 in NI.

Securing Service Delivery

1. The SSCT will work with the relevant Trusts and/or primary care colleagues to identify the requirements associated with the provision of these developments in each Trust area.

2. SSCT will continue to progress the establishment of both local and national clinical networks to enhance resilience and sustainability across a range of specialities. Work will initially focus on those services provided in Belfast Trust but will be set within a framework which identifies opportunities for linkages and integration with local services.

3. SSCT will progress through existing forums, including the Regional Biologics Forum, Regional MS Group and Cancer Commissioning Team, the arrangements for ensuring timely provision of existing and newly approved drug therapies throughout 2015/16 within available resources.

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Needs and Assessment

4. A Ministerial decision has been made on the future model for Paediatric Congenital Cardiac Services which will in the future see surgical services for children from NI in the main provided in Dublin

5. There is a need to ensure delivery of additional infrastructure and activity in a number of specialist areas including cardiology and cardiac surgery.

6. Due to the complex and lengthy treatment undertaken for patients with severe intestinal failure, every effort has been made to provide as much of this care as possible in NI.

Services to be Commissioned

4. HSCB will put in place arrangements with relevant specialist surgical centres to ensure the provision of safe and robust services for children from NI during the implementation of the Ministerial decision on the future model of care.

5. SSCT will agree gaps in current capacity which are impacting on the ability of Trusts to deliver on waiting time targets and negotiate with Trusts on the level of resource required to meet the demand for services.

6. To meet national service framework standards for this highly specialist service, investment in excess of £0.5m has been made available to improve support for high dependency patients in the Belfast Trust.

Securing Service Delivery

4. HSCB will secure Service Level Agreement with the relevant surgical centres in GB and ROI for the provision of Paediatric Congenital Cardiac Services in 2015/16. HSCB will also be represented on the all-island network board which will be responsible for taking forward the timely implementation of the proposed model of care.

5. SSCT will work with relevant Trusts to secure additional capacity in areas with agreed gaps with a view to improving the waiting time position for patients in these specialist areas.

6. Belfast Trust will increase their high dependency capacity from 4 to 10 beds with additional nursing, medical pharmacy, AHP and support staff.

Needs and Assessment

7. Adult Critical Care capacity across NI operates as a network to ensure access to critical care beds as required. HSCB has a clear understanding of commissioned capacity for this high cost specialist service. In recent years there appear to have been difficulties and staffing challenges in maintaining the consistent availability of all beds in the network. Issues have also been highlighted for the review of the model for adult critical care transport service (NiCCaTs)

8. The CPD for 2015/16 includes the target that by March 2016, ensure the delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.
   - There is a need to increase the numbe of kidneys retrieved and transplanted in NI that are kidneys donated after circulatory death (DCD)
   - There is a need to increase the use of peritoneal dialysis and home haemodialysis

Services to be Commissioned

7. SSCT will, through the Critical Care Network,
   - confirm the bed stock and staffing levels across the region, review the number and frequency of bed non availability and reasons for same for the last 12 months.
   - Introduce a 12 hourly monitoring report from each ICU to be collected from April 2015. This will be reviewed by PMSI to identify daily capacity issues. SSCT will, through the Critical Care network
   - Review the proposal for the transfer of ICU capacity to Phase 2b in RVH
   - Bring forward proposals for a future model for the adult critical care transport service

8. The HSCB and PHA will continue to work closely with the service towards ensuring the delivery of a minimum of 80 kidney transplants in total to include live, DCD and DBD donors by March 2016. This will include optimising the potential for organ donation to include:
   - Continuing to provide at least 50 live donor transplants per annum
   - Maintain and if possible increase the number of kidneys transplanted in NI that are kidneys donated after circulatory death (DCD) (subject to the donation of kidneys) and increasing consent rates for deceased organ donation
   - Maximise the use of peritoneal dialysis / home haemodialysis

Securing Service Delivery

7. Each Trust will
   - undertake to provide the twice daily reporting through PMSI from April 2015. Belfast Trust will work with SSCT and the Network to agree the way forward for the future configuration of ICU capacity across the region as appropriate.
   - provide the information requested on bed stock, staffing and bed availability over the past 12 months for comparison against the 2009 baseline

8. The HSCB and PHA will:
   - Work with Belfast Trust to ensure that the appropriate infrastructure is in place to ensure that the required level of kidney transplants are undertaken during 2015/16

   - Work with all stakeholders to:
     - Ensure that the potential for organ donation in NI is maximised in 2015/16
     - Maximise the use of peritoneal dialysis / home haemodialysis during 2015/16 and beyond

Regional Priorities (see appendix A): Organ Transplants (MT18), Patient Safety (MT25), Delivering Transformation (MT29)
Key Strategies: National Intestinal Failure Service Framework Standards, DHSSPS PCCS Review, Transforming Your Care

Specialist Services – Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 19

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Specialist	**Specialist**	Emergency FCEs Cardiology switch to procedural contract	6,950	162	7,112
		Elective Contract	7,291	41	7,332
		Daycase	9,727	300	10,027
		New OP	45,208	3,593	48,801
		Review OP	97,765	8,986	106,751
		Other (Changes to SBA including cardiology procedural contract and specialist drugs and inject SBA volumes inc Cardiology)	16,202	4,343	20,545
		Beddays	20,094	3,650	23,744
		Planned investment in 2015-16		£1.5m	

NB: Cardiology other - include 11,000 procedures which were excluded from 2014/15 volumes

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of specialist acute service developments including the delivery of:

- increase in availability of endovascular stents associated with the impact of AAA screening
- availability of a range of specialist "sendaway" diagnostic tests for a range of genetic disorders
- required expansion in critical care capacity required in acute hospitals
- an accessible resilient specialist immunology service
- an accessible apheresis service for patients requiring bone marrow and stem cell transplantation associated with oncological/ haematological disorders
- a local, accessible cranial stereotactic service for all appropriate patients with cerebral brain metastases
- an accessible service for adults with Cystic Fibrosis.
- delivery of accessible paediatric asthma and anaphylaxis services
- availability of insulin pumps and associated services for children with diabetes

The HSCB has supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

Access to NICE Treatments

NICE provides guidance on current best practice in health and social care, including public health, health technologies and clinical practice. The DHSSPS has a formal link with the Institute under which NICE Technology Appraisals, Clinical Guidelines and other types of guidance are reviewed locally for their applicability to Northern Ireland and, where found to be applicable, are endorsed by the DHSSPS for implementation within Health and Social Care (HSC).

The funding position in 2015/16 means that it may not be possible to fund all new NICE-approved treatments; however each Technology Appraisal will be assessed to arrive at decision on timeframe for implementation which takes account of costs and benefits. The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to enable access to these treatments.

7.3 Prisoner Health

Prisoner Health Services are delivered within three prison establishments and are managed by the South Eastern Health and Social Care Trust. These are;

- HMP Maghaberry, which is a high security prison for adult males (both remand and sentenced).
- HMP YOC Hydebank Wood which provides accommodation for young male offenders. Women prisoners are also accommodated (in Ash House).
- HMP Magilligan. This is a medium to low secure prison for sentenced adult males.

Prisoners receive a full range of healthcare services. The majority of services provided within the prison are primary care services, complemented by dedicated services for a number of mental health and addiction needs. Access to secondary care services are usually provided in acute hospitals through normal referral processes.

Within N Ireland there are just over 5,000 committals annually and approximately 1,800 – 1,900 prisoners throughout the prison estate at any time. NI has an imprisonment rate of 99/100,000 of the population. In line with prisons elsewhere in the UK the prison population has continued to increase over the last ten years and there is a growing population of older prisoners. Routine figures from Northern Ireland Prison Service show that the average prison population has increased by 73% between 2002 and 2012.

These figures report that the proportion of the average population sentenced to immediate custody over age 60, has increased from 1.5% to 2.8% between 2002 and 2012. This is a small proportion of the overall population but the relative increase is almost double. Male prisoners and young offenders predominate, with females constituting approximately 3% of the prison population. Prisoners in 2012 were over two thirds immediate custody, 31% remand and 2% fine defaulters. Prisoners in NI are on more prescription items per person than the general population of the same age.

The 2013/14 Health Needs Assessment (HNA) highlighted that mental health needs are very important to identify and address for prisoners. Mental health needs of a diverse population whilst can be difficult to describe, prisoners can be separated into two categories for the purpose of considering need; those with a mental health diagnosis, and those with mental health symptoms who may require support from mental health services but who may not otherwise be identified as having a mental health condition. The 2014/15 HNAs will provide a detailed mental health and addictions prisoner health needs assessment.

The HSCB takes as an underlying principle of prisoner healthcare delivery that people in prison should be entitled to the same level of healthcare as those in the community, although it is accepted that security considerations may modify exactly how healthcare is structured and delivered. In addition, there are a number of factors arising from the prison environment and the nature of prison populations which need to be taken into account in taking forward service development and change agendas:

- Prison populations have risen since the transfer of healthcare in 2008 from Department of Justice to Department of Health placing increased pressure on available resources.
- There is a particular need to address the healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities.
- Rates of mental ill health for those in prison are higher than the general population, with the prison population having a much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses.
- Work continues on developing better integration with community and secondary care services on committal and discharge.
- There is a need to ensure that, following the identification of prisoners' healthcare needs at committal, these are followed up with appropriate action.
- There are issues associated with the misuse of prescribed medicines and the supply of illicit drugs.
- There is a need to forge improve relationships and cooperation between the Criminal Justice System and Health and Social Care.

Following the 2010 Owers Review, the Department of Justice and the Department of Health continue to work together to develop a joint Healthcare and Criminal Justice Strategy. The joint strategy seeks to address 5 key areas in the offender journey:

- Police response and prosecution
- The Courts Process
- Custody
- Supervision in the Community
- Resettlement

The HSCB and the PHA will work with the Department of Justice, the Department of Health and Health and Social Care Trusts in taking forward the Joint Healthcare and Criminal Justice Strategy.

Prisoner Health – Key Commissioning Priorities 2015/16

Needs and Assessment

1. Chronic disease management systems and services within prisons are currently not equivalent to those available for the general population

2. Needs assessment reveals higher rates of mental health issues within the prisoner population
3. There are issues associated with the misuse of prescribed medicines and the supply of illicit drugs within prisons

4. Needs assessments demonstrate that there are higher rates of risky health behaviours within the prison populations (e.g. smoking, addiction)

Services to be commissioned

HSCB to work with provider to:

1. Continue to progress development of equivalent chronic disease management services informed by a profile of prisoner population by chronic disease category produced as per Quality and Outcomes Framework

2. Further develop services in line with Bamford to include: the development of the recovery ethos within mental health services and increased provision of psychological therapies

3. Make improvements in medicines management, with a particular emphasis on the safe use of prescription medications

4. To produce an Action Plan to implement new health improvement initiatives, programmes and resources within the prison environment

Securing Service Delivery

SET will:

1. Provide prisoners with chronic disease management in line with community provision

2. Ensure provision of the Stepped Care Model and maintain registers for addiction, personality disorder and learning disability across prison sites

3. Revise and monitor medicines management policies, ensure that GP prescribing is in line with accepted regional standards and implement improvements in medicines management with an emphasis on safer use

4. Implement evidence based health improvement programmes: mental health promotion, smoking, healthy eating & nutrition, healthy lifestyles, including sexual health and relationships, and substance misuse

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Owers Review, Joint Healthcare and Criminal Justice Strategy

Prisoner Health – Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 20

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Prison Healthcare	**Primary Care**	Face to face contacts	20,488	0	20,488
	Secondary Care – in-reach clinics	Face to face contacts	1,970	0	1,970
	Allied Health Professionals	Face to face contacts	11,336	0	11,336
	Mental Health	Face to face contacts	46,800	0	46,800
	Substance misuse (inc supervised swallow)	Face to face contacts	295,147	0	295,147
	Dental Health	Face to face contacts	7,652	0	7,652
		Planned investment in 2015-16		Nil	

7.4 Northern Ireland Ambulance Service

Meeting emergency ambulance response times, regionally and at LCG level, is challenging in the face of increasing demand and a constrained financial environment. The number of emergency calls received by NIAS in 2013/14 was 154,755, a rise of 3.1% on the previous year. Category A response (within 8 minutes) also fell from 68.3% in 12/13 to 67.6% in 13/14. Particular challenges were evident in meeting the Category A target in Northern, Southern and South-Eastern areas.

The HSCB is supporting NIAS to respond to this demand by delivering alternative care pathways, which avoid transporting patients to hospital, where appropriate. These pathways provide NIAS with options to 'hear and advise', thereby avoiding a response to a 999 call which is not an emergency or urgent; to 'see and treat or refer', where a paramedic can provide the appropriate medical response without requiring transport of the patient to hospital; and to transport to an appropriate facility other than an Emergency Department, such as a Minor Injury Unit. (Which after a period of improvement, turnaround times at some major acute hospitals have begun to lengthen with loss of ambulance response capacity due to crews waiting longer to handover patients to Emergency Departments).

The HSCB has supported a pilot of Hospital Ambulance Liaison Officers which it intends to mainstream in 2015/16 in a drive to reduce handover times to no more than 30 minutes. The pilot will address:

- Development of eligibility criteria for non-emergency transport. NIAS provided over 205,000 non-emergency patient journeys in 2013/14. 55.4% of journeys (i.e. 113,623 journeys) were provided by NIAS Patient Care Service (PCS) which is a direct service provided by NIAS staff. 44.6% of journeys (i.e. 91,489 journeys) were provided by the Voluntary Care Services (VCS), which is a NIAS coordinated service delivered by volunteer drivers. Eligibility criteria, based on patient mobility, would serve to limit non-emergency transport to those in greatest need and release capacity to support intermediate care, such as inter-hospital transport and timely hospital discharge.

Nevertheless, despite the planned additional investment and service reform, it is unlikely that the 8 minute target response time for 999 calls will be delivered throughout the year. HSCB will work with DHSSPS to consider opportunities for further reform, service improvement or funding opportunities to address this challenge.

The funding position in 2015/16 will also impact upon the required expansion of community resuscitation including:

- Recruitment of permanent Community Resuscitation Development Officers (CRDOs) to deliver training in Emergency Life Support (ELS) and in the use of Automatic External Defibrillators.
- Development of information infrastructure to assist in the measurement of outcomes of Out of Hospital Cardiac Arrests (OHCA).

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

NIAS– Key Commissioning Priorities 2015/16

Needs and Assessment

1. NIAS reports increasing volumes of 999 calls and reducing ability to achieve 8 minute category response times.

2. NIAS have been working in the past year to introduce appropriate care pathways to prevent unnecessary hospital attendances. Several pathways are now in place which 'hear and advise', 'see and treat/refer' or transport patient to an alternative to ED, e.g. Minor Injuries Unit.

3. Hospital Ambulance Liaison Officers (HALOs) have been piloted in 4 major acute hospitals across NI. Initial evidence shows improved ambulance turnaround times at ED and better coordination of hospital discharge.

4. In 2013/14, NIAS provided over 212,000 non-emergency (PCS) journeys. 48% of journeys were provided to users described as 'walking' and 83% of journeys were to outpatient appointments. The current provision of non-emergency patient transport services is not sustainable in the longer term.

Services to be Commissioned

1. Commissioner will put in place plans to improve performance against Ministerial emergency ambulance response targets by March 2016.

2. Commissioner will support NIAS to continue to put in place alternative care pathways which avoid unnecessary hospital attendances.

3. Commissioner will mainstream Hospital Ambulance Liaison Officers (HALOs) at the major acute hospitals to support patient flow and ambulance turnaround.

4. Commissioner, in partnership with NIAS, will, by November 2015, complete a public consultation on the future provision of non-urgent patient transport services. This will include the proposed introduction of eligibility criteria for non-emergency transport which seeks to prioritise mobility need in the face of limited capacity.

Securing Service Delivery

1. Commissioner, in collaboration with NIAS, will review demand for an emergency ambulance response against available commissioned capacity and in light of alternative care pathways.

2. Commissioner will seek to evaluate alternative care pathways with a view to maintaining where successful. The introduction of related, NIAS-managed Directory of Services with support from the 5 HSC Trusts will be essential in taking forward the pathways.

3. Commissioner will seek a proposal from NIAS to maintain HALOs at major acute hospitals

4. Commissioner will work with NIAS to take forward recommendations following the review and public consultation of non-urgent patient transport services, including the implementation of eligibility criteria.

Regional Priorities (see appendix A): Unscheduled Care (MT13), Unplanned Admissions (MT5 and MT6), Emergency Re-admissions (MT14)

NIAS – Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 21

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
NIAS	**Calls**	Emergency	181,577	338	181,915
		Emergency Cat C HCP	28,188	0	28,188
		Urgent	7,525	600	8,125
		Non-Urgent	27,433	0	27,433
		Planned investment in 2015-16		£1.07m	

7.5 Family Practitioner Services

Family practitioner Services comprise the following four key areas:

1. General Medical Practitioners Services
2. General Ophthalmology Services
3. General Dental Services
4. Community pharmacy provision

Primary care and adult community services play a critical role in terms of supporting people to stay well, for as long as possible in the community and avoiding unnecessary hospital attendance and admissions. The development of these services in line with the transformation agenda is therefore key to reducing pressure on scarce resource within secondary care.

7.5.1 General Medical Practitioners Services

General Medical Services are delivered by 350 General Medical Practices, through a contract between the HSCB and each individual practice (contractor).
The GMS Contract covers three main areas:

- The Global Sum covering Essential and Additional Services to treat patients who are sick
- The Quality and Outcomes Framework (QOF) which aims to promote the use of evidence based practice and a systematic approach to long term care, thereby reducing inequalities and improving health outcomes. Practices can choose whether to deliver these standards.
- Enhanced Services which practices can choose to provide. They can be commissioned regionally or locally to meet the populations healthcare needs.

The HSCB remains responsible for 24 hour high quality care being available to all patients. The Out of Hours service is commissioned from three Trusts and two individual organisations to provide urgent care for patients when their normal GP surgery is closed. Recognising the current pressure on the Out of Hours Service, the Health Minister is investing up to £3.1 million.

This is part of a £15 million package which includes:

- Up to £1.2 million helping GPs meet demand for blood tests and other diagnostic work in the community delivered through GP Federations.
- Up to £300,000 to recruit and retain GPs
- Releasing up to £10 million of funding for GP practices to borrow to upgrade and expand their premises and £350,000 to meet the on-going costs of these new premises.

However, the funding position in 2015/16 together with associated workforce issues will impact on the ability of commissioners to ensure effective primary care services. A particular issue is the ability to maintain accessible GP services in-hours and out of hours. The HSCB will continuously review commitments to ensure best use of all available resources and has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to enhance unscheduled care services; this bid includes elements to increase GP sessions and practice nurse sessions, and to enhance out of hours capacity.

The HSCB currently encourages practices through comprehensive demand management enhanced services to further improve the management of workload, demand, capacity and responsiveness within primary care. This work needs to be built on during 2015/16.

In response to the issues identified above the HSCB will prioritise the following during 2015/16:

- The HSCB commissions a range of Enhanced Services to meet the clinical needs of patients. The focus in 2015/16 will be on service delivery that will enable a structured annual review of patients with chronic conditions in order to improve their management and avoid unnecessary hospital admissions.
- The HSCB will revise NILES Demand Management to further improve the management of workload, demand, capacity and responsiveness within primary care. The HSCB will also continue to promote and encourage increased self-care among patients.

Enhanced Services uptake by general practice will continue to be challenged to ensure equity of provision to patients. The GP annual reporting requirements

enable the HSCB to evaluate and review all Enhanced Services. This information will be used to improve future services and patient care.

7.5.2 General Ophthalmology Services

The main priority for general ophthalmic services during 2015/16 is to enhance community provision for glaucoma. Glaucoma as a long term ophthalmic condition which requires lifetime monitoring and patients once diagnosed, are subject to treatment and ongoing review. Following introduction of NICE Clinical Guideline 85[3] the demand on ophthalmology services in Northern Ireland increased exponentially with increasing numbers of referrals to secondary care resulting in patient access problems with subsequent threats to patient experience and outcomes.

During 2013/14 the HSCB introduced a local enhanced service (LES) within primary care which utilises a first-stage refinement of referrals (based on one clinical indicator). This LES have demonstrated a reduction of 65% in referral rates. Evidence[4] [5]exists that further enhancements/refinement strategies for primary care optometry could assist in further reducing the referrals to secondary care thus reducing the demand capacity gap for the glaucoma service. The adoption of strategies to stratify risk and deliver enhanced services to patients in primary care aligns to the theme of ensuring that services are resilient and provide value for money in terms of outcomes achieved and costs.

Commissioning Priorities 2015/16

During 2015/16 the HSCB will seek to further enhance skillsets in primary care, and use of eHealth technology to ensure glaucoma patients are treated to high quality safe and effective care closer to home.

- LCGs will commission training and accreditation of community optometrists in line with NICE and Joint College Guidelines to make full use of the available skillset across primary and secondary care.

[3] Glaucoma: Diagnosis and Management of Chronic Open-Angle Glaucoma and Ocular Hypertension, 2009, NICE
[4] Hall, D., Elliman,D. 2003 Health For All Children Revised Fourth Edition. Oxford University Press
[5] Das et al. Evidence that children with special needs all require visual assessment. Arch Dis Child 2010

- LCGs will ensure there is adequate access to Level 2 LES practitioners (in terms of both geography and timeliness)

Regional glaucoma hubs will continue to quality assure service provision, providing clinical leadership and governance. HSCB will monitor qualitative and quantitative data inputs to ensure timely access, clinical and patient experience outcomes and value for money.

7.5.3 General Dental Services

Responsibility for managing the General Dental Services (GDS) budget moved from DHSSPS to HSCB in July 2010. The population's utilisation of dental services has never been as high as it is now. In the last twenty years the proportion of patients who attend the dentist regularly has increased from 42% to 60%. Over the last five years GDS expenditure has increased by more than 50%.

The most recent Children's Dental Health Survey undertaken in Northern Ireland showed that Northern Ireland's children have, across all age groups, the poorest oral health in the UK. Among five year olds, for example, 60% had experienced dental decay while the UK average is 43%. In contrast, adult oral health in Northern Ireland is comparable with other parts of the UK and has shown a marked improvement over the last thirty years.

The current GDS contract is demand led – the more health service treatments that are provided the greater the cost to the GDS budget. At this time it is not possible to limit the number of dental practices in Northern Ireland or the number of dentists who may work in General Dental Practice.

HSCB and DHSSPS agree that a new contract is required if the GDS is to maintain access levels and continue to improve population oral health within an affordable funding envelope. The HSCB will pilot this new contract in 2015-16 and 2016-18.

HSCB will commission 18 dental practices to provide primary dental care for 50,000 patients for a 12 month period in order to test the new contracting arrangements.

Practices will be selected so that they represent, as far as is possible, the main types of dental practice found in Northern Ireland.

Each practice will have their income fixed at the 2014 level but rather than remuneration being linked to treatment activity as it is under the current GDS contract, for this level of funding dentists will be required to maintain and secure the oral health of the patients registered with their practice.

It is hoped that moving away from the item of service elements of the current contract will incentivise practitioners to adopt a more patient centred and preventive approach to care, which will lead to improved outcomes for children over time.

HSCB will monitor the quality of care received by patients during the pilot. Patients' access to dental services (both routine and emergency) will also be checked. In addition, HSCB is collaborating with the University of Manchester to evaluate the pilot. A £500k research grant has been secured from the National Institute of Health Research. The evaluation will focus on changes in dentists' treatment patterns, the costs and value for money of the contract under test and patients' and dentists' views of the new arrangements.

7.5.4 Community Pharmacy and Medicines Management

There are three key areas of focus that HSCB will take forward strategically in 2015/16:

General Pharmaceutical Services

Incremental development of community pharmacy services has occurred over the past ten years. The Terms of Service for community pharmacy provision are dated compared to other parts of the UK. The HSCB is seeking to modernise the Terms of Service upon which community pharmacy services can be safely and effectively developed to encompass quality improvement, service review and specification, health improvement and modernisation of service provision.

Negotiations on the development of revised community pharmacy contractual arrangements have been challenging in 2014/15 not least with the initiation of

Judicial Review proceedings by the community pharmacy contractor representative body, Community Pharmacy NI.

Looking forward into 2015/16, it is anticipated that the HSCB will lead on a series of actions set out in the DHSSPS *Making it Better Strategy Implementation Plan* which seeks to extend community pharmacy involvement in the delivery of services to address public health challenges and improve medicines use (e.g. minor ailments, repeat dispensing; medicines use review and smoking cessation services).

Medicines Management

Integrated Care has specific budgetary responsibility for prescribing in primary care and as the use of medicines spans all care settings with the majority of use and spend in primary care. NI Audit Office and the Public Accounts Committee have specifically highlighted the need for improved efficiency with respect to prescribing in primary care.

During 2015/16, HSCB will seek to both manage and influence the use of medicines throughout the HSC system:

- Deliver the Pharmaceutical Clinical Effectiveness programme in order to improve the quality and safety of medicines use and also realise £20m of efficiencies
- Further refinement and implementation of the NI Formulary
- Further refinement of Managed Entry (and exit) of medicines.

This work will be supported through the commissioning of practice based pharmacists' provision through an Enhanced Service to all GP practices in Northern Ireland.

Medicines Safety

Medicines are the most commonly utilised intervention in the HSC and the HSCB has a key leadership role in supporting the delivery of safer medicines systems. Electronic Prescribing has been identified as a key issue to be addressed in secondary care.

During 2015/2016 the key deliverables will include:

- Performance measurement of medicines reconciliation processes to with the aim of increasing the percentage of patients having their medicines reconciled on admission and at discharge;
- Implementation of a number of medicines safety initiatives; and
- Support for the Electronic Prescribing and Medicines Administration project within secondary care.

8.0 Achievement of Ministerial Targets

The Commissioning Plan Direction sets out the Minister's targets and standards for the HSC for 2015/16, in many cases building on the targets and standards in 2014/15.

The HSCB is committed to working with Trusts to deliver these targets and standards, and to improve services for patients and clients. The constrained financial environment will however present significant challenges to improving or maintaining performance across a number of service areas. Notwithstanding this, it is important that the best possible outcomes are secured through the implementation of best practice and the full delivery of commissioned activity.

In 2015/16, the HSCB's performance management function will continue to enable and support a formal, regular, rigorous process to measure, evaluate, compare and improve performance across the HSC, identifying trends and performance issues, assessing performance risk, agreeing corrective actions, setting improvement goals and taking appropriate escalation measures in relation to the achievement of those improvement goals.

This section provides a brief overview of performance against the Ministerial standards and targets set for 2014/15. It also outlines the proposed approach to the delivery of the Ministerial targets set out in the Commissioning Plan Direction 2015/16. It does not seek to address every target; rather it seeks to outline how we intend to:

1. Support the continued achievement of targets of the required levels of performance in areas where the standards have been retained in 2015/16.
2. Address underperformance against existing targets and standards through the commissioning of additional capacity or other actions during 2015/16.
3. Support the achievement of new targets introduced for 2015/16.

In addition to the content within this section reference has been made in the preceding sections as to those commissioning intentions which are in line with or support delivery of Ministerial Targets.

1. *Support the continued achievement of targets of the required levels of performance in areas where the standards have been retained in 2015/16*.

During 2014/15, the HSCB continued to closely monitor Trusts' progress against the standards and targets set out in the Minister's Commissioning Plan Direction 2014/15 and take action as necessary.

Progress was made in a number of areas including:

- the target to deliver a minimum of 80 kidney transplants by March 2015 has been exceeded.
- significant improvement in performance against the 14-day breast cancer standard during the second half of 2014/15 – regionally during quarter three, 98% of urgent referrals were seen within 14 days and this improving trend is expected to continue.
- regionally, performance is on track to secure a 5% increase in the number of direct payments by March 2015
- the standard to ensure that no patient waits longer than 3 months to commence specified NICE approved specialist therapies has been substantially achieved.

2. *Address underperformance against existing targets and standards through the commissioning of additional capacity or other actions during 2015/16.*

There have also been a number of performance challenges on which the HSCB will continue to work with Trusts during 2015/16 to secure improvements, including:

- Cancer Care Services (62 day)
- Unscheduled Care (4 hour and 12 hour)
- Elective Care waiting times
- Mental health services
- Children's services
- Access to AHP services

The HSCB and PHA will work with Trusts during 2015/16 to maximise performance against all of the standards and targets set out in the Commissioning Plan Direction.

Cancer Care Services: From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Significant improvement has been made against the 14-day breast cancer standard during the latter half of 2014/15 compared to 2013/14. While performance has deteriorated slightly in the latter part of 2014/15 this is primarily in one HSC Trust (regionally during quarter three, 98% of urgent referrals were seen within 14 days). Actions to address this have been agreed and performance is expected to improve during quarter one of 2015/16 and be sustained thereafter. Performance against the 31-day standard has been consistently strong regionally, ranging from 95.1% - 97.4% for the period April December 2014 and it is the expectation this too will continue. However for the same period Trust level performance has ranged from 90.6% - 100%.

In relation to the 62-day standard, good progress has been made by the HSC during 2014/15 to reduce the number of cancer patients actively waiting longer than 62 days and the length of time they were waiting. It will take further time until this improvement is evident in the completed waits 62-day performance. In delivering this improved position, the HSCB has introduced enhanced monitoring arrangements with Trusts specifically around improving cancer performance. Further focussed efforts will be required in 2015/16 to improve the percentage of patients with a diagnosis of cancer who commence definitive treatment within 62 days of urgent referral, in particular in relation to the continued modernisation of the urological pathway. There will continue to be a particular focus on the longest waiting patients to reduce both the number of patients waiting longer than 62 days to commence cancer treatment and the length of time they wait.

To support the delivery of the cancer standards, the HSCB will continue during 2015/16, to seek to commission sufficient capacity across all relevant specialties as required to ensure that all patients have timely access to assessment, diagnosis and treatment. During early 2015/16 the HSCB will agree with Trusts the key messages and actions following analysis of 'red flag referral' information.

Another area for focused attention during 2015/16 will be a review of the Upper and Lower GI pathways in line with best practice, and to ensure more patients go straight to the appropriate diagnostic test, so avoiding any unnecessary delay in their diagnosis and treatment.

Unscheduled Care: From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.
The number of patients who have waited longer than 12 hours in Emergency Departments has been reducing steadily over the past number of years – from over 10,000 in 2011/12 to 3,100 in 2013/14. Unvalidated figures for 2014/15 indicate a slight increase to 3,175. Eliminating breaches of the 12-hour standard and significantly improving the percentage of patients attending an Emergency Department who are treated and discharged, or admitted within four hours of arrival will continue to be a top priority for the HSC in 2015/16.

During 2015/16 the HSCB will provide additional recurrent funding to enable Trusts to implement plans to ensure that key services (diagnostics, AHPs, social care, pharmacy etc.), at the five main hospital sites in the first instance, are delivered on a seven-day basis thereby improving patient flow at weekends.
The HSCB Unscheduled Care Team and LCGs will also work with Trusts during 2015/16 to develop plans to support twice daily senior decision making for all inpatients, and to ensure patients with the highest clinical priority are seen first during hospital ward rounds followed by patients potentially fit for discharge to facilitate early discharge and improve patient flow.

The HSCB also intends to take forward a programme of work to improve the efficiency of the utilisation of non-acute beds, building on the findings of audits undertaken during 2014/15.

The HSCB will also continue to support Trusts to improve the unscheduled care pathway through enhanced implementation of the 18 key actions.

Elective Care: From April 2015 at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks; no patient waits longer than nine weeks for a diagnostic test, and at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.

Regionally performance against the elective access standards deteriorated during 2014/15. The increase in waiting times in the first half of 2014/15 was due to a combination of increased referrals and an underdelivery of commissioned volumes of core activity by Trusts across a range of specialties. The delivery of core position improved in quarters three and four however, the inability to fund additional activity in the second half of the year led to a continued increase in waiting times for assessment and/or treatment.

At the end of March 2015, 44% of patients waiting for a first outpatient appointment were waiting less than nine weeks, and almost 70,000 were waiting longer than 18 weeks. In relation to inpatient / daycase treatment, 52% were waiting less than 13 weeks and 13,600 were waiting longer than 26 weeks.

The level of funding available to invest in elective care services in 2015/16 is likely to result in a significant and rapid increase in the number of patients waiting and in the length of time they wait for a first outpatient appointment, and for inpatient or daycase treatment.

To mitigate some of implications of the increase in waiting times, the HSCB will continue to work with Trusts to maximise the delivery of funded capacity and ensure the application of good waiting list management practice, including assessing and treating urgent cases first, and thereafter seeing and treating patients in chronological order.

In addition, the HSCB has prioritised the use of available funding in additional diagnostic capacity to ensure that serious conditions are diagnosed, and can then be prioritised appropriately.

Finally, the HSCB and DHSSPS will work together to consider opportunities to secure additional funding throughout the year. The HSCB will continuously review commitments to ensure best use of all available resources and have also supported DHSSPS to bid for additional in-year resources for elective care services as part of the June monitoring process.

Mental Health Services: From April 2015, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; 9 weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Regionally performance against the Mental Health and Psychological Therapy access standards deteriorated during 2014/15. The increase in waiting times in the first half of 2014/15 was due to a combination of increased referrals and capacity shortfalls within Trusts. There have also been difficulties within some Trusts in recruiting and retaining staff in Child and Adolescent Mental Health Services.

During 2014/15, the HSCB worked with the Trusts to review demand and capacity across a number of Mental Health services, including Child and Adolescent Mental Health Services (CAMHS) and Dementia Services, and to agree the service improvement steps to be taken to address the waiting time position. As a result numbers waiting in excess of 9 weeks at the end of March 2015 had fallen to 96 in CAMHS and 43 in Dementia Services and the HSCB is continuing to work with Trusts to reduce these numbers further during 2015/16.

The HSCB has also reviewed demand and capacity across all Psychological Therapy Services and agreed a range of service improvement actions across all Trusts to ensure that Trusts are delivering within their agreed activity framework. During 2014/15 the HSCB has worked with Trusts to expand capacity in Psychological Therapy Services with a recurrent capacity gap, subject to available funding and available funding will be prioritized during 2015/16 towards undertaking additional activity. This will not be sufficient to achieve the 13 week standard in 2015/16 but it will secure an improved position during 2015/16. The HSCB will continue to monitor Trusts' performance to ensure full delivery of capacity in all specialties, the

improvement of capacity through service improvement and the implementation of good waiting list management practice.

Children's Services: From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%.
By March 2015, ensure a three year time frame for 90% of children who are to be adopted from care.
During 2014/15, the HSCB has put in place arrangements to monitor trends for these children in care, acknowledging the time gap in performance reporting, with the most recent information for the year 2014/15 showing an improvement from 2013/14, whilst still not meeting the targets. The HSCB will be working with Trusts to agree the steps to be taken to improve performance in these areas during 2015/16.

AHPS: From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.
During 2014/15, revised AHP waiting time definitions were developed and arrangements put in place to consistently report performance in line with these definitions. An AHP demand and capacity exercise was undertaken by PHA during 2014/15 and the HSCB and PHA will be working with Trusts to agree the steps to be taken to address the waiting time position during 2015/16.

Ambulance Response Times: By March 2016, 72.5% of Category A (Life Threatening) calls responded to within eight minutes, 67.5% in each LCG area.
There was a deterioration in ambulance response times during 2014/15 compared with the previous year.

NIAS has advised that challenges remain in securing adequate levels of staffing to cover evening and weekend rotas due to sickness absence (long and short term) and staff cancelling planned overtime and the HSCB will work with the Trust in this regard.

NIAS has also experienced an unexpected increase in demand for Category A calls following the introduction of the Card 35 scheme. A software upgrade to the

booking system associated with this scheme is expected to resolve the current difficulties, resulting in improved response times for Category A calls in 2015/16.

The HSCB is working with NIAS to finalise a demand-capacity modelling exercise during 2015/16, and ongoing work to introduce alternative care pathways and to prioritise non-emergency transport are all expected to support improved Category A response times.

3. Support the achievement of new targets introduced for 2015/16

The Commissioning Plan Direction includes four new targets to be met during 2015/16:

Unplanned admissions (acute setting): During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.
The HSCB is working with Trusts, Community and Primary Care Providers to address this target. Information from the monthly download of the Hospital Inpatient System will be analysed so that emerging patterns can be reviewed against relevant care pathways and the capability of primary care services to see, treat and support patients in a primary / community setting.

Public Health lifestyle messages including the 'Choose Well' campaign will continue to be promoted. It is anticipated that the introduction of Acute Oncology Services at the Cancer Units / Cancer Centre will reduce unplanned admissions of acutely ill oncological patients - as has been the experience nationally.

Patient safety: From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.
Day of the week should not be a discriminator in the delivery of timely, resilient safe and sustainable services for patients. Just as people become unwell seven days a week, they get better seven days a week and there is a challenge to respond effectively and in a timely manner across 7 days to deliver care as required.

During 2015/16 commissioning will focus on improving 7 day working to improve the flow of patients through hospital systems, and ultimately improve both the patients' outcomes and experiences. PHA/HSCB have a process for managing RQIA reports through the Safety & Quality Alerts Team meetings and monitoring of implementation. The above target will be monitored and included monthly in the HSCB Report for 2015/16.

Cancelled Appointments: By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment.
Following the work undertaken by the Short Life Working Group, timely and accurate information on the number of hospital cancelled consultant-led outpatient appointments that had an actual impact on patients is now available. During 2015/16, the HSCB will continue to monitor Trusts' performance in this area and will work with Trusts to identify opportunities to reduce the number of hospital cancellations.

Pharmaceutical Clinical Effectiveness Programme: By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.
The programme focuses on key therapeutic areas where by application of clinical evidence (e.g. NICE) and promotion of formulary choices as per NI formulary can result in improvements in quality and safety whilst producing efficiency and gains.

The HSCB have developed a detailed action plan outlining the efficiencies and actions to be taken in 2015/16 and the programme is overseen by a Prescribing Efficiency Review team. This team will review efficiencies and actions on a monthly basis to ensure delivery of the PCE target and to consider remedial action where required.

Delivery of the targets will be achieved through engagement with GPs, LCGs and Trusts. The HSCB will continue to work with GPs to further develop commissioning arrangements for provision of prescribing support for all GP practices in NI. The

HSCB will also identify opportunities to collaborate more effectively with Trusts to ensure delivery targets through joint HSCB/LCG/Trust meetings focusing on particular therapeutic topics where key clinicians will be attendance.

9.0 Belfast Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure delivery either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

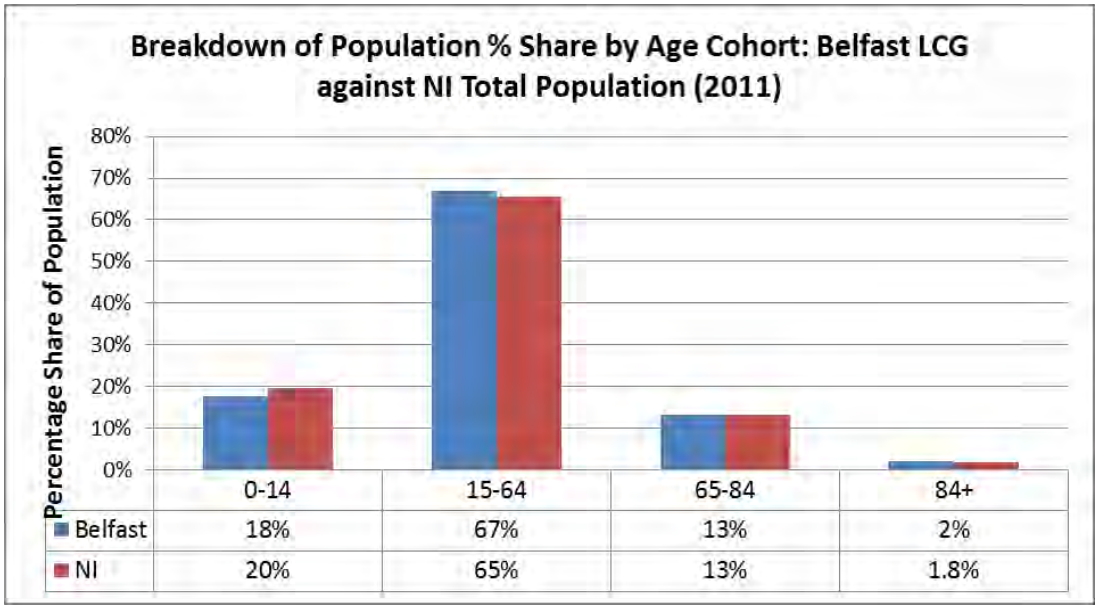
9.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Belfast LCG. A range of info and analyses has been used to identify the challenges facing the LCG in 2015/16 and beyond.

9.1.1 Demographic changes / pressures

This section gives a general overview of the population Belfast LCG serves, describing the age structure, general health and income of the resident population.

Figure 4



Source: NISRA 2012

Demography

Figure 4 above shows that the Belfast LCG area has a relatively older population profile than other areas of Northern Ireland. The breakdown of the Belfast LCG population change at five year intervals from 2012 – 2027 below indicates that the largest increases will be in the numbers of children and older people which are groups with greater needs than other age groups. The increase in people aged 85 and over is also significant as this group tends to have the greatest need for health and social care.

Belfast LCG population changes

Table 22

AGE / YEAR	2012	2017	2022	2027	Total Change 2012-2027
0-14	61912	66179	69305	66885	4973
15-64	233354	234627	231392	228663	-4691
65-84	45732	46847	50332	56838	11106
84+	7255	8346	9418	10575	3320
TOTAL	**348253**	**355999**	**360447**	**362961**	**14708**

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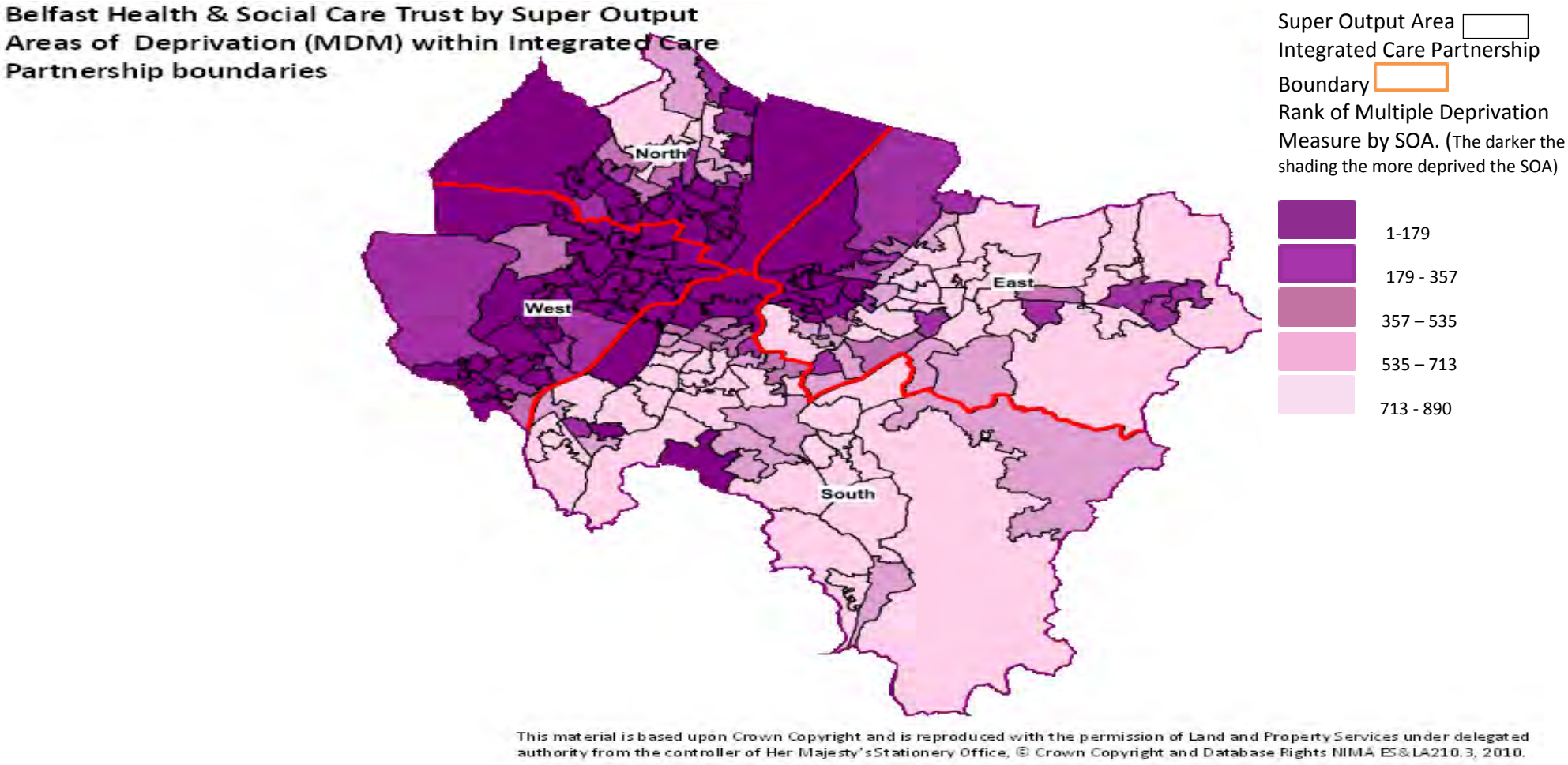
Deprivation

The extent of deprivation in Belfast Council area is greater than in any other Local Government District in Northern Ireland, with 46% of the population estimated to be living in multiple deprivation (NINIS 2010). The map below shows the areas of deprivation across the 4 ICP localities within the Belfast area. The population in multiple deprivation tends to be concentrated in north and west Belfast but there are also significant areas of deprivation in south and east Belfast. Figure 5 shows that people living in more deprived areas tend to have greater health needs than those in less deprived areas.

Figure 5



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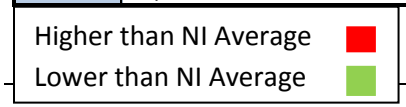
Health Summary

The table below shows the health of the Belfast LCG population in comparison to Northern Ireland as a whole which indicates that for most of the key health indicators the population of the Belfast LCG area is in poorer health and have greater need.

Table 23

Domain	Indicator	Descriptor	BELFAST	NI Average	Most Deprived in BLCG	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.33	19.12		
	COPD	Prevalance per 1000	21.8	18.56		
	Stroke	Prevalance per 1000	18.61	17.94		
	Diabetes	Prevalance per 1000	42.49	42.61		
	Dementia	Prevalance per 1000	6.91	6.67		
Disability	Pain or Discomfort	% of population (2012-13)	36	35	43	
	Learning Disability	Prevalance per 1000	4.56	5.33		
Emotional Health and Wellbeing	Mental Health	Prevalance per 1000	10.38	8.54		
	Crude Suicide Rates	All Persons	21.5	15.8		
Risk Factors	Smoking- current smoker	% of population (2012-13)	26	24	37	
	Obese or overweight	% of population (2012-13)	62	62	66	
	Meeting Physical activity levels	% of population (2012-13)	51	53	45	
	Anxious or Depressed	% of population (2012-13)	33	26	37	
Maternal and Child Health	Children in Need	Rate per 100,000	85.67	60.18		
	Diabetes in Pregnancy	Belfast Mothers (12/13)	3.19	3.6		
	Obesity in Pregnancy	BMI >30	18.7	19.3		
	Births to Teenage Mothers	Percentage 2013	5.39	3.86		
Life Expectancy	Male	Age (2009-11)	75.1	77.5	73	
	Female	Age (2009-11)	80.18	82	79.4	
	Cancer (All ages)	Standardised Death Rate	333.7	291.6		
	Circulatory Diseases	Standardised Death Rate	118	93		
	Respiratory Diseases	Standardised Death Rate	125	113		
Carers	Unpaid Care	50+ Hours provided (2011)	3.4	3.1		



9.1.2 Personal and Public Involvement

Belfast LCG continually engages with key stakeholder including service users, carers, community and voluntary sectors, political representatives, HSC organisations and health and social care professionals.

In developing the specific proposals in the Commissioning Plan, the Belfast LCG has involved service users, advocacy groups and community groups, particularly members of the Long Term Conditions Alliance such as Diabetes UK and Arthritis Care; Carers groups such as Carers NI; mental health such as NIAMH and local community groups providing counselling and other services; groups representing Older People such as the Greater Belfast Seniors' Forum, local lifestyle forums in Belfast and Castlereagh and Age Partnership Belfast; groups representing people with Disabilities such as the Prosthetic Users' Forum and the Stroke Survivors and Carers Forum; and members of the five Area Partnerships in Belfast.

The Draft Commissioning Plan was thoroughly discussed at a plenary workshop of interest groups hosted by the LCG. Issues raised were considered by the LCG and amendments were made to the plan. This will be followed up by regular workshops to ensure that implementation of the plan reflects the agreed plan.

9.1.3 Summary of key challenges

- Higher standardised mortality ratios for cancer, heart disease and respiratory diseases;
- A growing population of elderly people with increased care needs and increasing prevalence of disease;
- Higher proportion of people living with long term illness;
- Highest proportion of individuals using prescribed medication for mood and anxiety disorders
- An over-reliance on hospital care, with activity exceeding current funds;
- Services which are fragmented and lack integration;
- Health and quality of life generally worse than the rest of NI

9.2 LCG Finance

Use of Resources

The Belfast LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £619.7m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 24

Programme of Care	£	%
Acute Services	208.6	33.59%
Maternity & Child Health	23.5	3.79%
Family & Child Care	44.9	7.24%
Older People	144.7	23.31%
Mental Health	60.3	9.71%
Learning Disability	56.9	9.17%
Physical and Sensory Disability	25.8	4.16%
Health Promotion	27.3	4.41%
Primary Health & Adult Community	27.7	4.63%
POC Total	**619.7**	**100%**

This investment will be made through a range of service providers as follows:

Table 25

Provider	£	%
BHSCT	530.8	85.51%
NHSCT	2.0	0.32%
SEHSCT	39.0	6.27%
SHSCT	0.8	0.13%
WHSCT	0.3	0.05%
Non-Trust	46.8	7.71%
Provider Total	**619.7**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Belfast Trust is

in the region of £20.6m. The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Belfast area and additional investment in the therapeutic growth of services.

9.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Belfast Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

9.3.1 POC 1: Acute – Elective Care

Strategic Context: The LCG will address the demand on elective services to ensure standards and response times are improved. The LCG will work with primary care to support GPs and others in developing innovative approaches to managing the care of patients as far within their locality, without the need for referral to a Consultant-provided service. The role of other healthcare professionals will also be extended to reserve Consultant appointments for those patients who require it.

Local Needs and Assessment

1. Demand for imaging exceeds capacity as follows: 8150 MRI Scans, 7160 CTs, 6000 Non-Obstetric Ultrasounds and 250 Fluoroscopies.
2. Demand for Endoscopies exceeds commissioned capacity by 660 per year.
3. Demand exceeds service capacity by 5900 outpatient consultations, 700 inpatient and 2650 day case treatments, across 12 local specialties.
4. 2700 patients per year presenting with musculoskeletal conditions and pain require a coordinated pathway to ensure they get the right care from the right clinician in the right setting as quickly as possible.

Services to be commissioned

1. The LCG will commission an additional 3455 MRI, 7244 CT, 6520 NOUS and nearly 6000 other tests to achieve a maximum wait of 14 weeks in 15/16; however this excludes existing waiters of nearly 4000.
2. Referrals for endoscopy will be scored on a JAG accredited points system to ensure more effective use of clinical capacity.
3. Primary care will be supported in managing demand for Neurology, Dermatology, ENT, Rheumatology, Respiratory, Urology and Gynaecology.
4. The LCG will also take forward an integrated Musculoskeletal pathway across Orthopaedics, Rheumatology

Securing Service Delivery

1. The Belfast Trust should bring forward proposals to fully utilise its in-house imaging capacity, including the new MRI scanner at RBHSC.
2. The Trust should fully develop the potential for Nurse-led Endoscopy and introduce an agreed points system to maximise utilisation of endoscopy services.
3. Demand management will be sought from primary care contractors where these can be shown to reduce the need to refer to Trust Consultant-led services.
4. ICPs should bring forward proposals in response to the LCG specification for integrated musculoskeletal services.

Regional Priorities (see appendix A): Cancer services (MT11), Unscheduled Care (MT12), Elective Care (MT15, 16, 17), Patient Safety (MT25),

9.3.2 POC 1: Acute – Unscheduled Care

Strategic Direction: The LCG will aim to commission an urgent care pathway which reduces reliance on hospital services, achieving a transfer of resources from hospital to community services through investment in alternatives to hospital and more effective decision-making when people attend an Emergency Department.

Local Needs and Assessment

1. The number of patients admitted as emergencies for less than 48 hours is increasing, in line with national trends.
2. Variation in demand for urgent care by hour of day and day of week is not matched by appropriate service responses in hospital or in the community, leading to delays in the delivery of care and requiring expansion of capacity in specific areas.
3. Around 46,000 people attend Emergency Departments for minor illnesses or injuries which could be addressed more appropriately within primary care or by self-care.

Services to be commissioned

1. The LCG will commission 7-day Acute Care at Home and Community Respiratory services to avoid unnecessary short stay admissions of the frail elderly and COPD patients to hospital.
2. The LCG will commission a new Emergency Department and supporting services at the RVH which match the pattern of attendances at this hospital. The LCG will commission 7 day services which support the Emergency Department and avoid unnecessary short stay admissions and delays.
3. The LCG will commission integrated Minor Injury, Minor Illness, Out of Hours and Primary Care services, supported by community and voluntary resources.

Securing Service Delivery

1. The Belfast ICPs should continue to implement the ICP Respiratory team and bring forward proposals to extend Acute Care at Home to 7 days.
2. The Belfast Trust should ensure that: the new RVH ED has sufficient support from hospital services to meet Ministerial targets for waiting times; senior decision-makers are able to assess and discharge rather than admit, where this is clinically appropriate, and the frequency of ward rounds is increased to ensure no unnecessary delays in discharging patients. Excess days in hospital should be reduced in line with best practice in the NHS.
3. The ICPs should bring forward proposals for minor illness/injury services based on the LCG specification.

Regional Priorities (see appendix A): Patient Safety (MT25), Unplanned Admissions (MT5/6)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 26

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	19,715		19,715
		Daycases	49,717		49,717
		New Outpatients	129,259		129,259
		Review Outpatients	284,278		284,278
	Unscheduled	Non Elective admissions - all	46,037	2,061	48,098
		ED Attendances	211,667	7,800	219,467
		Planned investment in 2015-16		£3.4m	

9.3.3 POC 2: Maternity and Child Health Services

Strategic Priorities: The LCG will commission implementation of the objectives of the Maternity Strategy and Healthy Child, Healthy Futures: including a strategic shift towards providing more maternity care in the community, more midwife-led care and tackling inequalities. The paediatric inpatient review led by the DHSSPS will set a framework for the future development of inpatient services which are safe and sustainable. The LCG will continue to work closely with ICPs in ensuring that children receive the best possible care in the most appropriate settings.

Local Needs and Assessment

1. Births at the RJMH are projected to decrease by a further 2% by the end of 2014/15. However, the RJMH also provides a range of regional services which deal with complex deliveries and peri-natal care. A regional review of neo-natal services identified a requirement to incrementally increase the number of intensive care costs from 27 to 31.

2. Higher levels of deprivation increase demands on the service. 1 in 5 Belfast mothers has a BMI over 30 with a growth of 37% in diabetes in pregnancy over past 2 years. 64 per 1000 babies have Low Birth Weight in Belfast (NI rate is 59). The needs of ethnic minorities must also be taken into account.

3. Emergency Department attendances at RBHSC are increasing each year.

Services to be commissioned

1. Investment to be reviewed in line with the Maternity Strategy, taking account of birth numbers, full utilisation of Midwife led Units and complexity of births.

2. Increasing complexity will require a gestational diabetes service, a multiple pregnancy ante-natal service and joint obstetric-specialist physician antenatal clinics to address increasing complexity.

3. The LCG will commission alternatives to ED attendance for minor illnesses. The LCG will ensure that a sustainable medical rota at the RBHSC ED. The age limit for admission to children's wards will be raised to 16.

Securing Service Delivery

1. The SBA with Belfast Trust will be adjusted to reflect changing needs and demands. The Trust should ensure that midwifery-led care is extended and work with GPs, midwives and the local community to ensure that capacity within the Mater Midwifery Led Unit is fully utilised.

2. The Trust should provide a gestational diabetes service, a multiple pregnancy ante-natal service and joint obstetric-specialist physician antenatal clinics. From April 2015, all eligible pregnant woman aged 18 years & over with a BMI of >40 at booking should be offered the weigh to a healthy pregnancy programme.

3. The ICPs should propose alternatives to ED for minor illness from ICPs. The Trust should secure a 5th ED consultant in RBHSC and

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 27

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	6,931		6,200
	Health Visiting	Contacts	20,702		20,702
		Planned investment in 2015-16		£0.06m	

9.3.4 POC 4: Older People

Strategic Priorities: additional community nursing support, acute care at home and direct access to specialist assessment will be commissioned to reduce the risk of hospitalisation and avoid Emergency Department attendance wherever appropriate. Early supported discharge with enhanced therapeutic interventions will reduce unnecessary days in hospital and improve long term outcomes. Early diagnosis and support for carers should improve outcomes for people with dementia.

Local Needs and Assessment

1. Older patients, especially those with multiple chronic conditions, are more likely to need to attend an ED and, once there, are far more likely to be admitted, often for assessment and short term nursing and medical care. (Audit Commission 2013).
2. Around 1000 people with Dementia in Belfast are undiagnosed and will therefore not benefit from early support and intervention.
3. 180 of the Belfast residents who suffer a Stroke and are admitted to the RVH Stroke Unit could have their outcomes improved by receiving Early Supported Discharge.

Services to be commissioned

1. The Acute Care at Home scheme will commence on 1 April 2015 to treat 3302 patients in their own homes per year. Admission to this "virtual ward" will be an alternative to admission to a hospital ward.
2. An enhanced Dementia Memory Service will be commissioned this will improve early diagnosis rates, support care planning and support for carers.
3. An Early Supported Discharge programme will be commissioned with a capacity of 180. The shorter length of stay will also ensure Stroke beds are available for those who need them.

Securing Service Delivery

1. ICPs should bring forward proposals to extend the Acute Care at Home scheme to receive admissions on a 7 day basis.
2. The Trust should provide an additional 1560 appointments for clients across 10 local Dementia Memory Clinics. This will reduce waiting times and increase early diagnosis.
3. ICPs should finalise proposals for Early Supported Discharge. The LCG will commission supported self-management programmes for those living with Stroke from Active Belfast and the voluntary sector.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency readmissions (MT14), Patient Discharge (MT21)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 28

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,029,469	25,600	2,055,069
	Residential and Nursing Home Care	Occupied bed days	924,874	10,600	935,474
	Community Nursing	Contacts	256,905		256,905
		Planned investment in 2015-16		£2.1m	

9.3.5 POC 5: Mental Health

Strategic Priorities: The LCG will work closely with the Regional Bamford Team to develop services for the severely mentally ill and for those with mild or moderate mental illness, emphasising recovery through the Stepped Care model which supports people to live independently with or without on-going mental illness. The LCG, Trust, ICPs and Belfast Strategic Partnership in developing a Primary Care Talking Therapies Service enabling GPs to help patients access appropriate C&V support, or specialist support when required. This approach also aims to reduce the relatively high dependency on prescription drugs for depression, anxiety and pain within Belfast.

Local Needs and Assessment

1. Belfast has the highest proportion of individuals of any constituency in NI (160 vs. 147 per 1000) using prescribed medication for mood and anxiety disorders; estimated demand of 4000 patients per year requiring treatment for mild to moderate mental health problems.
2. Evidence indicates that intensive early intervention when symptoms of psychosis first emerge can significantly improve life chances and health outcomes. Similarly early intervention in respect of eating disorders can reduce the severity and longevity of harmful behaviours and associated physical health problems.
3. Evidence indicates that Recovery approaches in mental health improves outcomes by supporting people with long term mental health conditions to take more responsibility for self-care, supporting them to become economically active, and to sustain family and social relationships.

Services to be commissioned

1. 32,000 sessions of NICE recommended evidence-based interventions (talking therapies) will be commissioned to meet the estimated demand for treatment.
2. The multi-disciplinary early intervention psychosis service will be expanded to enhance peer support; primary care based early intervention provision will be commissioned from the specialist eating disorder service.
3. HSCB will support the Trust in reshaping practice and services initiatives to ensure a Recovery Focus, develop a Recovery College and to continue to enhance the provision of peer support. A Substance Misuse Liaison Service (SMLS) will be commissioned in appropriate acute hospital settings, delivering regionally agreed Brief Intervention Programmes.

Securing service delivery

1. The Trust and ICPs should develop the Primary Care Talking Therapies Service with a Hub in each ICP area. The Trust should commission the range and volumes of therapies from community-based organisations to meet the estimated demand and offer a training programme to organisations to support the delivery of the evidence-based interventions.
2. The Trust should bring forward plans for the further development of the early intervention psychosis and eating disorder services in response to a commissioner specification.
3. The Trust should bring forward plans for the development of a Recovery College in response to a commissioner specification. The Trust should respond to a commissioner specification for an SMLS.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 29

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	90,683		90,683
	Residential and Nursing Home Care	Occupied Bed days	57,461	150	57,611
	Domiciliary Care	Hours	96,242	350	96,592
		Planned investment in 2015-16		£0.2m	

9.3.6 POC 6: Learning Disability

Strategic Priorities: The Bamford principles of promoting independence and reducing social isolation for people with learning disabilities continues to underpin the commissioning objective for Belfast LCG. With a focus on supporting family carers; and working with other statutory, voluntary and community partners to deliver services that enable people with a learning disability to maximise their potential and enjoy health, wellbeing and quality of life.

Local Needs and Assessment

1. Better health care has resulted in an increase in the number of young people with complex learning disability and physical health needs surviving into adulthood.
2. The resettlement of people from long stay hospital to community settings is reaching completion. There is a need to further develop community based services to support people with complex needs to sustain their community placements.
3. As the life expectancy of people with a learning disability increases there is an increase in the number and age of family carers. Also as people live longer they develop health needs associated with old age. This is increasing the complexity of needs that family carers are coping with. The Trust has identified 82 clients with a risk of family care breakdown because of caring pressures.

Services to be commissioned

1. Day opportunities will be commissioned for up to an additional 20 young people with complex needs transitioning to Adult Services.
2. An enhanced range and availability of intensive community support services will be commissioned to prevent placement breakdown, avoid the need for hospital admission and facilitate timely discharge from hospital.
3. Innovative forms of support will be commissioned for parents and other family carers living with adults with learning disabilities at home.

Securing Service Delivery

1. Belfast Trust should commission a number of day opportunities packages, to be specified by the LCG, in line with the Regional Day Opportunities Model and criteria, for young people transitioning to adult services, to be specified and funded by the LCG.
2. The Trust should develop intensive support services to reduce the risk of hospital admission and extend availability out of hours.
3. The Trust should make proposals in response to a commissioner specification for the extension of the parenting support services, and implement other carer support initiatives identified in the "Short Break" review.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Patient Discharge (MT21), Unplanned Admissions (MT5)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 30

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	251,247	310	251,557
	Residential & Nursing Home Care	Occupied bed days	111,071		111,071
		Planned investment in 2015-16		£0.1m	

9.3.7 POC 7: Physical Disability and Sensory Impairment

Strategic Priorities: The LCG will continue to support regional approaches to increasing supported living and self-directed support. A particular focus for Belfast LCG is ensuring that patients with complex acquired disabilities are able to be discharged as soon as appropriate from specialist acute inpatient services to specialist rehabilitation or local settings where they can avail of the most appropriate care and maintain as much independence as possible.

Local Needs and Assessment

1. Prevalence of hearing impairment (5.6%), visual impairment (2.0%) is higher for Belfast LCG than for Northern Ireland as a whole (5.1% and 1.7% respectively);
2. 11,700 people in the Belfast LCG population each provide more than 50 hours of care per week (585,000 hrs.)
3. The rate of major amputations per 1000 on the diabetes register was 3 for NI in 2013/14 compared to 1 per 1000 in England.

Services to be commissioned

1. Subject to the outcome of recent pilot schemes, the LCG plans to increase investment in sensory impairment services including deaf/blind training and audiology support services for hearing aid users and people with tinnitus;
2. Following a regional review, investment will be made in innovative Short Breaks for carers as an alternative to traditional forms of respite care;
3. The LCG will commission a Foot Protection Team model of service to reduce the risk of foot disease and ulceration, so reducing the need for amputation. Outcomes for amputees through investment in rehabilitation and modernisation of the service through E-Health and technology development.

Securing Service Delivery

1. Services for people who are deaf/blind use hearing aids or have tinnitus will be procured from the community and voluntary sector.
2. The Trust should bring forward proposals for additional investment in short breaks for carers which balance the need for intervention and responding to crisis situations; the LCG will expect innovative proposals which make greater use of Direct Payments and which are underpinned by improved identification of carers
3. The Belfast ICPs will be commissioned to provide a Foot Protection Service. The Trust should also bring forward proposals for additional investment in AHPs to support the regional Amputee Service and should develop proposals for modernisation using technology.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Allied Health (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC 7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 31

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	339,886	2500	342,386
	Residential & Nursing Home Care	Occupied bed days	39,649	180	39,829
		Planned investment in 2015-16		£0.16m	

9.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better was launched by DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. Belfast Strategic Partnership Framework for Action sets out a range of priorities to address life inequalities in the BLCG area. In 2015/16 Community Planning will be introduced. BLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs Assessment

1. Higher standardised mortality of Cardiovascular, Cancer and Respiratory disease, especially in more deprived areas leading to lower life expectancy.
2. Risk factors and evidence of parental stress include relatively high rates of teenage pregnancy, lower breastfeeding rates, prevalence of self-harm and alcohol intake during pregnancy.
3. Between 32% and 4% of households in the LCG are Fuel poor which can lead to poor health and even death.

Services to be commissioned

1. Chronic Disease Prevention Hubs will be commissioned in each locality to enable GPs, Pharmacists and others to refer patients with known health risks, including stress, smoking and obesity to accredited, community based risk-reduction programmes. Community-based organisations will support health promotion by targeting workplaces and schools using community development approaches.
2. Evidenced based parenting programmes will be promoted and supported by an Early Interventions Officer.
3. NICE guidance on Excess Winter Deaths will be implemented through the Belfast Strategic Partnership

Securing Service Delivery

1. ICPs should bring forward proposals to provide Chronic Disease Prevention Hubs which develop, coordinate and deliver programmed risk reduction plans for individuals. These should be closely linked to Primary Care Talking Therapy Hubs to support emotional health and well-being. The Hubs should also work with GPs and the Trust Reablement Team and Falls Prevention Team to provide practical and emotional support to older people to support independent living.
2. Belfast Trust should ensure that appropriate staff are released to take Brief Intervention Training.
3. The LCG and PHA will work through the Belfast Strategic Partnership and Community Planning to secure implementation of agreed objectives to address life inequalities.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1), Patient Safety (MT25), Mental Health (MT22)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

9.3.9 POC 9: Primary Health and Adult Community

Strategic Context: The LCG will continue to support the modernisation of primary care services. A programme of co-location of primary and community care services is being taken forward involving local communities and the new Councils. The NIAO has drawn attention to higher spending on prescription drugs in NI than in the rest of the UK and the LCG has developed a joint action plan with the four ICPs in its area to reduce this by funding practice-based pharmacists, encouraging adherence to guidelines and offering alternative therapies. The LCG will also work with practices to reduce variation in services.

Local Needs and Assessment

1. Referral rates of patients with Type 2 Diabetes to hospital vary significantly between GP practices in Belfast. There are also patients with Diabetes who are house-bound and require domiciliary visits.

2. Spending on the drug Pregabalin in Belfast is higher than the NI average and its abuse is a public health hazard. There is a 13 week wait for psychological therapies by people with long term health conditions, such as chronic pain, who have associated mental health conditions.

Commissioning Requirements

1. The LCG will commission a 'Shared Care' service for Diabetes which will provide specialist support to GP practices to ensure consistency of care management and prescribing, reduce referral variation and carry out domiciliary care visits per year.

2. The LCG will commission a Pain Management Programme with sufficient capacity to provide an alternative or complement to prescription of Pregabalin for pain relief.

Securing Service Delivery

1. The ICPs should bring forward proposals for a Diabetes 'Shared care' service which builds on the South Belfast Care Pathway and reduces variation in service provision.

2. The LCG will commission a Pilot Pain Management Programme (PMP) from Arthritis Care and, if positively evaluated, will procure a PMP through a tendering process.

Regional Priorities (see appendix A): Unplanned Admissions (MT5,6), Emergency Readmissions (MT14), Pharmaceutical Clinical Effectiveness Programme (MT30)

10.0 Northern Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure deliver either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

10.1 Overarching assessment of need and inequalities for LCG population

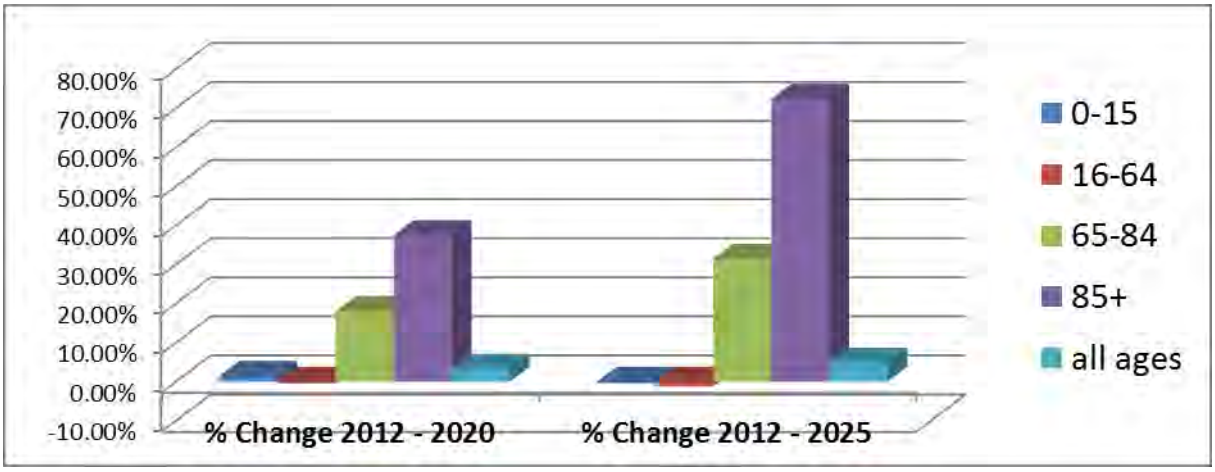
This section provides an overview of the assessed needs of the populations of the Northern Local Commissioning Group (NLCG). A range of information and analyses have been used to identify the challenges facing the NLCG in 2015/16 and beyond.

10.1.1 Demographic changes / pressures

This section provides a general overview of the population the NLCG serves, describing the age structure and general health of the resident population. The NLCG covers an area of 1,670 square miles with a total population of 466,724 (49% or 228,731 are male and 51% or 237,933 are female). The NLCG has the highest share (26%) of the Northern Ireland population.

NLCG Population Forecast Change: 2012-2020 vs. 2012 - 2025

Figure 6



	Year: 2012	Year: 2020	Year: 2025	Variance from 2012 - 2020	Variance from 2012 - 2025	% Change 2012 - 2020	% Change 2012 - 2025
0-15	96,199	97,628	95,828	1,429	-371	1.49%	-0.39%
16-64	296,079	294,900	292,513	-1,179	-3,566	-0.40%	-1.20%
65-84	64,710	76,379	85,044	11,669	20,334	18.03%	31.42%
85+	8,541	11,743	14,724	3,202	6,183	37.49%	72.39%
all ages	**465,529**	**480,650**	**488,109**	15,121	22,580	3.25%	4.85%

Source: NISRA, 2012

The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five to ten years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group.

Current Population for NLCG Residents Aged 65+ by Age Band and Local Government District

Table 32

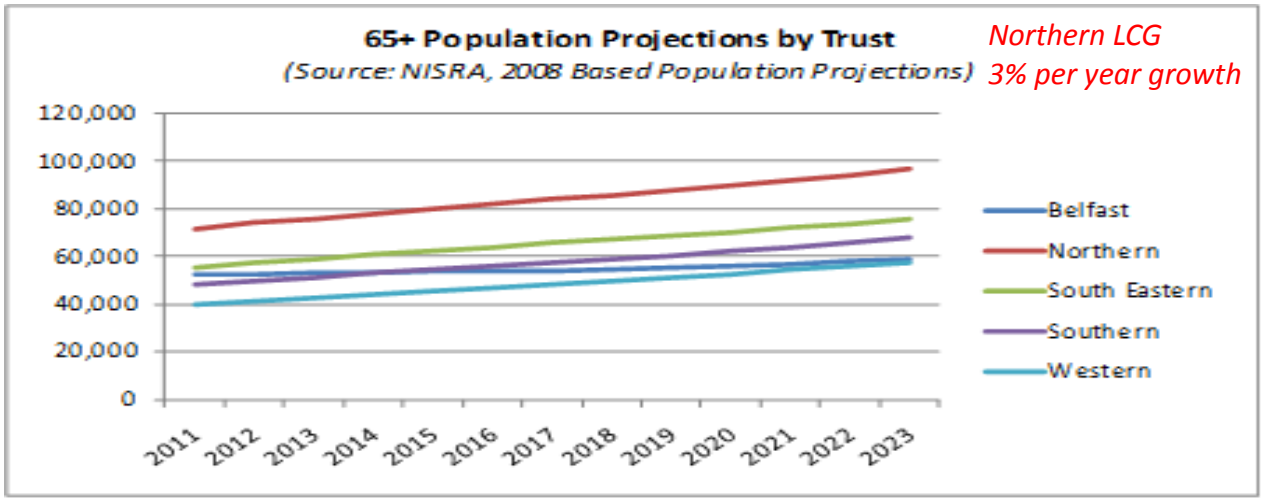
LGD	65-74	75-84	85+	Total 65+
Antrim	4,549	2,347	798	7,694
Ballymena	6,117	3,707	1,393	11,217
Ballymoney	2,751	1,570	570	4,891

Carrickfergus	3,783	2,174	747	6,704
Coleraine	5,887	3,495	1,192	10,574
Cookstown	2,950	1,577	613	5,140
Larne	3,350	1,862	661	5,873
Magherafelt	3,445	1,928	711	6,084
Moyle	1,756	934	339	3,029
Newtownabbey	7,488	4,551	1,701	13,740
NLCG Total	**42,076**	**24,145**	**8,725**	**74,946**
NI Total	**155,300**	**90,550**	**33,284**	**279,134**

Source: NISRA, Mid-Year Estimates 2013

Current >65 Population

Figure 7

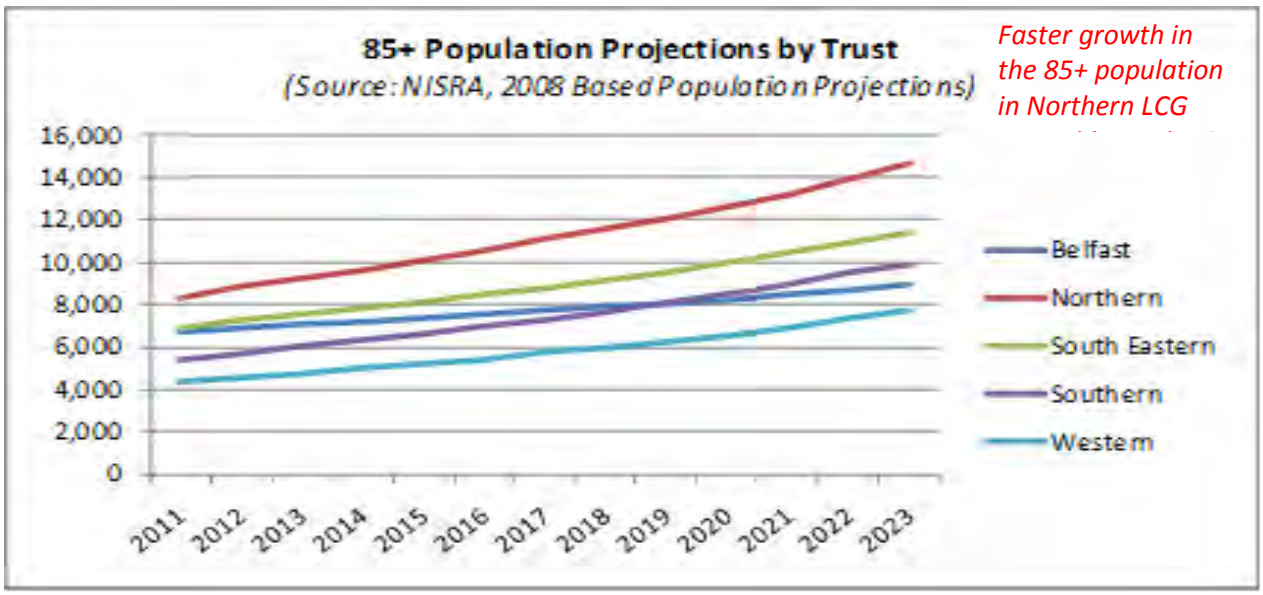


Year:	2011	2012	2013	2014	2015	2016	2017
65+ Pop	71,527	73,876	75,912	77,834	79,785	81,725	83,706
	2018	**2019**	**2020**	**2021**	**2022**	**2023**	
65+ Pop	85,693	87,661	89,630	91,777	94,024	96,386	

Source: NISRA, 2008 Population Projections

Current Over 85 Population

Figure 8



Year:	2011	2012	2013	2014	2015	2016	2017
85+ Pop	8,340	8,882	9,232	9,584	10,065	10,590	11,064
	2018	2019	2020	2021	2022	2023	
85+ Pop	11,538	12,073	12,608	13,185	13,935	14,660	

Source: NISRA, 2008 Population Projections

The table below highlights the greater prevalence of certain conditions in the Northern LCG area namely: cancer, stroke, atrial fibrillation, coronary heart disease, hypertension and diabetes.

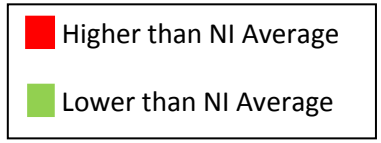
MAHI - STM - 120 - 2005

Health Summary

The table below shows the health of the Northern LCG population in comparison to Northern Ireland as a whole.

Table 33

Domain	Indicator	Descriptor	NLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	19.49	19.12	
	COPD	Prevalance per 1000	18.43	18.56	
	Stroke	Prevalance per 1000	18.44	17.94	
	Atrial Fibrillation	Prevalance per 1000	15.99	15.12	
	Coronary Heart Disease	Prevalance per 1000	41.34	38.81	
	Hypertension	Prevalance per 1000	137.67	130.5	
	Diabetes	Prevalance per 1000	45.93	42.61	
	Asthma	Prevalance per 1000	61.8	60.48	
	Dementia	Prevalance per 1000	6.46	6.67	
	Learning Disability	Prevalance per 1000	5.19	5.33	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.86	8.54	
	Anxious Depressed	% of population (2012-2013)	24	26	
	Crude Suicide Rates	All Persons	13.1	15.8	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	61	62	
	Meeting Physical activity levels	% of population (2012-2013)	54	53	
	Pain or Discomfort	% of population (2012-2013)	36	35	
	Bowel Cancer Screening	Programme Uptake	53.39	49.8	
Child Health	Children in Need	Rate per 100,000	47.19	60.18	
	Births to Teenage Mothers	Perecentage 2013	4.04	3.86	
Life Expectancy	Male	Age (2009-11)	77.95	77.5	
	Female	Age (2009-11)	82.45	82	
	Neonatal	Death Rate (2013)	0.3	0.3	
	Infant Mortality	Death Rate (2013)	3.9	4.6	
	Lung Cancer	STD Death Rate (2008-2012)	58.3	66.5	
	Female Breast Cancer	STD Death Rate (2008-2012)	35	38.1	
Carers	Unpaid Care	50+ Hours provided (2011)	2.9	3.1	



10.1.2 Personal and Public Involvement

The Northern LCG had a successful joint working forum with representatives from the 10 district councils and the Northern Trust. This group has been reconstituted to take account of the new Council structures. The group will continue to meet quarterly and more often when appropriate to discuss matters relating to health and social care locally and in particular progress the agenda relating to transformation. The group is chaired by the Chair of the Northern LCG and the Vice Chair is a local elected representative. The group also shares information relating to developments in local government such as community planning which is relevant to the work of local commissioning.

The Northern LCG has also established links with Causeway Older Active Strategic Team (COAST), Mid and East Antrim Agewell Partnership (MEAAP) and Age Well Mid Ulster in order to ensure that there is on-going dialogue in respect of issues of common interest relating to older people.

More recently the Northern LCG has also engaged with the local community networks of South Antrim, Causeway Rural and Urban Network, Cookstown Western Shores and North Antrim Community Network.
Service Users and Carers are involved in specific initiatives undertaken by the Northern LCG. These include work that is on-going to develop specific pathways such as the MSK pathway and the preparatory work on pathways undertaken to inform the work of the Integrated Care Partnerships for example in dementia.

Representatives from the Northern LCG also participate in the Carers Steering Group locally and in the Northern Area Promoting Mental Health and Suicide Prevention Group.

It is recognised that the Northern LCG will need to continue to extend opportunities for engagement and user involvement in the coming year as significant reforms will continue to be progressed as part of improving efficiency and rolling out the transformational agenda.

10.1.3 Summary of Key Challenges

A summary of the key challenges in 2015/16 are as follows:

- A growing older population with increasing prevalence of long term conditions;
- An over reliance on hospital care with capacity issues in some service areas;
- Growing demand for elective specialties and the need to reshape and redesign services to better meet demand;
- Meeting the needs of older people for domiciliary care and support in the context of a therapy led reablement service;
- Delivering on the potential of ICPs to implement agreed care pathways to reduce reliance on hospital care and effect a shift of resources;
- With the NLCG having a large rural hinterland, access to services can be problematic – e.g. access to emergency ambulances.
- Maximising the role of the voluntary and community sector in the delivery of health and social care.
- Working with Partners in local government and other statutory services to deliver on the Community Planning functions.

10.2 LCG Finance

Use of Resources

The NLCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £728.4m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 34

Programme of Care	£	%
Acute Services	281.2	38.54%
Maternity & Child Health	33.0	4.53%
Family & Child Care	46.5	6.37%
Older People	166.2	22.78%
Mental Health	59.3	8.12%
Learning Disability	61.0	8.37%
Physical and Sensory Disability	21.6	2.96%
Health Promotion	24.0	3.29%
Primary Health & Adult Community	35.6	5.05%
POC Total	**728.4**	**100%**

This investment will be made through a range of service providers as follows:

Table 35

Provider	£	%
BHSCT	125.1	17.15%
NHSCT	539.2	73.89%
SEHSCT	3.0	0.41%
SHSCT	5.0	0.68%
WHSCT	6.5	0.88%
Non-Trust	49.6	6.98%
Provider Total	**728.4**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst Emergency Department (ED) services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Northern Health and Social Care Trust (NHSCT) is in the region of £17m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Northern area and additional investment in the therapeutic growth of services.

10.3 Commissioning Priorities 2015/16 by Programme Of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Northern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

10.3.1 POC 1: Acute – Elective Care

Strategic Context: The NLCG will continue to meet demand shortfalls across both elective and non-elective services to achieve ministerial waiting times. The NLCG will seek commissioning opportunities with emerging GP Federations, in addressing Acute demand shortfalls.

Local Needs and Assessment

1. NLCG patients require a diagnostic test within the Ministerial waiting time of 9 weeks. There are currently (February 2015) 7,900 patients waiting more than 9 weeks across priority tests.
2. Elective capacity across a number of local specialties such as Dermatology, ENT, Rheumatology, Neurology, Respiratory, Urology and Gynaecology remains insufficient to meet current demand. The number of patients waiting over 18 weeks for assessment and 26 weeks for treatment is increasing.
3. Local Cancer pathways continue to evidence capacity challenges to meet expected
31 days and 62 days Ministerial objectives.

Commissioning Requirements

1. Local demand levels for diagnostic services mean that additional capacity is required. NLCG will commission this capacity to address elective demand and deliver 7 Day working across the main modalities to support unscheduled pathways.
2. Commission additional Elective capacity across Inpatient and Daycase treatments, and New and Review Outpatient Appointments. NLCG will explore options to deliver this outside secondary care settings, where appropriate, together with securing optimum Trust performance across existing elective outpatient, in-patient, day case, capacity including reducing cancellations.
3. Develop local pathways to improve access times and promote direct to test for patients, to reduce un-necessary delays in cancer pathways.

Securing Service Delivery

1. Subject to available funding, additional diagnostic capacity will be commissioned from the NHSCT. Additional capacity will be secured from existing equipment with the existing MRI scanner being replaced in 2015, alongside a 2nd MRI scanner in 2016.
2. NLCG will work on a regional basis to take forward primary care alternatives to secondary care referral. Specialties include Dermatology, ENT, Rheumatology, Neurology, Respiratory, Urology and Gynaecology and MSK/Pain. Develop E-Health opportunities across the Tele Dermatology, Neurology Triage and Pain Management pathways.
3. NLCG will secure additional Nurse Specialist and Cancer Nurse Specialist capacity to meet elective demand.

Regional Priorities (see appendix A): Cancer services (MT11), Unscheduled Care (MT12), Elective Care (MT15, 16, 17), Patient Safety (MT25), Excess Bed Days (MT27),

10.3.2 POC 1: Acute – Unscheduled Care

Acute POC: Unscheduled Care: The NLCG will aim to develop and commission services in the community which will provide an urgent care pathway for patients and reduce reliance on hospital services. This will be achieved by transferring appropriate resources from hospital to community services.

Local Needs and Assessment

1. Unplanned admissions to hospital resulting in stays of <48 hours are increasing.
2. Variation in demand for urgent care by hour of day and day of week is not matched by service capacity, leading to delays in the delivery of care. Patient flow remains challenging especially in Antrim with a significant number of 12 hour breaches and unsatisfactory 4 hour performance, leading to bed capacity issues.
3. Of the 133,000 people who attend ED every year, around 46,000 attend for minor illnesses or injuries.
4. Approximately two thirds of paediatric admissions stay <48 hours
5. Ambulance response times for Cat A calls are below the required target

Commissioning Requirements

1. NLCG will commission 7-day Acute Care at Home to avoid unnecessary short stay admissions of frail elderly patients to hospital. NLCG will commission an Elderly Assessment Service to be based in Antrim, which will prevent admission when appropriate.
2. In line with the recommendations of the Regional Co-ordinating Group for Unscheduled Care, the NLCG will commission an enhanced 7 day service in Antrim ED.
3. NLCG will procure a GP Out of Hours service that is aligned to the wider Unscheduled Care Pathway.
4. NLCG will commission a Paediatric Ambulatory service in Antrim and then Causeway to better match the demand with capacity.
5. The LCG will work with the HSCB and NIAS to improve Ambulance response times and to commission additional capacity.

Securing Service Delivery

1. Northern Integrated Care Partnerships (ICPs) should bring forward proposals to develop Acute Care at Home in this area. NLCG will work with the Trust and other stakeholders to develop an Elderly Assessment Service in Antrim.
2. NLCG should ensure that the Antrim ED has sufficient support within the ED to avoid delays and that senior decision-makers are able to assess and discharge rather than admit, where this is clinically appropriate, by implementing a 7 day model. The Trust will take forward the 5 key commissioning priorities.
3. Out of Hours provider to deliver required service changes.
4. Within identified resources, the LCG and Trust will develop required capacity in Antrim; this capacity may be helped by service improvement and redesign.
5. Ongoing engagement with HSCB and NIAS to secure additional capacity and sustained improvement in response times.

Regional Priorities (see appendix A): Unscheduled Care (MT12), Patient Safety (MT25),

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 36

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	8,127	260	8,387
		Daycases	23,552	2450	26,002
		New Outpatients	109,881	6100	115,981
		Review Outpatients	110,769		110,769
	Unscheduled	Non Elective admissions - all	36,645	2000	38,645
		ED Attendances	133,088	250	133,338
		Planned investment in 2015-16		£1.5m	

10.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The NLCG is committed to commissioning high quality, safe and sustainable maternity services for women and babies in line with the Strategy for Maternity Care in NI 2012-18. The forthcoming Departmental Paediatric Review, NICE guidance and the recommendations from the regional Review of Neonatal Services will focus the NLCG in its commissioning of efficient and value for money networked neonatal and paediatric acute services at both acute sites and the supporting primary and community services give the best outcomes for all involved.

Local Needs and Assessment

Despite a modest fall in births, there is a growing number of complex pregnancies with older mothers, multiple births and women with a BMI >40. Around 6% of mothers have diabetes requiring more frequent care during and after pregnancy.

There have been challenges in maintaining safe and sustainable consultant led obstetric and paediatric services at Causeway.

Services to be commissioned

NLCG will work with the PHA and the Trust to bring forward a robust plan to ensure safe and sustainable consultant led obstetric and paediatric services at Causeway in the medium term (not less than 5 years).

In paediatrics, a training programme for Advanced Paediatric Nurse Practitioners will commence to support the delivery of paediatric services in Causeway and other units.

NLCG will commission an alongside midwife led unit/midwife led pathways at **both** Antrim and Causeway, within the existing footprint on both sites. NLCG will review neonatal service at Antrim following publication of the Neonatal Review.

Securing Service Delivery

Monitoring of consultant and midwife births will continue, with emphasis on normalisation of birth. An action plan will be developed to ensure that the plans to maintain services at Causeway are robust, deliverable to meet relevant standards.

Progress of the APNP will be monitored.

From April 2015, all eligible pregnant woman aged 18 years & over with a BMI of >40 at booking are offered the weigh to a healthy pregnancy programme with an uptake of at least 65% of those invited.

The development of alongside midwife led units will be monitored through regular meetings with the Trust.

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 37

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,069		4,069
	Health Visiting	Contacts	68,046		68,046
		Planned investment in 2015-16		Nil	

10.3.4 POC 4: Older People

Strategic Context: The LCG will continue support people to live in their own home and maintain their independence with the appropriate provision of domiciliary care and reablement. However there remains a proportion of older people who will require nursing home care. The provision of a number of intermediate care beds providing step up and step down care will help to provide support and rehabilitation when necessary in community settings. The ongoing implementation of key actions of the Dementia Strategy will remain a priority in the area in light of the growing demand and the need to address this issue by introducing innovative ways of working.

Local Needs and Assessment

1. Each year the 65+ population increases by approximately 2,000 people with the over 85s increasing by approximately 500 people. This places increased demand on a range of services including: domiciliary care; Reablement; intermediate care and dementia services.

2. The number of nursing home placements has increased by 80 from March 2013 to March 2014.Trends would indicate that Nursing home placements are projected to rise by the end of 2015/16.

Services to be Commissioned

1. The LCG will:
   - commission additional domiciliary care hours to meet the estimated rise in the older population.
   - continue to commission OT Led Reablement service which is effective in supporting older people to maximise their independence and remain at home.
   - continue to commission Inter-mediate Care beds in the local community to avoid admissions to hospital and to enable timely discharge for older patients requiring support to recover from an acute episode. This will form an element of the pathway associated with Acute Care at Home model.

2. The LCG will commission additional Nursing Home placements to meet projected demand.

Securing Service Delivery

1. NHSCT will:
   - Ensure the provision of additional domiciliary care hours
   - Ensure the provision of the regional reablement model throughout the NHSCT's area.
   - Ensure that the optimum number of Intermediate Care beds is provided in order to enable rehabilitation in the most appropriate setting.
   - Ensure that the diagnosis rate for dementia is increased and that reviews are handled in line with the integrated service model which will be developed on a regional basis.

2. NLCG will invest in order to enable the NHSCT to purchase additional nursing home placements.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency readmissions (MT14), allied Health (MT9)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 38

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,190,035	40,500	2,230,535
	Residential and Nursing Home Care	Occupied bed days	870,518	18,980	889,498
	Community Nursing	Contacts	265,198		265,198
		Planned investment in 2015-16		£5.5m	

10.3.5 POC 5: Mental Health Services

Strategic Context: The LCG will work with the Regional Bamford Team to develop services for the severely mentally ill and for those with mild or moderate mental illness, placing an emphasis on recovery through the Stepped Care model which supports people to live as independently as possible with or without on-going mental illness. The LCG is taking a lead role, in conjunction with the Trust, ICPs and Northern Strategic Partnership in developing a Primary Care Emotional Wellbeing Service enabling GPs to help access appropriate community and voluntary support, or specialist support when required. This approach aims to reduce the high dependency on prescription drugs for depression, anxiety and pain within NLCG.

Local Needs and assessment

1. 25% of patients admitted to acute care have an underlying psychiatric problem. A Rapid Assessment, Interface and Discharge (RAID) service was commissioned last year to provide a specialist multidisciplinary mental health team to work within both acute hospitals.
2. High demand for support services for patients with mild to moderate mental health conditions; this is associated with higher usage of prescription drugs for mood disorder. Evidence shows service users benefit from support provided by peers who also benefit in turn.
3. The number of long-stay patients in hospital must be reduced by 5 by 31st March 2016.

Services to be Commissioned

1. NLCG will commission an expanded RAID model to include linkages with substance misuse, older people, younger people and people with learning disability in acute care.
2. NLCG will commission Emotional Wellbeing Hub pilots in the Coleraine and Larne areas at Level 1 and Level 2 of the Stepped Care Model.

   NLCG will commission Peer Support workers to be appointed in every community mental health team (9) in the Northern area over the next three years.
3. The HSCB will commission resettlement packages of care for 5 long stay patients. NLCG will commission additional domiciliary care to support people with mental health

Securing Service Delivery

1. One year change funding from Directorate of Finance & Personnel (DFP) has been secured to develop this model.
2. Funding has been secured for Co-ordinator posts and voluntary services and the NHSCT should commence the pilots in September 2015.

   NHSCT should commence appointment and training of peer support workers.
3. NHSCT will provide resettlement packages for 5 long stay patients by 31st March 2016, reducing the total number of their long stay patients to 0.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22), Allied Health (MT9), Excess Bed days (MT27)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 39

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	37,280		37,280
	Residential and Nursing Home Care	Occupied Bed days	50,100		50,100
	Domiciliary Care	Hours	108,150	2,000	110,150
		Planned investment in 2015-16		£0.4m	

10.3.6 POC 6: Learning Disability Services

Strategic Context: The LCG will continue to work with the Regional Bamford Team to develop services for people with a learning disability. The focus is on promoting independence through use of day opportunities and supported living models. The NLCG is working closely with the Trust in securing places in day care for young people transitioning to adulthood who require intensive support packages. In addition, support for ageing carers is a key regional priority which will require enhanced access to short breaks in the next year.

Local Needs and Assessment

1. People with a learning disability who experience crisis out of hours are more likely to be admitted to hospital.
2. Service users with learning disabilities are now living longer thanks to the medical advancements in their care. There is therefore an increase in numbers and complexity.
3. Carers provide a valuable service in the day to day care of people with a learning disability. Support needs to be provided to these carers in the form of breaks from the caring responsibility.
4. The number of long-stay patients in hospital must be reduced by 9 by 31st March 2016.

Services to be Commissioned

1. NLCG will commission an Out of Hours (OoH) crisis response service for service users with a learning disability.
2. In light of the increasing complexity and numbers of young people with a learning disability, the NLCG will commission additional day care places.
3. NLCG will commission additional packages of care for carers of people with a learning disability in the Northern area.
4. NLCG will support the HSCB to commission resettlement packages of care for 9 long stay patients. NLCG will commission additional domiciliary care to support service users with Learning Disabilities to live in the community.

Securing Service Delivery

1. NHSCT should commence development of a similar service as to that provided for mental health.
2. NHSCT will provide an additional 15 daycare places for school leavers.
3. NHSCT will provide an additional 20 short breaks including overnight stays.
4. NHSCT will provide resettlement packages for 9 long stay patients by 31st March 2016, reducing the total number of their long stay patients to 0.

Regional Priorities (see appendix A): Unplanned Admissions (MT5), Carers' Assessments (MT7), Patient Discharge (MT21), Excess bed days (MT27), Delivering Transformation (MT29)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 40

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	81,112	1,500	82,612
	Residential & Nursing Home Care	Occupied bed days	111,688		111,688
		Planned investment in 2015-16		£0.08m	

10.3.7 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: The LCG will continue to promote the main aim of the Physical and Sensory Disability Strategy and Action Plan which is to improve the lives of those with a disability by promoting independence and supporting a more personalised approach to the provision of services in terms of choice, control and self-directed support.

Local Needs and Assessment

1. In December 2014, 28% of those with a physical disability/sensory impairment in the NHSCT were in receipt of direct payments which is lower that the regional average of 31.6%.
2. 65% of people needing a wheelchair wait less than 13 weeks. Of the 106 waiting more than 13 weeks across the region, 50% were in the Northern area.
3. Provision of care for patients with ME – Chronic Fatigue Syndrome is variable, with no agreed care pathways.
4. NLCG has a small number of complex, high cost cases each year. These patients require to be to be supported in the community.

Services to be Commissioned

1. NLCG will support the roll out of Self Directed Support and as part of this initiative will expect a 10% increase in the number of direct payments. NLCG will commission additional domiciliary care to support those with a Physical Disability or Sensory Impairment to live in the community.
2. NLCG will continue to commission the provision of wheelchairs and will work with the Trust to examine models of service delivery to improve the waiting times.
3. Following a pilot of an ME service during 14/15 in the NLCG area, the LCG will invest recurrently in the service
4. NLCG will commission additional community nursing inputs to enable patients with complex needs to be discharged from hospital to a community environment.

Securing Service Delivery

1. NHSCT will appoint a Practice Development Officer for Self Directed Support and will implement the model in accordance with the regional guidance.
2. NHSCT will improve the waiting time for wheelchairs and identify new ways of working which will achieve long term benefits for the service.
3. NHSCT will appoint a ME / Chronic Fatigue Syndrome lead to work with the Condition Management Programme team to assess and treat 100 new referrals per annum.
4. NHSCT to bring proposals for community nursing input to address ongoing care of people with complex needs.

Regional Priorities (see appendix A): Direct Payments (MT8), Patient Discharge (MT21)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 41

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	324,450	6,000	330,450
	Residential & Nursing Home Care	Occupied bed days	30,603		30,603
		Planned investment in 2015-16		£0.14m	

10.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better (MLB) was launched by the DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. In 2015/16 Community Planning will be introduced and the NLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs and Assessment

1. The prevalence of cardiovascular disease and cancer is high in the NLCG area compared to other areas in the region. 21% of the population in the NLCG area smoke cigarettes and there are 62% adults and 29.4% Year 8 children overweight or obese. Up to 30% of all hospital admissions (adults) potentially demonstrate some degree of alcohol/substance misuse. This, however, is often not detected: local hospital admissions statistics bear out a detection level of around 3%.
2. At present in N Ireland there are 19,000 people living with dementia. As the population ages, dementia will become be a major public health and societal issue, with numbers of people with dementia rising to 23,000 by 2017 and around 60,000 by 2051.
3. Births to Teenage mothers in the NLCG area are above average for the region.

Services to be commissioned

1. NLCG will:
   - Commission stop smoking support targeting those with long term conditions and mental health issues
   - Ensure delivery of "Fitter Future for All" Strategy & facilitation of multi-agency obesity partnership. NLCG will explore options for commercial weight management programmes following the positive regional pilot programme.
2. NLCG will commission a part-time Community Dementia Co-ordinator to increase awareness of dementia within the community in order to support early detection and intervention.
3. NLCG will commission Family Nurse Partnership (FNP) and Roots of Empathy (RoE). A suite of evidenced based parenting programmes will be promoted /supported by a newly appointed Early Years/Early Interventions Officer.

Securing Service Delivery

1. NHSCT should ensure that commissioned services meet specified quality standards which are monitored, i.e. Stop Smoking Services.

   NHSCT should be smoke free by No Smoking Day 2016.

   By March 2017, screen 90% of all (adult) non elective acute admissions per year and 25% of ED attenders per year; provide structured brief advice and interventions; and direct care of more complex patients.
2. Key Performance Indicators are being developed and will be used to monitor progress and performance locally.
3. NHSCT will meet the required performance standards which will be monitored quarterly by the LCG.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1), Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

10.3.9 POC 9: Primary Health and Adult Community

Strategic Context: The LCG will continue to work with the ICPs to implement the Transforming Your Care ethos for the provision of care to service users. The LCG will also endeavour to address the recommendations from RQIA and the Sexual Health Promotion Strategy regarding Genito-Urinary Medicine. The LCG recognises the importance of eHealth and the electronic care record being accessible to all staff involved in a patient's care.

Local Needs and Assessment

1. A growing older population has led to an increase in the number of people with chronic diseases. In particular, NLCG has a higher prevalence of stroke. Sentinel Stroke National Audit Programme, RQIA and NICE have all made recommendations in respect of Stroke.
2. There is an increase in the numbers of young people contracting sexually transmitted diseases.
3. eHealth solutions have a role to play in managing patient health by enhancing decision-making and improving communication.
4. Prescribing Data highlights high usage of Benzodiazepines and "Z" drugs

Services to be Commissioned

1. NLCG will work with ICPs to develop and monitor chronic disease management programmes in the ICP clinical priority areas to prevent unplanned admissions or emergency readmissions.
2. NLCG will support the development of an additional sexual health hub and will work to progress this initiative with the NHSCT.
3. NLCG will continue to support the regional roll out of the Electronic Care Record will be progressed on a regional basis.
4. NLCG will work with the NHSCT and primary care colleagues to develop a programme to improve the quality of patient care in respect of Benzodiazepines.

Securing Service Delivery

1. ICPs will implement and evaluate services commissioned in 2014/15 and respond to commissioner priorities for 2015/16.
2. NHSCT should assess the feasibility of an additional sexual health hub and submit proposals to the NLCG.
3. NHSCT should increase access to the Electronic Care Record.
4. NLCG will achieve a reduction in use of Benzodiazepines.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency Readmissions (MT14), Pharmaceutical Clinical Effectiveness Programme (MT30)

11.0 South Eastern Local Commissioning Plan

This plan sets out what the South Eastern Local Commissioning Group (SELCG) will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population. This response takes account of feedback from patients, clients and carers and community and voluntary organisations who the LCG have engaged with during 2014/15, through our Personal and Public Involvement (PPI) process and other commissioning processes which the LCG have in place.

The Plan outlines, on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to those needs and how we intend to ensure deliver either through a Health and Social Care Trust, Integrated Care Partnership (ICP) or other provider. The Plan reflects the themes identified at regional level, with a focus on how we can transform services while delivering efficiency and value for money.

The SELCG will work closely with its community partners in the delivery of the Plan, in particular seeking to take advantage of the opportunities that partnerships with the new local Councils presents through improved community planning.

The SELCG is one of five LCGs across Northern Ireland and is a committee of the Health and Social Care Board (HSCB). The SELCG Management Board is made up of 17 members including 4 General Practitioners (GPs), 4 Local Government Councillors, 5 Health and Social Care Board and Public Health Agency (PHA) officers, 2 community and voluntary representatives, a general dental practitioner and a community pharmacy representative.

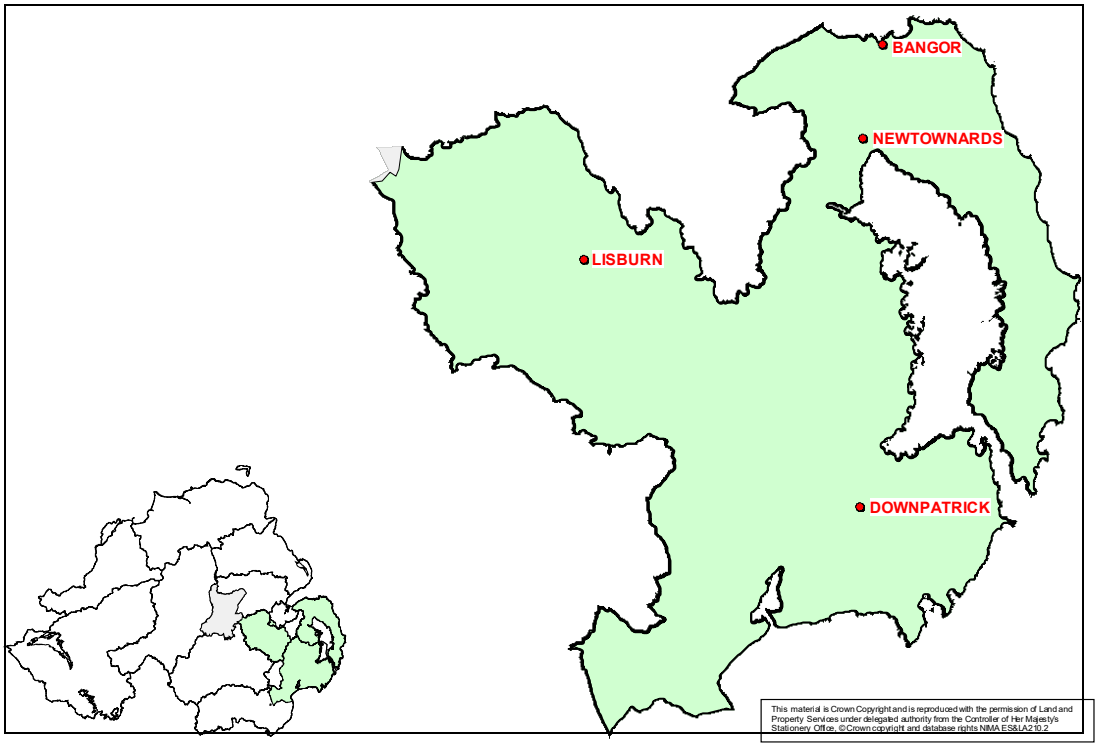
The SELCG rotates its monthly public board meetings around various communities across the locality as part of its engagement process.

11.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the SELCG. A range of information and analyses has been used to identify the challenges facing the LCG in 2015/16 and beyond.

Geography and Communities

The SELCG covers an area which can be characterised as a mix of urban and rural settlements. The main population centres are Lisburn City, Downpatrick, Bangor and Newtownards. The LCG area is co-terminus with the boundaries of the South Eastern HSC Trust, but not co-terminus with the new Council boundaries which came into effect on 1 April 2015. While Ards/North Down Council will be within the SELCG area, only the Down sector of the Newry Mourne and Down Council will be within the LCG area, while the Lisburn sector of the new Lisburn and Castlereagh City Council will be within our geography. Figure 9 sets out the LCG area and the main centres.



11.1.1 Demographic changes / pressures

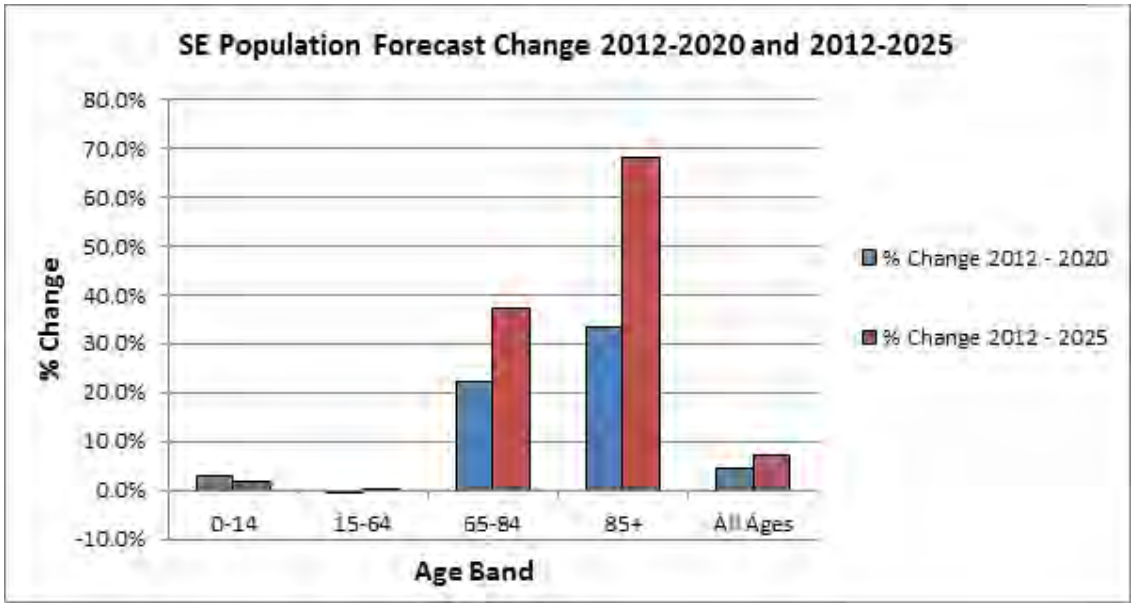
This section gives a general overview of the population within the LCG area, describing the age structure, general health and income of the resident population.

Demography

The population of the SELCG is circa 347,000 (NISRA: 2011 Census). 20.5% of that population are between the 0-15 years age group, 30.3% 16-39 years, 33.32% 40-64 years, 13.88% 65-84 years and 1.92% 85 plus.

Population Forecast Change

Figure 10



Regionally since 2001 the total population in N. Ireland has increased by circa 8.3% with the largest percentage increase (41.9%) from the ages shown in the 85+ age band.

The population in the south east has similarly increased by 8.5% in total however, the percentage increase in the 85+age band is significantly lower in the south east (38.4%) compared to N. Ireland (41.9%)

Population Projections

Table 42

	Age / Year	2012	2017	2022	2027	% Change 2012 - 2027
Down	0-14	14030	14246	14692	14470	3%
	15-64	45570	45663	45547	45337	-1%
	65-84	9474	10963	12287	13922	47%
	85+	1366	1682	2157	2697	97%
	ALL AGES	**70440**	**72554**	**74683**	**76426**	**8%**
Lisburn	0-14	24925	25515	26516	26272	5%
	15-64	79326	81212	83065	84709	7%
	65-84	15486	17683	20001	23109	49%
	85+	1950	2364	3082	3935	102%
	ALL AGES	**121687**	**126774**	**132664**	**138025**	**13%**
Ards / North Down	0-14	27931	27934	27706	26602	-5%
	15-64	101015	98513	97418	95758	-5%
	65-84	25401	29094	32088	35309	39%
	85+	3623	4094	4956	6238	72%
	ALL AGES	**157970**	**159635**	**162168**	**163907**	**4%**
SE LCG Area	0-14	66886	67695	68914	67344	**1%**
	15-64	225911	225388	226030	225804	**-0.05%**
	65-84	50361	57740	64376	72340	**44%**
	85+	6939	8140	10195	12870	**85%**
	ALL AGES	**350097**	**358963**	**369515**	**378358**	**8%**

As can be seen by the above table, we predict significant increases in our elderly population, particularly in the 85 plus grouping. While this highlights the success of past and current health, social care and wellbeing initiatives and advances in medical and drug technologies, it also points to the need for an incremental reshape of HSC services to ensure that community services are responsive to the future needs of an older population profile.

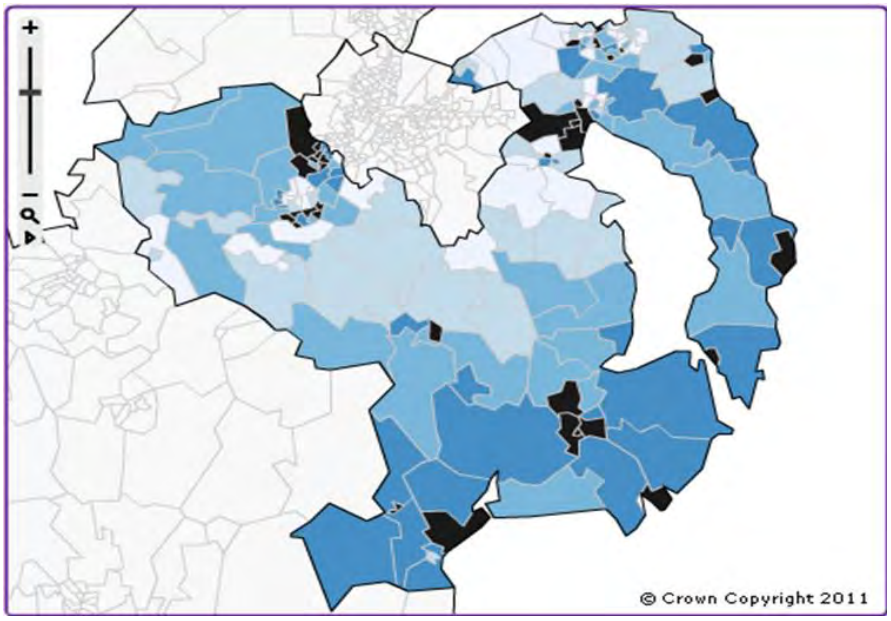
Deprivation

The map below shows the differences in deprivation within the SELCG area based on deprivation quintiles at Super Output Area. Those shaded black represent the 20% most deprived areas in the LCG area; those shaded light the least deprived 20%.

Life expectancy for males within the most deprived areas of the south east at 2010-12 was 3.4 years lower than the overall figure for the area, and 2.5 years lower than N. Ireland as a whole. Female life expectancy within the most deprived areas over the same period was 1.6 years lower, and 1.2 years lower than N.Ireland as a whole.

Deprivation Mapping

Figure 11



One in ten people residing within the SELCG area in 2013 were living within the most deprived of the N. Ireland deprivation quintiles. Across N. Ireland 18.8% of the population live in the most deprived quintile. This is represented in the figure below.

Percentage of Population in NI Deprivation Quintiles
Figure 12

Source: PMSI South East Local Area Health Profile

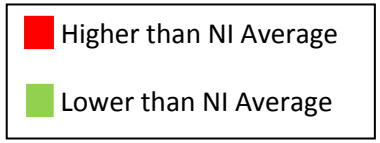
Work produced by the N. Ireland Health and Social Care Inequalities Monitoring System (HSCIMS) sub regional inequalities (2015) has been helpful in identifying, across a range of domains, inequalities across the south east in comparison to the N. Ireland average. The general picture shows that within the LCG area there is an overall trend of reducing deprivation, however the reduction in gap between the deprived and most deprived is variable. In comparison to the N. Ireland averages the LCG population is under these figures with the following exceptions; drug related mental health disorders, admissions due to self-harm and ambulance response times.

Health Summary

The table below shows the health of the SELCG population in comparison to N. Ireland as a whole.

Table 43

Domain	Indicator	Descriptor	SELCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	20.96	19.12	
	COPD	Prevalance per 1000	15.94	18.56	
	Stroke	Prevalance per 1000	19.55	17.94	
	Atrial Fibrillation	Prevalance per 1000	16.36	15.12	
	Coronary Heart Disease	Prevalance per 1000	41.48	38.81	
	Hypertension	Prevalance per 1000	136.76	130.5	
	Diabetes	Prevalance per 1000	44.4	42.61	
	Diabetes Prescriptions	Stdised Prescription Rate	37	39	
	Asthma	Prevalance per 1000	63.95	60.48	
	Dementia	Prevalance per 1000	8.39	6.67	
	Learning Disability	Prevalance per 1000	5.48	5.33	
	Bowel Cancer Screening	Programme Uptake	55.19	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.49	8.54	
	Crude Suicide Rates	All Persons	13.5	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score 2013	45.75	46.23	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	67	62	
	Meeting Physical activity levels	% of population (2012 -2013)	56	53	
	Pain or Discomfort	% of population (2012-2013)	35	35	
	Anxious Depressed	% of population (2012 -2013)	26	26	
Maternal and Child Health	Children in Need	Rate per 100,000	47.52	60.18	
	Births to Teenage Mothers	Percentage 2013	4.04	3.86	
	Births to unmarried mothers	Percentage 2013	41.13	42.46	
	Births to Mothers from outside NI	Percentage 2013	16.12	17.88	
Life Expectancy	Male	Age (2009-11)	78.36	77.5	
	Female	Age (2009-11)	82.4	82	
	Neonatal	Death Rate (2013)	0.4	0.3	
	Infant Mortality	Death Rate (2013)	5.3	4.6	
	Lung Cancer	STD Death Rate(2008-2012)	54.7	66.5	
	Female Breast Cancer	STD Death Rate (2008-2012)	38.8	38.1	
Carers	Unpaid Care	50+ Hours provided (2011)	3.2	3.1	



11.1.2 Personal and Public Involvement

Across the south eastern locality there is a strong and vibrant community development culture and infrastructure in the form of many voluntary and community networks.

The SELCG has been proactive in engaging with communities to ensure that local patients and carers have an opportunity to influence and shape what services might be commissioned in the future.

The SELCG has maintained its policy of initiating engagement with political representatives at local Council level and through locality meetings with MLAs and MPs. LCG Board Meetings are in public and time within these meetings is set aside for discussion with the public. The LCG also participates in workshops undertaken by voluntary organisations. A full list of LCG Personal and Public Involvement (PPI) activity can be viewed on the LCG web page www.hscboard.hscni.net

11.1.3 Summary of Key Challenges

From the needs assessment analysis undertaken, our engagement with communities and our ongoing work with providers the LCG has identified the following summary of key challenges for 2015/16:

- The increasing levels of overweight and obese adults, with few people meeting the recommended national guidelines in physical activity. There are higher prevalence of heart disease, stroke, hypertension, asthma and diabetes in the south east compared to the N.Ireland average.
- With a significant rural geography, access to services has been identified as a concern for those communities highlighted in the *Regional Health Inequalities Report (March 2015)* e.g., emergency care requiring a 999 ambulance or specialist/urgent services located in Belfast.
- An over-relevance on hospital services with current demand causing pressure on the system and the need to address improving patient flow at the Ulster Hospital.

- A growing older population with increasing health and social care needs.
- The increasingly complex health needs of some children and adults with disabilities living longer.
- Promoting the Transformation agenda in working with ICPs in the designated Clinical Priority Areas.
- Ensuring close working with Primary Care specifically in regard to the quality of referrals to secondary care and opportunities to improve prescribing in General Practice.
- Continuing to push to address inequality gaps within our population.
- Supporting the capital infrastructure programme in the south east to ensure the modernisation of services in respect of the Ulster Hospital (Phase B), the Primary and Community Care Centre planned for at the Lagan Valley Hospital site.

Equality and Human Rights

The SELCG is mindful that the changing make-up of the south eastern population brings challenges in ensuring that identified groups within communities have equity of access to services and that individuals' human rights are upheld. In this regard the LCG has carried out an equality screening of the proposals set out in the section below and the findings and the mitigating actions are available for review.

11.2 LCG Finance

Use of Resources

The SELCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £531.6m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 44

Programme of Care	£	%
Acute Services	192.9	36.25%
Maternity & Child Health	28.2	5.30%
Family & Child Care	39.4	7.39%
Older People	127.0	23.85%
Mental Health	39.4	7.39%
Learning Disability	52.2	9.80%
Physical and Sensory Disability	17.1	3.21%
Health Promotion	15.2	2.86%
Primary Health & Adult Community	20.2	3.96%
POC Total	**531.6**	**100%**

This investment will be made through a range of service providers as follows:

Table 45

Provider	£	%
BHSCT	116.8	21.97%
NHSCT	0.4	0.07%
SEHSCT	371.9	69.78%
SHSCT	5.9	1.12%
WHSCT	0.2	0.05%
Non-Trust	36.4	7.02%
Provider Total	**531.6**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the Family Health Services (FHS).

Whilst Emergency Department (ED) services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of emergency care by the South Eastern Trust is in the region of £27.8m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the South Eastern area and additional investment in the therapeutic growth of services.

11.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the South Eastern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key Health and Social Care priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

11.3.1 POC 1: Acute (Elective)

Strategic Context: The LCG, with stakeholders, will consider the demand on elective services to ensure standards and response times are further improved. Key to this approach will be to explore optimising the opportunities through GP Federations and community service for safe and viable services to closer to home.

Local Needs and Assessment

1. Demand for diagnostic services across a range of modalities has increased.
2. Elective capacity for outpatients and treatments across many specialties remains insufficient to meet demand. The number of patients waiting up to and over a year to be seen is increasing.
3. SET has the lowest number of surgical patients in NI admitted for treatment on the day of surgery which impacts length of stay.
4. The Cardiology model in the SE area needs reformed to address increasing demand and advances in treatment.
5. The number of referrals for suspected cancer in the SE area continues to increase.

Commissioning Requirements

1. LCG will commission additional capacity to meet projected increases in demand in MRI, CT, Non-Obstetric Ultrasounds and Plain film X-rays.
2. The LCG will invest in a number of specialties to increase capacity through provision of new outpatient clinics, as well as inpatient and day case treatments are required.
3. The LCG will seek a proposal from SET to pilot a surgical admissions Unit at Ulster Hospital to provide dedicated beds.
4. The LCG will reshape the cardiology service in SET by putting in place a rapid assessment and diagnostic model to support elective and non–elective care and enhance communication with primary care.
5. The LCG will work with the Trust to identify improvements in cancer care within the SE area.

Securing Service Delivery

1. SET will deliver additional diagnostic capacity and reporting as commissioned
2. To ensure demand is met, the LCG will work with the Trust/ICP/GP Federations to ensure there is sufficient capacity and to provide care out of hospital and closer to home.
3. LCG will support agreed plans to establish a surgical admissions unit to increase capacity by reducing patient lengths of stay.
4. SET will implement the new cardiology model in line with the commissioner specification.
5. SET to implement approved service developments.

Regional Priorities (see appendix A): Cancer services (MT11), Elective Care (MT15, 16, 17), Patient Safety (MT25), Excess Bed Days (MT27)

11.3.2 POC 1: Acute (Non-Elective)

Strategic Context: The SELCG, with stakeholders, will address the demand non-elective services to ensure standards and response times are further improved. Key to this approach will be to explore commissioning opportunities from GP Federations/ICPs, to provide safe and effective services to complement secondary care and to community services to provide more complex care at home.

Local Needs and Assessment

1. Attendances at the Ulster Hospital have increased by 8,272 since 2011/12 to a projected 86,000 for 2014/15. The demand for unscheduled admissions to the Ulster Hospital since 2011/12 has increased by 3,200 to 30,000.
2. SET is not consistently delivering on unscheduled care targets.
3. The current model of emergency care in SE area remains vulnerable due to pressures in the medical workforce. The local community acknowledges the need for changes in emergency/urgent care services and seek to have in place an appropriate and sustainable model of care which ensures access to emergency /urgent care, particularly for rural communities.
4. The local community has voiced its concern on ambulance response times.

Commissioning Requirements

1. The LCG will commission a Care at Home model to improve care between the acute and community interface.
2. The LCG will commission an increasing range of 7-day services to improve patient flow at the Ulster Hospital.
3. The model of acute care in the SE area needs to further evolve to ensure that communities can access appropriate care in the right place when required. A new urgent care model will require changes to the provision of acute medical care on some sites.
4. The LCG will work with the HSCB to look at opportunities to improve Ambulance response times specifically in the Down and Ards localities.

Securing Service Delivery

1. ICPs to deliver a comprehensive range of care closer to home and specifically to ensure that patients with more complex needs who are currently admitted to hospital can be supported and cared for at home.
2. SET will deliver 7 day working in a range of service areas at the Ulster Hospital
3. The LCG has requested that the SET submits a proposal supporting the continued modernisation of acute and urgent care provision and associated acute medical services in relevant hospitals.
4. SET will work with HSCB/NIAS to support the improvement of response times in the SE area.

Regional Priorities (see appendix A): Unscheduled Care (MT12), Patient Safety (MT25), Excess Bed Days (MT27), Patient Discharge (MT21)

POC 1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 46

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**[6]	Inpatients	5,849		5,849
		Daycases	22,071		22,071
		New Outpatients	77,570		77,570
		Review Outpatients	128,511		128,511
	Unscheduled[7]	Non Elective admissions[8]	33,214	3,086	36,300
		ED Attendances[9]	125,255	11,926	137,181
		Planned investment in 2015-16		£1.5m	

[6] Baseline elective volumes include FYE of 14/15 in-year investments.
[7] Baseline unscheduled volumes based in 2014/15 SBA
[8] UHD, Downe, LVH sites only
[9] UHD, Downe, LVH sites only

11.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The LCG will continue to work with the Regional Maternity and Pregnancy Related Gynae, Fertility, Paediatric and Child Health Commissioning Service Team, the SET and other key stakeholders (including the ICP) to develop services that are in line with the DHSSPS Strategy for Maternity Care in N.Ireland 2012 -2018, relevant NICE Guidelines, the regional Neonatal Network Review and the DHSSPS Paediatric Strategy for N.Ireland (anticipated to be published during 2015).

Local Needs and Assessment

1. There has been an increase in births above the commissioned capacity (4,941 in 14/15). In particular, there has been an increase in births at the Ulster Hospital (UH). This has put pressure on both inpatient and outpatient provision.

   The prevalence of mothers with higher BMIs and births where diabetes was identified as a maternal risk factor is increasing.

2. The incidence of asthma and allergies among children has increased in recent years and there is currently no paediatric consultant in place in the SE with an interest in Epilepsy.

   Medical cover in paediatrics – there are fewer consultant paediatricians serving the locality than in other LCG areas despite having the second largest childhood population.

3. There are a small number of children with complex needs requiring specialised, high cost care.

Services to be Commissioned

1. Core baseline funding will be reviewed due to sustained increase in births above commissioned capacity. The LCG will commission additional resource to make labour rooms 6 and 7 operational at the UH.

   The LCG will also seek to address capacity issues within the UH's maternity outpatient area to deal with the volume of Gynae, fertility and other maternity clinics, to include diabetes clinics. The LCG will also review neonatal services at the Ulster Hospital following the publication of the Neonatal Review.

2. The LCG will explore with the SET, a new paediatric model, to include a consultant with an interest in epilepsy and will work with the SET to support improved access to paediatric services at the Ulster Hospital.

3. The LCG will continue to work with SET to address pressures associated with complex care packages at home.

Securing Service Delivery

1. The LCG will seek to commission an evaluation of Downe and Lagan Valley Midwifery Led Units in conjunction with the Leadership Centre.

   SET should continue to ensure that the model of care in place is in line with the Maternity Strategy and participate in projects led by the HSCB/PHA to implement other key priorities.

   SET should relocate gynae and speciality outpatient clinics from the UH maternity unit to community hubs (or other appropriate sites) where it is safe to do so.

   SET should ensure that all eligible pregnant women, aged 18 years or over, with a BMI of 40 or more at booking are offered the 'Weight to a Healthy Pregnancy Programme', with an uptake of at least 65% of those invited.

2. SET to provide a paediatric epilepsy service subject to funding.

3. SET to increase access to paediatric services by extending the opening hours of the paediatric short stay assessment unit at the UH.

Regional Priorities (see appendix A): Tackling Obesity (MT2), Patient Safety (MT25)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC 2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 47:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,941		4,941
	Health Visiting	Contacts	24,430		24,430
		Planned investment in 2015-16		Nil	

11.3.5 POC 4: Older People

Strategic Context: The elderly population (65+) of the south eastern locality is growing faster than any other age group. With an ageing population, gains in life expectancy often present challenges in the context of higher prevalence rates of long term conditions such as COPD, diabetes, heart failure and stroke. Population ageing means that overall health and social care need has risen. This holds new responsibilities and challenges for us to commission services that help older people to stay healthy, independent and active for as long as possible

Local Needs and Assessment

1. SE LCG locality has, and into the future is projected to have, the highest number of 65+ older people in NI as a % of its population (18.3% of SELCG population by 2017). By 2023, 11,418 people will be 85+, a rise of 57.8%.

   This is leading to increased demand on both acute and community services including, unscheduled care, domiciliary care, dementia care, psychiatry of old age, safeguarding and provision of end of life care.
2. SE LCG the highest prevalence of Stroke and TIA in Northern Ireland and it continues to rise. (Source GP QoF)
3. As the population ages, the LCG area has an increased number of people providing unpaid care. Evidence shows that caring impacts negatively on both the mental and physical wellbeing of the carer.

Services to be Commissioned

1. To meet the increasing demands the LCG will commission:
   - additional domiciliary care hours
   - additional community equipment
   - appropriate care at home as an alternative to ED and acute hospital admission where clinically appropriate for elderly patients.
   - a 'Safe and Well 'model of community support.

   The SELCG will also work with PHA to develop and commission preventive services to include falls prevention, social inclusion and the promotion of active and healthy lifestyles
2. A new stroke model for the SE will be designed.
3. The LCG will commission additional short break provision for carers of older people.

Securing Service Delivery

1. SET will provide additional hours of domiciliary care for older people through a mix of statutory and independent domiciliary care provision and implement a 'Safe and Well' model.

   The ICP will:
   - implement a Care at Home initiative in North Down in 15/16.
   - develop initiatives to support older people to remain at home e.g. Falls programme.
   - progress actions coming from the Transforming Your Palliative and End of Life Care initiative to support people to die in their preferred place of death.
2. A new stroke model will be delivered by the ICP.
3. SET will provide additional short break provision for carers of older people.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC 4 Values & Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 48

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,048	58,700	2,316,748
	Residential and Nursing Home Care	Occupied bed days	730,804		730,804
	Community Nursing	Contacts	206,704	6,400	213,104
		Planned investment in 2015-16		£4.2m	

11.3.6 POC 5: Mental Health Services

Strategic Context: The LCG will continue to work with the Regional Bamford Team to develop services for those with mild, moderate or severe mental illness, placing an emphasis on recovery through the Stepped Care Model which supports people to live as independently as possible. Focus should also be on people who have significant life events and/or stressors that increase the threshold of harm. The LCG will also work to develop access as appropriate to community voluntary or specialist support by targeting clients at an earlier stage to prevent crisis intervention.

Local Needs and Assessment

1. Clients are waiting longer than 13 weeks for psychological therapy within the secondary care service.

   There is an over dependency in the SE area on prescription drugs for those with mental health issues.
2. Current hospital admissions and length of stay for acute patients are currently higher in NI compared to England and could be further reduced with greater use of Crisis Response/Home Treatment and a new acute MH in-patient model.
3. Carers continue to provide vital support to family members with mental health issues. Carers have reported to the LCG poorer mental and physical health as a consequence of their caring role.

Services to be Commissioned

1. The LCG will commission additional psychological therapies within primary care at levels 1 and 2 of the Stepped Care Model; and within secondary care at Level 3.
2. The LCG will commission a reprofiling of Crisis Response Home Treatment with the inclusion of a skill mix based staffing complement and the opportunity to develop a new MH centre of excellence.
3. The LCG will commission additional carers assessments and support to include short breaks in addition to uplifting nursing and residential home places.

Securing Service Delivery

1. SET will establish a Primary Care Mental Health and Well-Being Hub pilot site in Dunmurry. The evaluation of this pilot will influence further commissioning intent in other sectors.

   SET will also deliver the additional commissioned capacity within secondary care for psychological therapies.
2. SET will further develop and extend access to the Crisis Response Home Treatment service in accordance with the commissioner specification.
3. LCG will monitor provision of short breaks.

Regional Priorities (see appendix A): Unplanned Admissions (MT6), Carers' Assessments (MT7), Mental Health Services (MT22), Excess Bed days (MT27)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC 5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 49:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	39,273	0	39,273
	Residential and Nursing Home Care	Occupied Bed days	41,808	720	42,528
	Domiciliary Care	Hours	13,042	2,612	15,654
		Planned investment in 2015-16		£0.43m	

11.3.7 POC 6: Learning Disability Services

Strategic Context: The key aims of Learning Disability services are to promote independence for people with a learning disability in inclusive community environments which promote their health and wellbeing and provide appropriate support for their families who care for children and adults with learning disabilities.

Local Needs and Assessment

1. A small number of LD clients remain to be resettled from Muckamore Abbey Hospital.
2. There is a need to reduce the number of LD clients presenting at EDs.
3. There is also a need to extend supported living schemes for LD clients.
4. A number of children with learning disability and complex health needs are transitioning to adult services in 2015/16.
5. There is a need to continue the delivery of Day Services in line with the Regional Day Opportunities model.

Services to be Commissioned

1. The LCG will respond to plans for resettlement to finalise the arrangements for the remaining LD clients in Muckamore Abbey.
2. The LCG will commission a pilot Crisis Response Home Treatment service for people with LD.
3. The LCG will continue to develop supported living schemes under South Eastern Area Supporting People Partnership.
4. The LCG will commission services for those young people with LD and complex health needs who are transitioning to adult services.
5. The LCG will commission the delivery of additional Day Services subject to budgetary constraints.

Securing Service Delivery

1. SET will be required to report on the progress of the remaining LD clients. If needed, appropriate funding will be made available to facilitate this process.
2. SET will pilot the Crisis Response Home Treatment service.
3. LCG will monitor provision of supported living places in line with need.
4. SET will be commissioned to provide a number of services for those young people with LD and complex health needs who are transitioning to adult services.
5. SET will provide additional Day Services for LD clients.

Regional Priorities (see appendix A): Delivering Transformation (MT29)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 - Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 50

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	108,582	4,000	112,582
	Residential & Nursing Home Care	Occupied bed days	116,456		116,456
		Planned investment in 2015-16		£0.13m	

11.3.8 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: SELCG will continue to the implementation of the Physical and Sensory Disability (P&SD) Action Plan and Transforming Your Care (TYC) recommendations to support people to live independently in their own homes as long as possible. We will continue to invest in additional neuro-rehabilitation services to support the increasing number of people being discharged from hospital with complex care needs.

Local Needs and Assessment

1. As of September 2014 there were 489 physical and sensory disabled clients in receipt of a domiciliary care package. Of these, 193 are receiving intensive domiciliary care. The number of people with complex needs is increasing and these people require significant packages of care.
2. Wait times for access to audiology services do not meet with regional guidelines
3. Over 5% of the SELCG population provide 20 hours or more of unpaid care per week.
4. It is anticipated that there will be increased pressure to discharge from secondary care those patients who suffer from brain injury and who are clinically appropriate for discharge to an alternative facility best placed to meet their longer term needs.

Services to be Commissioned

1. The LCG will commission an appropriate mix of domiciliary care and direct payments via a mix of statutory and Independent providers and additional Nursing Homes for P&SD clients.
2. The LCG will commission additional audiology capacity for those with a hearing impairment.
3. The LCG will commission short break provision for Carers of People with Physical and Sensory Disabilities.
4. The HSCB will commission additional bed days in Thompson House to support the brain injury pathway.

Securing Service Delivery

1. SET will ensure delivery of additional domiciliary hours and nursing home beds.
2. SET to appoint an additional audiologist and ensure improvements in audiology access.
3. SET will provide the required number of short breaks.
4. SET will ensure provision of the neuro-rehabilitation additional bed days and consultant sessions.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Direct Payments (MT8), Allied Health (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC 7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 51

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	342,870	500	343,370
	Residential & Nursing Home Care	Occupied bed days	27,192	80	27,272
		Planned investment in 2015-16		£0.08m	

11.3.9 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing health inequalities are key priorities for the SELCG and the PHA. In line with the new public health strategy 'Making Life Better' and the Marmot Review 2010 and 2012, action will focus on strengthening coordination and collaboration across organisations and communities, and with the community planning function of the new councils, to ensure children and young people get the best start in life, people are supported to make healthy choices and together with partners we seek to ensure structural, economic, environmental and social conditions are conducive to health.

Local Needs and Assessment

1. In the SE area 20% of the population continue to smoke (NI 22%), 37% of adults are overweight (NI 37%), 26% are obese (NI 25%) and 18% of adults drink above recommended weekly limits (NI 16%).
2. Communities experiencing higher levels of deprivation continue to experience lower levels of life expectancy and higher levels of disability and poor health.
3. There is a high rate of suicides and self-harm among the south east population.
4. Local Councils now have a lead role in developing Community Plans which include Health and Wellbeing.

Services to be Commissioned

1. The LCG/PHA will commission programmes to encourage changes in behaviour related to physical activity, healthy eating, alcohol and drug use, cancer prevention, sexual health and smoking.
2. The LCG/PHA will commission evidence based parenting programmes to ensure accessible and equitable family support services & programmes across the area.
3. The LCG/PHA will commission programmes to promote mental and emotional wellbeing and prevent suicides and self-harm.
4. The LCG/PHA will engage with the new Councils in the development of Community Plans.

Securing Service Delivery

1. The LCG with PHA will continue to invest in the work of the SET Health Improvement Service to provide effective operational leadership, coordination and support across all communities and organisations contributing to health and wellbeing improvement.
2. Early Years Intervention communities to deliver programmes in Colin, Lisburn, Downpatrick, Ards/North Down .
3. ICPs, Primary Care Teams & SET to deliver commissioned mental health support programmes.
4. New Partnerships through Local Councils should deliver and support improved health outcomes.

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

12.3.10 POC 9: Primary Health and Adult Community

Strategic Context: This programme of care includes all work, except screening, carried out by General Medical Practitioners, Out of Hours, General Ophthalmic, Dental, and Pharmacists as well as community based AHPs and nursing services. The GP practice population for the SELCG is 315,664 (overall population is circa 350,000). The SELCG will continue to commission primary care led services for the frail elderly and people with long term conditions, such as coronary heart disease, diabetes, respiratory conditions and TIAs/strokes.

Local Needs and Assessment

1. There are increasing numbers of adults being referred to ED and admitted to hospital. Many of these people could be alternatively treated at home or in the community.
2. SELCG population has higher than average prevalence of cancer, stroke, coronary heart disease, hypertension, asthma, diabetes and chronic pain.
3. Along with the rest of N.Ireland, reliance on prescription medication remains high within the population.
4. Prevalence rates of sexually transmitted infections are higher than the NI average.

Services to be Commissioned

1. LCG will continue to commission services in relation to the 'Care at Home' model of care and Frail Elderly LES.
2. LCG will invest in ICP developed care pathways. Subject to funding, Arthritis Care NI will be commissioned to provide a Peer Education Pain Management Programme for patients with chronic pain.
3. LCG will continue to invest in Practice Based Pharmacists to facilitate efficient medicines management and further reduction of prescribed medication costs.
4. LCG will commission the roll out of Asymptomatic STI testing in Primary Care to the Down and Ards localities with a view to developing a fully integrated sexual and reproductive (family planning) service.

Securing Service Delivery

1. SE ICP will implement the Care at Home initiative in the North Down locality in 2015/16.
2. ICPs will implement new care pathways for respiratory disease and diabetes.
3. The SELCG will continue to monitor prescribing practice and costs within south east locality.
4. SET Sexual Health service will build the Primary Care Asymptomatic STI testing service LCG wide and will seek to redesign and integrate the FP service.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Pharmaceutical Clinical Effectiveness Programme (MT30)

12.0 Southern Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure deliver either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

12.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Southern LCG. A range of information and analyses have been used to identify the challenges facing the LCG in 2015/16 and beyond.

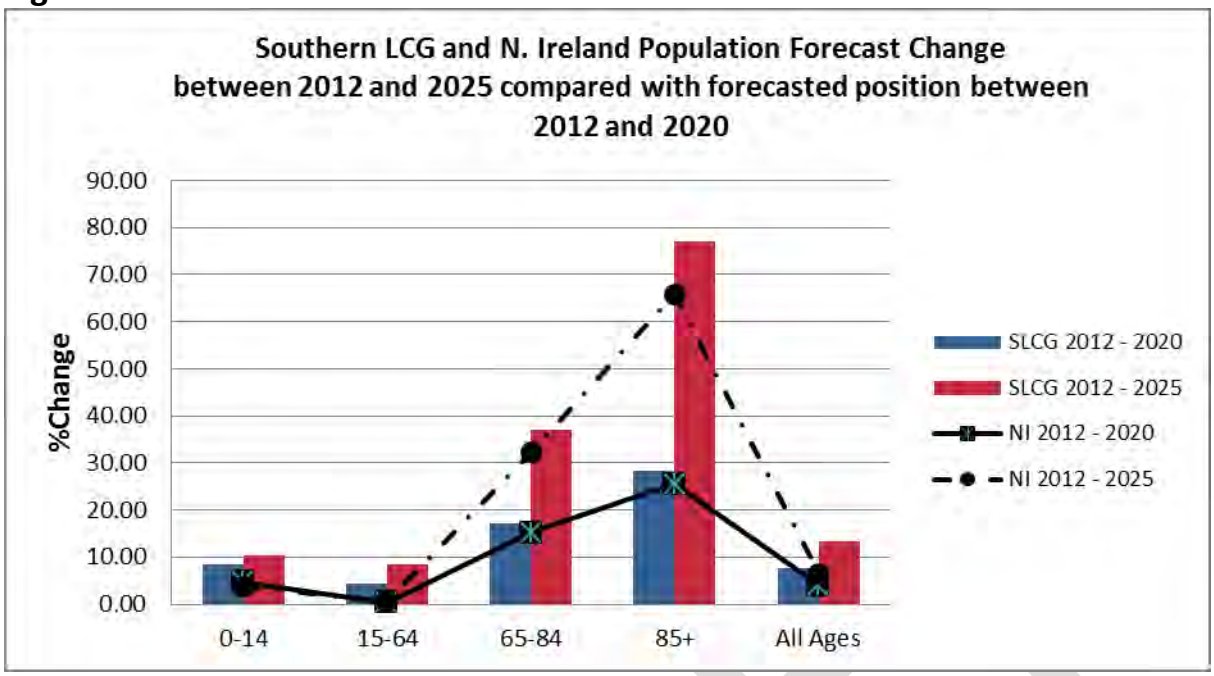
12.1.1 Demographic changes / pressures

This section gives a general overview of the population which the Southern LCG serves, describing the age structure, general health and income of the resident population.

Demography

The Southern LCG currently has a population of 365,712, representing 20.0% of the overall N. Ireland population. 93,595 SLCG residents aged 0-17 years account for 25.5% of the total SLCG population. 60.5% are aged 18-64 years, and 14% make up 65 years and over SLCG population.

Figure 13



The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five to ten years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group. Investment in the "Acute Care at Home" model and District Nursing will be pivotal in meeting this need.

Migration

The Southern LCG area has experienced a high influx of foreign nationals, between July 2004 and June 2013 the 5 Local Government Districts within the Southern LCG area experienced a net international migration population of 20,233 which accounts for 68% of the overall N. Ireland total. In addition, 4 of the 5 SLCG LGDs fell within the highest net figures across N. Ireland, with Dungannon LGD accounting for 22% of the NI total.[10]

[10] NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 52

NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 4.3: Estimated Net International Migration, by Age and Gender (July 2012 - June 2013) - N. Ireland, Trust and SLCG LGD

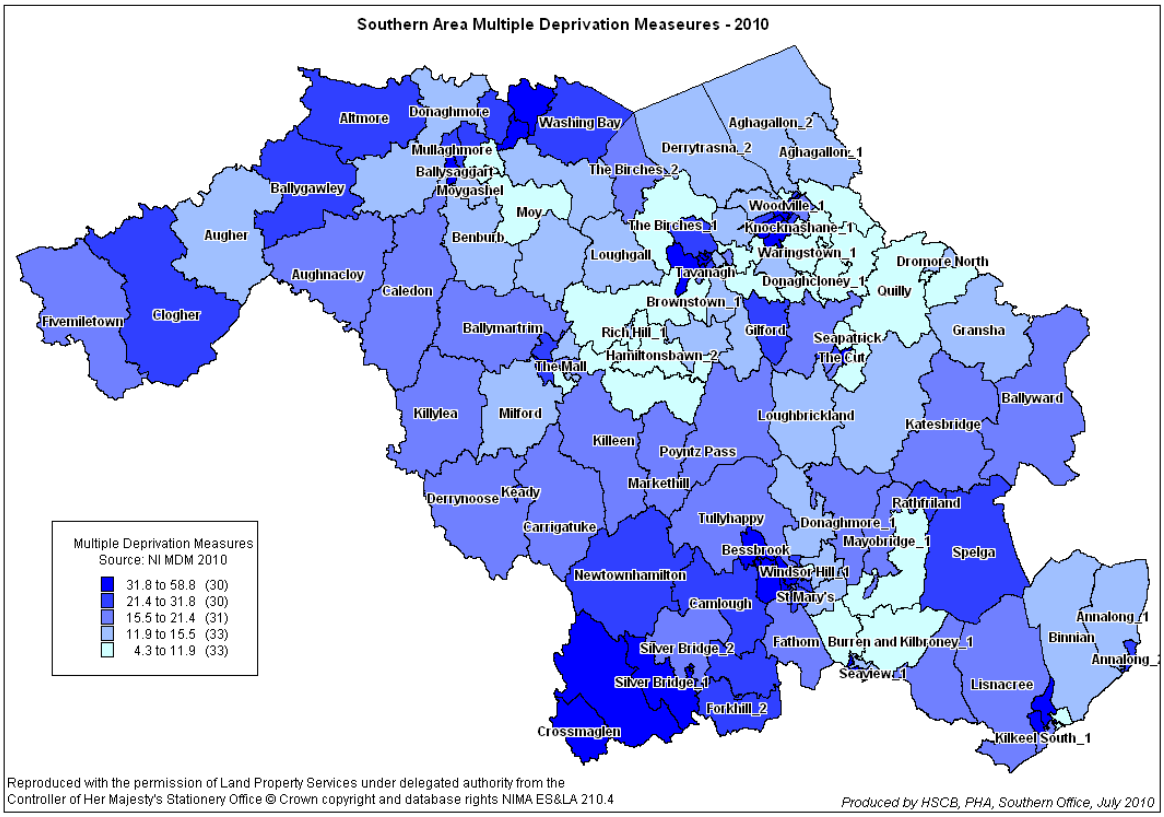
Gender / Age	Estimated Net International Migration	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Armagh	Banbridge	Craigavon	Dungannon	Newry and Mourne
Male	**-547**	**-756**	**-89**	**-124**	**527**	**-105**	**86**	**-9**	**207**	**156**	**87**
Less than 18 years	263	52	49	-20	158	24	27	0	44	60	27
18-24	216	-168	51	28	314	-9	28	-2	113	109	66
25-34	-529	-386	-125	-17	23	-24	21	-5	40	-19	-14
35-44	-331	-182	-61	-59	34	-63	12	1	6	0	15
45-54	-32	-12	8	-33	15	-10	6	-2	10	-3	4
55-64	-69	-29	-10	-10	-9	-11	-2	3	-3	1	-8
65 years and over	-65	-31	-1	-13	-8	-12	-6	-4	-3	8	-3
Female	**-340**	**-367**	**-202**	**-56**	**493**	**-208**	**55**	**7**	**205**	**126**	**100**
Less than 18 years	421	132	42	27	178	42	18	8	42	58	52
18-24	225	-22	-19	32	236	-2	19	9	77	73	58
25-34	-652	-322	-173	-54	25	-128	6	1	33	-3	-12
35-44	-254	-125	-44	-39	-6	-40	-1	-14	24	0	-15
45-54	-44	-24	-15	-17	35	-23	6	2	20	-2	9
55-64	-1	15	-1	0	9	-24	-1	-1	1	1	9
65 years and over	-35	-21	8	-5	16	-33	8	2	8	-1	-1
Total	**-887**	**-1,123**	**-291**	**-180**	**1,020**	**-313**	**141**	**-2**	**412**	**282**	**187**

Source: NISRA (June 2014)

Deprivation

- Using the Multiple Deprivation Measure, the most deprived Super Output Area across the Southern area is Drumnamoe_1 (Craigavon LGD) whilst the least deprived is Waringstown_2, (Craigavon LGD).
- Using Multiple Deprivation, Drumnamoe_1 is ranked 16 out of 890 and Waringstown_2 is ranked 830 out of 890 across Northern Ireland.
- *Summary Measures* - using the Extent score (% of an area's population living in the most deprived SOAs in NI); the highest % in the Southern area is within Craigavon LGD, 21%. This LGD ranks 4th across NI using this score.
- The summary measures also indicate that almost 30,000 people or 29% of the total population in Newry/Mourne LGD are considered income deprived (ranked 3rd in NI).

Southern Area Multiple Deprivation Measures (2010)
Figure 14

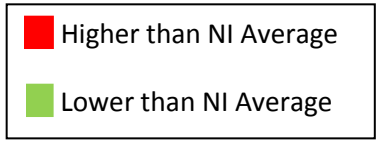


Health Summary

The table below shows the health of the Southern LCG population in comparison to Northern Ireland as a whole.

Table 53

Domain	Indicator	Descriptor	SLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.61	19.12	
	COPD	Prevalance per 1000	15.82	18.56	
	Stroke	Prevalance per 1000	15.86	17.94	
	Atrial Fibrillation	Prevalance per 1000	13.45	15.12	
	Coronary Heart Disease	Prevalance per 1000	35.59	38.81	
	Hypertension	Prevalance per 1000	124.32	130.5	
	Diabetes	Prevalance per 1000	38.47	42.61	
	Asthma	Prevalance per 1000	55.35	60.48	
	Dementia	Prevalance per 1000	5.8	6.67	
	Learning Disability	Prevalance per 1000	5.35	5.33	
	Bowel Cancer Screening	Programme Uptake	47.76	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.66	8.54	
	Crude Suicide Rates	All Persons	15.2	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	61	62	
	Meeting Physical activity levels	% of population (2012-2013)	51	53	
	Pain or Discomfort	% of population (2012-2013)	34	35	
	Anxious Depressed	% of population (2012-2013)	23	26	
Maternal and Child Health	Children in Need	Rate per 100,000	45.64	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	2.57	3.86	
	Births to unmarried mothers	Percentage 2013	53.44	42.46	
	Births to Mothers from outside NI	Percentage 2013	20.98	17.88	
Life Expectancy	Male	Age (2009-11)	77.5	77.5	
	Female	Age (2009-11)	82.11	82	
	Neonatal	Death Rate (2013)	0.2	0.3	
	Infant Mortality	Death Rate (2013)	3.5	4.6	
	Lung Cancer	STD Death Rate	58.8	66.5	
	Female Breast Cancer	STD Death Rate	42.2	38.1	
Carers	Unpaid Care (2011)	50+ Hours provided	3	3.1	



12.1.2 Personal and Public Involvement

The Southern LCG has over the past year initiated, faciliated and supported a range of opportunities to engage directly with patients, service users and the public on both their experiences of using health and social care services in the southern area and their views on how these could be commissioned and provided in the future to improve outcomes for patients. Specific engagement events[11] have been held on:

- Integrated Care Partnerships and their role in the delivery of health and social care at a local level
- The views of carers and carers representatives on the provision of short breaks
- Urgent Care, as provided by emergency departments, minor injuries units and the GP Out of Hours services

In addition and as a consequence of the second event above, the LCG has established a carers group of 10 local carers who will work directly with the LCG to contribute to and support its commission decisions. Already and in response to carers input, the LCG has invested in support for carers in a number of programmes of care and intends to continue this support in year.

The LCG has also recognised that the voice of adults with a physical disability and /or sensory impairment is often not heard and so has set up a User Panel to seek the views of individuals who have experienced these services to improve the outcomes for service users.

The LCG has also extensively engaged with public representatives on a range of issues and has and will continue to offer community and voluntary groups the opportunity to come to meet LCG members. Groups have used these opportunities to share what they are doing to improve outcomes for individuals, families and communities at both a service and / or geographical level.

[11] Full reports on the events can be found at www.hscboard.hscni.net in the Southern LCG section

Following all these events and processes, a number of key themes have emerged which the SLCG is committed to taking forward, namely:

- **Improved communication with service users**: The SLCG will continue to hold 3-4 engagement events annually.
- **Continued support for carers**: The SLCG has identified this as a commissioning priority in Programmes 4, 6 and 7.
- **Need for more flexible services which respond to real life situations, especially at weekends**: The SLCG is committed to working toward extended day and /or 7 day services where possible

12.1.3 Summary of key challenges:

- A growing population of elderly people with increased care needs and increasing prevalence of disease;
- Higher proportion of people living with long term illness;
- Highest proportion of individuals using prescribed medication for mood and anxiety disorders
- An over-reliance on hospital care, with activity exceeding current funds;
- Services which are fragmented and lack integration;
- Health and quality of life generally worse than the rest of NI

12.2 LCG Finance

Use of Resources

The Southern LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £562m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 54

Programme of Care	£m	%
Acute Services	205.6	36.50%
Maternity & Child Health	27.3	4.85%
Family & Child Care	38.8	6.89%
Older People	128.2	22.79%
Mental Health	48.4	8.60%
Learning Disability	54.3	9.65%
Physical and Sensory Disability	18.8	3.34%
Health Promotion	19.5	3.46%
Primary Health & Adult Community	21.1	3.93%
POC Total	**562.0**	**100%**

This investment will be made through a range of service providers as follows:

Table 55

Provider	£m	%
BHSCT	49.1	8.69%
NHSCT	0.1	0.02%
SEHSCT	5.3	0.93%
SHSCT	463.1	82.32%
WHSCT	3.7	0.65%
Non-Trust	40.7	7.39%
Provider Total	**562.0**	**100.00%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Southern Trust is in the region of £15.7m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Southern area and additional investment in the therapeutic growth of services.

12.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Southern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

12.3.1 POC 1: Non Specialist Acute – Elective Care

Strategic Context: The LCG, working with key providers, will address the demand on elective and non-elective services to ensure Ministerial targets, extant standards and response times are improved, as per priorities below. Key to this approach will, in 15/16, be exploring opportunities to commission from Integrated Care Partnership, GP Federations and other new providers, for safe and viable services to complement secondary care.

Local Needs and Assessment

1. Demand for imaging exceeds capacity and it is recognised that this needs to be addressed.
2. Demand for Endoscopies exceeds commissioned capacity by 3352 per year.
3. Demand exceeds service capacity by 11,820 outpatient consultations, 972 inpatient and 1,046 day case treatments
4. There is no longer a local Consultant Ophthalmology service in the Southern area and this gap needs to be addressed.

Services to be Commissioned

1. The LCG will commission an additional 1324 MRI Scans, 7364 CTs, 10,545 Non-Obstetric Ultrasounds and 37,675 plain film
2. Referrals for endoscopy will be scored on a JAG accredited points system to ensure more effective use of clinical capacity.
3. The LCG will support initiatives in Primary care to manage demand for Neurology, Dermatology, ENT, General Surgery, Urology and Gynaecology.
4. The LCG will work with the Trust to agree the future configuration of BHSCT Ophthalmology outreach clinics and the possible provision of clinics in the WHSCT in order to meet demand

Securing Service Delivery

1. The Trust should fully develop the potential for Nurse-led Endoscopy and introduce an agreed points system to increase capacity.
2. Demand management will be sought from primary care contractors where these can be shown to reduce the need to refer to Trust Consultant-led services.
3. The Trust should seek to recruit to funded capacity particularly where recent investments have been made to further enhance the service. This is particularly relevant to T&O, Rheumatology, Obs & Gynae and to ENT
4. BHSCT and WHSCT to deliver the agreed service model.

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Cancer services (MT11), Elective Care (MT15, 16, 17),

12.3.2 POC 1: Non Specialist Acute – Unscheduled Care

Strategic Context: The SLCG aim is to ensure that there is a fully integrated care system in place in the Southern area where patients know who to contact in an urgent care situation, receive appropriate care and treatment as close to home as possible, move through the patient pathway in a seamless manner and where outcomes, as per the regional priorities identified below.

Local Needs and Assessment

1. The number of new and unplanned ED attendances at all SHSCT emergency departments is expected to increase by 8% this year compared to last

   Performance against the 4 hour target has reduced in recent years, currently averaging 85%

   Conversion from attendance to admission is low, (24%) with discharges spread evenly Monday to Friday but less at weekends

2. Baseline position for the Regional Unscheduled Care Task Force's 5 identified key tasks has identified gaps in AHP, Social Care, Nursing and Pharmacy input to EDs and wards

Services to be Commissioned

1. Subject to a satisfactory evaluation of the current Phase 1 of the Acute Care at Home model, the LCG will consider further roll out of this to support and manage patient flow within the Trust.

   The LCG will commission integrated Minor Injury, Minor Illness, Out of Hours and Primary Care services, supported by community and voluntary resources.

2. The LCG will take forward the implementation of the recommendations in the unscheduled care plan to address 5 identified key tasks including additional capacity for CAH ED

Securing Service Delivery

1. The Trust should provide evidence of improved discharges at weekend, reducing transfers after 7pm and increased use of minor injury streams at CAH

2. The Trust will implement the agreed recommendations of the Unscheduled Care Plan with defined activity agreed in SBA

Regional Priorities (see appendix A): Unscheduled Care (MT12), Excess Bed Days (MT27)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 56

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	6,947		6,947
		Daycases	23,573		23,573
		New Outpatients	78,976		78,976
		Review Outpatients	132,485		132,485
	Unscheduled	Non Elective admissions	33,108	1,236	34,653
		ED Attendances	129,961	4,548	134,509
		Planned investment in 2015-16		£1.9m	

12.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The SLCG is committed to commissioning high quality, safe, effective and sustainable maternity services for women and babies in line with the objectives of the "Strategy for Maternity Care in Northern Ireland 2012 -2018". The forthcoming Departmental Paediatric Review, NICE guidance and the recommendations arising from the regional Review of Neonatal Services will focus the SLCG in its commissioning of efficient and value for money networked neonatal and paediatric acute services at both CAH and DHH and the supporting primary and community services to give the best outcomes for mothers, babies and children.

Local Needs and Assessment

1. Projected number of increased births until 2017 /2018 (circa total 6000 births per annum)

   Increased number of complex pregnancies are circa 105 multiple births annually, 20% mothers present with a BMI over 30 and 4% of mothers present with Diabetes, all of whom require more frequent clinic visits in an ambulatory care setting

   Caesarean sections rates are significantly higher than NI average (34%v29%)

2. A 29% increase in birth rate in the decade from 2002, has resulted in a growing child population in SLCG with associated rising demand for child health services, including universal services provided by Health Visitors i.e. Healthy Child Healthy Futures.

Services to be commissioned

1. The LCG will work with the Trust to achieve an increase in midwife led births and promoting midwife as first point of contact, particularly in DHH. Commissioning requirements for the neonatal services at both CAH and DHH will be clarified following the publication of the Neonatal Review recommendations

   The Treating Obesity in Pregnancy programme will be commissioned by the PHA

2. The LCG will issue a commissioner specification for paediatric ambulatory care will be issued in 2015/2016 outlining required performance and monitoring standards to be delivered.

   In paediatric care, a planned programme of investments will continue in 2015 / 2016 to ensure that appropriate paediatric medical and nursing capacity is provided and that ambulatory paediatric care is available to the standard outlined in the commissioner specification

Securing Service Delivery

1. Monitoring of consultant and midwife births along with intervention rates will continue, including full implementation of the Trust's normalisation of birth action plan on both sites

   The Trust should put in place additional consultant obstetric capacity to monitor and support mothers with identified risk factors, including multiple pregnancies and complex risk factors in line with NICE and other relevant guidance

   Midwifery and Health Visiting capacity will continue to be monitored.

   The Trust will implement the Treating Obesity in Pregnancy Programme. At least 139 women per year will receive this additional support.

2. Universal child health programmes will provide data on the state of health of children in the SLCG area informing targeting of initiatives, such as FNP, at those sub-populations with poorer health outcomes

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 57

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	5995		5995
	Health Visiting	Contacts	116,073		116,073
		Planned investment in 2015-16		Nil	

12.3.4 POC 4: Older People

Strategic Context: The SLCG is committed to promoting independence and choice and securing care closer to home, with an appropriate range of inpatient services for those who require it. We will work with providers including Integrated Care Partnerships to commission a range of services to meet the needs of our frail elderly population. Our commissioning intent will underpin the principles of TYC, the Regional Dementia Strategy and the Older People's Service Framework.

Local Needs and Assessment

1. 2012 Population Estimates would suggest that there are 48,922 people aged 65 and over living in the Southern LCG area, over 5,500 of these are aged 85 and over. Every year our older population increases by 3% (almost 1,500 persons).

2. Alzheimer's Society suggests that 1 in 14 people over the age of 65 have dementia. This number rises to 1 in 6 over the age of 80. Currently 2,234 patients are registered with the Southern Trust as living with dementia. Application of prevalence rates would indicate that there could up to 3,490 people in the SLCG area currently living with dementia, rising to as many as 4,435 people by 2020.

3. Demand for nursing home beds has increased Currently 1,360 beds are used by older people in the SLCG area.

Services to be Commissioned

1. The LCG will continue to commission phase 1 of the Acute Care at Home model and will conduct a detailed evaluation of the service during 2015/16, the outcome of which will inform its further development. The LCG will continue to support the ICP through commissioning extended hours and pharmacy input to this service.

   The SLCG will explore the potential to implement a crisis response model to address the urgent needs of people with dementia and their carers. An OT-led cognitive model will also be considered.

2. The LCG will commission additional care packages in line with assessed need and demographic growth. The reablement model will be extended to the full LCG area during 2015/16.

3. The LCG will work with the Southern Trust to assess the demand and capacity within district nursing services. This may require additional investment to ensure a 24/7 DN service which is GP aligned

Securing Service Delivery

1. The SHSCT should report against agreed KPIs to demonstrate the activity of the Acute Care at Home team, taking account of patient outcomes impact on unscheduled/urgent care services and stakeholder feedback.
   Investments in dementia should be implemented and the SHSCT should report on demand/capacity of the memory service which commenced in 2014/15.

2. The LCG will continue monitoring of domiciliary care provision against SBA volumes. This will include assessment of the impact of extended reablement services.

3. The SHSCT will comply with data requests on community nursing activity through community indicators, ensuring consistent ECAT's implementation across the Trust.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7), Emergency readmissions (MT14)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 58:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,781	35,000	2,293,781
	Residential and Nursing Home Care	Occupied bed days	662,160	17,549	679,709
	Community Nursing	Contacts	207,073	6,187	213,260
		Planned investment in 2015-16		£4m	

12.3.5 POC 5: Mental Health Services

Strategic Context: Bamford Strategy, Regional Psychological Therapies Strategy, Mental Health Services Framework and NICE guidance, all outline the need for a focus on improving access to psychological therapies. The SLCG is committed to securing local services which focus on prevention and early intervention to improve and protect the mental health and wellbeing of our population. We believe that through this we can reduce unnecessary demand for secondary care services, protecting access to more specialist services for those most in need.

Local Needs and Assessment

1. During 2012/13, within the SLCG there were 308 mental health compulsory admissions which represented the highest number across NI accounting for 28.7% of the NI total for 2012/13
2. SLCG GP registers indicate that 3,040 patients are registered as having schizophrenia, bipolar affective disorder and other psychoses or are on lithium therapy
3. During 2009/10, the Southern Trust received 2,460 referrals to the community addictions service (686 per 100,000 people against the NI average of 665 per 100,000 people). There has been a significant increase in the gap between the least and most deprived areas in the SLCG in terms of the standardised death rate relating to, alcohol and standardised admission rates relating to drugs, alcohol and self-harm (DHSSPSNI Sub Regional Health Inequalities).

Services to be Commissioned

1. The SLCG will seek assurance that there are adequate levels of staff to support complex patients in local inpatient units. The SLCG will monitor use of the regional addiction beds by Southern residents during 2015/16 to ensure fair access.

   The LCG will commission the first talking therapies hub in the Southern area to support people with low level mental health needs resident in the Armagh and Dungannon locality.
2. The LCG will seek to invest in additional staff to support community addictions services during 2015/16.
3. The SLCG will consider local capacity to support the diagnosis of adults with ASD.

Securing Service Delivery

1. SHSCT should ensure that local addictions staffing is in line with regionally recommended levels.
2. The Trust should progress against the action plan for implementation of psychological therapies primary care hubs.
3. The Trust will closely monitor short breaks and day opportunities investment in 2014/15 will be measured during 2015/16.

   SHSCT to implement the alcohol liaison 7 day service during 2015/16.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22),
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 59

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	34,230		34,230
	Residential and Nursing Home Care	Occupied Bed days	64,119		64,119
	Domiciliary Care	Hours	120,505	2000	122,505
		Planned investment in 2015-16		£0.66m	

12.3.6 POC 6: Learning Disability Services

Strategic Context: People with learning disabilities have a variable range of health and social care needs and often experience greater health and wellbeing inequalities than the general population and can experience difficulty in accessing services. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. Both TYC and the DHSSPS Learning Disability Service Framework highlight the needs of the increasing numbers of young people with complex needs surviving into adulthood and the importance of the right support at transition stage.

Local Needs and Assessment

1. In 2013/14 there were 2,123 people identified on Southern LCG GP Practice registers for learning disability. Uptake of day opportunities has increased in line with the regional direction - an increase from 274 persons in 2012 to 359 by 2014.
2. It is expected that there will be at least 50 young people who will transition into adult learning disability services during 2015/16.
3. The regional caseload review audit as part of the learning disability service framework suggests a need for an increased focus on carer's assessments, recording of service user satisfaction levels and the documentation of person centred plans.
4. There are 536 adult carers known to the learning disability programme in the Southern area, representing 23% of the NI total for this programme.

Services to be Commissioned

1. The SLCG will commission the development of additional day opportunities for people with learning disabilities.
2. The SLCG will invest further to support the additional needs of young people transitioning into adult services, including enhancement of the transitions team.
3. Following on from investment in 2014/15, the LCG will provide further support to carers, particularly older carers
4. The SHSCT will be required to produce health action plans for people with learning disabilities.

Securing Service Delivery

1. The Trust should develop a menu of day opportunities across a range of sectors, continuing to engage with service users/carers and monitor uptake and change in demand patterns for day care.

2. The LCG will develop and implement a monitoring proforma for high cost packages in transition to adult services.

3. The Trust should continue to deliver the required complex caseloads and conduct ensure following on from the caseload review audit improved outcomes

4. The LCG will monitor the use of health action plans to ensure equity of outcomes for people with a learning disability.

Regional Priorities (see appendix A): Carers' Assessments (MT7),
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 60:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	276,991	2100	279,091
	Residential & Nursing Home Care	Occupied bed days	113,740	800	114,540
		Planned investment in 2015-16		£0.36m	

12.3.7 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: In support of the strategic direction to provide as much support and care close to home as possible, the SLCG are aware of a sharp increase in the number of people with complex disabilities being cared for in hospital settings who require discharge. In addition, demand for services to support people with a brain injury is increasing. The LCG will work within the Physical and Sensory Disability Strategy to ensure the provision of safe, high quality and effective services which are person-centred, promoting independence, choice and control.

Local Needs and Assessment

1. The Physical Disability Strategy estimates that 21% of adults in Northern Ireland live with a physical or sensory disability. In terms of the adult population of the Southern area, this would equate to around 54,781 people (based on an adult population of 260,860 people - 2011 Census persons aged 19+).
2. The SHSCT provided details on 25 complex hospital discharges requiring significant care packages.
3. Population growth in the Southern LCG area, including a significant growth in the child population, has resulted in increased demand for hearing aids.
4. Headway UK state that 661 persons per 100,000 sustained an acquired brain injury in 2011-12 in NI, the highest rate in the UK. Pro rata to the Southern area, this would equate to 2,379 persons. There were 6,943 finished episodes in NI hospitals relating to head

Services to be Commissioned

1. The SLCG will commission an appropriate mix of care to meet the needs of persons with complex disability upon discharge from hospital. This will require investment across a range of community service such as domiciliary care, short breaks and care homes.
2. A monitoring template will be developed to enable to LCG to capture information on the ongoing care needs of complex hospital discharges.
3. The LCG will invest further in equipment to support both children and adults with sensory disabilities, including audiology services and hearing aids.
4. The existing service agreements with community and voluntary sector organisations should be reviewed to ensure that people with a brain injury across the southern area are able to avail of a range of supports to meet their needs.

Securing Service Delivery

1. The Trust should continue to move towards increased uptake of direct payments and self-directed support.
2. Trust to put in place arrangements to address the outcomes of the LCG monitoring process
3. The Trust should ensure that there is appropriate access to audiology services including hearing aids.
4. The SHSCT should report to the LCG on plans to re-procure community and voluntary sector supports for people with a brain injury.

Regional Priorities (see appendix A): Direct Payments (MT8)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 61

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	365,130	5200	370,330
	Residential & Nursing Home Care	Occupied bed days	20,805	259	21,064
		Planned investment in 2015-16		£0.22m	

12.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better was launched by the DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. In 2015/16 Community Planning will be introduced and the SLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs and Assessment - SLCG

1. 17% of babies born are to mothers who themselves were born outside of the UK or ROI. Approximately one fifth of the population live in relative poverty, including 22% of children.
2. 20% of adults smoke cigarettes and 13% drink in excess of weekly recommended alcohol limits. 57% of adults and 17% of boys and 24% of girls in P1 are overweight or obese. In 2012 an estimated 656 people died prematurely of potentially avoidable causes
3. Uptake for screening programmes in 13/14 was 78% cervical; 76% breast; 49% bowel; 82% AAA and 79% diabetic retinopathy.

Services to be Commissioned

1. Family Nurse Partnership, Roots of Empathy and a suite of evidenced based parenting programmes will be made available.
2. The LCG will commission a range of health promotion services will be available on smoking; healthy eating; physical activity; alcohol; drugs; mental health and suicide prevention.
3. The LCG will commission a range of screening programmes including the Be Cancer Aware Programme

Securing Service Delivery

1. The Early Years/Early Interventions Officer will support this work. These services will link with the existing Family Support Hubs and the EITP.
2. Trusts should ensure that services commissioned meet specified quality standards which are monitored i.e. Stop Smoking Services; Drugs and Alcohol; Mental Health and Emotional Wellbeing
3. Performance targets for all programmes commissioned are specified and monitored quarterly.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

12.3.9 *POC 9: Primary Health and Adult Community*

Strategic Context: Enabling people to maintain their independence, live at home and receive care at or as close to home as possible remains a key strategic and local commissioning priority. Ensuring effective community nursing and therapeutic interventions, 7 day working and developing work with Integrated Care Partnerships and the emerging GP Federations will assist in addressing known shortfalls in capacity and quality concern of service users.

Local Needs and Assessment

1. NI Quality and Outcomes Framework (QOF) 2013 registers indicate that there are 6,012 patients registered in Southern LCG GP practices as having Chronic Obstructive Pulmonary Disease (COPD) and 6,068 registered as having survived a stroke. During 2012/13, there were 528 people admitted to hospital in the Southern area following a stroke.

2. In the NI Diabetes Inpatient Audit (2013 Draft Report), the Southern Trust performance was below that of other NI hospitals and also suggested there were lower levels of specialist nursing investment in NI compared to the rest of UK.

3. The LCG has seen a higher increase than the NI average in both cost 2.5% compared to 1.9%) and volume of prescribed drugs (1.7% to 1.5%).

Services to be Commissioned

1. The LCG will work with the SHSCT to assess the demand and capacity within district nursing services which may require additional investment to ensure a 24/7 DN service which is GP aligned

The LCG will consider enhanced specialist nursing input to diabetes services to improve patient care, specifically inpatients.

2. Through the Southern ICPs, the LCG will continue to develop pathways and commission services to deliver on ICP specifications

3. The LCG will work closely with primary and secondary care to ensure efficient and effective prescribing in line with the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Proposals for the allocation of the SLCG prescribing budget will be brought forward in early 2015/16.

Securing Service Delivery

1. The Southern Trust should contribute to community indicators data to monitor activities of community nurses. The Trust should also ensure eCAT is implemented consistently throughout the Trust.

2. The SLCG will continue to monitor the progress of the Southern ICPs in delivering on the agreed specifications for priority groups – frail elderly, diabetes, respiratory and stroke.

3. Primary and Secondary Care should ensure that the prescribing budget is brought into line with the requirements of the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Regional Priorities (see appendix A): Pharmaceutical Clinical Effectiveness Programme (MT30)

13.0 Western Local Commissioning Plan

This plan sets out what Western LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines, on a Programme of Care (PoC) basis, what our local needs are, what we will commission in-year in response to that need and how we intend to ensure delivery either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

13.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Western LCG, covering the council areas of Derry and Strabane District; Fermanagh and Omagh District; and the former Limavady Borough now within Causeway Coast and Glens.

13.1.1 Demographic changes / pressures

On Census Day (27 March 2011), the resident population of the Western LCG area was 294,417 persons accounting for 16.26% of the NI total. Mid-Year Estimates (2013) show projected increase in population to 296,883 persons.

The age profile on Census Day includes:

- 22.1% were aged under 16 years and 13.1% were aged 65 and over;
- 49.6% of the usually resident population were male and 50.4% were female; and

- 36 years was the average (median) age of the population

The older people population is lower proportionately than the NI average (13.1% and 14.6% respectively) although the Western area is projected to see the greatest increase in 65+ persons in the next ten years, i.e. 40.1% increase compared to 29.7% for NI as a whole. There were 3,951 births to Western families during 2013/14.

Deprivation

One in four people (25.3%) residing within the Western area in 2013 were living within the most deprived of the Northern Ireland deprivation quintiles. Across Northern Ireland, 18.8% of the population live in the most deprived quintile.

Key Indicators of Health and Wellbeing

Table 74 below provides an overview of key indicators of health and wellbeing. Despite high levels of deprivation, Western population shows better health outcomes than the NI average, apart from for respiratory conditions, i.e. asthma and chronic obstructive pulmonary disease (COPD). Mental health however is considerable worse, particularly due to anxiety and depression. There is higher rate of children in need.

Health Summary

The table below shows the health of the Western LCG population in comparison to Northern Ireland as a whole.

Table 62

Domain	Indicator	Descriptor	WLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.49	19.12	
	COPD	Prevalance per 1000	20.36	18.56	
	Stroke	Prevalance per 1000	17.33	17.94	
	Atrial Fibrillation	Prevalance per 1000	15.11	15.12	
	Coronary Heart Disease	Prevalance per 1000	36.08	38.81	
	Hypertension	Prevalance per 1000	128.91	130.5	
	Diabetes	Prevalance per 1000	41.45	42.61	
	Asthma	Prevalance per 1000	61.62	60.48	
	Dementia	Prevalance per 1000	6.02	6.67	
	Learning Disability	Prevalance per 1000	6.34	5.33	
	Bowel Cancer Screening	Prevalance per 1000	50.22	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	9.12	8.54	
	Crude Suicide Rates	All Persons	16.7	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012 - 13)	28	24	
	Obese or overweight	% of population (2012-13)	60	62	
	Meeting Physical activity levels	% of population (2012-13)	51	53	
	Pain or discomfort	% of population (2012-13)	39	35	
	Anxious Depressed	% of population (2012-13)	28	26	
Maternal and Child Health	Children in Need	Rate per 100,000	85.51	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	3.34	3.86	
	Births to unmarried mothers	Percentage 2013	43.79	42.46	
	Births to Mothers from outside NI	Percentage 2013	15.58	17.88	
Life Expectancy	Male	Age (2009-11)	77.23	77.5	
	Female	Age (2009-11)	81.84	82	
	Neonatal	Death Rate (2013)	0.4	0.3	
	Infant Mortality	Death Rate (2013)	4.9	4.6	
	Lung Cancer	STD Death Rate	67.9	66.5	
	Female Breast Cancer	STD Death Rate	37.4	38.1	
Carers	Unpaid Care	% of population 50+ Hours provided	3.1	3.1	

13.1.2 Personal and Public Involvement

In 2014, Western LCG undertook a flagship engagement programme, *Voice of Older People*, which engaged with 1,050 older people between January and March. The LCG worked with a range of Community Networks who undertook semi-structured interviews in line with an LCG brief to ascertain the views of older people from across the West on using Primary Care, Secondary Care and Community Care; on Transforming Your Care; and their expectations of future services.

The Networks engaged with older people in places which they routinely used, such as Luncheon clubs, Community Centres, Healthy Living Centres Community Theatre, Art Groups, Drop in Clubs, Exercise Classes, Singing Groups, Smoking Cessation Groups, Diabetes and Podiatry clinics in Healthy Living Centres to ascertain their views on the services they receive and use through the health service. The views of older people who did not attend community activities/centres or did not access local Voluntary and Community groups, and who are harder to reach were also sought through the Networks contacts and member organisations. Participants ranged from 65 to 90 years. Each participant completed.

Providers nominated one “Champion”, an older person who had participated in the exercise, from each area who attended the Local Commissioning Group meeting in May 2014. There was an opportunity for LCG members to hear initial findings and to engage directly with the Champions on issues of interest and concern. The LCG gave an undertaking to convene feedback sessions to inform and discuss with participants the outcomes and findings of the engagement process. The undertaking to feedback to stakeholders is a crucial element in getting the Networks to agree to accept the commission as it showed the HSCB’s commitment.

Key issues from the engagement initiatives:

- Need for more joined up approach in tackling health inequalities;

- Need for greater communication with older people regarding the services available;
- Need to tackle anxiety experienced by older people when attending the Emergency Department;
- Importance of transport in accessing health and social care services and alignment of appointments to transport schedules;
- Need for more support to carers; and
- More services delivered in local health centres, such as Physiotherapy, Minor injuries

LCG has committed to feedback sessions in response to issues raised and has published a report on the engagement programme.

The LCG also held a conference on health and social care in rural communities, in partnership with five local Community Networks, in Enniskillen on 3rd April 2014. The conference focused on:

- Rural issues of poverty, isolation, transport and access to services;
- Mental Health Services, promoting positive mental health; and
- Community planning, access and influencing key agencies

82 participants attended this event, largely comprising service users and carers living in rural areas across the Western area. Representatives from Rural Community Network, community and voluntary sector organisations, local Government, HSCB, WHSCT, NIAS and PHA also attended to hear participant views on services and related issues.

13.1.3 Summary of Key Challenges

Key challenges for the LCG in 2015/16 include:

- Fulfilling the potential of Western Integrated Care Partnerships in driving the *Transforming Your Care* agenda through integrated care pathways;
- Extending Pain Management programmes;

- Delivering the proposed Primary Care Infrastructure programme for the Western area, in line with agreed priorities;
- Further enhancing carers support and short breaks opportunities;
- Progressing plans towards having in place appropriate 24-hour community nursing services, including Acute Care at Home;
- Meeting domiciliary long-term care demand supported by the roll-out of reablement model;
- Tackling impact of alcohol on HSC services, particularly Emergency Services;
- Ensuring provision of Older People's Mental Health Services;
- Putting in place across key acute specialties processes to allow GPs to gain consultant and specialist professional advice which might prevent the need for referrals and improve management of patients in primary care;
- Maximising utilisation of hospital theatres and in-patient beds; and
- Identification of opportunities to consolidate the provision of intermediate and acute beds and/or sites.

13.2 LCG Finance

Use of Resources

The WLCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £519.1m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Table 63

Programme of Care	£m	%
Acute Services	196.8	37.85%
Maternity & Child Health	25.2	4.84%
Family & Child Care	42.1	8.09%
Older People	114.9	22.10%
Mental Health	47.3	9.10%
Learning Disability	39.2	7.53%
Physical and Sensory Disability	15.5	2.98%
Health Promotion	17.0	3.28%
Primary Health & Adult Community	21.1	4.22%
POC Total	**519.1**	**100%**

This investment will be made through a range of service providers as follows:

Table 64

Provider	£m	%
BHSCT	26.2	5.05%
NHSCT	1.1	0.21%
SEHSCT	0.2	0.03%
SHSCT	1.9	0.38%
WHSCT	450.4	86.60%
Non-Trust	39.3	7.73%
Provider Total	**519.1**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Western Trust is in the region of £12.7m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Western area and additional investment in the therapeutic growth of services.

13.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Western Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

13.3.1 POC 1: Non-Specialist Acute Services

Strategic Context: Growing demand for hospital care, coupled with challenges recruiting and retaining medical and other staff, remain a key feature for Western services. Alternative pathways, designed to reduce demand, have been championed by LCG and ICPs and further opportunities exist in light of emerging GP Federations. The prerogative to extend Acute Care at Home, building on enhanced community nursing services adds an important dimension to transformation of care.

Local Needs and Assessment

1. Demand for OP assessment in the West currently outstrips capacity by around 6,000 patients per year, with referral rates continuing to rise annually.
2. Unscheduled care patient flow at Altnagelvin Hospital remains challenging. In 14/15, there were 25 12-hours breaches of Emergency Dept standards across WHSCT; 4-hour performance fell below 95%; and delayed discharges were a feature of pressures through the winter months.
3. Older Persons Assessment and Liaison Services in Altnagelvin demonstrated that through comprehensive geriatric assessment that a 4-day reduction in length of stay was achievable
4. Demand for neurology services exceeds commissioned capacity by 750 outpatients per year and demand for Orthopaedics exceeds commissioned capacity by 1,100 outpatients and resulting conversions.

Services to be Commissioned

1. The LCG, working with ICPs, will seek the introduction of GP request for advice across acute specialities, including extension of virtual clinics and direct GP access to hospital diagnostics
2. The HSCB approved 5 key commissioning priorities to improve patient flow. The LCG, supported by the Unscheduled Care Team, will prepare costed proposals for Altnagelvin Hospital for implementation.
3. The LCG will ensure the introduction of the commissioned Older People's Assessment and Liaison Services at South-West Acute Hospital with the provision of a multi-disciplinary assessment for all patients admitted to hospital, leading to reduced length of stay of 4 days for over 75 year olds
4. LCG will commission additional capacity in neurology and orthopaedics services to meet demand

Securing Service Delivery

1. Demand management initiatives will be sought from Integrated Care Partnerships where these can be shown to reduce the need to refer to Trust Consultant-led services.

2. The Trust will take forward the 5 key commissioning priorities, including delivering additional multi-disciplinary access and activity 7 / 7; extended senior clinical decision making; and a seven day dedicated minor injury stream in ED.

3. The Trust should implement Older Persons Assessment and Liaison Services in the South West Acute Hospital.

4. The Trust should bring forward proposals to close the elective gaps for neurology and orthopaedics.

14.3.1 POC 1: Non-Specialist Acute Services (continued)

Local Needs and Assessment

5. Increased annual demand on elective surgery, unscheduled admissions and GP surgical assessments.
6. Acute Care at Home (POC 1&4) can provide active treatment by health care professionals in the patients home avoiding unnecessary inpatient care.
7. The Western area has the largest increase in prevalence rates for stroke between 2007 (13.8/1000 population) and 2014 (17.3/1000 population) at 25%. RQIA recommends clear definition of a stroke unit, accessible thrombolysis service and TIA assessment and treatment at weekends for high risk cases.
8. In Western hospitals, there were 25,024 hospital cancelled outpatient appointments in 2014/15

Services to be Commissioned

5. The LCG will review the Elective Day of Surgery Unit and Surgical Assessment Area pilot with a view to mainstreaming if successful in reducing length of stay and admissions.
6. The LCG will commission a proportionate 24-hour community nursing service, building on district nursing, Rapid Response nursing and Treatment Room services which prevents unnecessary hospital admissions and supports the introduction of Acute Care at Home.
7. The LCG will consider the redesign of stroke services in line with regional model of care, including creation of a specialist acute unit and appropriate rehabilitation in hospital and at home.
8. The LCG will seek assurances that hospital cancelled appointments are minimised and appropriate and in line with Departmental requirements, i.e. reduced by 20% by March 2016.

Securing Service Delivery

5. The Trust should complete an evaluation of the Elective Day of Surgery Unit and Surgical Assessment Area.
6. The Trust should implement a phased Acute Care at Home model, building on commissioned expansion within Community nursing with Demographics investment in 15/16 focused to enhance the delivery of the 24/7 Community Nursing Model aligned to GPs, pathway development for >65years frail elderly Disease Specialist Nursing and an Acute Care at Home Team.
7. The LCG will work with the Trust to review existing medical, nursing and AHP capacity with a view to agreeing a new stroke service model later 2015.
8. By June 2015, the Trust will provide a plan to reduce cancelled consultant-led hospital appointments by March 2016

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Unscheduled Care (MT12), Elective Care (MT15, 16, 17) Stroke (MT19)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 65

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	11,302		11,302
		Daycases	31,915		31,915
		New Outpatients	115,379		115,379
		Review Outpatients	150,756		150,756
	Unscheduled	Non Elective admissions	37,053		37,053
		ED Attendances	100,733		100,733
		Planned investment in 2015-16		£1.4m	

13.3.2 POC 2: Maternity and Child Health Services

Strategic Context: Normalisation of birth remains the imperative in line with the Maternity Strategy. There have been fewer births in Western hospitals in recent years although there is some evidence of increased complexity, particularly a marked increase of mothers with a diabetes risk. Medical staffing challenges continue and are exacerbated by moves to extend cover of middle and senior obstetrician and paediatricians at South West Acute Hospital in the face of safety concerns regionally.

Local Needs and Assessment

1. WHSCT SBA outturn in 2013/14 outstripped the legacy SBA volume across a number of POCs with an increase in demand for health visiting 1,446 contacts within maternity & child health.
2. There are typically 3,600 medical admissions to paediatric wards in Altnagelvin, with requirement for escalation beds every year over the winter period.
3. While 27% of births were by caesarean section (elective & non elective), 2.1% below the NI average, caesarean section rates at SWAH have increased steadily and were 0.7% higher than the NI average in 2013/14
4. The pilot weight management programme for pregnancy women, "Weigh to a Healthy Pregnancy" is underway offering a lifestyle intervention to all pregnant women with a

Services to be Commissioned

1. In the context of on-going regional review, LCG will review capacity and demand for health visiting services (across PoCs) with a view to closing any gap and in line with normative nursing levels.
2. The LCG will review the pilot of the Paediatric Assessment Unit (PAU). If successfully evaluated, the LCG will consider commissioning recurrently, leading to reduction of admissions by 20%.
3. The LCG will work with Western Trust to promote normalisation of births in line with Maternity Strategy 2012-18.
4. The LCG, working with PHA, will seek to mainstream "Weigh to a Healthy Pregnancy", drawing on the learning of the pilot programme.

Securing Service Delivery

1. The LCG in collaboration with PHA will realign the WHSCT Health Visiting SBA 15/16 to reflect current service and modernisation reform that has been undertaken in line with normative nursing.
2. The Trust will carry out an evaluation of the PAU by July 2015 and LCG will consider the findings in due course.
3. The Trust will take steps to reduce Caesarean section rates to NI average within 12 months.
4. The Trust will bring forward proposals to continue "Weigh to a Healthy Pregnancy" programme.

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC 2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 66:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,009		4,009
	Health Visiting	Contacts	67,633		67,633
		Planned investment in 2015-16		Nil	

13.3.3 POC 4: Older People's Services

Strategic Context: In the face of rapid growth of the older population and in light of *Transforming Your Care*, it is imperative that services for older people change and grow. The priority will be to provide support to enable all older people to remain independent and living in their own home for as long as possible.

Local Needs and Assessment

1. The number of over 65 years continues to grow in the LCG area; increasing demand on domiciliary care and among people with mental health difficulties and those with disabilities.
2. The demand for domiciliary care service has increased by 23% (2010-2014 estimated contact hours). Reablement services provide considerable benefit to patients with reduction in care requirements following period of intervention.
3. Older people with mental health challenges, particularly dementia continue to increase.
4. From April to September 2014, 1,168 people over 65 years attended Altnagelvin ED due to a fall. 82% of these falls were at the home.

Services to be Commissioned

1. The LCG will seek to increase the number of Domiciliary Care hours although this may be reduced by initiatives, such as the roll-out of Reablement.
2. The LCG will commission the further roll-out of Reablement across the Western area with a view to realising 45% reduction in referral rates to long term caseloads during 2015/16.
3. The LCG will review older people's mental health services, including dementia care, to ensure recent investments have proven successful and need is appropriately met.
4. The LCG will support ICP initiative to coordinate falls prevention through integrated care pathways supported by GPs, Western Trust, NIAS and voluntary sector agencies.

Securing Service Delivery

1. The Trust will deliver the required domiciliary care hours and other initiatives as specified by the commissioner.
2. The Trust should complete the roll-out of Reablement to the Southern sector to include an OT led Reablement Team and Contact and Information Centre covering the whole Western area, leading to 45% of discharges requiring no on-going care.
3. In collaboration with the Trust, LCG will produce a needs assessment of older people's mental health by October 2015, taking into account ICP plans to develop an integrated dementia care pathway.
4. ICPs will lead in building on GP pathway to Stepping On programmes and developing a Western wide falls prevention service.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 67

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	1,606,351	38,624	1,644,975
	Residential and Nursing Home Care	Occupied bed days	511,947		511,947
	Community Nursing	Contacts	162,488	7,000	169,488
		Planned investment in 2015-16		£2.8m	

13.3.4 POC 5: Mental Health Services

Strategic Context: In line with *Transforming Your Care* and taking forward the *Bamford Review*, the importance of maintaining mental health and intervening early in Primary Care remains the priority. A focus on Recovery Approaches in line with *Transforming Your Care* which states that "At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives."

Local Needs and Assessment

1. Mental health in NI is poor compared to GB. 25% of those surveyed in the West for NI Health Survey in 13/14 reported being anxious or depressed; higher than the NI average.
2. Patients on the Mental Health Register have risen by almost 10% in the 5 years to 2012.
3. HSCB has reviewed in-patient addiction services which recommends a regional model for detoxification and stabilisation care and rehabilitation.
4. The number of patients waiting longer than 13 weeks for a first appointment with psychological therapies service has increased through 2014.

Services to be Commissioned

1. The LCG will commission the introduction of Primary Care Talking Therapies, with support from ICPs to put in place clear GP referral pathway and appropriate access protocols.
2. The LCG will seek a consistent model of Primary Care Liaison and Crisis Response Home Treatment services across the Western area.
3. The LCG will support regional plans to have in place a 7-day in-patient addiction treatment service, including 8-beds in the Western area.
4. The LCG will review demand and capacity in psychological therapies required to deliver 13 weeks waiting times for first appointment.

Securing Service Delivery

1. The Trust will provide 400 talking therapy sessions through community and voluntary sector providers in 2015/16. The LCG will work with the Trust to ensure roll-out across the entire Western area during 2016.
2. The Trust will ensure consistent access to these services, particularly in the Southern Sector, leading to further reductions of acute mental health beds.
3. The Trust will ensure appropriate staffing levels are in place in line with investment.
4. The Trust will ensure that additional capacity is made available, in line with the commissioner requirements.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22),
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 68

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	38,759		38,759
	Residential and Nursing Home Care	Occupied Bed days	30,086	210	30,296
	Domiciliary Care	Hours	29,294	250	29,544
		Planned investment in 2015-16		£0.26m	

13.3.5 POC 6: Learning Disability Services

Strategic Context: The population of people with a learning disability is continuing to rise in line with the very welcome increase in the average lifespan. Consequently, there are greater numbers of people with a learning disability reaching adulthood and requiring day opportunities and appropriate community support. As adults reach old age in greater numbers, planning is required for their future long term care and housing and support for carers, in particular older carers, is crucial.

Local Needs and Assessment

1. The LCG area has the highest prevalence in NI of people with learning disabilities (6.17 per 1,000 people) and the number of people with a severe learning disability has increased by 30% since 2000.
2. For adult carers of LD clients, availability of alternatives to traditional forms of respite (day and residential care) is very limited.
3. Transition from children's to adult services is a challenging time for young adults with a learning disability and their families. Collaborative work between Education and Health sectors seeks to manage smooth transition and ensure individual needs are addressed through a coherent transition plan.

Services to be Commissioned

1. The LCG will seek to keep pace with growing demand for day opportunities to adults with learning disabilities, including providing support to up to 50 school leavers and meeting the needs of older adults.
2. The LCG will extend innovation fund for Adult carer recipients of short break hours in line with SDS approaches. Further short break options will be tested to extend the range of choice and flexibility for carers.
3. Given anticipated transition of up to 50 school leavers in 15/16; continued pressures on adult services and the emphasis on day opportunities, the LCG will seek assurance that the current transition process is effective in supporting individuals.

Securing Service Delivery

1. The LCG will continue to work with Western Trust to extend day opportunities and meet the needs of school leavers in 2015 as a priority, in line with emerging self-directed support model.
2. The Trust will provide additional innovative short breaks hours based on the outcomes of an LCG workshop in April 2015
3. The LCG and Trust will review the transition process and identified needs leading to any gaps in service.

Regional Priorities (see appendix A): Carers' Assessments (MT7)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 69

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	92,760		92,670
	Residential & Nursing Home Care	Occupied bed days	135,520		135,520
		Planned investment in 2015-16		Nil	

13.3.6 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: Developments in services for people with Physical and Sensory Disabilities have received a renewed impetus with the recent publication of Departmental and OFMDFM strategies. Implementation has benefited from the involvement of voluntary sector partners and emphasis on the participation of service users.

Local Needs and Assessment

1. In September 2014, 70 adults were awaiting a multi-disciplinary assessment for autistic spectrum disorder, most in excess of 13 weeks. 85 adults with a learning disability also required ASD assessment and support.
2. Western Trust figures show there are 279 deaf service users in the Western area, 127 of whom have no speech. Some have significant mental health and developmental difficulties and at risk behaviours in later life.
3. There is an increasing number of people with physical disabilities which are more complex including service users requiring high cost care packages and young people transitioning to adult services.

Services to be Commissioned

1. The LCG is investing in development of assessment and support service for adults with autism spectrum disorder leading to no one waiting longer than 13 weeks for an assessment by March 2016.
2. The LCG will commission community-based flexible service model of enablement, communication and skills development, providing 7 places in 15/16.
3. The LCG, working with regional colleagues, will consider a review of physical disability services, taking account of Trust reported pressures; the move to self-directed support; and population needs.

Securing Service Delivery

1. The multi-disciplinary Adult ASD service will provide integrated care plans for all young people transitioning to adult services; 30 adults supported by dedicated psychologist; 40 adults supported by dedicated Speech & Language Therapist and 40 adults supported by a dedicated Occupational Therapist.
2. The Trust will provide the commissioned service through Action for Hearing Loss.
3. The LCG will seek the input of Western Trust and relevant voluntary organisations in reviewing current services and evident gaps against regional standards.

Regional Priorities (see appendix A): Allied Health Professionals (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 70

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	298,781	1,200	299,981
	Residential & Nursing Home Care	Occupied bed days	24,283		24,283
		Planned investment in 2015-16		£0.06m	

13.3.7 POC 8: Health Promotion

Strategic Context: NI Executive published Making Life Better in 2014, a whole systematic strategic framework for public health which sets out clearly the action required to address the determinants of health alongside a life course approach. The health and social care system will play a full part through embedding health improvement and health inequalities in planning, commissioning and delivery processes.

Local Needs and Assessment

1. Hospital attendances and admissions continue to disproportionately relate to substance misuse and in particular alcohol.
2. 11% of Travellers live in Derry City Council area. The 2009 All Ireland Travellers Health Study has highlighted the huge disparities in life expectancy and other health outcomes for Travellers.
3. The number of older people who rely on HSC services is increasing. Initiatives to build or restore self-confidence and self-reliance among older people, providing practical support to help them achieve their aspirations and reduce dependency are required

Services to be Commissioned

1. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days
2. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days
3. The LCG, in collaboration with ICPs, will pilot the Social Prescribing scheme which seeks to offer alternatives to medicine prescription and overcome social isolation and loss.

Securing Service Delivery

1. The LCG, PHA and Trust will review the progress in the brief intervention and alcohol liaison service relating to both acute hospitals with a view to having in place a development plan by October 2015.
2. The LCG is co-funding support workers who will scope needs and services leading to an Action Plan, including health improvement programmes and improve access to HSC services.
3. ICPs have appointed a voluntary organisation to pilot the Social Prescribing Scheme with a number of GP Practices. Review will be undertaken in Autumn 2015 to inform decisions on mainstreaming in 2016/17.

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

13.3.8 POC 9: Primary Health and Adult Community Services

Strategic Context: Integrating primary and secondary care is central in the drive for Health and Social Care reform. Integrated Care Partnerships are established to be a key driver in this with their emphasis on integrated care pathways focused developing the role of primary care. Challenges in developing the necessary physical infrastructure in terms of primary care hubs and spokes; appropriate hospital accommodation; and IT systems are of critical importance. Engagement with service users and staff to ensure services meet their needs remain the strategic priority.

Local Needs and Assessment

1. An innovative partnership with community networks across the West elicited the views of over 1,000 older people, with older person champions raising their concerns directly with the LCG.
2. Chronic pain is estimated to affect approximately 20% of people in Northern Ireland. 35% of people in the West, surveyed as part of the NI Health Survey 2012/13, reported having pain or discomfort. Demand for pain management service outstrips commissioned capacity.
3. Clinical Interventions centres (CICs) reducing avoidable hospital admissions, facilitates early hospital discharge, reduces ALOS

Services to be Commissioned

1. During 2015, LCG will provide feedback on the issues raised during engagement projects in 2014, highlighting progress in addressing issues raised and will engage with community networks to elicit the views of HSC services from 1,000 adults in the Western area.
2. The LCG will commission a Pain Management Programme in the Northern sector of the Trust to reduce demand on assessment and treatments.
3. The LCG will commission Clinical Intervention Centres at Enniskillen Health Centre and Strabane Health Centre

Securing Service Delivery

1. LCG will engage with 5 local community networks who will each undertake at least 200 semi-structured interviews in a council area, including the involvement of Section 75 groups. LCG will engage with older person champions and network representatives to provide feedback on issues raised during engagement projects in 2014.
2. The Trust should bring forward proposals to expand the Pain Management Programme Trust wide
3. The Trust will provide an ambulatory service for patients in the community in Enniskillen and Strabane CICs in an ambulatory setting when it is safe and effective to do so

POC 9: Primary Health and Adult Community Services (continued)

Local Needs and Assessment

4. There is a need to put in place Primary Care Infrastructure (PCI) capital projects within primary care to support wider system change and the implementation of the recommendations of Transforming Your Care (TYC)

5. Altnagelvin's Emergency Department is not fit for purpose to meet the needs of its annual 58,000 patients. Outpatient demand also continues to rise placing considerable pressure on existing clinic space. There is also anticipated pressure on ICU/HDU.

6. The Transforming Your Palliative and End of Life Care Programme is supporting the redesign and delivery of coordinated services to enable people across Northern Ireland with palliative and end of life care needs to have choice in their preferred place of care.

Services to be Commissioned

4. The LCG will commission the opening of Omagh Local Enhanced Hospital, expansion of Enniskillen Health Centre and Lisnaskea Primary Care Centre as hubs in line with the HSCB's Primary Care Infrastructure programme and continue to progress hubs in Cityside, Limavady and Strabane

5. LCG judges that the completion of Phase 5.1 in 2017 leading to reduction of theatre capacity by 25% means it is imperative that 5.2 progresses as soon as possible. Improved accommodation for the Emergency Department and clinical adjacencies will also considerable improve patient flow and clinical decision-making.

6. LCG, working closely with Western ICPs, will commission 8 initiatives agreed within programme.

Securing Service Delivery

4. LCG in collaboration with WHSCT and Primary Care GPs deliver development of relevant Tranches of PCI programme for Western locality

5. The Trust will bring forward an Outline Business Case for the proposed Altnagelvin Hospital Phase 5.2.

6. The Programme is being delivered by the HSCB/PHA in partnership with Marie Curie working with statutory, voluntary and independent sector providers.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency Readmissions (MT14), Excess bed days (MT27)

Appendix 1 - Programme of Care Definitions

Acute Services (POC 1)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in an acute specialty. It also includes all activity, and resources used, by a hospital consultant in an acute specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

Acute specialties are all hospital specialties with the exception of the following (specialty codes in brackets); Geriatric Medicine (430), Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), GP Maternity (610) and mental health specialties (710 to 715).

Maternity and Child Health (POC 2)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), and GP Maternity (610). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts by any health professional where the primary reason for the contact was maternity or child health reasons. All community contacts to children under 16 are included as long as the contact was not in relation to mental health, learning disability or physical and sensory disability.

Family and Child Care (POC 3)
This programme is mainly concerned with activity and resources relating to the provision of social services support for families and/or children. This includes

Children in Care; Child Protection; Child Abuse; Adoption; Fostering; Day Care; Women's Hostels / Shelters and Family Centres. This is not a definitive list of the type of support which may be offered under this programme. This programme includes community contacts by any health professional where the primary reason for the contact is because of family or child care issues.

Elderly Care (POC 4)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Geriatric Medicine (430), Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts with those aged 65 and over except where the reason for the contact was because of mental illness or learning disability. All community contacts where the reason for the contact was dementia are also included, regardless of the patient's age, as well as all work relating to homes for the elderly, including those for the Elderly Mentally Infirm.

Mental Health (POC 5)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Mental Illness (710), Child & Adolescent Psychiatry (711), Forensic Psychiatry (712) and Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to mental health. If the reason for contact is that the patient has dementia, the activity is allocated to the Elderly Care programme of care.

Learning Disability (POC 6)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in the Learning Disability specialty (710). It also includes all activity, and resources used, by a hospital consultant in this specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to learning disability. All community contacts with Down's Syndrome patients who develop dementia, for any dementia related care or treatment are included as are all contacts in learning disability homes and units.

Physical and Sensory Disability (POC 7)

This programme includes all community contacts by any health professional where the primary reason for the contact is physical and/or sensory disability. All patients and clients aged 65 and over are excluded. These contacts should be allocated to the Elderly Care programme.

Health Promotion and Disease Prevention (POC 8)

This programme includes all community and GP based activity relating to health promotion and disease prevention. This includes all screening, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisation and community dental screening and prevention work.

Primary Health and Adult Community (POC 9)

This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability.

Appendix 2 - Ministerial Priorities & Targets

Ministerial Theme:

To improve and protect population health and wellbeing and reduce health inequalities

Standards and Targets

Bowel cancer screening

1. By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited.

Tackling obesity

2. From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.

Substance misuse

3. During 2015/16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes.

Family Nurse Partnership

4. By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme.

Ministerial Theme:

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

Standards and Targets

Unplanned admissions

5. By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas.

6. During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.

Carers' assessments

7. By March 2016, secure a 10% increase in the number of carers' assessments offered.

Direct payments

8. By March 2016, secure a 10% increase in the number of direct payments across all programmes of care.

Allied Health Professionals (AHP)

9. From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.

Hip fractures

10. From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Cancer services

11. From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of

patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Unscheduled care

12. From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.

13. By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.

Emergency readmissions

14. By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.

Elective care – outpatients / diagnostics/ inpatients

15. From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks.

16. From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken.

17. From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.

Organ transplants

18. By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.

Stroke patients

19. From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.

Healthcare acquired infections

20. By March 2016 secure a reduction of x% in MRSA and *Clostridium difficile* infections compared to 2014/15. **[x to be available in April/May 2015 following analysis of 2014/15 performance and benchmarking process.]**

Patient discharge

21. From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

Mental health services

22. From April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Children in care

23. From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.

24. By March 2016, ensure a three year time frame for 90% of children who are adopted from care

Patient safety

25. From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.

Normative staffing

26. By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.

Ministerial Theme:

To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

Standards and Targets

Excess bed days

27. By March 2016, reduce the number of excess bed days for the acute programme of care by 10%.

Cancelled appointments

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

Delivering transformation

29. By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model.

Pharmaceutical Clinical Effectiveness Programme

30. By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

Appendix 3 - Summary of Unfunded Service Pressures

As indicated within the Commissioning Plan the funding position for 2015/16 means that a range of key service developments cannot be progressed or can only be taken forward at a significantly reduced scale and/or pace. These service areas are listed below along with the location of relevant information.

Service Area	Section	Page
Maternity services	3.10	15
Physical and sensory disability services	3.11	16
Implementation of the regional reform programme	4.3.2	38
Health Protection Services	6.1.5	48
Services for older people	6.2.3	53
Unscheduled care waiting times	6.3.2	58
Services for people with long-term conditions	6.3.5	61
Cancer services	6.3.6	63
Mental Health services	6.5.2	71
Learning Disability services	6.5.2	71
Family & Childcare Services	7.1	82
Specialist acute services	7.2	87
Access to NICE treatments	7.2	87
Ambulance response times	7.4	94
Primary care and adult community services	7.5.1	98
Elective care waiting times	8.0	108

Steps are being taken, where possible, to mitigate risk and HSCB will continuously review commitments to ensure best use of all available resources.

In addition the HSCB have supported the DHSSPS in preparing bids for June Monitoring amounting to £89m –the bids remain subject to approval.

Bid	Amount £m
Learning Disability Resettlement	6.0
Public Health	4.0
Unscheduled care/Patient Flow	6.0
Revenue Consequences of Capital	7.0
Elective Care/Diagnostics	45.0
Specialist Services	7.5
Mental Health and Learning Disability	4.0
Children's Services	2.0
Transforming Your Care	5.0
Other Departmental Priorities	2.5
	89

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the DHSSPS in N Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / longterm conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the HSCB and PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction – A document published by the Minister on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not publicly funded. Also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

Cord blood is blood that remains in the placenta and in the attached umbilical cord after childbirth. Cord blood is collected from the umbilical cord because it contains cells called stem cells, which can be used to treat some blood and genetic disorders.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Directed cord blood donations - These are collected from the umbilical cord of new born siblings of children with a condition such as acute leukaemia (sometimes referred to as saviour sibling donations). They are arranged with the haematologist treating the affected child.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a

range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, pharmacists, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector as well as service users and carers.

Lesbian, Gay, Bisexual & Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the HSCB arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Neoplasm – Any new and abnormal growth of tissue. Usually a cancer.

Palliative Care – The active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of N Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) – these pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Reablement - range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Service Framework - a document which contains explicit standards underpinned by evidence and legislative requirements. Service Frameworks set standards, specific timeframes and expected outcomes

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Transforming Your Care – Published in 2011 the Review of Health and Social Care in Northern Ireland "Transforming Your Care", sets out a model of care for health and social care which makes recommendations about how we change our services to enhance prevention, early intervention, care closer to home, and greater choice and access. The HSCB is taking forward the implementation of around 70 of the 99 proposals sets out in the TYC Report.

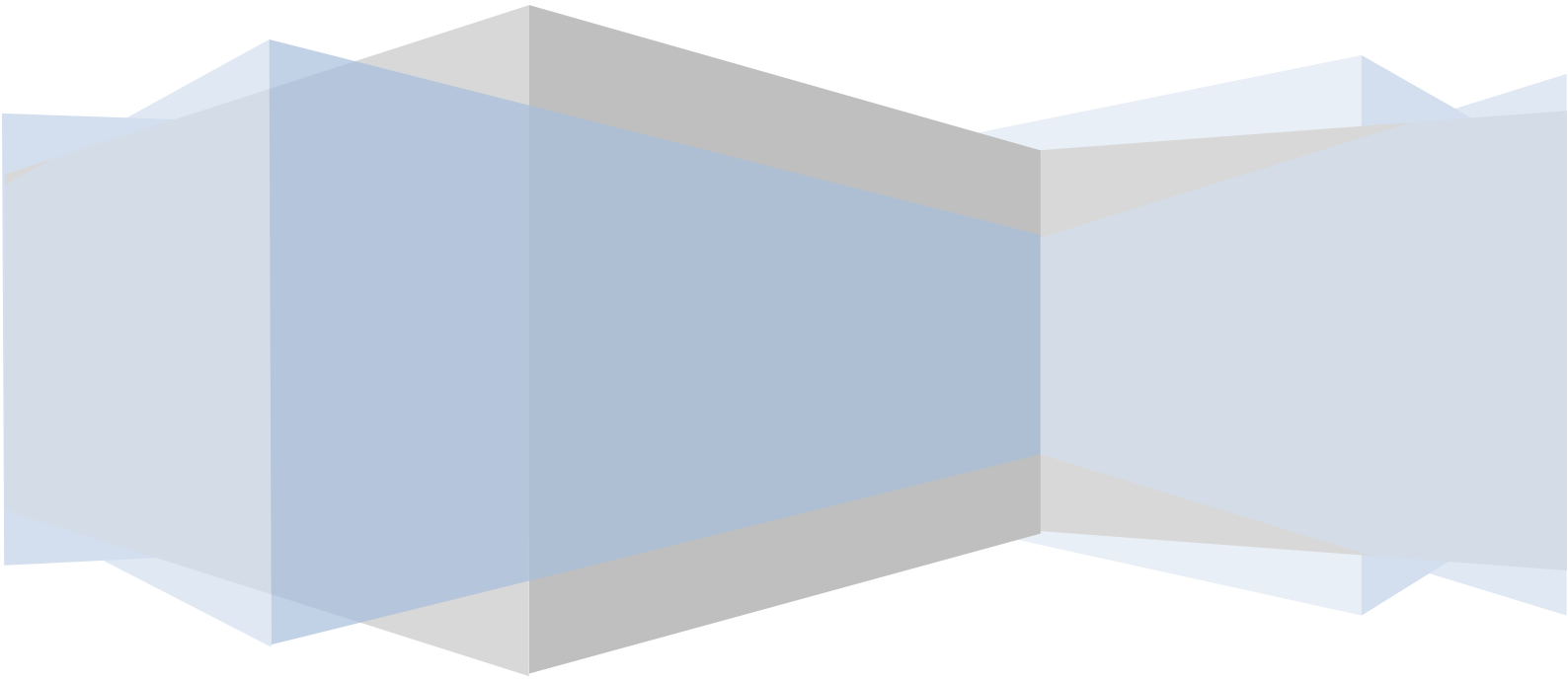
Trust Delivery Plans – In response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Ministerial targets, key themes and objectives outlined for the year ahead.

Unrelated cord blood donations - Also known as undirected or public donations, these are altruistic donations of blood taken from volunteers' umbilical cords at the time of delivery. They are processed and typed for storage in a public cord bank. Registers of public cord banks can be searched internationally to provide the best match for a stem cell transplant.

Health and Social Care Board

Public Health Agency

Commissioning Plan 2016/17



Contents

Foreword

The 2016/17 Commissioning Plan describes the actions that will be taken across health and social care during 2016/17 to ensure continued improvement in the health and wellbeing of the people of Northern Ireland within the available resources. The Plan has been developed in partnership by the Health and Social Care Board and the Public Health Agency, and responds to the Commissioning Plan Direction as approved by the Minister for Health, Social Services and Public Safety, and formally issued on the 11 April 2016.

The Commissioning Plan describes the actions to be taken across Health and Social Care to ensure continued improvement in health and wellbeing of the people of Northern Ireland within the available resources.

The Plan also identifies the key priority areas to be commissioned regionally and locally, with a particular emphasis on how providers will respond to demographic changes, service risks and reform and transformation opportunities.

However, it should be noted that the Plan does not seek to highlight all of the work being taken forward by HSCB/PHA in 2016/17. Rather, the Plan focusses on a number of key strategic and service priorities which are likely to yield the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level.

The Commissioning Plan has been produced within a challenging commissioning and financial context with more direct oversight by the Department. The Plan outlines a number of key investments to be made in 2016/17 consistent with prior discussion with the Department. Trusts have already been provided with indicative allocations – from these allocations Trusts will be required to respond appropriately to the changing patient and client needs and to the specific service pressures identified within the Plan.

The Ministerial Themes and Outcomes highlight the need to redesign and transform services in order to:

- Ensuring that people are able to look after and improve their own health and wellbeing and live in good health for longer
- Ensure people using health and social care services are safe from avoidable harm
- Ensure people who use health and social care services have positive experiences of those services
- Provide health and social care services are centred on helping to maintain or improve the quality of life
- People are supported to recover from periods of ill health and are able to live independently and at home or in a homely setting in the community
- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
- Resources are used effectively and efficiently in the provision of health and social care services.
- People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide.

The HSCB/PHA commits to supporting the delivery of the actions outlined in the Plan by:

- Listening to Patient and Client experience and learning from Personal and Public Involvement;
- Supporting our staff through training and development;
- Working with clinicians to ensure delivery of best practice;
- Working in partnership with providers, including the private and voluntary sector to support greater choice and innovation;
- Embracing innovation and technology;
- Use eHealth (technology) to improve citizens' experience of interacting with health and social care and to improve care by making it easier for staff to get the information they need to provide that care; and
- Through a continued focus on reducing health inequalities.

1.0 Introduction and Context

1.1 The Purpose of the Plan

The Commissioning Plan sets out the priorities to be taken forward by HSC and providers. The Plan has been developed in partnership by the Health and Social Care Board and the Public Health Agency, and responds to the Commissioning Plan Direction as approved by the Minister for Health, Social Services and Public Safety, and formally issued on the 11 April 2016. The priorities outlined within the Commissioning Plan also take account of the 2016/17 investments announced by the Minister for Health, including the new Transformation Fund.

The Commissioning Plan aims to respond to the three strategic themes and statutory obligations identified by the Minister in the Commissioning Plan Direction:

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

The Plan specifically responds to each of these strategic aims within Section 4. In line with established commissioning arrangements, the plan provides an overview of Regional Commissioning priorities for 2016/17 (Section 5) together with information on the priorities at local level (Section 6). Within these sections, the Plan makes explicit reference to areas of service development, service delivery and service reform and modernisation required from providers, who will be expected to respond, in their delivery plans for 2016/17. These sections will also highlight known unfunded areas where applicable. The HSCB/PHA will, through existing mechanisms, monitor the performance of providers against these plans.

In addition to the strategic themes within the Commissioning Plan Direction there are a number of outcomes and objectives for the wider HSC service to deliver. A summary of the objectives can be found in Appendix 1.

The Plan also incorporates funding from the most recent June monitoring round. These investments are reflected across both the regional and local Commissioning sections. Trusts are expected to respond to respond to the Commissioning Plan via the submission of Trust Delivery Plans. The financial allocation for 2016/17 includes a block sum to Trusts and as such the Commissioning Plan outlines the 2015/16 commissioned values and volumes as a baseline and it is expected that values and volumes will be amended following the submission of the Trust Delivery Plans.

The plan provides a view of the strategic transformation, reform and modernisation aims across all programmes of care both regionally and locally. The Plan does not seek to highlight all of the work being taken forward by HSC in 2016/17.

In compiling the Commissioning Plan, input from service users, carers and the public was drawn from a variety of sources, ensuring that HSC commitment to the principles, practice & duty of Personal & Public Involvement was respected. Information, input and guidance was drawn from a very diverse and wide range of reference groups, advisory groups, advocacy organisations and patient and service users themselves.

1.2 Delivering on Key Policies and Strategies

This section provides an overview of a range of key policies and strategies which inform the key regional and local priorities set out in sections 5 and 6 of this Plan. While the majority of these strategies are specifically referenced within the Plan, the HSCB and PHA remain committed to the delivery of all policies, frameworks, guidance and strategies highlighted below. It should be noted that it not an exhaustive list.

- Programme for Government (following NI Executive approval)
- Quality 2020

- Institute of Healthcare Improvement Liaison
- Service Frameworks
- Workforce Planning & Development
- Transforming Your Care
- Donaldson report
- Sexual Health Strategy
- Domestic Violence and Sexual Violence Strategy
- Making Life Better
- Maternity Strategy
- Physical and Sensory Disability Strategy
- Delivering Care: Nurse Staffing in NI
- Primary & Community Care Infrastructure
- eHealth & Care strategy
- Living Matters Dying Matters
- RQIA Reports
- NI Rare Disease Implementation Plan
- NICE guidance

1.3 Maximising Opportunities for Innovation

There are a number of enablers within the HSC which have and will continue to be utilised in order to deliver reform including Managed Clinical Networks, Integrated Care Partnerships, Project Echo, the Regional Unscheduled Care Network, and IHI Triple Aim Framework and the NI Genomes Medicine Centre. In addition GP Federations will be an invaluable tool working alongside secondary care to deliver outpatient reform during 2016/17.

1.3.1 ICT and eHealth

ICT and eHealth continue to be key enablers to maximising opportunities for innovation. An eHealth & Care strategy has been developed by the HSCB, supported by the PHA and by other HSC organisations. The strategy was formally launched by Minister Hamilton in March 2016. By September 2016, the current regional implementation plan will be developed to form an NI wide implementation plan to deliver the objectives in the published HSC eHealth & Care Strategy.

Key priorities to be taken forward in 2016/17 include:

- The development of a business case for the establishment of an integrated record for citizens and patients to build on the success of the NI Electronic Care Record, to be complete by March 2017.
- Working with NI Direct to further develop web portal access to support citizens for self-care; and rolling out the capacity to support online booking and repeat prescribing on line for 90% of all practice patients by June 2016.
- Roll out the electronic triage of GP to consultant referrals to all Trusts during 2016/17, and agree plans for the development of electronic referrals for non-consultant services.
- The development of a Directory of Services to support care professional staff to rapidly access and safely refer to appropriate HSC services to avoid unnecessary interventions.

1.3.2 Transforming Your Care

Transforming Your Care is built upon four main themes:

- The individual at the centre – building and designing our health and social care services with the individual at the centre, and providing care closer to home, where that is safe and appropriate.
- Independence – supporting people to live independently if possible, and giving people greater choice and control, and access to services when and where they need them.
- Sustainability & Resilience – building services to be sustainable and resilient into the future. This requires us to work differently, and across traditional boundaries of professions and settings and focus on delivering care in the right place at the right time.
- Having the right enablers in place and making the best use of what we have to meet our population's needs.

2016/17 will see a continued focus to embed the delivery of these themes across core services. Examples of the transformation, reform and modernisation agenda are reflected throughout the Commissioning Plan.

1.4 Achievement of Ministerial Targets

The Commissioning Plan Direction sets out the Minister's key themes, outcomes and objectives for the HSC for 2016/17, in many cases building on the targets and standards in 2015/16.

The HSCB is committed to working with Trusts and other stakeholders to deliver these targets and standards, and to improve services for patients and clients. The ongoing constrained financial environment will however present significant challenges to improving or maintaining performance across a number of service areas. Notwithstanding this, it is important that the best possible outcomes are secured through the implementation of best practice and the full delivery of commissioned activity.

In 2016/17, the HSCB's performance management function will continue to enable and support a formal, regular, rigorous process to measure, evaluate, compare and improve performance across the HSC. Providers must have in place their own systems for identifying and responding early to performance issues but the HSCB will continue to identify trends and key performance issues, assess risk and where necessary work with providers to agree corrective actions and set goals. Where Trusts fail to improve in line with those goals appropriate escalation measures will be used.

The HSCB and PHA will work with Trusts during 2016/17 to maximise performance against all of the standards and targets set out in the Commissioning Plan Direction. Further detail on specific Ministerial Targets can be found in Section 5 under the relevant service area.

2.0 Summary of Key HSC Demographic challenges

This section provides an overview of key demographic changes of the NI population and outlines information relating to lifestyle and health inequalities. Consideration has been given to these within the needs assessments outlined within sections 5 and 6 in order to inform the commissioning of services at both regional and local level.

N Ireland Resident Populations by Local Commissioning Group

Table 1

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	67,143	96,179	71,396	84,234	64,831	383,783
16-39	124,457	142,451	102,921	118,711	94,075	582,615
40-64	106,226	153,576	117,007	114,890	96,485	588,184
65+	53,728	76,845	60,977	51,556	42,810	285,916
All ages	351,554	469,051	352,301	369,391	298,201	1,840,498
%	19.1%	25.5%	19.1%	20.1%	16.2%	100%

Source: NISRA, 2014 MYEs

Some of the key demographic changes which will have an impact on the demand for health and care services in NI are noted below:

- Mid-Year Estimates for 2014 indicate that there are approximately 1.84m people living in N Ireland (NI). Current population projections anticipate the population will rise to 1.935m by 2024.
- Western Trust has the lowest proportion of younger people aged 0-15 years, in comparison to other Trusts (17% or 65,000) and the Northern Trust has the highest percentage at (25% or 96,000).
- Persons aged 16-64 account for the highest proportions across all Trusts, ranging from 65.6% of the population in Belfast to 62.4% in the South Eastern Trust.
- There are a total of 286,000 older people (65+ years) in N Ireland, equating to 15.5% of the NI population.

- 19% of these or 54,000 persons are in Belfast Trust, 27% or 77,000 are in Northern Trust; 21% or 61,000 reside in South Eastern; 18% or 52,000 are in Southern Trust, and the remaining 15% or 43,000 live in Western Trust.
- The anticipated population increase is characterised by a marked rise in the proportion of older people. From 2016-2024 the number of people aged 65+ is estimated to increase by 62,500 to 362,000 – a rise of 21%. The number of older people will represent 19% of the total population compared with 15.5% currently.
- At sub-regional levels, the areas with the highest projected growth overall is the Southern Trust (+8%), for the aged 65+ and 75+ cohorts of the population is in the Western Trust at +24% and South Eastern Trust at +42%. For aged 85+ years, the highest projected growth is in the Southern Trust (+46%).
- Births in N Ireland have increased slightly from 24,300 in 2013 to 24,400 in 2014 – an increase of 0.5%
- 14,678 deaths were registered in N Ireland during 2014, which is a slight decrease of 290 or 1.9% since 2013.
- The main cause of death was cancer accounting for 29% of deaths in N Ireland (4,323).
- In 2011, males could expect to live to the age of 78 years and females to the age of 82 years. Males living in the 10% least deprived areas in NI could expect to live on average approximately 9 years longer and females, approximately 6 years longer than their counterparts living in the 10% most deprived areas.
- The prevalence of long term conditions such as COPD, diabetes, stroke, asthma and hypertension is increasing. In conjunction the number of people coping with co-morbidities is increasing.
- Deprivation has an impact on health and wellbeing in many ways resulting in the lack of social support, low self-esteem unhealthy life-style choices, risk taking behaviour and poor access to health information and quality services.

3.0 Commissioning and the use of Financial Allocations

The Commissioning Plan Direction requires the Commissioning Plan to explain how services will be commissioned within the available budget. This includes providing details of how the total available resources, as specified by the Department in its respective budget allocation letters to the HSCB and PHA for the financial year 2016/17 have been committed to the HSC Trusts and other organisations.

This chapter sets out:

- A summary of income sources for the HSCB and PHA in line with DHSSPS 2016-17 Budget Allocation letters
- A summary of HSCB spend areas for the planned additional investments in 2016-17
- An analysis of HSCB and PHA allocations by Provider including HSC Trusts
- An analysis of HSCB and PHA allocations by Programme of Care
- An analysis of HSCB and PHA allocations by LCG area
- An analysis of the in-year June Monitoring monies

In response to the Commissioning Plan, Trusts are required to provide Trust Delivery Plans which will incorporate individual financial plans for each Trust. These plans will provide further information for the HSC on additional financial pressures such as those resulting from population and price increases and how each Trust plans to address these. These plans can then be incorporated into an overall Strategic Resource Framework for the whole HSC which will be available later in the financial year.

Summary of Income Sources - Budget Allocations HSCB and PHA

The DoH issued separate allocation letters to the HSCB and PHA in April and May 2016. These allocation letters show the budgeted income, along with administrative savings reductions of 10%, for each respective organisation. These are set out in Table 2 below.

Income 2016/17

Table 2

Income 2016/17	HSCB £m		PHA £m		TOTAL £m
Opening Allocation	4,309	*	85	**	4,394
DHSSPS Additional funding	127		1		128
10% Admin Reduction	(3)		(2)		(4)
TOTAL	**4,433**		**85**		**4,518**
* adjusted to take account of Early Years Funding					
** adjusted to take account of R&D reclassification to capital					

In addition a further £72m of non-recurrent monies was secured through the June Monitoring round, of which £67m is to address a range pressures across health and social care and the remaining £5m is for capital spend. Of the £67m, £60m has been reflected in the Commissioning Plan.

HSCB/PHA spend areas and funding sources

The DoH allocation letters set out how the additional resources available for each organisation are to be applied in the financial year beginning April 2016. In addition a further £72m of non-recurrent monies was secured through the June Monitoring round, of which £67m is to address a range pressures across health and social care and the remaining £5m is for capital spend.

Additional resources are planned to be used to address the recurrent cost of 2015-16 service pressures, new HSCB/PHA pay and inflation related costs and Family Health Service pressures. In addition the DoH have ring fenced new resources for a detailed list of inescapable pressure areas such as elective and funding for NICE approved drugs and Transformation Fund resources which have been prioritised to meet the transformation of services vision. Table 3 summarises the areas of planned additional investment. A total of £36m has also been allocated to HSC Trusts. This allocation should form part of individual Trusts financial plans.

The table below shows how the total planned spend areas (pressures) will be addressed. In addition to the DoH additional allocation source (£128m), the

HSCB has been tasked with delivering £20m of productivity efficiency savings from the Family Health Services.

2016/17 Summary of spend areas and funding sources

Table 3

2016/17		£m	£m
PRESSURES	FYE of 15/16 pressures	(20)	
	HSCB/PHA Pay related pressures	(5)	
	Family Health Services	(20)	
	Inescapable Pressures	(38)	
	Transformation Fund	(29)	
	Contribution to Trust Pressures	(36)	
			(148)
SOURCES			
	Additional allocation from DHSSPS	128	
	Family Health Services Savings	20	
			148

HSCB Allocations to Providers

The following table shows how the total of the HSCB/PHA allocations of £4,518m are planned to be allocated across providers. Figure 1 provides a sub analysis of the allocations to HSC Trusts.

Allocations to Providers

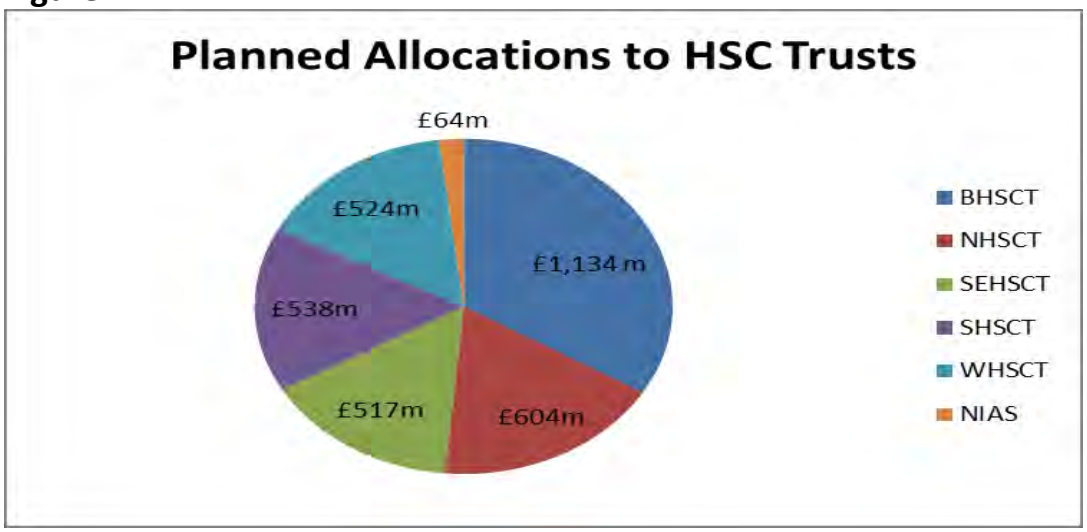
Table 4

Allocations to Providers	£m
HSC Trusts	3,382
FHS	865
Other*	271
TOTAL	**4,518**

* Managed at HSCB/PHA incl Elective and non Trust contracts

Planned Allocations to HSC Trusts

Figure 1



Trusts have been asked to develop individual savings plans which reflect the HSCB/PHA allocations and ensure pay, non-pay, additional national insurance contributions, national living wage and demography pressures are addressed. The HSCB will review these plans including any efficiency and savings proposals to ensure their deliverability and acceptability in the context of the need for financial breakeven, safety and quality considerations.

HSCB planned spend by Programme of Care

The following table categorises inescapable and Transformation Fund pressures set out by Programme of Care.

Programme of Care Analysis

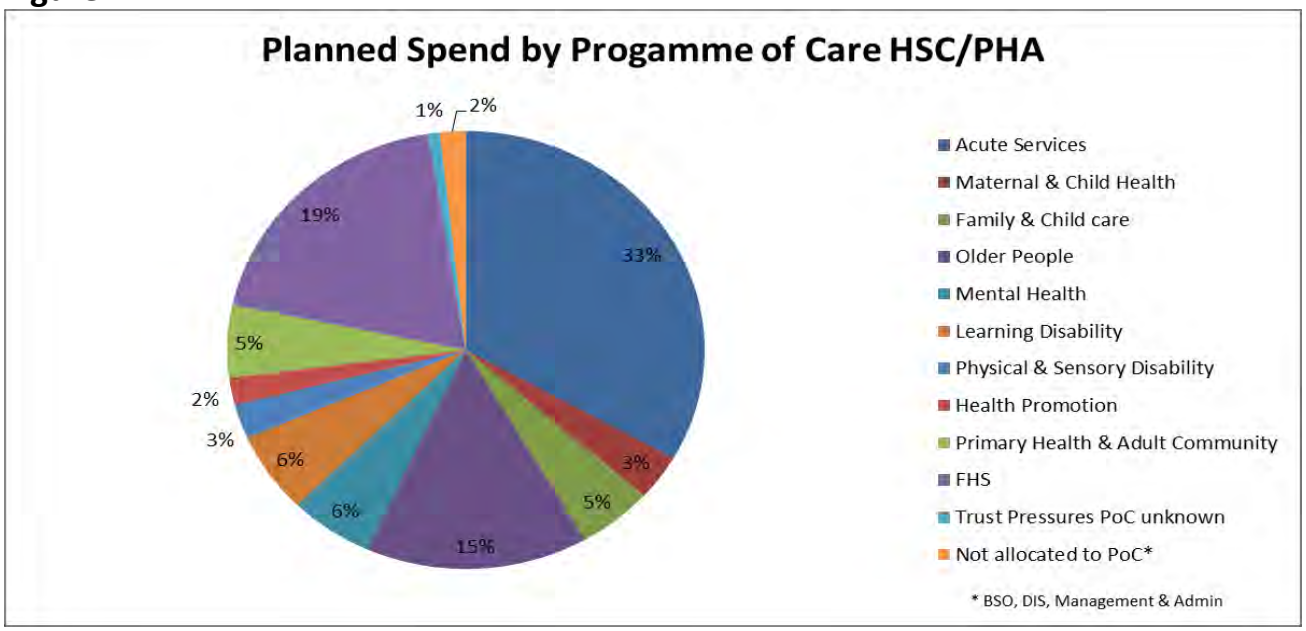
Table 5

Planned Spend by Programme of Care	Inescapable Pressures £k	Transformation Fund £k
Acute Services	25,805	4,765
Maternity & Child Health	319	-
Family & Child Care	1,462	355
Elderly Care	-	311
Mental Health	175	700
Learning Disability	9,100	-
Physical & Sensory Disability	220	-
Health Promotion	-	-
Primary Health & Adult Community	625	14,219
All POCS	-	6,030
Not allocated to POC	-	2,300
TOTAL	**37,707**	**28,680**

Figure 2 below shows how the total of the HSCB/PHA allocations of £4,518m are planned to be allocated across Programmes of Care. A more complete picture of planned investment across the HSC by Programme of Care will be available when Trusts have completed their Trust Delivery Plans. In particular the HSCB will seek to ensure that demographic needs in the elderly and other Programmes of Care such as mental health and learning disability are addressed.

Planned spend by Programme of Care

Figure 2



HSCB planned spend by Local Commissioning Group

The following table shows how the total of the HSCB/PHA allocations of £4,518m are planned to be allocated across Local Commissioning Group.

Planned spend by Local Commissioning Group

Table 6

	LCG								
Trust	**A&E**	**Belfast**	**Northern**	**South Eastern**	**Southern**	**Western**	**Regional**	**FHS**	**Grand Total**
BHSCT	45	574	124	108	48	27	209	0	**1,134**
NHSCT	21	1	550	1	0	1	30	0	**604**
NIAS	64	0	0	0	0	0	0	0	**64**
SEHSCT	20	46	3	397	6	0	45	0	**517**
SHSCT	22	1	8	6	477	2	22	0	**538**
WHSCT	16	0	10	0	4	466	28	0	**524**
Non-trust **	1	39	46	34	33	34	6	865	**1,057**
Total	**188**	**660**	**741**	**546**	**568**	**531**	**340**	**865**	**4,439**
Not Assigned to LCG *									**79**
Grand Total									**4,518**

* Includes Mgmt & Admin, BSO, DIS

** Non Trust includes voluntaries and Extra Contractual Referrals

The HSCB carries out an annual equity review to assess whether its total resources have been fairly deployed across local commissioning group populations. This will be carried out later in the year, following the submission of Trusts' TDPs.

Tables 7 and 8 detail the Inescapable Pressures and the Transformation Fund. In arriving at these prioritised funding areas the DoH sought submissions from the HSCB and PHA.

Inescapable Pressures

Table 7

Service Development Pressures identified as inescapable	£k
Maintaining existing approved drug regimes	10,750
Elective Care	9,821
Community Learning Disability Cost pressure	4,500
GMC Recognition of Trainers	2,412
Young people transitioning to adult services	2,000
Autism Investment	2,000
Recruitment requirements for Altnagelvin Radiotherapy Centre	1,500
High Cost Cases - Family & Childcare	1,200
Complex discharges from Learning Disability	600
Paediatric Asthma and Anaphylaxis	425
Insulin pumps	465
Diabetes Strategy	319
Palliative Care Modernisation – Final implementation DHSSPS LMDM	284
Community Dentists	280
Major Trauma Network	242
Regional communication support services for deaf people	220
Implementation Plan for Rare Disease – UK Genetics Testing Network (UKGTN)	190
Mental Trauma Service	175
Jointly Commissioned Supported Accommodation Projects	212
RCCE Banbridge Community Care and Treatment Centre (CCTC)	61
Remaining with Former Foster carers (GEM Scheme)	50
TOTAL	**37,707**

Transformation Fund

Table 8

Transformation Fund	£k
	£k
Practice Based Pharmacists	1,700
GP Federations -innovation in managing elective care	800
Delivering Social Change – Dementia Project	311
Family Support Hubs	295
ICT reform	1,000
ICPs	7,463
Stroke Services (Coordinator & NHSCT & SHSCT)	574
Trust Backfill	1,631
Day Opportunities	390
Self Directed Support	327
ICP Business & Clinical Support/Committees	1,500
HSCB Programme Team	597
HSCB Project Support costs	107
Ambulance Alternative Care Pathways	495
RAID (NHSCT)	700
MOIC (NHSCT)	300
Outpatient Reform (Regional)	600
Care Pathways Reform (Regional) HF & Asthma	250
Project ECHO	474
DNAV (net of Primary Care prescribing savings) - SEHSCT	1,227
Specialist Foster Carers	60
Direct Access Physio (4 Trusts - excludes SEHSCT)	100
NI Participation in UK Genomes project	1,270
Medicines Optimisation	2,000
Innovation in diabetes	1,000
Primary Care quality improvement	1,920
District Nursing and Health Visiting	850
HEMS	250
Community Resuscitation	250
Paediatric and obstetrics services at Causeway hospital	190
SABR	50
Total Transformation Fund	**28,680**

June Monitoring Monies

In recognition of the significant financial challenge and pressures set out in this chapter, in particular facing local Trusts, the Executive has allocated a further £72m (£5m of which is for capital) to the Department in the June Monitoring Round. The £67m revenue funding will help address a range of front line pressures, including unscheduled care, improving patient flow through our hospitals, childrens' services, mental health/learning disability services and additional social care provision to help meet increasing demands. Trusts should incorporate these additional resources as they continue to develop their TDPs.

Unfunded Pressures

The additional funding received in the June Monitoring round does not cover all of the pressures facing health and social care in 2016/17. The HSCB will therefore continue to work with the Department to explore all available measures that can be taken to maximise the resources available for investment in health and social care.

4.0 Overarching Strategic Themes

This section demonstrates how services will be commissioned in line with the key themes/aims set out within the Commissioning Plan Direction 2016, namely:

- Improving and Protecting Population Health & Reducing Inequalities
- Providing High Quality, Safe and Effective Care
- Listening to Patient and Client experience and learning from Personal and Public Involvement
- Ensuring services are efficient and provide value for money

4.1 Improving and Protecting Population Health and Reducing Inequalities

4.1.1 Improving health and reducing health inequalities

Improving health and reducing health inequalities requires coordinated action across health and social care, government departments and a range of delivery organisations in the statutory, community, voluntary and private sectors. DOH published Making Life Better in 2014, a whole system strategic framework for public health which sets out key actions to address the determinants of health. Investment in prevention is a key contributor to reducing future demand for health and social care. A healthy population also contributes to economic prosperity, better educational attainment, and reduced reliance on welfare.

In NI between 2002 and 2012 more than 41,000 people died prematurely of disease which was potentially avoidable through public health interventions or potentially treatable through high quality healthcare. Nearly 700,000 life years were lost. In 2012, 3,756 people died of illness which could either have been prevented in the first place (84%) or if detected early enough could have been treated successfully.

Those most likely to die prematurely included men (61% for 2012), reflecting the four and a half year gap in life expectancy between men and women, and those living in our most deprived areas. Residents of most deprived areas are two and a half times as likely to die prematurely of preventable causes as those in least

deprived areas. This increases to a factor of four for drug and alcohol related deaths and three times for suicide, respiratory problems and lung cancer[1] .

The DOH disaggregation of life expectancy differentials in NI[2] highlighted the reducing impact of circulatory disease on premature mortality with the increased contribution of cancers and accidental injuries and suicide amongst the younger age groups, particularly in more deprived areas. Known inequalities in health have been identified across a range of groups including:

- Travellers
- Young men
- Ethnic minorities
- Lesbian, Gay, Bisexual and Transgender (LGB&T)
- Migrants
- Carers
- Prisoners
- Homeless
- Disabled
- People living in more deprived areas

In producing local action plans, the LCGs have taken consideration of these groups and where appropriate how they may be targeted. Likewise any health improvement programmes, information and support services will assess any necessary additional requirements in order to enable full engagement or access for these population groupings.

The PHA aims to improve the health and wellbeing of the population of NI and to reduce health inequalities. This work is founded on partnership with many different sectors and disciplines in order to maximise the benefits that can be gained through these collective efforts.

[1] http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-and-age-65-in-the-united-kingdom/2008-10/index.html
[2] http://www.dhsspsni.gov.uk/life-expectancy-decomposition

Health and Social Wellbeing Improvement activity is underpinned by six themes set out in Making Life Better, which include:

- Giving Every Child the Best Start
- Equipped Throughout Life
- Empowering Healthy Living
- Creating the Conditions
- Empowering Communities
- Developing Collaboration

During 2016/17 the PHA will advance these objectives by building strong connections across society to improve health and wellbeing and reduce inequalities.

Joint working with the 11 councils will be strengthened to ensure close alignment with community planning processes to improve health and wellbeing.

The PHA will continue to progress the early years intervention agenda, in particular through the work-streams of the Early Intervention Transformation Programme, sponsored by a consortium including Government Departments. Work with communities and organisations will continue to focus on reducing some of the structural barriers to health and seek the active engagement of communities wherever possible.

In response to Commissioning Plan Direction, the PHA will advance the following specific objectives:

Giving Every Child the Best Start

The PHA will continue to prioritise investment in early years' interventions. Specific commissioning intentions during 2016/17 will include:

- Expansion of the Family Nurse Partnership Programme, within all five Trusts to cover the whole population of NI, and ensuring an increased level of availability to eligible mothers, thereby providing NI wide

coverage, and developments in health visiting, early intervention services and family support hubs.

- Expansion of evidence based parenting support programmes which will support the development of the infant mental health action plan; the implementation of the Early Intervention Transformation Programme.
- Implementation of the breast feeding strategy across all trust areas with specific attention to the training of staff, peer support and accreditation of facilities to meet the World Health Organisation UNICEF Baby Friendly standards.
- Contribution to the health improvement and safeguarding focus of LAC as a key target group and continue to contribute to the achievement of the goals for adoption and placement of LAC through support for the HSCB Residential Care, Fostering and Adoption Commissioning Leads.
- Continuing to work with DOH, HSCB and Trusts to ensure that the complete range of universal contacts as outlined in the Healthy Child, Health Future Child Promotion Programme is delivered to every child entitled to receive them.
- Three-monthly performance monitoring, using regionally agreed measures will continue until March 2018. Efforts relating to workforce planning, and securing sufficient education and training places for student health visitors, will continue.

Equipped Throughout Life

Specific commissioning intentions for 2016/17 will include:

- Delivery of the MARA programme funded by the Department of Agriculture and Rural Development and PHA; this programme reduces rural isolation and poverty and achieves a 9-fold return on investment.
- Support through community networks for a range of local programmes.
- Keep Warm initiatives with vulnerable populations.

Empowering Healthy Living

The PHA will continue to implement a range of public health strategies to empower healthy living. Specific commissioning intentions for 2016/17 include:

- Addressing rates of obesity in children and adults through the rolling action plan of the multi-agency Regional Obesity Prevention Implementation Group.
- Focusing on providing individuals with the knowledge, skills and opportunities to make healthier choices in relation to nutrition and physical activity.
- Implementation of the tobacco control strategy including smoking cessation services. First results published from the Health Survey, NI (2014/15) reveal that 22% of respondents were current smokers, a reduction from 26% in 2004/05. Data from the Young Persons Behaviour and Attitude survey (2013) shows the proportion of 11-16 year old children who smoke is 5%, a reduction from 8.4% in 2010. Data from NIMATS (2014/15) shows the proportion of pregnant women who smoke is 14.7%.
- Continuing to work with DOH on the development of a new strategy for the prevention of suicide and self harm, and the promotion of positive mental health. In 2016/17, this will include:
  - Public information campaigns to promote mental and emotional wellbeing and to promote help-seeking;
  - Offering training courses on suicide prevention and mental health awareness;
  - Community-led prevention support programmes and bereavement support services;
  - Support to address alcohol/substance misuse;
  - Local research into suicide;
  - Development of cluster response plans, to continue to ensure Health and Social Care Trusts are involved in any activation of community response plans and the reporting of 'SD1s'.
- Continue to improve access to public information and sexual health services – to include the development of a service specification which will enable closer integration of sexual and reproduction health services.
- Implementation of the New Strategic Direction for Alcohol and Drugs and the procurement of new services including a priority to work toward a seven day integrated and coordinated substance misuse liaison service in

acute hospital settings using agreed Structured Brief Advice or Intervention programmes.

Creating the Conditions

Specific commissioning intentions for 2016/17 will include:

- Build capacity of local people to support vulnerable adults to live independently in caring and responsive communities, such as Creative Local Action Response & Engagement (C.L.A.R.E.).
- Lead and implement programmes which tackle poverty (including fuel, food and financial poverty) and maximise access to benefits, grants and a range of social inclusion services for vulnerable groups.
- Develop and implement a consistent approach to health and social wellbeing programmes, working with local government and other partners.

Empowering Communities

The PHA will continue work with a range of partners to use sports, arts and other leisure opportunities to improve the health and wellbeing of local populations. Specific commissioning intentions for 2016/17 include:

- Implementation of the Action Plan of the Regional Travellers Health Forum.
- Expansion of the NI New Entrants service; and support to a range of community development and health programmes.

Developing Collaboration

PHA will continue to support and extend strategic multi-agency partnerships in 2016/17, in particular supporting community planning with local government, to improve health and social wellbeing and reduce health inequalities. A key focus of developing collaboration should include strengthening and embedding Making Life Better across all HSC organisations.

4.1.2 Screening

Screening is an important public health function that involves inviting members of the public, who have no symptoms of a particular disease, to be tested to see if they might have the disease, or are at risk of getting it. Population screening allows certain diseases and conditions to be identified at an early stage when they are more amenable to treatment. The PHA is the lead organisation for commissioning and for quality assuring population screening programmes.

During 2016/2017 the key deliverables will include:

- The bowel cancer screening programme has been fully rolled out to include the population aged 60-74. As the service has attained in excess of the 55% uptake. Investment will be made to ensure that standards are maintained. Preliminary work on introducing a new testing regime will be undertaken.
- Consolidate the business case for an IT system to support the new-born hearing screening programme (NHSP) in N Ireland in order to reduce the risk of adverse incidents, improve quality assurance and eliminate many manual processes within the programme
- Introduce surveillance clinics to the diabetic eye screening service and improve quality assurance of retinal photographs through the introduction of test and training sets for graders. Consider new models for the delivery of the diabetic eye screening programme and undertake preliminary work on the introduction of revised screening intervals
- Improve the infrastructure support to breast screening units to ensure that standards are maintained.
- Plan for the introduction of a QA management system for images taken as part of the AAA Screening Programme.
- Establish a planning group for the introduction of HPV testing as the primary screening tool in the cervical screening programme
- Input to the development of a specification and business case for the NHAIS transformation project, ensuring that this meets the future

needs of the adult screening programmes and that appropriate call recall functions are maintained in the transition period.

4.1.3 Health Protection

The Health Protection Service is a multidisciplinary service in the Public Health Directorate in the PHA. It comprises Consultants in health protection, nurses in health protection, epidemiology and surveillance staff, and emergency planning staff. The health protection service delivers on statutory responsibilities of the Director of Public Health, with respect to protecting the health of the NI population from threats due to communicable diseases and environmental hazards. It provides the acute response function to major issues, such as outbreaks of infection and major incidents. The PHA Health Protection Duty room is the first point of call for all acute issues in relation to infectious disease incidents and for notifications of infectious diseases.

During 2016/17 will support the ability of commissioners will take forward the introduction of a surveillance system for antimicrobial resistant organisms and a region wide programme on antimicrobial stewardship.

Communicable diseases disproportionally affect certain groups in the population including those at social disadvantage, living in poor housing conditions, migrants from countries that have higher prevalence of infectious diseases, and those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities. Healthcare Associated Infections (HCAIs) are an important cause of morbidity and mortality. Levels of infections are increasing across Trusts. Tackling antimicrobial resistance is a key priority for the Chief Medical Officer and DOH.

Commissioning priorities for 2016/17 include:

- *Healthcare Associated Infections (HCAIs)*
  - Trusts, supported by PHA will develop and deliver improvement plans to reduce infection rates. This will be monitored via PHA

surveillance programmes for HCAIs. (In accordance with Ministerial Target for 2016/17.)

- *Flu immunisation*
  - Trusts urgently need to increase uptake of flu immunisation among healthcare workers.

- *Antimicrobial Resistance and Stewardship*
  - Trusts and Primary Care, supported by PHA, will work to monitor antimicrobial resistance and develop improvement programmes for antimicrobial stewardship.

4.2 Providing High Quality, Safe and Effective Care

A key priority for the Minster, Department and HSC is to ensure that people across NI are able to access high quality services in an appropriate setting.

Consistent with the strategic vision set out within Transforming Your Care, the HSC will continue to seek to provide care at home, or as close to home as possible supporting people to live independent, fulfilling lives.
Central to the delivery of high quality care will be the availability of appropriately resourced and trained clinical staff (doctors, nurses, allied health professionals, etc.) and social care staff.

The contribution of informal carers is also key to the delivery of this objective, and it is important that they are supported in this role.

The HSCB and PHA continue to place the quality of patient care, in particular patient safety, above all other issues, and are working on an ongoing basis to monitor and review services. In the context of continuing significant resource challenges, this focus on safety is more important than ever.

The HSCB and PHA will continue to work with Trusts and the HSC Safety Forum to better manage patients with sepsis and sever sepsis in acute care and improve the management of these patients across the interface between

secondary and primary care. This work will build upon existing work in EDs in the early management of sepsis. Current work will develop and embed the use of the sepsis 6 approach in pilot wards in pilot wards in all Trusts, with the intention to incorporate into general wards.

Specific commissioning intentions for 2016/17 in relation to the safety and quality agenda are set out below and in subsequent sections of this Commissioning Plan.

4.2.1 Providing care closer to home

A key priority for the HSC is to allow people to be cared for in their own home or as close to their home as possible potentially avoiding the need for visits to hospital.

During 2016/17 the HSCB and PHA will continue to work with providers (individually and through Integrated Care Partnerships (ICPs) and wider network arrangements) within available resources to enhance both the range of community services available to support people to remain at home, and to ensure the better integration of services, including linkages between:

- Primary and secondary care services, both in-hours and out of hours, including acute/enhanced care at home
- Statutory services and services provided by the independent sector, and by community and voluntary organisations
- The range of services provided in the community and those provided by the NI Ambulance Service.

Through the enhancement and better integration of community services – organised around the needs of patients and the maximisation of opportunities presented by technology, the expectation is that significantly more patients can be cared for at or near their homes, allowing them to retain their independence for as long as possible.

4.2.2 Delivering Care Same Day/Next Day

While the over-riding aim is to provide care for people at home or as close to home as possible, there will nonetheless be occasions where access to more specialist assessment, diagnosis and treatment services are required, typically in a hospital setting. Access to these services should not however require patients to be admitted to hospital, rather they should be available on an ambulatory basis, allowing the patient to return home as soon as possible without a lengthy hospital stay which, for elderly patients in particular, can significantly impact on their ability to return home and live independently.

Ambulatory care is used as an umbrella term to describe a range of pathways and models of care aimed at avoiding admission or reducing length of stay for both acute and chronic disease. Clinical staff in hospital Emergency Departments and the main acute specialties already aim to avoid unplanned admission where possible, with ambulatory services being delivered on a same day/next day basis, as appropriate. However the potential to which ambulatory care services have been maximised varies by individual Trust, site, time of day, day of week, special interest and availability of clinical staff, community service options and the configuration of the HSC estate.

During 2016/17 the HSCB and PHA will continue to work with providers (individually and through ICP and wider network arrangements) to secure greater consistency of service provision in relation to ambulatory care. Within available resources we shall seek to improve ambulatory services for unscheduled care patients and to explore opportunities to use such same day/next day models as an alternative to existing outpatient clinics for planned patients.

4.2.3 Improving the patients journey through hospital

Even with more effective services in the community (to allow patients to remain at home) and at the “front door” of hospitals (to allow them to receive specialist ambulatory care, avoiding the need for admission), there will continue to be some patient for whom admission to hospital is appropriate. The expectation is that such patients will be admitted to an appropriate hospital bed in a timely fashion, typically less than four hours and always less than 12 hours. Once

admitted, patients should be pro-actively managed throughout their hospital stay to ensure their period in hospital is as short as possible and allowing them to return to their home with appropriate support as required – living as independently as possible.

During 2016/17 the HSCB and PHA will work with providers (individual and through ICP and wider local network group arrangements) to improve the patient journey through hospital, both in the period of admission to the patient being declared medically fit to being discharged.

Key to improving patient flows and reducing the length of time patients spend in hospital will be the continued move towards seven day working. Good progress has already been made in this regard in 2015/16 including the establishments of seven-day radiology. ED minor injury streams, and increased specialist clinical and social care support into larger EDs seven days a week.

During 2016/17 the HSCB and PHA will continue to work with providers (individually and through ICP and wider network group arrangement) to secure improved patient flow through hospitals with a particular focus on ensuring timely, multi-disciplinary decision making onwards, and to ensuring that, once declared medically fit, patients are discharged from hospital in a timely fashion, ensuring hospital beds are available for those patients with truly acute needs.

4.2.4 Supporting recovery from ill health

It is important that, following a period of ill health, patients are supported to recover and return to independence. Reablement services are now in place across NI to provide short term support to help people perform the necessary daily living skills such as personal care, walking and preparing meals so that they can regain their confidence within their own home. Reablement helps people to do things for themselves rather than having to rely on others.

During 2016/17 the HSCB will seek to further embed reablement services across NI, specifically:

- Each local health economy should work with ICPS to support the implementation of the New Stepped Care Model for Older People and for People who have a Long Term Conditions.
- Develop a comprehensive understanding of population need by systemically adopting and implementing anticipatory care approaches and through needs/risk stratification target preventative intervention in response to identified population needs.
- Require a stronger focus on evidence based preventative health and social care interventions particularly in addressing frailty, falls prevention, incontinence, poly-pharmacy dementia and social Isolation.
- Enhance and integrate community nursing, AHP and Social Care professionals into single care teams.
- Make more effective use of enabling technologies.
- Develop a social enterprising approach in partnership with Local Councils and Third Sector organisations.
- Consolidate and integrate intermediate care services including Acute/Enhance care at home into a single system.
- Consolidate discharge function into a single integrated team. This team, working in partnership with acute specialities and community services should 'pull' through all discharges. This work should be organised around three key re-enabling pathways:

  - **Pathway 1:- Low Intensity:** -The individual has made a good recovery and their personal and social circumstances means they require minimum short-term support with activities of daily living (1-2 weeks). Usually the person's needs are met by core Health and Social Care Services (Nursing, Allied Health Professional and Home Care Services).

  - **Pathway 2:- Medium Intensity:** The person requires post-acute care and continuing rehabilitation. The person usually requires intensive support for up to six weeks with activities of daily living. Care at this level will usually entail the provision of enhanced home care or step down in a sub-acute/intermediate care facility. This

pathway also supports the proactive discharge and in-reach support from community services for those people who have been admitted to hospital from supported living and nursing home care services.

- **Pathway 3:- High Intensity:** The person has complex health and social care needs and requires long-term home care package at home or in supported living or indeed in care home setting. In this context every effort should be made to support the person at home before decisions are taken for a long-term care home placement. Should a person not be able to return home an interim placement supported by intensive rehabilitation for support for up to twelve weeks should be considered before a commitment is made for a long term placement.

4.2.5 Enhancing the availability of nursing care

Delivering Care: Nurse Staffing in NI is a key quality initiative in terms of identifying minimum nurse staffing requirements in a range of hospital and community settings, and ensuring these requirements are met.

To date the HSCB and PHA working with the Department, Trusts and RCN, has focussed on nurse staffing levels in medical and surgical hospital wards. During 2015/16, the required nurse staffing levels for each medical and surgical ward were developed and agreed with Trusts across NI. In total, some £12m has been invested for additional permanent nursing staff during 2016/17. The HSCB and PHA will continue to work closely with Trusts to ensure timely and effective implementation and ongoing monitoring against agreed targets.

During 2016/17 the HSCB and PHA will continue to support the regional work being taken forward in relation to the development of the staffing principles and recommendations for the other areas of the nursing workforce that have been identified as part of the Delivering Care strategy. £1.25m has been secured in year for district nursing and health visiting.

4.2.6 Allied Health Professionals (AHPs)

Allied Health Professions (AHPs) are critical to the ongoing assessment, treatment and rehabilitation of patients throughout the illness episodes whether transient or long lasting. AHPs enable children and adults to make the most of their skills and abilities and to develop and maintain healthy lifestyles. They play a crucial role in 'transitioning' patients between different care settings and across service boundaries within health services, e.g. from secondary care to primary care.

In NI on average 30,000 referrals a month are made to 'elective AHP services' equating to around 360,000 elective referrals per year. As the population ages and with the anticipated increase in the burden of Long Term Conditions this is expected to increase. In addition to elective services patients also require timely access to AHP services in acute hospital services, specialist tertiary services and in hospital outpatient settings.

Access to AHP services

Over the last year, the HSCB and PHA have worked with Trusts to complete a demand and capacity exercise to ensure there is sufficient capacity in each of the AHP services to meet patient demand. During 2016/17, the HSCB and PHA will work with Trusts to agree the steps to be taken to implement the outcomes from this exercise and to address the waiting time position as far as possible within available resources.

Specific issues and opportunities for 2016/17 are as follows:

- To provide enhanced access to timely, effective and evidenced based AHP intervention for patients.
- Ensure dysphagia awareness training is available for relevant staff and that people with swallowing difficulties are assessed.
- Maximise AHP services capacity to provide interventions and services that aim to reduce ED admissions and facilitate safe timely and appropriate discharge from secondary care to appropriate primary care facilities.

- Evidence that the safety and quality of home enteral feeding regimens meets International Standard (ISO 80369)and ensure that the required standards for home enteral feeding is available across primary care particularly in nursing homes

4.3 Listening to Patient and Client experience and learning from Personal and Public Involvement

Personal and Public Involvement (PPI) is core to the effective and efficient design, delivery and evaluation of HSC services. PPI is about the active and meaningful involvement of service users, carers and the public in those processes. The legislative requirements for HSC organisations in regard to PPI are outlined within the HSC (Reform) NI Act 2009. The need to embed the Involvement concept more effectively into HSC culture and practice has been shown through the Francis and Donaldson Reports and was also highlighted in the recent Human Rights Inquiry into Emergency Departments.

Recent Developments

The PHA launched a training and support programme for PPI, ranging from a short e-learning programme, to team briefings, coaching and direct taught materials.

A set of Standards and Key Performance Indicators for PPI which were developed under the leadership of the PHA, have been in the system for just over a year now and compliance against these standards and the legislative Duty of Involvement is assessed using a monitoring and performance management mechanism co-designed by the PHA & Service Users and Carers. This has again brought forth evidence of some excellent practice across the HSC. However, it has also revealed the depth and range of challenge facing such large and diverse organisations in truly embedding PPI.

The PHA working with HSC partners and service users and carers will take forward the following during 2016/17:

- Plan and oversee the roll out of Engage & Involve, the PPI training programme for HSC
- Lead and oversee the redevelopment of the Engage Website and associated outreach programme
- Organise a high profile, international PPI Conference, showcasing best practice and sharing learning for the benefit of service users and carers
- Work with the DoH and Trusts to identify ways to ensure adequate resources are aligned to deliver the Statutory Duty of Involvement
- Develop the implementation of building a vision for Nursing in older peoples services within the MLB strategy steering group

As part of the HSCB work with the PCC, the HSCB is currently working with Trusts to develop a regional approach to managing Myalgic Encephalomyelitis/Chronic Fatigue Syndrome which is estimated to affect 5-7,000 people in Northern Ireland, 10% of whom have a moderate-severe condition.

Those 10% of patients who have a moderate condition may be referred to Trusts for a short programme of condition management. This is being implemented on a pilot basis in the Northern HSC Trust to address the needs of those with moderate Myalgic Enc/CFS and to support GPs and primary care to manage these patients. The HSCB and PHA will also develop secondary care capability for this patient group. The pilot is the first step in the development of a regional network of expertise in ME/CFS.

The Patient Client Council will also support the progression of the following key service developments across 2016/17 alongside HSC partners:

- Endometriosis – Stage IV
- Recurrent Miscarriage
- Chronic Pain
- ME/CFS
- Continuation of work on elderly carers and planning for the future

Patient Client Experience and 10,000 Voices

The HSCB alongside the Public Health Agency are responsible for monitoring and reporting to the DOH on the Patient Client Experience (PCE) Standards. During 2015/16 the Patient Client Experience work programme was integrated with the 10,000 Voices Initiative to provide a robust and systematic process to listen to, learn from and act upon patient/client and staff experience. This approach is based on partnership working to ensure that the voices of patients/clients and staff are central to and can inform local and regional quality improvements.

Based on the outcomes from the Patient Client Experience /10,000 Voices work streams, the HSCB/PHA is committed to the following priorities in 2016/17:

- Monitoring Trust requirements to ensure a policies are in place for the provision of safe and effective care and treatment in mixed gender accommodation and compliance with same gender accommodation
- Monitoring the availability of meals and drinks in EDs
- Continuing to raise the profile of “Hello my Name is…” across all Health & Social care settings.
- Identifying and sharing processes to reduce ‘Noise at Night’ in hospital wards.

In addition, the HSCB/PHA are committed to:

- Undertaking a comprehensive Patient Client Experience work programme using various methodologies to capture the experiences of patients/clients and staff in a range of settings.
- Ensuring analysis of Patient Client Experience information is communicated to all staff involved in the commissioning and delivery of services.
- Engaging with education providers to ensure that findings inform training for pre and post registration medical, nursing and Allied Health Professional staff.

4.4 Ensuring services are efficient and provide value for money

The N.Ireland Health and Social Care System faces the same basic challenges moving forward as those experienced by other health and care systems in developed countries. Major drivers for change include a continuing increase in the average age of our population, the rising cost of new technologies in healthcare and the need to address the balance between care in the community and that delivered within a hospital setting. Of more immediate consequence are the financial challenges facing the health and social care system in 2016/17 and beyond. For these reasons it is essential that all appropriate opportunities to improve productivity and cost effectiveness are identified and taken.

At the highest level the HSCB seeks to ensure that the allocation of the additional funds available to it in any given year:

- Is in line with the strategic intentions of the Minister and the Department; and
- Contributes to the change agendas identified in the 2016/17 Commissioning Direction.

At an operational level, it is important to ensure that Trusts and other health and care providers funded by the HSCB deliver high quality services at the minimum possible cost. The HSCB has in place Service and Budget Agreements (SBAs) with Trusts which identify (amongst other things) the funding made available for services and the volume of activity which Trusts are expected to deliver for that funding. The Trust should ensure the most effective use of staffing resources by reducing sickness levels. This would include promoting uptake of the flu vaccination among staff.

Each year the HSCB engages in regular meetings with Trusts on the extent to which the levels and volumes of care specified in SBAs are being delivered. At the same time, Trusts are asked to re-examine how services are delivered with a view to:

- Improved management of demand in acute, community and social care, leading to a shift in how services are delivered in line with Departmental strategic intentions.
- Improved performance within a Trust's existing funded capacity.
- The transfer or reconfiguration of resources; both within programmes of care but also across programmes where this can be demonstrated to improve models of care delivery in line with our population's needs.

For several years the HSCB has produced a range of comparative measures to support Trusts in identifying the partial areas to target further efficiency and productivity gains. This work has included benchmarking Trust to Trust performance locally, and comparing Trust performance against equivalent healthcare providers in GB. During 2016/17, the methodology used to benchmark Trust performance will continue to be reviewed and refined, taking account of input from Trusts and the Department and changes to service models. In addition, the scope of the benchmarking indicators is being revised to include a wider range of performance measures for community-based services.

These indicators will be used to support ongoing work with Trusts to improve the efficiency and effectiveness of service delivery; as appropriate they will also be used to support the case for commissioning from alternative providers.

4.4.1 Procurement from Alternative Providers

The majority of health and social care services for the NI population are purchased by LCGs from their 'local' Trust. The size of NI, the limited number of statutory providers and the need to maintain financial stability both at individual provider and system level means that, in practice, the opportunities to establish a truly competitive provider market locally are limited. Nonetheless, the HSCB will continue to pursue opportunities in this regard in the context of the need to secure improved value for money.

Specifically, the HSCB will seek to respond to existing and new patient demands by commissioning services where appropriate from a provider other than the local Trust to include commissioning from:

- Another Trust in NI
- The community/voluntary sector
- Partnerships of providers e.g.GP Federations
- Providers from Independent Sector or the Statutory Sector in GB or RoI.

This approach will be adopted across a range of service areas. In each case the over-riding priority will be to identify opportunities for more patient-focused, sustainable and cost effective delivery while at the same time seeking to maintain the integrity of other related services commissioned from existing providers.

4.4.2 Delivery of Contracted Volumes

Instances have arisen where the volume of services delivered by providers has fallen considerably short of the level of service commissioned – impacting directly on patient care. In some instances performance difficulties have arisen as a result of ongoing operational difficulties, in others they may have arisen directly as a result of vacancy controls.

While the HSCB will continue to work with Trusts and other providers to support improved performance, the HSCB will in addition, remove funding in full in targeted service areas where there have been performance difficulties with the funds being used to secure services from another provider.

It is recognised by the HSCB that this intervention will present challenges for Trusts and other provider organisations, particularly in the current financial context. However at the same time it is essential that scarce commissioning resources are used to best effect to deliver commissioned services for patients.

4.4.3 Workforce

Health and Social Care need in Northern Ireland has continued to change over the last 10 years, due to an aging population with increasing levels of complex and chronic conditions. Changing demographics in Northern Ireland continue to drive the need to change service provision to meet this demand. More recently, Transforming Your Care has informed service transformation between Secondary and Primary Care, with greater provision of services in Primary Care. The HSCB/PHA will continue to develop the appropriate workforce requirement to meet existing demand and planned future service provision and appropriate skill mix, in partnership with Trusts and DOH.

Additionally, to extend the GMC requirements to hospital based training in Northern Ireland, £2.4m has been secured to provide hospital based trainers with the additional time in their job plans to adequately and safety supervise trainees that are placed in hospital training units. For postgraduate medical training in NI to be confirmed to be recognised by the GMC, it is essential that the GMC standards for recognising and approving trainers are met.

This increased level of weekly training provision will ensure that Northern Ireland delivers medical postgraduate training on a par with the rest of the United Kingdom.

The regional HSC Workforce Planning Framework (March 2015) provides a joined up approach in managing workforce challenges across Health and Social Care. The HSCB, PHA and Trust will continue to support this framework. Trusts will ensure ongoing assessment of current and future staffing requirements to ensure that services are safe and sustainable to continue to meet the needs of the population of Northern Ireland.

5.0 Regional Commissioning

There are a number of services which are commissioned at regional level. These include:

- Unscheduled Care
- Elective Care
- Maternity and Child Health
- Family & Childcare services
- Care of the Elderly
- Mental Health Services
- Learning Disability
- Physical Disability
- Family Practitioner Services
- Specialist services
- Cancer Services
- Long Term Condition
- Palliative and End of Life Care
- Prisoner health
- NI Ambulance Service

Commissioning priorities for 2016/17 for these areas are outlined below. Regional commissioning priorities complement the local commissioning priorities. To avoid duplication, priorities are reflected once in the Commissioning Plan, either locally or regionally.

5.1 Unscheduled Care Services

Service Context

The delivery of safe and effective unscheduled care remains a challenge for commissioners and providers. In September 2015 the DOH approved revised structures and governance arrangements to take forward implementation of the unscheduled care agenda with the establishment of new regional and local network arrangements. Improving performance as well as the patient experience remains a priority for the HSCB and it will continue to work with Trusts under the new regional unscheduled care arrangements, jointly led by the HSCB and PHA, to take this work forward during 2016/17.

Achievement of Ministerial Targets

Unscheduled Care (4 hour and 12 hour)

The HSCB and PHA will continue to work with Trusts and other partners under the new regional unscheduled care arrangements, to take forward implementation of the unscheduled care agenda during 2016/17. It is important to note that the reforms of unscheduled care, older people's services, long term conditions and ambulatory services are inextricably linked. All service improvement actions should recognise this interdependency. The primary objective of these reforms is to enable people to safely live more days independently at home.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the new regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to Unscheduled Care services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective, integrated arrangements – organised around the needs of individual patients – should be in place in community settings to provide care for people at home, avoiding the need for hospital	Trust responses should demonstrate how core primary and community care teams will be effectively resources and organised around the needs of individual patients.

	attendance/admission.	Trust responses should demonstrate how, working with appropriate partners, Acute Care at Home services and equivalent (offering demonstrably more specialist services than those that should routinely be delivered by core primary and community care teams) will be made available for patients throughout the Trust area, 24/7; and how these services will be integrated with other services delivered in the community, including linkages to core primary/community care teams and NIAS Alternative Pathways.
2.	Effective arrangements should be in place at the front door of hospitals to provide ambulatory, rapid-response services for patients on a same-day or next-day basis, avoiding the need for patients to be admitted to hospital.	Trust responses should demonstrate how, working with appropriate partners, comprehensive ambulatory care services will be made available for patients, initially at the larger hospital sites, on a seven-day basis and where appropriate linked to planned (elective) services.
3.	Effective arrangements should be in place to optimise patient flow through hospital, both before and after the patient being declared medically fit.	Trust responses should demonstrate the particular actions to be taken in 2016/17, working with appropriate partners, to further improve LOS through timely, multi-disciplinary decision making and effective discharge arrangements on a seven-day basis, to include participation in the Unscheduled Care Champion Wards pilot arrangements.
4.	Effective arrangements should be in place to manage ambulance demand across hospital sites, consistent with regional planning assumptions.	The NIAS response should demonstrate how the Trust will ensure effective arrangements for ensuring equitable demand across sites on a rolling, seven-day basis.
5.	Effective arrangement should be in place to manage major Trauma. Each year around 370 people in NI suffer from major trauma, this is often life threatening and requires a prompt and coordinated approach.	All Trusts should participate in the establishment of a regional Trauma Network which seeks to reduce mortality and morbidity due to major trauma through coordinated care pathways, clinical leadership and participation in TARN (Trauma Audit and Research Network)
6.	Effective arrangements should be in place to manage Winter Pressures demand across the Trusts.	Trust responses should demonstrate the actions to be taken in 2016/17, working with appropriate partners to ensure effective arrangements to manage unscheduled care pressures to include the preparation of seasonally-adjusted, evidence-based resilience plans.

In the context of available resources in 2016/17, it is not expected that workforce levels within Emergency Departments can be brought fully in line with expected levels to be prescribed within Delivering Care. More generally, in the context of available financial and staffing resources and the current configuration of acute services, there will be challenges in ensuring appropriate levels of medical and other staffing in EDs and on wards.

5.2 Elective Care

Service Context

Demand for Elective Care services continues to exceed current Trust capacity, resulting in increasing waiting times to access elective services across NI.

In recent years a programme of planned recurrent and non-recurrent investments had the effect of reducing Outpatient, Diagnostic, Inpatient and Day case waits, however waiting times across NI remain extremely challenging. The HSCB plans to further invest, where possible, in both core service and waiting list initiatives to manage demand. Long term service redesign and modernisation will be expected to continue across 2016/17 and future budget years to deliver improved patient journeys within and between primary and secondary care.

It is important to note that the planned Transformation, Reform and Modernisation agenda will take several years to deliver across all specialties. An example of such reform is the Heart Failure Pathway associated with initial investigation and diagnosis, will be rolled out across the region. The pathway implementation is supported by a range of measures (a regionally standardised cardiac rehabilitation programme, locality based one-stop-shops and better utilisation of the valuable resources of Heart Failure Nurses) designed to improve patient outcomes and experience, at the same time as seeking to manage the increasing demand for heart failure services.

Preparations are under way for a consultation on modernising HSC Pathology Services and, subject to approvals, the consultation should be undertaken this Autumn.

The HSCB has developed a long-term plan to deliver sustainable short waiting times for patients. This plan will require substantial additional annual resources and is with the Department for consideration.

Achievement of Ministerial Targets

Elective Care waiting times

Progress was made in the last quarter of 2015/2016 in securing reductions in the length of time people are waiting to be assessed and treated. However it is clear that it will take time and significant non recurrent and recurrent investment to bring waiting lists back to an acceptable level while simultaneously increasing capacity to meet demand for a first outpatient appointment, and for inpatient or daycase treatment.

The HSCB plans to further invest, subject to the availability of funding, in both core service and waiting list initiatives to manage demand. In addition, to minimise the increase in waiting times, the HSCB will continue to work with Trusts to maximise the delivery of funded capacity and ensure the application of good waiting list management.

Issues and Opportunities

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place in primary and community care settings to minimise the need for patients to be referred by GPs to hospital consultants for specialist assessment.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to support the development of new enhanced services in primary and community care settings in a range of specialities including: • General Surgery • Gastroenterology • ENT • Gynaecology • Dermatology • Rheumatology • MSK/Pain • T&O • Cardiology • Neurology • Urology • Ophthalmology

2.	Effective arrangements should be in place at the interface between primary and secondary care, organised around the needs of patients with effective communication between GPs and hospital consultants.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to include further roll out of e-referral and e-triage arrangements.
3.	Opportunities exist to improve further the efficiency and effectiveness of elective care services (outpatients, diagnostics and inpatients/daycase treatment) delivered by Trusts.	Trust responses should describe the specific actions being taken in 2016/17, working with appropriate partners, to improve elective care efficiency and effectiveness including: • Development of one stop 'see and treat' services, linked to unscheduled care services as appropriate • Application of Transforming Cancer Follow Up principles to transform review pathways • Maximisation of skill mix opportunities in the delivery of assessment, diagnostic and treatment services • Phased introduction of seven-day working for elective specialities • Plans to ensure maximum wait of 9 weeks for scopes by 31 March 2017. • Plans to address AHP staffing requirements in line with the recent AHP demand and capacity exercise. • More generally, actions to improve the efficiency and effectiveness of outpatients, diagnostics and treatment services.

Within Elective Care, the following are unable to be fully progressed at this time:

- Vascular Services Review
  Framework to improve the outcomes of Abdominal Aortic Aneurysm Surgery, with the aim of reducing the overall mortality rates.

- Pathology – Pre Referral Testing H-Pylori
  Investment in community based patient testing which evidences a reduction in unnecessary patient journeys into secondary care.

- Neurological Nursing – to include Huntingdon's
  Investment across neurology to enhance nursing capability and skill mix to meet demand. This includes sub specialisation including Huntingdon's disease.

More generally, substantial additional resources are required to reform waiting times for elective care services to acceptable levels.

5.3 Maternity and Child Health

Service Context

The Maternity Strategy 2012-2018 sets the context for the delivery of maternity services across NI, promoting improvements in care and outcomes for women and babies from pre conception through to the postnatal period.

The HSCB and PHA have commissioned a review of neonatal services. Now being finalised, it will be used to inform the future planning of safe, high quality, sustainable neonatal services for the population. The Department has consulted on a Paediatric Strategy and once issued it will inform the planning and delivery of paediatric services across 2016/17.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to maternity and child health services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that maternity services are arranged to meet the needs of all pregnant women. Effective arrangements should be in place to ensure that the agreed regional antenatal care pathway is delivered. Effective arrangements should be in place to ensure that women with more complex pregnancies are offered the best possible care in line with national evidence based guidelines.	Trust responses should demonstrate how they will implement the agreed care pathway for antenatal care for women with low risk pregnancies. They should evidence that they implement UNICEF Baby Friendly Initiative Standards. Trusts should also demonstrate how they will deliver services to meet the needs of more complex pregnancies. Plans should evidence; • How recent investment in ante-natal diabetic services is being used to improve care. • The implementation of the 'Weigh to a Healthy Pregnancy' programme targeting women with a BMI of >40. • How multiple pregnancies will be managed in line with NICE guidelines, including the delivery of dedicated 'twin clinics'.

		Trusts should continue to work with PHA/HSCB on the development and implementation of early pregnancy assessment and epilepsy care pathways both of which are based on NICE guidelines. Trusts should also work with PHA/HSCB to clarify and standardise the referral and clinical pathways for women who have recurrent miscarriages.
2.	Effective arrangements should be in place to ensure that required data is captured to monitor service activity, compliance with standards and to underpin quality improvement work.	Trust responses should demonstrate commitment to collecting data to evidence best practice and identify opportunities for further service improvement. Plans should include evidence of full utilisation of NIMATS and Badgernet.
3.	Effective arrangements should be in place to ensure that opportunities to offer early intervention and prevention of long term disability by enhanced therapy services in neonatal units are realised.	Trust responses should evidence how recent investment in AHP services for neonatal units is resulting in the integration of AHP services into neonatal services with a focus on neurodevelopment and nutritional support.
4.	Effective arrangements should be in place to ensure that paediatric services respond to patient need, are accessible and provided in a timely way. This should include arrangements for same day and next day assessment, short stay assessment and ambulatory models of care.	Trust responses should demonstrate how they: • Offer short stay assessment models of care with agreed access to for primary care professionals and opening hours agreed with HSCB and PHA to maximise their impact. • Continue to work with the HSCB/PHA to develop and test models of care which reduce the reliance on in-patient and secondary care paediatric services.
5.	Effective arrangements should be in place to ensure children and young people receive age appropriate care and that the regional upper age limit for paediatric services of 16th birthday is implemented.	Trust responses should demonstrate how their paediatric services operate a minimum upper age limit of 16th birthday. Trusts should also describe how they will ensure that children aged up to their 16th birthday, who are admitted to hospital, are cared for in an age appropriate environment by staff with paediatric expertise with input from paediatricians where necessary.

6.	Effective arrangements are in place to support multidisciplinary learning and service improvement through regular multidisciplinary morbidity and mortality review.	Trust responses should evidence how they are taking forward Departmental direction to implement a child death review pilot which is based on multidisciplinary mortality review.

Within Maternity & Child Health, the following are unable to be fully progressed at this time:

- Implementation of current draft DOH Paediatric and Palliative Paediatric Strategies:
  Will be used to inform the future development of services and additional funding will be required to meet all of the requirements in the Strategies.

- Improving pre-conceptual and pregnancy care of women with epilepsy:
  There are safety risks for women with epilepsy who become pregnant. National recommendations are that women with epilepsy should receive accurate pre-conception advice before pregnancy and that antenatal care is shared between an epilepsy specialist and obstetrician. A regional care pathway for women with epilepsy has been developed and funding is required to implement this.

- Implementation of Neonatal Review:
  The PHA/HSCB is finalising a review of neonatal care. The review is based on the principles of ensuring that babies who need neonatal support are cared for in the right setting by the right staff with the right skills and that mothers and babies are not separated unless there is a clinical need to do so through admission to a neonatal unit. Additional funding will be required to ensure optimum configuration of safe, high quality and sustainable neonatal services.

- Improving maternity services to meet the needs of vulnerable women:
  There is an increase in the numbers of migrant women giving birth in NI. A proposal for a specialist midwifery service for minority ethnic and migrant

women has been developed to meet the specific needs of this cohort of women.

- AHP support for children with statements of special education needs: A *service review has been completed and funding to ensure implementation is required.*

5.4 Family and Childcare Services

Service Context

The Child and Family Care Programme is a heavily legislated service which all aspects should be adhered to through the Delegation of Statutory Functions. Children are presenting with increasingly complex needs which continues to place demand on resources. An increased focus on societal awareness and responsibility for the wellbeing of children is required to ensure that all children have a positive experience of childhood. Where additional support for families is required, it should be made available at the earliest opportunity to help prevent future trauma as well as inputting positively to a child's emotional and mental well-being.

Achievement of Ministerial Targets

Children's services

In working to ensure, as far as possible, that children grow up in a stable environment, the HSCB will build on the work carried out with Trusts during 2015/16 in actively reviewing and promoting residential care structures.

The increasing demand for CAMHS remains a challenge and the HSCB will continue to work with Trusts to complete and implement the regionally agreed CAMHS Integrated Care Pathway and to reconfigure existing investment to establish a Managed Care Network for Children and Young People with Acute and High Intensity Care Needs to ensure a more standardised approach and streamlined access to services.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to family and childcare services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to appropriately manage the increasing number of children with complex health care needs and challenging behaviour.	Trusts responses should demonstrate how service provision will meet the needs of children with complex health care needs and challenging behaviour.
2.	Effective arrangements should be in place to appropriately manage the increasing number of Looked After Children (LAC) entering the system.	Trusts responses should demonstrate how: • criteria will be set to ensure children become looked after where there is a clear indication that their long term outcomes will be improved or removal is required in order to safeguard the child/young person; • initiatives will be put in place to increase the number of placements and specify how these will be provided; • support will be provided to young (16/17 year olds), homeless individuals who are seeking to achieve a safe, stable return to a family; • Specialist Therapeutic Foster Carer placements in keeping with the needs of children and in line with regional criteria will be provided which will be monitored as part of the DSF process; • appropriate safeguarding measures will be put in place for extra-ordinary placements; • intensive edge of care interventions and family support will be provided to enable children to remain within their families where this is in the child's best interest. • required volumes of service activity for 2016/17 will be delivered.
3.	Effective arrangements should be in place to meet the ever increasing demand for Autism Services to include the creation of an integrated care system for Children, Young People with Developmental, Emotional and Mental Health services.	Trusts responses should demonstrate plans to address autism waiting lists in line with Autism Access Standard and support the development of an integrated service model to include assessment, early intervention, diagnostic and transitional services.
4.	Effective arrangements should be in place to establish a Managed Care Network for Children and Young People with Acute and High Intensity Care Needs as recommended by the independent review into CAMHS Inpatient Services.	Trusts responses should demonstrate plans to establish a Managed Care Network for Acute CAMHS which includes Secure Care, Youth Justice and Forensic CAMHS to deliver a more consistent service across the region and equitable access to acute services.

5.	Effective arrangements should be in place to prevent the increasing threat of Child Sexual Exploitation (CSE) as identified by the Marshall Inquiry.	Trusts responses should outline their reporting arrangements to the HSCB in relation to the regional action plan.
6.	Effective arrangements should be in place to safeguard children and promote their welfare in line with Co-operating to Safeguard Children (2016).	Trusts responses should demonstrate plans to • provide effective safeguarding services • ensure robust HSC child protection processes are in place • ensure safeguarding policy and procedures are in place relating to referrals, assessment, service planning, case management and record keeping • monitor and audit effectiveness of policy, practice and service provision in achieving specified outcomes for children and young people. • to ensure access to an effective range of therapeutic supports based on assessed needs.
7.	Effective arrangements should be in place to appropriately manage the increasing number of unplanned/emergency placements where children are known to a Trust.	Trusts responses should demonstrate plans to ensure that admissions to care are planned and children are provided with placements matched to their assessed need to provide stability and continuity.
8.	Effective arrangements should be in place to appropriately manage the increasing demand for CAMHs and to improve the interface between acute and community CAMHs teams including working arrangements with secure care and the regional Youth Justice Centre.	Trusts responses should demonstrate how placements will be provided and ensure the implementation of the regionally agreed CAMHS Integrated Care Pathway by April 2017.
9.	Effective arrangements should be in place to ensure a seamless care pathway for LAC which promotes stability and permanency for children.	Trusts responses should demonstrate how the number of placement moves will be minimised as per the Placement Services – Strategic Direction Paper.
10.	Effective arrangements should be in place to ensure that children's care plans explicitly state what is to be achieved by the admission to care, what is expected from parents in order for the child to return home and the anticipated duration of the placement.	Trusts responses should demonstrate how robust assessments (in keeping with policy and procedures) will be undertaken for all children who are to return home, enabling the Trust to determine the feasibility of such a move and to identify any support required to maintain the placement and discharge any existing Care Order.

11.	Effective arrangements should be in place to improve data collection in CAMHS services to capture need, demand activity, outcomes and service user experience.	Trusts responses should demonstrate how they will use information to assess the effectiveness of CAMHS and evaluate outcomes, fully implement CAPA and ensure effective case management in line with NICE guidance. Trusts responses should demonstrate plans to strengthen NICE approved Psychological Therapies to include a skills analysis and workforce plan to identify gaps in the delivery of evidenced based therapies and skill mix requirements to deliver a range of therapeutic interventions. Trusts should demonstrate how the findings from the Sensemaker Audit on service user experience of CAMHS (expected October 2016), will drive any required service improvements.
12.	Effective arrangements should be in place to manage an increasing number of children who are looked after, those who are placed in kinship and non kinship foster carers, in keeping with the provisions and entitlements of GEM	Trust responses should demonstrate how recent investments will ensure equitable access by all young people in foster care to avail of GEM.

5.5 Care of the Elderly

Service Context

The most significant demographic change impacting on health and social care services is the increase in the number of people aged over 65, particularly those over 85. Whilst many have healthy and active lives older people place significant demands on acute and community services. Whilst there is a need to continue to promote healthier lifestyles, encourage independence and support carers, the challenges associated with managing the interface between acute and community services and sustaining a viable network of community based support services are priorities which need to be addressed. Additional funding has been made available through the Transformation fund to support the ongoing Dementia project during 2016/17.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to services for older people.

Specific issues and opportunities in 2016/17 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to optimise recent demography funding to meet domiciliary care demand and wider demographic demand.	Trust responses should demonstrate plans to deliver the recent demography in investment to meet the needs of the aging population.
2.	Effective arrangements should be in place to optimise capacity to meet the numbers of people aged over 65 and over 85 which are projected to increase by 12% and 22% by 2022 respectively.	Trust responses should demonstrate plans to actively promote a range of health ageing initiatives in areas such as promoting good nutrition, social inclusion and falls prevention.
3.	Effective arrangements should be in place to optimise capacity to meet the number of people with dementia which is projected to increase by 35% by 2025.	Trust responses should demonstrate plans to work within the regional strategic implementation arrangements to develop early intervention models and timely access to memory services.

4.	Effective arrangements should be in place to ensure the implementation of requirements contained in Adult Safeguarding and Protection in Partnership (2015).	Trust responses should demonstrate plans to promote the development of the Adult Protection Gateway model.
5.	Effective arrangements should be in place to address the issue of delayed discharges from the acute sector and other institutional settings due to the non-availability of independent sector community based services especially domiciliary care.	Trust responses should demonstrate plans to examine the potential for progressing the tendering of services based on a more outcomes based approach to domiciliary care provision.
6.	Effective arrangements should be in place to support services for carers that can be developed to maintain individuals to live as independently as possible in their own home.	Trust responses should demonstrate plans to expand and promote the availability of short breaks.
7.	Effective arrangements should be in place to ensure the promotion of personalisation through Self Directed Support to increase individual choice and facilitate responsive remodelling of service models.	Trust responses should demonstrate plans to actively engage with the regional project implementation arrangements to optimise opportunities for services tailored to user needs and include the training and development needs of staff.
8.	Effective arrangements should be in place to review existing day opportunities for older people to ensure that they meet current needs and expectations.	Trust responses should demonstrate plans to review existing day care provision to make best use of resources.
9.	Effective arrangements should be in place to further develop ICP initiatives targeted at frail older people.	Trust responses should demonstrate plans that engage with the range of integrated care initiatives/projects designed to maintain older people in the community.
10.	Effective arrangements should be in place to support the full implementation of the regional model of reablement.	Trust responses should demonstrate a review of local progress with reablement, in line with the regional model and targets.
11.	Effective arrangements should be in place to support an appropriate balance of services between the statutory and independent sectors in relation to domiciliary and residential care.	Trusts should remain engaged with the current reform of statutory residential care and review the most appropriate balance and focus of statutory/independent sector domiciliary care provision.

12.	Effective arrangements should be in place to support the development of intermediate/step down care to relieve pressures on acute care and promote rehabilitation.	Trust responses should demonstrate review options for remodelling existing provision or negotiating options with the independent sector to increase availability of these services.
13.	Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with Dementia.	Trust responses should outline plans to work with ICPs to implement the New Stepped Care Model for Older People and for people with Dementia.

Within Care of the Elderly services, the full implementation of the Domiciliary Care Review cannot be progressed at scale and pace in light of available resources.

5.6 Mental Health

Service Context

The development and delivery of mental health services is governed through the implementation of the Regional Mental Health Care Pathway and the Mental Health Service Framework. The development and delivery of mental health care has been organised around a Stepped Care framework. The framework supports the integration of systems and practices across primary, secondary and specialist mental health care services. This model aims to promote a culture of earlier intervention, facilitates co-production and enables the development of outcome, recovery orientated approaches across all mental health care services. Other areas impacting on future service provision include the outcome of the Bamford evaluation (Autumn 2016).

Achievement of Ministerial Targets

Mental health services

The HSCB has previously identified the funding gap between need and provision in respect of mental health services and the level of funding available to invest in psychological therapies is likely to result in significant numbers continuing to wait longer than 13 weeks, particularly in adult heath psychology services. The HSCB will continue to work with Trusts to identify opportunities address this position, including plans to strengthen the range and scope of psychological therapies, arrangements for ensuring safe and effective case management and the promotion of Primary Care Talking Therapy Hubs to help manage demand in to Community Mental Health services in the longer term.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to mental health services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to manage the increased demand for psychological therapies.	Trust responses should demonstrate the particular actions to be taken in 2016/17 to further develop and implement Primary Care Talking Therapy Hubs in partnership with ICP leads.
2.	Effective arrangements should be in place to enhance clinical and personal outcomes by improving access to evidence based NICE approved psychological therapies including increasing the range and scope of Talking Therapies in primary care.	Trust responses should demonstrate how the range and scope of psychological therapies will be strengthened, including arrangements to ensure safe and effective case management.
3.	Effective arrangements should be in place to ensure that people with mental health needs and their families receive the right services, at the right time by the right combination of professionals.	Trust responses should demonstrate what specific measures will be taken in 2016/17 to further embed the Regional Mental Health Care Pathway and to strengthen the provision of psychological care within the role and function of Community Mental Health Services.
4.	Effective arrangements should be in place to improve the effectiveness of Crisis and Acute mental health interventions through the integration of Crisis Resolution, Home Treatment and Acute Inpatient Services and through the provision of modern therapeutically focused inpatient care to safeguard those people who are experiencing acute mental health needs	Trust responses should demonstrate plans to align and integrate their respective Crisis Home Treatment and Acute Inpatient Service into a single care service consistent with the development of a new regional High Intensity Care Pathway. Furthermore, Trust responses should outline plans to strengthen Acute Hospital Liaison Services in line with the principles of the RAID model.
5.	Effective arrangements should be in place to support the new Regional Mental Health Trauma Network arrangements to enhance services and integrate all existing mental health trauma care into a new single managed care network.	Trust responses should demonstrate plans to support and participate in the development and implementation of the Network in line with NICE guidance and to nominate two staff to undertake advanced Trauma Care training to facilitate the development of a dedicated psychological trauma clinical team.
6.	Effective arrangements should be in place to strengthen approaches to support people on their recovery journey in line with the principles and objectives of the Regional ImROC Programme.	Trust responses should demonstrate how, building on the findings of the Sense Maker Audit, co-production across their mental health services will be strengthened, including the appointment of Lived Experience Consultant, Peer Support Workers and Peer Educators and Peer Advocates. Trust responses should also provide details of the next phase of recovery

		college development and demonstrate the actions to be taken to promote the role and influence of carers across mental health services.
7.	Effective arrangements should be in place to develop condition / service specific care pathways in order to safeguard the physical wellbeing of people with mental health needs.	Trust responses should demonstrate how the recommendation of the RQIA Review into Eating Disorders will be implemented.
8.	Effective arrangements should be in place to ensure full implementation of the Choice and Partnership Framework in order to ensure the effective delivery of mental health and psychological care to patients.	Trust responses should demonstrate that the Choice and Partnership Framework has been fully implemented across all mental health services. Trust responses should also demonstrate that a full demand and capacity analysis has been completed in line with regional guidance and that each community mental health professional has an agreed job plan.
9.	Effective arrangements should be in place to ensure that the workforce delivering mental health care is appropriately skilled.	Trust responses should demonstrate the actions to be taken to implement the Mental Health Learning Together Framework. Details of Trusts' mental health workforce plans should also be provided.
10.	Effective arrangements should be in place to provide evidence of the impact of all mental health services.	Trust responses should demonstrate what measures are in place to ensure that an annual comprehensive analysis will be provided in line with the indicators set out in the new Mental Health Services Framework and that this will include an overview of presenting need, the volume of interventions provided, the outcomes achieved and the quality of people's experience of using the services.

Within Mental Health services, it is not possible to fully progress the implementation of the Alcohol/Substance Misuse Service within available resources. Phase 2 implementation would include the expansion of the alcohol/substance misuse service to encompass the wider range of admission wards, including enhanced ED cover.

5.7 Learning Disability

Service Context

The number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in NI. A lifelong service response is required to support people to live as healthy, fulfilling and independent lives as possible. Crucial to this is support for families and other carers who in NI continue to provide the bulk of care and support which people need.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to learning disability services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to increase the number of individuals availing of community based Day Opportunities.	Trust responses should demonstrate what specific actions will be taken in 2016/17 to further develop partnership working with community / voluntary / independent sector organisations to meet the needs of individuals already in services or coming through transition.
2.	Effective arrangements should be in place to manage the increased demand on Day Centres for those individuals with complex physical and health care needs or behavior support needs.	Trust responses should demonstrate what measures are in place to ensure facilities are appropriately designed and meet the needs of individuals with complex needs.
3.	Effective arrangements should be in place To appropriately manage people with LD developing dementia and other conditions associated with old age including short breaks/respite which are varied and flexible in nature.	Trust responses should demonstrate how short breaks/respite will be extended outside of the traditional model in order to meet the needs of families/carers including Dementia Memory Services and other appropriate services.

4.	Effective arrangements should be in place to complete the resettlement of people from learning disability hospitals to appropriate places in the community.	Trust responses should demonstrate what processes are in place to complete the person centred resettlement of individuals from learning disability hospitals into the community, with appropriate long term support, in line with recent investments.
5.	Effective arrangements should be in place to manage the demand from individuals living with carers, specifically older carers, for future housing and support needs.	Trust responses should demonstrate what plans are in place to address future housing and support needs of those in the community through community integration.
6.	Effective arrangements should be in place for discharge once the patient has been declared medically fit for discharge.	Trust responses should outline clear protocols, processes and procedures to ensure timely discharge from hospital with appropriate support, where required.
7.	Effective arrangements should be in place to manage the increased demand for specialist services to respond to specific additional needs such as forensic services, behaviour support services etc.	Trust responses should demonstrate that specialist services are in place to meet the increased demand from individuals with complex needs in the community.
8.	Effective arrangements should be in place to further enhance the current Learning Disability Service Framework including arrangements to provide an appropriate range and type of day opportunities for people with a learning disability transitioning from school.	Trusts should demonstrate plans to ensure that standards outlined within the LDSF Framework including the extension of the Transitions Planning Scheme.

5.8 Physical Disability and Sensory Impairment

Service Context

Recent developments for people with a disability have been shaped by the implementation of the regional Physical and Sensory Disability Strategy (2012-15). This work has been led by the HSCB in conjunction with statutory and voluntary sector partners. Limited funding has been made available to support this process but the expectations of service users and their carers remain high as the current phase of implementation is reviewed. The principles of independence and autonomy have underpinned all of the work to date and will shape any future decision making.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to physical disability and sensory impairment Services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to further develop services for the increasing number of people who are deaf-blind as a result of an ageing population.	Trust responses should demonstrate how existing services will be developed, awareness of the condition will be improved and appropriate staff training provided.
2.	Effective arrangements should be in place to manage the increased number of high cost packages due to increased life expectancy and an increased focus on supporting people at home.	Trust responses should demonstrate how domiciliary, equipment and staffing budgets will be targeted to provide appropriate service responses for individuals with increased support needs.
3.	Effective arrangements should be in place to ensure individuals are transitioned from childrens to adult services in a timely manner.	Trust responses should outline clear protocols, processes and procedures to facilitate transition planning which includes inter programme coordination.

4.	Effective arrangements should be in place to further enhance the current PDSI Strategy arrangements.	Trusts should demonstrate plans to support, participate and lead in maintaining coordinated strategic planning arrangements outlined within the PDSI Strategy.
5.	Effective arrangements should be in place to ensure there are appropriate accommodation options for people with severe disabilities in the community.	Trust responses should demonstrate how it will work within the existing Supporting People arrangements to examine the potential for further accommodation options.
6.	Effective arrangements should be in place to ensure service information and advice is accessible to all service users and that Trusts have a skilled and informed workforce.	Trust responses should demonstrate plans to ensure that all health and social care staff have access to disability, equality and human rights training and are trained to communicate appropriately with people who are blind or partially sighted.
7.	Effective arrangements should be in place to ensure that people with a disability receive a personalised package of care.	Trust responses should outline plans to change the pattern of service allocation including the promotion of Self Directed Support.
8.	Effective arrangements should be in place to ensure the appropriate provision of Day Opportunities.	Trust responses should demonstrate how it will partner with the Community and Voluntary Sector to develop alternatives to existing service provision.
9.	Effective arrangements should be in place to ensure that wheelchairs and equipment, and the maintenance and repair of the same continue to made available in line with demand.	Trust responses should consider the introduction of an access and eligibility criteria in order to ensure equitable allocation of equipment.
10.	Effective arrangements should be in place to ensure that people with Neurological conditions are supported to live as independently as possible.	Trusts should demonstrate plans to review the needs of people with neurological conditions, particularly those with life limiting circumstances, ensuring equitable access to support.
11.	Effective arrangements should be in place to ensure to provide appropriate communication support for people who are deaf.	Trusts should demonstrate plans to use transformation funds to provide appropriate services and support.

5.9 Family Practitioner Services

Family practitioner Services comprise the following key areas:

- General Medical Practitioners Services
- General Ophthalmic Services
- General Dental Services
- Community pharmacy provision
- Primary Care Infrastructure Development

Primary care and adult community services play a critical role in terms of supporting people to stay well, for as long as possible in the community and avoiding unnecessary hospital attendance and admissions. The development of these services in line with the transformation agenda is key to reducing pressure on scarce resource within secondary care.

5.9.1 General Medical Practitioner Services

Service Context

General Medical Practitioners (GPs) play a key role in ensuring that health service provision in NI is effective and efficient. GPs provide:

- The main point of entry to the health care system
- Person focused, on-going care covering whole episodes of ill health
- Delivery of the majority of care for all but the most uncommon conditions
- Coordination of care provided by others

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to General Medical Practitioner Services.

Specific priorities for 2016/17 are as follows:

REGIONAL PRIORITY		GMS REQUIREMENT
1.	Effective integrated arrangements should be in place to; • Support patients with Long Term Conditions, • Manage Elective Care services and • Deliver Out of Hours pathways	As part of the HSCB's wider reform priorities, GMS will: • promote enhanced services for the management of patients with chronic conditions • develop common pathways across unscheduled care • evidence integrated working across GP Federations to provide innovative alternatives to hospital based elective services.
2.	Effective arrangements should be in place to improve access to GP services, both in and out of hours.	FPS will develop pathways to improve access for unscheduled services at the interface between in hours and out of hours GP services and include options to develop a baseline of GP appointments across NI to support practices in managing demand.
3.	Effective arrangements should be in place to optimise recruitment and retention challenges and ensure safe and accessible GP services.	FPS will develop plans to: • Support 20 additional GP training places • Implement and monitor the impact of the revised GP Retainer Scheme • Improve current working arrangements to attract more OOH GPs and implement skill mix, including both in hours and out of hours services
4.	Effective arrangements should be in place to develop Practice Based Pharmacists within GMS to help improve capacity for GPs.	FPS will develop plans to release GP time spent on prescribing to increase overall GP capacity and assist collaborative working through GP Federations. This will further improve quality and safety of prescribing whilst achieving prescribing efficiency and cost effectiveness

5.9.2 General Ophthalmic Services (GOS)

Service Context

Ophthalmology accounts for around 10% of all outpatient demand and first outpatient demand of 36,976 appointments in 15/16. "Developing Eyecare Partnerships; improving the commissioning and provision of eyecare in NI" (DEP) (DHSSPSNI, 2012) is a five year strategy aimed at taking a partnership, clinical networks and pathway approach to transforming how and where services are to be provided, enhancing skills mix and improving interfaces, and treating people closer to home where safe and appropriate.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to General Ophthalmic Services.

Specific issues and opportunities in 2016/17 are as follows:

REGIONAL PRIORITY		GOS REQUIREMENT
1.	Effective integrated demand management arrangements should be in place to address the increasing levels of age related long term conditions such as glaucoma, macular degeneration, Diabetes mellitus and complications such as sight threatening retinopathy.	FPS will develop plans to: • Meet the needs of this demographic increase in dealing with increasing attendances for long term review patients • Manage diabetic retinopathy screening and surveillance clinics to deliver timely access • Evidence full utilisation of skill mix opportunities • Promote robust data quality and participate in the development of regional performance indicators
2.	Effective arrangements should be in place to support improvement science and quality improvement initiatives that have the potential to improve patient flows, experience and outcomes.	FPS will advance plans to improve the examination, application and implementation of Improvement Science in healthcare to the following areas of Ophthalmology; • Eye Casualty • Cataract Pathway Plans will also indicate a method of capturing and reporting patient centred outcome and experience measures.

3.	Effective arrangements should be in place to ensure the transformation of eyecare services. Demand-management initiatives (Local Enhanced Services) such as glaucoma referral refinement, minor eye conditions, and primary care based post-operative cataract assessment schemes have the potential to positively impact on treating more people closer to home, away from secondary care.	FPS will ensure the provision of placements for primary care optometrists undertaking independent prescribing training. (DEP Objective10) HSCB will engage with GOS providers in the development of training to support this transformative care and facilitate participation in innovative governance and training models such as Project ECHO, building knowledge networks to expand capacity and capability in primary care and improve the interface between primary and secondary care.

5.9.3 Dental Services

Service Context

There are 1,100 General Dental Practitioners (GDPs) in NI working across 380 practices. Approximately 1.1m people are registered with a GDP for Health Service care and each year under the General Dental Services (GDS) over 1.7m courses of treatment are provided. In the past, the NI population had poor oral health, however, in recent years significant improvements have been observed in both children's and adult's dental health.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to Dental Services.

Specific issues and opportunities in 2016/17 are as follows:

REGIONAL PRIORITY		GDS REQUIREMENT
1.	Effective arrangements should be in place to understand the distribution of oral disease in the NI population. This includes dental decay prevalence and severity in hard to reach groups such as the elderly/infirm and very young children.	HSCB and PHA will develop plans to reconfigure local salaried dental services to support dental service capacity requirements.
2.	Effective arrangements should identify the number of patients being referred from	A regional three-part plan will be established to

	primary care to Trust Oral Surgery/OMFS departments, which significantly exceeds capacity in most Trusts.	enable : • Transfer 80 patients per month from SET OMFS department to BHSCT Oral Surgery department where there is more capacity • Provide training to GDPs in basic Oral Surgery treatments to reduce referrals from dental practices to Trusts • Establish a pilot PDS in Oral Surgery to increase the amount of treatment provided by High Street Oral Surgery Specialists and therefore reduce Trust referrals
3.	Effective arrangements should be in place that evidences a new GDS contract, that focuses on prevention, provides a sustainable business model for GDPs and allows cost control	FPS will review the 11 pilot practices that have completed the 1 year pilot period and engaged in the evaluation process. University of Manchester to produce evaluation report by 31 March 2017
4.	Effective arrangements should be in place to improve the 8 week turnaround times for GDS	FPS will develop a new prior approval process will be piloted in 2016/17 with the aim of reducing turnaround time and the current resources required to deliver the service.

Within Dental services, the following are unable to be fully progressed at this time:

- Pilot PDS for Primary Care Oral Surgery:
  An innovative form of dental contract for high street oral surgeons that increases the amount of work that they provide for HSC. The pilot evidences a reduction in referrals from GDPs to Trust oral surgery services and Trust oral surgery waiting times

- Regional Consultant Special Care Dentistry (SCD) service:
  All Trusts have specialist care dentistry teams offering specialist dental care to patients with complex medical co-morbidities. A small number of cases are so complex that they need to be managed in a regional service which is suitably staffed and equipped to manage the most challenging patients.

5.9.4 Pharmaceutical Services and Medicines Management

Service Context

Medicines are the most frequently used intervention in healthcare with over 40 million prescriptions issued each year in primary care and several million more prescriptions in secondary care. Pharmaceutical services are commissioned from a range of providers in primary and secondary care and with the volume and complexity of medicines being used, there is a requirement for on-going medicines management and optimisation. Indeed the DOH has set out a range of quality standards associated with its Medicines Optimisation Quality Framework and it is expected that services will be commissioned to take this forward in 2016/17.

In primary care, demand for GPs impacts on their ability to manage prescribing processes. There are increasing expectations around community pharmacy provision in line with DOH policy while at the same time there has been an on-going financial dispute that will require resolution in 2016/17. There is recognition of the need to develop pharmaceutical care models within both primary and secondary in order to maximise the quality and safety of service provision while at the same time deliver substantial efficiencies. In 2016/17, the Commissioning Direction has identified £20m to be delivered in primary care with further efficiencies of £10m required in secondary care.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to Pharmaceutical Services and Medicines Management Services.

Specific issues and opportunities in 2016/17 are as follows:

REGIONAL PRIORITY		PSMMS REQUIREMENT
1.	Effective arrangements should be in place to Commission Practice based Pharmacists services within General Medical Services to	The Pharmaceutical Services and Medicines Management Services Team will develop plans to re-orientate existing service provision, to

	improve capacity within GMS to meet additional demand and improve the safety and effectiveness of service	support the development of Practice Based Pharmacists.
2.	Effective plans should be in place to develop a service model for Medicines Optimisation for Older people and for Home Treatment Mental Health Services	The Pharmaceutical Services and Medicines Management Services Team will develop plans to ensure they will recruit additional pharmacy capacity in line with agreed spending.
3.	Effective plans should be in place to deliver £20m efficiencies in primary care through the Pharmaceutical Clinical Effectiveness programme (requiring support from secondary care) and deliver further additional efficiencies of £10m in secondary care	The Pharmaceutical Services and Medicines Management Services Team will develop plans to deliver the £20m target for primary care and further efficiencies of £10m to be delivered in secondary care.

5.9.4.1 Primary Care Infrastructure Development

Service Context

In 2011/12, the then Minister indicated that he wished to invest in the development of the primary and community care infrastructure as part of the strategy for improving the overall health and well-being of the community and for improving the delivery of integrated primary, community and secondary care services.

In 2014/15 a Strategic Implementation Plan was developed based on the hub and spoke model which sets out the regional plan for investment in primary care infrastructure. It includes an outline of the prioritised hub projects within the programme and proposed funding plan.

Each hub will be a 'one stop shop' for a wide range of services including GP and Trust led primary care services. This model will improve access to, and responsiveness of, primary and community care services, particularly making available more specialised services nearer to where people live and work. This includes provision of an enhanced diagnostic and treatment capability where appropriate.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to Primary Care Infrastructure Development.

Specific issues and opportunities in 2016/17 are as follows:

REGIONAL PRIORITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to improve the quality of primary care facilities to meet all statutory standards	For Trust owned facilities, responses should demonstrate that facilities meet the minimum standards and provide adequate accommodation for services to be provided

5.10 Specialist Services

Service Context

Specialist acute hospital services include tertiary or quaternary level services delivered through a single provider in NI or designated centres in Great Britain/ROI. High cost specialist drugs are supported through this branch of commissioning. A process is underway to revise the process for consideration Individual Funding Requests (IFRs). The implications of any changes to the current arrangements will need to be taken account of by the HSCB.

Specialist Acute Hospital services have and will continue to develop strong clinical alliances with specialist peers in GB, ROI and with local clinicians across the region making best use of available information and communication technologies to facilitate delivery of care.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to specialist services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to address the growth in the number of patients accessing approved specialist drug therapies for a range of conditions. Each year there is growth in the number of patients receiving specialist drug therapies previously approved by NICE.	Trusts responses should demonstrate how they will engage with the HSCB to inform the projected requirements associated with the increase in the number of patients on existing treatment regimes across a range of conditions including rheumatoid arthritis, psoriasis, IBD, Hep-C, MS, HIV, specialist ophthalmology and cancer conditions.
2.	Effective arrangements should be in place to develop the model for specialist neuromuscular services.	Belfast Trust response should demonstrate the agreed service model /pathways for adults and children (including transitional care) with specialist neuromuscular conditions incorporating baseline resources as well as more recent investment. The proposed model and implementation plan to be submitted by end of June 2016.

3.	Effective arrangements should be in place to continue to support the implementation of the NI Rare Disease Implementation Plan through a programme of in-reach and networked services through formal alliances with tertiary and quaternary providers outside NI.	Belfast Trust response should demonstrate an implementation plan, by 30 September 2016, to deliver the NI Rare Disease Implementation Plan.
4.	Effective arrangements should be in place to ensure access to genetic tests in line with UKGTN recommendations.	Belfast Trust should submit an IPT by 30 September 2016 to ensure timely access to UKGTN tests approved for 2016/17 net of baseline costs.
5.	Effective arrangements should be in place to ensure access to new NICE TAs and other NICE recommended therapies approved during 2016/17.	Trust responses should demonstrate how they will deliver on the requirements of new NICE TAs in line with recent investment.
6.	Effective arrangements should be in place for the provision of Paediatric Congenital Cardiac Services in line with Ministerial decision on the establishment of an All-Island Network including: • SLAs, with specialist centres to provide a safe and robust service for children from NI during the implementation period for patients with paediatric cardiac conditions. • Improved antenatal detection rates of structural cardiac anomalies by issuing a standardising regional protocol for the cardiac scan and putting in place a training and audit programme for staff in this area.	Belfast Trust should demonstrate how they will work with the HSCB to develop an IPT related to the elements of the Full Business Case for an All-Island Congenital Heart Disease Service specific to local developments in NI e.g. Paediatrician with Specialist Interest in Cardiology role, additional specialist nursing liaison support etc. Timelines for submission will be consistent with the requirements of the Departmentally Chaired, NI CHD Implementation Group. Trusts should ensure implementation of the regional scanning protocol, participate in the training and audit programme.
7.	Effective arrangements should be in place to ensure the opening of the Phase 2B Critical Care Unit to accommodate the transfer of ICU/HDU capacity with service to be fully operational in 2017.	Belfast Trust response should (with input from the NI Critical Care Network) demonstrate that it will finalise the IPT for this development and submit a detailed project plan for staff recruitment/training by end of August 2016, with a view to opening in 2017.
8.	Effective arrangements should be in place to ensure the development of weekend access to neuroradiology intervention for patients with subarachnoid haemorrhage, arising as a result of recommendations from the NCEPOD report 'Managing the Flow'.	Belfast Trust response should demonstrate that it will submit an IPT to achieve the NCEPOD recommendations with a project plan for establishment of the weekend access. Services expected to be in place by September 2016.

9.	Effective arrangements should be in place to ensure the further expansion of the NISTAR (NI Specialist Transport and Retrieval Service) for neonates, children and adults across NI and ROI. The service will ensure critical and supported clinical transports undertaken are managed consistently and to best effect. NISTAR will also work closely with the fixed wing Air Ambulance / Air Transfer provider.	Belfast Trust working with the NI Critical Care Network and the regionally established NISTAR group should bring forward proposals to identify phases of development for this service. This will include consultation with DGH and NIAS colleagues. The Belfast Trust should submit a final IPT by end of September 2016 with a view to services expanding on a phased basis from 1 December 2016.
10.	Effective arrangements should be in place to improve access to specialist immunology services for adults and children through establishment of a tertiary referral arrangement.	Belfast Trust should submit proposals incorporating the operational arrangements to move this service to a tertiary referral service for adults and children and effect this change by 1 November 2016.
11.	Effective arrangements should be in place to improve access to specialist paediatric services through the establishment of regional networks.	Belfast Trust should submit by 31 July 2016, an IPT and associated action plan to provide centralised waiting lists and outreach services in respect of paed orthopaedics, paed gastroenterology, paediatric cardiology and paed surgery.
12.	Effective arrangements should be in place to ensure the introduction of cranial stereotactic radiotherapy in NI to reduce the need to send some patients for treatment in GB and provide more accessible service and plans to expand stereotactic ablative radiotherapy (SABR) to include the treatment of oligometastatic and oligo-progressive advanced cancer disease.	Belfast Cancer Centre should deliver a cranial stereotactic service to treat 50 patients with Cerebral Metastases in 2016/17 increasing to 65 patients in 2017/18. Belfast Trust will bring forward plans to extend SABR in the treatment of oligometastatic and oligo-progressive advanced cancer disease.
13.	Effective arrangements should be in place to optimise drug efficiency savings.	Trust responses should demonstrate a co-ordinated approach to bringing forward proposals to maximise drug efficiency savings in line with key principles shared with Trusts during 2015/16.
14.	Effective arrangements should be in place to optimise the use of specialist capacity through development of protocols to support timely discharge of patients in specialist acute beds.	Trust responses should demonstrate a schedule of specialist acute areas, with timelines, for review by 1 October 2016. Protocols will follow and will be available on a phased basis from 1 December 2016.
15.	Effective arrangements should be in place to appropriately manage the service demands associated with an increasing number of patients requiring specialist services.	The Trust response should demonstrate how the Trust will deliver the required volumes of service activity in light of the changing population need and demand for specialist services in 2016/17.

Within Specialist services, the following are unable to be fully progressed at this time:

- Specialist drugs and infrastructure to deliver new drug regimes including NICE and HSTAs. Subject to policy clarification, there are also issues in relation to the funding of emerging NICE guidance in respect of previous CDF therapies.

- The provision of new technology and therapies within neurosurgery and neuro-radiology including Deep Brain Stimulation and to ensure availability and resilience of small highly specialist services.

5.11 Cancer Services

Service Context

In NI around 24 people are diagnosed with cancer each day, around 9,000 per year. With the increasing age of the population, this number is expected to rise by 25% for men and by 24% for women by 2020. Current estimates suggest that there are around 69,000 people living with cancer in NI today. With more new diagnoses and improvements in care and survival, this figure is increasing every year. As the population grows, ensuring they have the right care and support across their care pathway is becoming increasingly important.

Achievement of Ministerial Targets

The main challenges relate to the 14 day breast performance and 62 day waiting times in urology, skin, upper GI and lower GI cancer pathways. The HSCB and PHA will continue to work with Trusts through the specialty-specific regional groups that have been established to develop innovative long term solutions to the ongoing workforce and capacity issues in these services. Pending the implementation of longer term solutions, the HSCB will continue to meet with all Trusts on a monthly basis via the cancer service improvement and AD forum to share best practice across the region and identify opportunities for delivering improved performance.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to cancer services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to deliver cancer access times.	Trust responses should demonstrate plans to deliver all cancer access standards across all relevant services.
2.	Effective arrangements should be in place to provide enhanced access to radiotherapy services for patients through	Trust responses should demonstrate that plans are in place to ensure that the new radiotherapy service in Altnagelvin will be operational by

	the delivery of a new radiotherapy centre at Altnagelvin.	November 2016 to provide high quality, sustainable services consistent with national standards.
3.	Effective arrangements should be in place to deliver the recently introduced Acute Oncology Service across NI in line with the agreed service model and to consider further development of the service to provide a more sustainable acute care service for patients across all Trusts.	Trust responses should demonstrate how acute oncology services will be provided in line with the agreed service model. Trust responses should also indicate how the acute oncology service will be developed to meet patient needs.
4.	Effective arrangements should be in place to improve the patient experience of cancer care services.	Trust responses should demonstrate how the key findings from the recent Cancer Patient Experience Survey will be addressed, in particular, the specific actions to be taken to: work more closely with primary care to improve early detection; improve access to patient information across the pathway; improve access to clinical nurse specialists; and, increase recruitment to clinical trials.
5.	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce in NI in line with national benchmarks, using a five-year phased approach.	Trust responses should demonstrate the particular actions to be taken in 2016/17 to expand the CNS workforce and, in doing so, how this will increase opportunities to modernise cancer care pathways and improve the patient experience of care.
6.	Effective arrangements should be in place to implement a regional Teenagers and Young Adults (TYA) Cancer Service in NI.	Trust responses should demonstrate what measures will be put in place to offer age appropriate care to TYA patients with cancer consistent with the regional service model.
7.	Effective arrangements should be in place to address any issues arising from the peer review of cancer multidisciplinary teams to ensure the quality of cancer services can be sustained or, as needed, improved.	Trust responses should demonstrate that arrangements will be in place to take action to address matters highlighted by the peer review team, and that priority will be given to immediate and serious risks where these have been identified.
8.	Effective arrangements should be in place to ensure timely access to chemotherapy.	Trust responses should demonstrate how chemotherapy services will be modernised in order to maximise current capacity and improve patient experience, with a particular focus on expanding non-medical prescribing.
9.	Effective arrangements should be in place to continue delivery of the Cancer Awareness Campaign in order to encourage people to seek medical advice at the earliest opportunity.	Trust responses should demonstrate plans to expand capacity to respond to potential increases in primary care referrals for patients with signs and symptoms suggestive of cancer.

5.12 Managing Long Term Conditions

5.12.1Stroke

Service Context

In NI around 1,000 people die each year and between 2,600 and 2,800 people are admitted to hospital every year with a diagnosis of stroke. There is a significant long term care cost associated with stroke.

Approximately a quarter of all nursing home residents have had a stroke, and around 300 stroke patients are newly admitted to residential care each year in NI. Current community stroke services treat around 2,000 new stroke patients every year. There are many opportunities to reduce the burden of stroke through the provision of better preventative, acute and community care. National audits and the 2014 RQIA report into stroke services have made several recommendations for improving stroke care in NI many of which are included in this commissioning plan. It will also be the intention of the HSCB to consult on a regional modernisation plan for stroke services in 2016/2017.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to stroke services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to provide appropriate stroke services for younger people as 20% of all stroke occurs in people aged under 65	Trust responses should demonstrate plans to improve stroke services for younger stroke patients in line with the recommendations of the RQIA inspection report (2014) to include vocational rehabilitation
2.	Effective arrangements should be in place to ensure that all stroke patients are admitted directly to a stroke unit in line with NICE guidance	Trust responses should outline plans to review their operational protocols for admission and develop processes that ensure that more than 90% of acute stroke patients are admitted to a

		stroke unit as the ward of first admission.
3.	Effective arrangements should be in place to provide appropriate specialist spasticity services for stroke survivors.	Trust responses should outline plans to work with the regional stroke network to develop a regional pathway for the management of spasticity after stroke.
4.	Effective arrangements should be in place to provide thrombolysis with alteplase as a possible treatment of acute ischaemic stroke.	Trust responses should demonstrate initiatives to ensure at least 15% of acute ischemic stroke patients, attending each of its hospitals, receive thrombolysis and that patients who receive thrombolysis do so within 60 minutes of arrival.
5.	Effective arrangements should be in place to provide mechanical thrombectomy for large vessel stroke as an effective intervention for selected stroke patients	The Belfast Trust response should demonstrate plans for the continued development of regional stroke mechanical thrombectomy services as per the NICE guidance.
6.	Effective arrangements should be in place to provide weekend outpatient assessment for TIA patients with high risk TIA patients assessed within 24 hours of an event and commence appropriate treatments to prevent stroke.	Trust responses should demonstrate plans to provide ambulatory services for suspected high risk TIA patients seven days a week, in line with NICE guidance.
7.	Effective arrangements should be in place to facilitate, where appropriate, early supported discharge (ESD) of acute stroke patients from hospital.	Trust responses should detail how ESD services for stroke patients will be made available over seven days a week, able to respond within 24 hours of discharge, and provide required levels of therapy in line with transformation fund or demography investments.

Within Stroke Services, the extension of the interventional radiology service to provide a 24/7 thrombectomy service and the development of a regional post stroke spasticity service cannot be fully progressed at this time.

5.12.2Diabetes Care

Service Context

There are 85,000 adults (aged 17+) in NI living with Type 1 and Type 2 diabetes at the end of March 2015. This represents a 65% increase in prevalence of

diabetes in N Ireland since 2004/05. Type 2 diabetes accounts for 90% of all cases of diabetes in adults and the increase in cases can be explained by rising levels of obesity and an ageing population.

There are 1,092 children and young people Type 1 diabetes attending paediatric clinics. 5.2% of all pregnancies are complicated by diabetes, a 12-fold increase in numbers since 2001. This increase in diabetic pregnancies can be explained by rising levels of obesity, changes to diagnostic thresholds for diagnoses of gestational diabetes (GDM) and older women having babies. This rapid increase in numbers of women with diabetes in pregnancy, particularly GDM, requires consideration of new models of care delivery.

Additional funding has been made available through the Transformation fund to support a number of priorities during 2016/17. There has been regional agreement to develop a network to focus on the planning, provision and improvement of services and proposals regarding its structure will be developed in the Autumn with an expectation for Trust/HSCB/PHA Board level involvement moving forward. All Trusts will be expected to be active participants in the evolving network structure over 2016/17 and going forward.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to diabetes care. This should be consistent with the aspirations and actions in the draft Diabetes Strategic Framework and implementations plan published in March 2016.

Specific issues and opportunities for 2016/17 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to expand • the use of insulin pumps and consumables for adults and children with Type 1 diabetes	Trust responses should demonstrate plans to continue to work with commissioners to review uptake in line with NICE guidance. Additional resources will be made available in

	• Consistent regional transition arrangements for children into adult services • consistent regional approach to the self-management and structured education programme	16/17 from the Transformation fund.
2	Effective arrangements should be in place to reflect that current transition arrangements from paediatric to adult services can be associated with sub optimal care	Trust responses should demonstrate plans to ensure effective transition arrangements are in place including increasing the upper age limit for in-patients to 16 years
3	Effective arrangements should be in place for antenatal management and post-natal assessment of gestational diabetes.	Trust responses should demonstrate new models of care to be implemented in 2016/17 to manage the increase in numbers attending antenatal clinics/develop capacity in the post natal pathway.
4	Effective arrangements should be in place to implement the Diabetic Foot Care Pathway	Trust responses should demonstrate plans to implement the regional pathway work in 2016/17 in partnership with the commissioner.
5	Effective arrangements should be in place to ensure the implementation of the recommendations of current reviews, e.g. inpatient audits, Thematic Review of Insulin	Trust responses should demonstrate plans to complete the baseline assessment of the NICE Clinical Guideline and plans for improvement, implement amended areas of practice, e.g. recommendations around Continuous Glucose Monitoring for Type 1 patients, use information from Near Patient Testing Trust responses should demonstrate plans to review their management of hypoglycaemia and hyperglycaemia in hospital in patient settings, including theatre. This should be linked in with Unscheduled Care Locality Network Groups in each Trust area.
6	Effective arrangements should ensure a consistent regional integrated pathway between primary and secondary care	Trust responses should demonstrate a commitment to participate in a workshop over the Autumn of 2016, to design new models of care for diabetes that clearly describes the delivery of Trust services in the overall care pathway.

7	Effective arrangements should be in place to enhance education of non-specialist health staff in diabetes through the use of competency frameworks, DNAV, WebEx or equivalent and Project ECHO.	Trust responses should demonstrate plans to ensure that educational resources are in place for all staff in hospitals to ensure: • Safe use of insulin • Effective management of hypoglycaemia • Effective management of hyperglycaemia • Early detection of foot problems when they arise in hospital

5.12.3Respiratory

Service Context

Respiratory services cover a wide ranging area of medicine that provide care for a number of illnesses affecting both the upper and lower respiratory tracts, either acutely or chronically. Patients with respiratory disease often require the expertise of a range of health and social care professionals who have specialised skills in the field of respiratory care. This includes prevention, assessment, diagnosis, treatment, care and rehabilitation.

Respiratory disease is the most commonly reported long term illness in children and young people and the third most commonly reported in adults, after musculoskeletal disorders and circulatory disorders. Respiratory disease continues to be one of the biggest causes of death and disability in NI.

Care for people with respiratory disease is a major contributor to the overall work and expenditure of health and social services. A report on the burden of respiratory disease by the British Thoracic Society reported that respiratory disease cost the United Kingdom (UK) £6.6 billion in 2004. This equated to £3billion in NHS care costs, £1.9billion in mortality costs and £1.7billion in morbidity costs.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to respiratory services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure local health economies deliver appropriate integrated pathways for both Adults and Children across primary, community and secondary care.	Trust responses should demonstrate plans to use transformational funding to deliver: • Pathways for children with asthma, allergies and anaphylaxis • Adult asthma pathways • Timely access to diagnostics for patients with suspected asthma • The implementation of Home Oxygen Service.
2.	Effective arrangements should be in place to deliver findings from the Respiratory baseline assessment.	Trust and NIAS responses should demonstrate that plans are in place to deliver: • Development of Trust area Respiratory Forum, including ICPs and primary care • Ambulatory oxygen therapy for patients continuing therapy outside the home • Access to discharge bundle for patients with COPD • Access to pulmonary rehabilitation courses and maintenance classes • Patients with a history of RF given alert cards in the event of conveyance • Patients should receive appropriately controlled oxygen when transported in ambulances to prevent acute hypercacnic failure • Maintenance of current service standards and where applicable, meeting minimum standards as outlined in the baseline review
3.	Effective arrangements should be in place to support the development of networked services across NI for the following diseases: • Interstitial Lung Disease (ILD) • Non-Invasive Ventilation (NIV) • Obstructive Sleep Apnoea (OSA) • Bronchiectasis Services • Home Oxygen Services (HOSAR)	Trust responses should demonstrate a commitment to: • nominate a clinical lead for ILD patients who will work closely with the regional specialist ILD regional centre • Belfast Trust to proceed with plans for one stop shop between neurology and respiratory services • Belfast Trust to reduce waiting list for sleep

		studies • work with ICPs to develop community based services for bronchiectasis • provide an end-to-end HOSAR service with an annual assessment service for every patient (i.e. existing not just new) in a local area – this is an invest-to-save scheme
4.	Effective arrangements should be in place to: • promote self-management, self-directed care and suitable training programmes for patients. • Provide access to psychological therapy and palliative care for all age groups.	Trust responses should demonstrate plans to deliver: • COPD Self-management programmes/pulmonary rehabilitation • Spirometry training programme • In-house or onward referral care pathways
5.	Effective arrangements should be in place to support 7 day delivery of COPD community support.	Trust responses should demonstrate plans to deliver this model in full across 2016/17

The Regional Interstitial Lung disease service (ILD) and regional specialist Non-invasive Ventilation (NIV) services for complex respiratory conditions are unable to be fully progressed at this time.

5.12.4Pain Management

Service Context

More than 400,000 people in NI suffer from pain persisting beyond the expected period of recovery; it is often the most important and disabling symptom of many long term conditions like diabetes, other cardiovascular diseases and arthritis, as well as being a long term condition in its own right. Persistent pain can be prevented and sufferers treated successfully in community, primary and secondary care.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures including the NI Pain Forum, will continue to seek to improve Pain Management Service availability, accessibility and patient experience.

Specific issues and opportunities for 2016/17 are as follows:

REGIONAL PRIORITY		TRUST REQUIREMENT
1.	Effective arrangements should be in place to enhance the skills and capacity and their capacity for integrated working.	Trust responses should demonstrate plans to; • Contribute to and participate in staff education and training for improved and integrated bio psychosocial management of persistent pain patients. • Contribute to the development and delivery of pain related public awareness campaigns and public awareness campaigns and other forms of information and education through the NI Pain Forum
2.	Effective arrangements should be in place to ensure patients have timely access to supported self-management options alongside a stepped care model.	Trust responses should demonstrate plans for a range of self-management options in line with the NI Pain Forum's service specification and in collaboration with LCGs. Depending on local priorities, this may include: • reworking of existing contracts with voluntary providers of self-management programmes and local support groups, • reconfiguration of community and primary care services • collaboration with other government agencies to booster condition management programmes
3.	Effective arrangements should be in place to ensure regional and local prescribing guidelines are followed and supported through pharmacy led regular medication reviews.	Trust responses should demonstrate plans to optimise prescribing practice, reduce the risk of side effects, misuse and addiction, as well as reducing prescribing costs by supporting services in secondary, primary and community care.
4.	Effective arrangements should be in place to ensure patients are managed along regionally agreed integrated pathways to improve outcomes and patient experience.	Trust responses should demonstrate plans to support ICPs in developing integrated patient pathways for painful conditions including MSK conditions, fibromyalgia, chronic fatigue syndrome, endometriosis and other long term surgical and medical conditions.
5.	Effective arrangements should be in place to ensure patients with persistent pain have equitable access to services.	Trust responses should demonstrate plans to develop referral pathways for pain management across inter-speciality based triage.

5.13 Palliative and End of Life Care

Service Context

Palliative care, as it relates to adults, focuses on the provision of care to those in the population who have an advanced progressive illness.

End of life care, is described as the period of time during which an individual's condition deteriorates to the point where death is either probable or would not be an unexpected event, within the ensuing 12 months. It is estimated that at any one time 1% of the NI population are in the end of life phase (approximately 19,000 people). Of the actual deaths in NI each year (about 15,000) it is estimated that 11,250 of these individuals will have palliative care needs.

Given the choice most people would prefer to be cared for in their own home (or nursing home) at the end of life. In 2014, 48% of all deaths occurred in hospital. The provision of good palliative and end of life care is complex as it covers a range of condition areas and relies on excellent partnership working between primary and secondary care, the voluntary sector and urgent care services.

Arrangements are in place to progress the former Living Matters:Dying Matters strategy and the wider palliative care agenda through a new regional work plan called 'Palliative Care in Partnership' to take forward further improvements in palliative and end of life care.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the new regional structures will continue to seek to improve the availability, accessibility and experience of patients, their families and carers in relation to palliative care services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Improved arrangements for identifying patients in their last year of life will support timely needs assessment and lead to more effective advanced care planning for these patients.	Trusts in collaboration with the palliative care locality board, including ICPs, should set out the specific arrangements to be put in place during 2016/17 to increase the number of patients identified as being in their last year of life and to ensure that this information is communicated across the HSC system.
2.	The keyworker function needs to be embedded within Trust arrangements to support care planning processes, improve communication with patients and their carers and ensure continuity of care for patients and families in hospital, community and other care settings.	Trusts in collaboration with the palliative care locality boards, including ICPs, should set out the specific actions to be taken during 2016/17 to further embed the keyworker function across all aspects of patient care.
3.	Support arrangements for patients and families should be in place out of hours (in conjunction with the voluntary sector as appropriate).	Trusts in collaboration with the palliative care locality boards, including ICPs, should ensure that out of hours arrangements are in place for generalist palliative care 24 hours per days 7 days per week.
4.	Effective arrangements should be in place to provide a range of specialist palliative care services.	Trusts in collaboration with the palliative care locality boards, including ICPs, should ensure that there is access to specialist palliative care services.

5.14 Prisoner Health Services

Service Context

Within N Ireland there are over 5,000 prison committals annually and approximately 1,800 – 1,900 prisoners throughout the prison estate at any time. Prisoner Health Services are delivered within the three prison establishments of Maghaberry, Hydebank Wood College and Magilligan and are managed by the South Eastern Health and Social Care Trust. The HSCB supports the principle of ensuring that people in prison are entitled to the same level of healthcare as those in the community. However, security considerations may modify exactly how healthcare is structured and delivered. In this regard, there is a need to strengthen co-operation between the Criminal Justice System and Health and Social Care.

There is a particular need to address the healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities. Rates of mental ill health for those in prison are higher than the general population, with the prison population having a much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses. Work continues on developing better integration with community and secondary care services on committal and discharge. There is also a need to ensure that, following the identification of prisoners' healthcare needs at committal, these are followed up with appropriate action. There remain issues associated with the misuse of prescribed medicines and the supply of illicit drugs.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the South Eastern Trust will continue to seek to improve the existing level of healthcare in relation to prisoner health services. There are a number of factors arising from the prison environment and the nature of prison populations which need to be taken into account in taking forward service development and change agendas.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	There is a particular need to address the healthcare requirements of vulnerable groups within the prison population.	SEHSCT should demonstrate plans to progress the development of healthcare services and chronic disease management in line with the principle of equivalence and produce a Health Needs Assessment in 2016/17 to help inform commissioning priorities moving forward
2.	Effective arrangements should be in place to develop Mental Health services in line with the Bamford Action Plan 2012 – 2015 for people with Mental Health and Learning Disability	SEHSCT should demonstrate how mental health services will be provided in line with the recovery ethos and develop registers for individuals with alcohol addiction, drug addiction, personality disorder and learning disability
3.	Effective arrangements should be in place to provide Learning Disability services in line with "Equal Lives"	SEHSCT should demonstrate how individuals with a learning disability are identified during the committal process and that senior nurses assess their needs in cooperation with other departments such as Education, Probation and NIPS Discipline Team.
4.	The social care needs of the prison population should be reviewed in the context of current provision with a view to identifying unmet need.	SEHSCT should demonstrate how the Trust will co-operate with DOH, NIPS and the Probation Board to collate and analyse information/data about the prison population to identify current support and/or social care needs of prisoners and any unmet social care needs.
5.	Effective arrangements should be in place to develop care pathways for prisoners with complex needs, both in and out of prison.	All Trusts should outline plans to develop care pathways for individuals with complex needs in Primary Care.
6.	Effective arrangements should be in place to develop Trust based information systems to help facilitate a whole systems approach to prisoner healthcare.	SEHSCT should develop recommendations for service development / improvement linked to Mental Health systems, the monitoring of chronic medical conditions, improved discharge arrangements and medicines management. SEHSCT should develop improved healthcare information systems to increase inter-agency working.
7.	Effective arrangements should be in place to implement a Health & Social Well-being Strategy for Prisoners throughout 2016/17	SEHSCT should produce an action plan to support health improvement initiatives, including mental health promotion, smoking, healthy eating & nutrition, healthy lifestyles, sexual health and relationships, drugs and other substance misuse.

8.	Effective arrangements should be in place to develop alternatives to prison transfers for specialist and/or emergency assessments and reviews including tele-health options.	SEHSCT should demonstrate plans to reduce the number of prisoner transfers outside of prison to access health and care services by exploring alternative proposals for in-reach and remote viewing (tele-monitoring) SEHSCT should provide an analysis of activity (i.e. emergency attendance, outpatient new/review, diagnostic, daycase or inpatient) and volume
9.	Effective arrangements should be in place to engage stakeholders in any service area undergoing development	SEHSCT should demonstrate how the Trust will engage with stakeholders and provide an Annual Report on findings from the analysis of the Committal User Survey.
10.	Effective arrangements should be in place to appropriately manage the service demands associated with an increasing prison population.	SEHSCT response should demonstrate how the Trust will deliver the required volumes of service activity in light of the changing population need and demand for prisoner health services in 2016/17.

5.15 Northern Ireland Ambulance Service (NIAS)

Service Context

Increasing demand for emergency ambulance services is placing considerable pressure on the NI Ambulance Service to deliver against 8-minute response targets despite additional investment in recent years. Ambulance plays an essential role in supporting effective community pathways, maximising patient flow through hospitals and assisting patients to access elective care. Continued increase in demand for ambulance services makes it necessary during 2016/17 to reform through aligned staff rostering and appropriate care pathways and to prioritise based on greatest need.

Also during 2016/17, the HSCB and PHA working with NIAS and with the designated charity, will establish a dedicated Helicopter Emergency Medical Service (HEMS) for NI.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to Ambulance Services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that available capacity within NIAS is maximised in the context of increasing demands for services.	The Trust's response should: • demonstrate plans to improve response times to CAT A calls across NI • outline how a robust capacity-demand analysis will be commissioned by the Trust in 2016/17, ensuring the full alignment of NIAS resources with predicted demand.
2.	While there have been some improvements in recent years, ambulance turnaround times in hospitals are too long, with more than half of ambulances spending more than 30 minutes at EDs	The Trust's response should describe how NIAS will improve significantly the handover time for patients, with at least 70% of handovers being completed in less than 30 minutes from March 2017.

3.	A new approach is required to the training of paramedics in the context of accreditation difficulties with existing programmes	The Trust's response should outline how NIAS will work with HSCB and DOH to develop proposals to support the training of new paramedics which may include a university degree route.
4.	Demand for non-emergency transport continues to grow and is delivered on a 'first come' basis which fails to ensure the most in need gain access to transport support.	The Trust's response should outline how NIAS will work with the HSCB to introduce in 2016/17 eligibility criteria for non-emergency transport which prioritise patients with mobility difficulties.
5.	There is a need to further expand NISTAR (NI Specialist Transport and Retrieval Services) for neonates, children and adults within NI, and to/from Dublin as appropriate.	The Trust's response should confirm arrangements for the introduction of a second retrieval ambulance during 2016/17.
6.	Effective, integrated arrangements – organised around the needs of individual patients – should be in place in community settings to provide care for people at home, avoiding the need for hospital attendance admission.	The Trust's response should demonstrate how NIAS will fully embed the range of alternative care pathways across all localities in NI during 2016/17 including the establishment of a paramedic-led clinical decision desk.
7.	A Helicopter Emergency Medical Service (HEMS) is to be established in NI to support the existing road-based emergency service.	The Trust's response should demonstrate how NIAS will work with HSCB/PHA and the designated charity to ensure the introduction in 2016/17 of a HEMS for NI.
8.	Effective arrangements should be in place to facilitate and promote collaboration, coordination, coordination, communication, learning, sharing of information between different agencies providing resuscitation training.	The Trust's response should demonstrate how NIAS will work with existing providers of community resuscitation and ensure a smooth transition to the new model of community resuscitation that reflects the recommendations of the 2014 NI Community Resuscitation Strategy
9.	Effective arrangements should be in place to deliver appropriate CPR and BLS training programmes.	NIAS should provide plans to increase access to CPR training across NI and Basic Life Support (BLS) in community and educational settings via: • Engagement with CPR training providers • Engagement with Voluntary and Community organisations • Further development of Community and first responder schemes

10.	Effective arrangements include the development of public information / guidance about Automatic External Defibrillators covering purchasing, maintenance, location, access and signage	NIAS should provide plans to develop website literature and guidance information materials on AEDs.
11.	Effective arrangements should be in place to appropriately manage the increasing demand on ambulance services in the winter period.	The Trust should bring forward a winter plan which outlines how it will manage increased demand in Winter 2016/17.

6.0 Local Commissioning

6.1 Belfast Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the Belfast LCG area was 348,253 persons accounting for 19% of the Northern Ireland total. Population projections indicate an increase in population to 358,904 by 2020, with the highest increases forecast in the 0-14 and 75+ age groups. The increase in people aged 75 and over is also significant as this group tends to have the greatest need for Health and Social Care services. The extent of deprivation in the Belfast Trust area is greater than other local government districts in NI with 46% of the population estimated to be living in multiple deprivations (NINS 2010).

The population of the Belfast LCG has poorer life expectancy, higher mortality rates for Cancer, circulatory and respiratory diseases and higher incidence of suicide than other LCG areas. QOF data show higher prevalence of stroke, learning disability, diabetes and mental health conditions such as depression, than any other LCG area and has an over reliance on hospital care.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population, an 8% increase in the population aged over 75 years, and an 8%	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements:

	increase in the population of children aged less than 16. These population changes will impact on the demand for unscheduled care services.	1. To address each of the regional unscheduled care priorities as set out section 5.1. 2. To deliver the required volumes of service activity for 2016/17. In responding account should be taken of recent investments in Acute Care at Home, COPD/HOSAR, Stroke Early Supported Discharge, Diabetes, the Clinical Assessment Unit, Ambulatory Phase 1, RBHSC ED and the Short Stay PAU.
BL2	Effective arrangements should be in place to ensure unscheduled care services in the Belfast LCG/Trust area are safe, sustainable and accessible.	The Trust's response should demonstrate how it will seek to maintain safe, sustainable, accessible unscheduled care services at the Mater Hospital.
BL3	Effective arrangements should be in place to ensure patients in the Southern LCG/Trust area have access to high quality ophthalmology services, to be delivered in 2016/17 by Belfast and Western Trusts.	The Trust's response should demonstrate how it will work with the Southern LCG and Southern Trust to ensure from 2016/17 the provision of appropriate ophthalmology outreach services to the Southern population.
BL4	Effective arrangements should be in place to support the establishment of a NI Genome Centre	The Trust's response should demonstrate plans to co-ordinate the planned investment in delivery of the NI Genome Centre to include IPT development for submission to the HSCB as required.

POC 2 Maternity & Child Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a continued increase in complex births in the Belfast LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are predicted to grow by 8% increase in the Belfast LCG /	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

	Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	

POC 4 Care of the Elderly

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be an 8% increase in the population aged over 75 years in the Belfast LCG/Trust population. This population change will impact on the demand for Care of the Elderly services.	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17.

POC 5 Mental Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[3] in prevalence within the Belfast LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. Deliver the proposed volumes of service activity for 2016/17
BL2	Effective arrangements should be in place to reduce the increasing number of people presenting to ED for Suicide and Self-Harm which are higher in Belfast area than the NI average.	The Trust's response should demonstrate plans to address the cultural / lifestyle issues that may be contributing to self-harm / suicide with partner agencies.
BL3	Effective arrangements should be in place to provide appropriate supported housing options across the Belfast LCG/Trust area.	The Trust's response should plan to review current supported housing schemes in line with the current NIHE review of Supporting People funding.
BL4	Effective arrangements should be in place to appropriately manage increasing	The Trust's response should demonstrate plans to redesign the current service to assist the

[3] Delegated Statutory Functions reports submitted by Trusts

	occupancy rates related to increased length of stay in the Medium Secure (Shannon) Unit.	implementation of the Community Forensic Service. This is to help to address case complexity, the increase in demand, adult safeguarding and assertive outreach.
BL5	Effective arrangements should be in place to appropriately manage bed occupancy rates within the Belfast which remain higher than the NI average.	The Trust's response should demonstrate plans to ensure that inpatient bed requirement are in line with the approved Business Case for the Single Unit, including development of a High Intensity Care Pathway to align and integrate the Crisis Home Treatment and Acute Inpatient Service into a single care service

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services.	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 9 Primary Care and Adult Community

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population. The population of Belfast LCG have poorer life expectancy, higher mortality rates for Cancer, circulatory and respiratory diseases and higher incidence of suicide than other LCG areas. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.
BL2	Effective arrangements should be in place to plan appropriate care for people at risk of hospital admission in the Belfast LCG/Trust area.	The Trust's response should outline plans to utilise senior community nurses to support GP Practices in the management of these patients in the Belfast LCG/Trust area.
BL3	Effective arrangements and infrastructure should be in place to support an integrated model of care across the Belfast LCG/Trust area.	The Trust's response should outline how the Trust will work closely with ICPs to design and implement a fully integrated model of care which supports GP practices, including co-location, reconfiguration of services aligned to local need.

6.2 Northern Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the Northern LCG area was 463,297 persons accounting for 26% of the Northern Ireland total. Population projections indicate an increase in population to 480,650 by 2020, with the highest increases forecast in the 75+ age group. The increase in people aged 85 and over is also significant as this group tends to have the greatest need for Health and Social Care services. The extent of deprivation in the Northern LCG area evidences that one tenth of the 228 Super Output Areas would be classified as being included in the 20% most deprived areas in Northern Ireland.

Almost all of the Northern LCG health outcomes were better than, or similar to, the NI average. There are, however, issues relating to hypertension and diabetes with obesity and meeting physical activity needs highlighted as particular risk factors in the Northern area.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a 2% increase in the total Northern LCG/Trust population, a 23% increase in the population aged over 75 years, and a 2% increase in the population of children aged less than 16. These population changes will impact on the demand for unscheduled care services.	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional unscheduled care priorities as set out section 5.1. 2. To deliver the required volumes of service activity for 2016/17.

		The response should include plans to reshape the Direct Access Assessment Service and the PAU in Antrim with opening hours better aligned in each case to meet demand. Plans should also evidence 2015/16 investments in extra Antrim Hospital capacity and the impact this will have.
NL2	Effective arrangements should be in place to ensure unscheduled care services in the Northern LCG/Trust area are safe, sustainable and accessible	The Trust's response should demonstrate how it will seek to maintain safe, sustainable, accessible unscheduled care services across the LCG/Trust area with a particular focus on Causeway Hospital.
NL3	Effective arrangements should be in place to address growth in demand for haematology and microbiology.	The Trust's response should demonstrate plans to increase capacity in haematology and microbiology to meet demographic growth and changing service patterns.
NL4	Effective arrangements should be in place to establish a nurse led service for family planning and the prevention of sexually transmitted infections	The Trust's responses should demonstrate plans to establish, in partnership with the University of Ulster, the Genito-Urinary Medicine (GUM) & Family Planning Comprehensive Sexual Health Service to be delivered across the Coleraine and Jordanstown sites.

POC 2 Maternity and Child Health

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a continued increase in complex births in the Northern LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are predicted to grow by 2% increase in the Northern LCG / Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

NL2	Effective arrangements should be in place to ensure Maternity & Child Health services in the Northern LCG/Trust area are safe, sustainable and accessible.	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17. This should include specific arrangements to: • Provide a Midwife Led facility on the Antrim and Causeway sites. • Provide safe and sustainable services on the Causeway site, to include appropriate middle medical cover in paediatrics out of hours.

POC 4 Care of the Elderly

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be an 23% increase in the population aged over 75 years in the Northern LCG/Trust population. This population change will impact on the demand for Care of the Elderly services.	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17
NL2	Effective arrangements should be in place to accommodate the increase in the older population in the Northern LCG area with an increasing range of well-being and prevention requirements	The Trust's responses should demonstrate the continued support of • the Community Navigator post • the Dalriada Pathfinder to reduce social isolation and improve access to services. • the Community Dementia Co-ordinator post Ensure appropriate links between health improvement, Falls Prevention Team and LCG/ICP to reduce the number of falls in the community.

POC 5 Mental Health

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[4] in prevalence within the Northern LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. Deliver the proposed volumes of service activity for 2016/17

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a 2% increase in the total Northern LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services.	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a 2% increase in the total Northern LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Physical Disability service priorities as set out in section 5.8. 2. To deliver the proposed volumes of service activity for 2016/17.

[4] Delegated Statutory Functions reports submitted by Trusts

NL2	Effective arrangements should be in place to manage complex high cost cases each year. These patients require to be supported in the community.	The Trust's response should demonstrate plans to ensure that additional community nursing inputs are commissioned to enable patients with complex needs to be discharged from hospital to a community environment as appropriate.

POC 9 Primary Care and Adult Community

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a 2% increase in the total Northern LCG/Trust population. The population of the Northern LCG / Trust have high levels of hypertension and diabetes with obesity and CHD. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.
NL2	Effective arrangements should be in place to develop a Local Enhanced Service (LES) for people with dementia that will allow the release of sufficient Psychogeriatrician time to allow for interventions in Primary Care complex cases	The Trust's response should demonstrate integrated plans with the Northern ICP in supporting the Dementia Shared Care Local Enhanced Service

Within the Northern LCG area, procurement of a second MRI scanner at Antrim Hospital to improve service resilience and provide additional local MRI and CMR capacity as part of the regional CMR 'Hub and Spoke' network will not be able to be progressed at this time.

6.3 South Eastern Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the South Eastern LCG area was 346,911 persons accounting for 19% of the Northern Ireland total. Population projections indicate an increase in population to 365,384 by 2020, with the highest increases forecast in the 75+ age group. The increase in people aged 85 and over is also significant as this group tends to have the greatest need for Health and Social Care services.

The population of the South Eastern LCG area is one of the least deprived in NI. 10% of the super output areas in the south east would be classified as the most deprived while 35% would fall into the least deprived category. When comparing the locality as a whole to the region, differences across health outcomes were small but typically better in the south east than in NI. While this describes an overview position, individuals and families who live in the areas of relative deprivation fair less well than their counterparts in the least deprived communities, males who live in the 20% most deprived SOH in the south east can expect to live 3.4 years fewer than the average, while females can expect to live 1.6 years less.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 3.5% increase in the total South Eastern LCG/Trust population, a 27% increase in the population aged over 75 years, and a 3% increase in the population of children	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional

	aged less than 16. These population changes will impact on the demand for unscheduled care services.	unscheduled care priorities as set out section 5.1. 2. To deliver the required volumes of service activity for 2016/17. In responding account should be taken of investments in 2015/16 to improve flow and expand capacity at the Ulster Hospital and the impact of the Enhanced Care at Home model. Plans should also evidence recent investments into the Downe emergency department and the development of Phase B at the Ulster Hospital.
SE2	Effective arrangements should be in place to ensure unscheduled care services in the South Eastern LCG/Trust area are safe, sustainable and accessible.	The Trust's response should demonstrate how it will seek to maintain safe, sustainable, accessible unscheduled care services across the LCG/Trust area with a particular focus on the Lagan Valley and Downe Hospitals. The Trust response should include proposals for the introduction of a weekend minor injuries service at Lagan Valley.
SE3	Effective arrangements should be in place to support Sexual and Reproductive Health services.	The Trust's response should demonstrate plans to develop an integrated sexual & reproductive health service

POC 2 Maternity and Child Health

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a continued increase in complex births in the South Eastern LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are predicted to grow by 3% increase in the South Eastern LCG / Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

POC 4 Care of the Elderly

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 27% increase in the population aged over 75 years in the South Eastern LCG/Trust population. This population change will impact on the demand for Care of the Elderly services.	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17.

POC 5 Mental Health

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[5] in prevalence within the SE LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. To deliver the proposed volumes of service activity for 2016/17

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 3.5% increase in the total South Eastern LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services.	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Physical Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

[5] Delegated Statutory Functions reports submitted by Trusts

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 3.5% increase in the total South Eastern LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 9 Primary Care and Adult Community

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 3.5% increase in the total South Eastern LCG/Trust population. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.
SE2	Enhanced Care at Home implementation	The ICP, working with the SET should confirm full implementation of the ECAH scheme and bring forward the appropriate evaluations to inform the phased roll-out of the initiative across the Down and Lisburn localities.

6.4 Southern Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the Southern LCG area was 358,034 persons accounting for 20% of the Northern Ireland total. Population projections indicate an increase in population to 392,632 by 2020, with the highest increases forecast in the 75+ age group.

Within the Southern LCG, 16% (25) of the 157 Super Output Areas are classified as being included in the 20% most deprived areas in Northern Ireland (NI) and a tenth (15) of areas in the Trust are classified as being among the 20% least deprived areas in NI.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a 6% increase in the total Southern LCG/Trust population, a 23% increase in the population aged over 75 years, and a 7% increase in the population of children aged less than 16. These population changes will impact on the demand for unscheduled care services.	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional unscheduled care priorities as set out section 5.1. 2. To deliver the required volumes of service activity for 2016/17. In responding account should be taken of investments in 2015/16 in Frail Elderly, Respiratory, Stroke and Diabetes services.

SL2	Effective arrangements should be in place to ensure unscheduled care services in the Southern LCG/Trust area are safe, sustainable and accessible.	The Trust's response should demonstrate how it will seek to maintain safe, sustainable, accessible unscheduled care services across the LCG/Trust area with a particular focus on Daisy Hill Hospital.
SL3	Effective arrangements should be in place to ensure patients in the Southern LCG/Trust area have access to high quality ophthalmology services, to be delivered in 2016/17 by Belfast and Western Trusts.	The Trust's response should demonstrate how it will work with the LCG and Western and Belfast Trusts to ensure the seamless introduction of new ophthalmology services during 2016/17
SL4	Effective arrangements should be in place to deliver safe and sustainable breast care services.	The Trust's response should outline its plans to address current service pressures within the breast care service and the longer term plans to deliver safe and sustainable breast care services.

POC 2 Maternity and Child Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a continued increase in complex births in the Southern LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are predicted to grow by 7% increase in the Southern LCG / Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

POC 4 Care of the Elderly

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be an 23% increase in the population aged over 75 years in the Southern LCG/Trust population. This population change will	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements:

	impact on the demand for Care of the Elderly services.	1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17

POC 5 Mental Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[6] in prevalence within the Southern LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. Deliver the proposed volumes of service activity for 2016/17
SL2	Effective arrangements should be in place to meet the needs of the growing older population and those with dementia.	The Trusts response should outline plans to ensure an appropriate nurse staffing model in the Gillis Unit as a result of recent investment.

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a 6% increase in the total Southern LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services.	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

[6] Delegated Statutory Functions reports submitted by Trusts

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a 6% increase in the total Southern LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Physical Disability service priorities as set out in section 5.8. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 9 Primary Care and Adult Community

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a 6% increase in the total Southern LCG/Trust population. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.

6.5 Western Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the Western LCG area was 294,417 persons accounting for 16% of the NI total. Population projections indicate an increase in population to 302,823 by 2020, with the highest increases forecast in the 75+ age group.
One in four people (25.3%) residing within the Western area in 2013 were living within the most deprived of the Northern Ireland deprivation quintiles. Across Northern Ireland, 18.8% of the population live in the most deprived quintile.

Despite high levels of deprivation, Western population shows equivalent or better health outcomes than the NI average, apart from for respiratory conditions, i.e. asthma and chronic obstructive pulmonary disease (COPD). Mental health however is considerable worse, particularly due to anxiety and depression. Smoking remains higher than average. More people are likely to suffer pain and discomfort than for NI as a whole. There is higher rate of children in need.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 1.6% increase in the total Western LCG/Trust population, a 25% increase in the population aged over 75 years, with no increase in the population of children aged less than 16. These population changes will	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional unscheduled care priorities as set out

	impact on the demand for unscheduled care services, including at both Altnagelvin and South-West Acute hospitals.	section 5.1. 2. To deliver the required volumes of service activity for 2016/17. The Trust's Response should include consideration of the introduction and impact of a Clinical Decision Unit, Acute Care at Home and the bolstering of seven day working, the continuation and evaluation of the Integrated Cardiac Ambulatory Care model, consideration of medical and nursing workforce in both emergency departments, and the role of the frail elderly hospital pharmacist. The Trust response should also outline plans to maintain a Paediatric Assessment Unit at Altnagelvin on a recurrent basis.
WL2	Effective arrangements should be in place to ensure patients in the Southern LCG/Trust area have access to high quality ophthalmology services, to be delivered in 2016/17 by Belfast and Western Trusts.	The Trust's response should demonstrate how it will work with the Southern LCG and Southern Trust to ensure that ophthalmology services are provided to the western part of the Southern area from September 2016.
WL3	Effective arrangements should be in place to address the deficit in trainee doctors in both Altnagelvin and SWA hospitals	The Trust's response should demonstrate plans to continue to work with NIMDTA for more equitable allocation of junior doctors, reflecting workload and population shares with a view to reducing capacity and financial strains on a number of acute specialties.
WL4	Effective arrangements should be in place to extend the minor surgery scheme which provides patients local access to experienced GP minor surgeons	The Trust's response should outline plans to extend the LCG minor surgery scheme including consideration of additional procedures which could be provided by GP minor surgeons.

POC 2 Maternity and Child Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a continued increase in complex births in the Western LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are not predicted to grow in the Western LCG / Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	The Trust's response should demonstrate how the change in population need for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

POC 4 Care of the Elderly

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 24% increase in the population aged over 75 years in the Western LCG/Trust population. This population change will impact on the demand for Care of the Elderly services.	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17
WL2	Effective arrangements should be in place to appropriately manage the increasing number of older people over 75 years which is impacting on hospital demand, length of stay and delayed discharge.	The Trust's response should outline plans to complete the establishment of 24-hour community nursing across the Western area, building on investment to date in district nursing, Rapid Response nursing and treatment rooms, and including the establishment of Clinical Intervention Centres in Enniskillen, Strabane and Limavady within the next two years.

WL3	Effective arrangements should be in place to provide an appropriate geriatric services, being cognisant of recent recruitment difficulties	The Trust's response should outline proposals to consider alternative models of care, including GP and nurse-led models, which would bolster geriatrician-led services.
WL4	There are an increasing numbers of older people who experience a fall which leads to reduce independence and increased reliance of health and social care.	Western Trust, working through Integrated Care Partnerships, to put in place a coordinated integrated falls pathway.
WL5	Effective arrangements should be in place to manage the increasing number of older people by building or restoring self-confidence and self-reliance and providing practical support to help achieve aspirations and reduce dependency.	The Trust's response should outline plans to support ICPs to further pilot the Social Prescribing scheme which seeks to offer alternatives to medicine prescription and overcome social isolation and loss.

POC 5 Mental Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[7] in prevalence within the Western LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. To deliver the proposed volumes of service activity for 2016/17

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 1.6% increase in the total Western LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7.

[7] Delegated Statutory Functions reports submitted by Trusts

	Learning Disability services.	2. To deliver the proposed volumes of service activity for 2016/17.

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 1.6% increase in the total Western LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Physical Disability service priorities as set out in section 5.8. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 9 Primary Care and Adult Community

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 1.6% increase in the total Western LCG/Trust population. The population of Western LCG/Trust have declining Mental health particularly due to anxiety and depression. Smoking remains higher than average. More people are likely to suffer pain and discomfort in the Western LCG/Trust, than for NI as a whole. There is higher rate of children in need. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.
WL2	Effective arrangements should be in place to appropriately manage the number of patients registered to Western GP practice as there are approximately 25,000 more patients registered with Western GP practices than live in the Western LCG area, some of which may live in ROI.	The Trust's response should demonstrate plans to keep under review requests for healthcare from residents of the Republic of Ireland and ensure these are from cross-border workers entitled to receive NI HSC services.

Within the Western LCG area, the following is unable to be fully progressed at this time:

- RCCE Omagh Project
  Scheduled to open early in 2017, the newly-built Omagh Local Enhanced Hospital will provide day surgery, outpatient clinics, intermediate care, minor injuries treatments, and cardiac assessment co-located with GP-led General Medical Services.

- RCCE Enniskillen PCI Hub
  Scheduled to open in Autumn 2016, the renovation of the Erne Health Centre in Enniskillen by a local developer will enable the co-location of GP services with Trust community services, including family support services, community nursing, primary care mental health services, and older people's services, including Reablement.

Appendix 1: Commissioning Plan Direction Outcomes Framework

COMMISSIONING PLAN DIRECTION OUTCOME	SECTION
Outcome 1. Health and social care services contribute to; reducing inequalities; ensuring that people are able to look after and improve their own health and wellbeing, and live in good health for longer.	
1.1 In line with the Departmental strategy A Fitter Future For AI by March 2022 reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.	4.1.1
1.2 In line with the Department's policy framework, living with Long Term Conditions, continue to support people to self-manage their condition through increasing access to structured patient education programmes. In 2016/17, the focus will be on consulting on and taking steps to begin implementation of the Diabetes Strategic Framework and implementation plan with the aim that by 2020 all individuals newly diagnosed with diabetes will be offered access to diabetes structured education with 12 months of diagnosis.	5.12.2
1.3 In line with the Department's ten year Tobacco Control Strategy, by March 2020 reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.	4.1.1
1.4 By March 2020, to reduce the differential in the suicide rate across NI and the differential in suicide rates between the 20% most deprived areas and the NI average. Areas of focus for 2016/17 should include early intervention and prevention activities, for example through improvement of self-harm care pathways and appropriate follow-up services in line with NICE guidance.	4.1.1
1.5 By March 2018 ensure full delivery of the universal child health promotion framework for NI, Healthy Child, Healthy Future. Specific areas of focus for 2016/17 should include the delivery of the required core contacts by health visitors within the pre-school child health promotion programme.	4.1.1
1.6 During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring that the proportion of children in care for 12 months or longer with no placement change is at least 85%.	4.1.1
1.7 During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring a three year time frame (from date of last admission) for 90% of children who are adopted from care.	5.4
Desired outcome 2: People using health and social care services are safe from avoidable harm	
2.1 In the year to 31 March 2017 secure a reduction of 25% in the total number of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over and in-patient episodes of MRSA infection compared to 2015/16.	4.12
2.2 From April 2016, ensure that the clinical condition of all patients is regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.	4.2

2.3 By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services.	4.2.5
2.4 The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice.	4.2.5
2.5 The HSC, through the application of care standards, should seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that receive a failure to comply notice and that subsequently attract a notice of decision.	4.2.5
Desired outcome 3: People who use health and social care services have positive experiences of those services.	
3.1 To support people with palliative and end of life care needs to be cared for in their preferred place of care. By March 2018 to identify individuals with a palliative care need and have arrangements in place to meet those needs. The focus for 2016/17 is to develop and implement appropriate systems to support this.	5.13
3.2 By March 2017, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need (or alternatively timely access to treatment).	4.3
3.3 Where patients are cared for in mixed gender accommodation, all Trusts must have policies in place to ensure that patients' privacy and dignity are protected.	4.3
3.4 HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.	4.3
3.5 By March 2018, to increase by 40% the total number of patients across the region participating in the PHA Biennial Patient Experience Survey, with particular emphasis on engaging patients in areas of low participation.	4.3
Desired outcome 4: Health and Social care services are centred on helping to maintain or improve the quality of life of people who use those services	
4.1 By March 2020 to have increased access to services delivered by GP practices. The focus for 2016/17 is on developing a comprehensive baseline of such activity, to be used to inform future work.	5.9
4.2 From April 2016, 95% of acute/ urgent calls to GP OOH should be triaged within 20 minutes.	5.9
4.3 From April 2016, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.	5.15
4.4 From April 2016, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.	5.1
4.5 By March 2017, at least 80% of patients to have commenced treatment, following triage, within 2 hours.	5.1
4.6 From April 2016, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	5.1
4.7 From April 2016, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate	5.12.1
4.8 By March 2017, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.	5.2
4.9 By March 2017, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.	5.2

4.10 By March 2017, 55% of patient should wait no longer than 13 weeks for inpatient/daycase treatment and no patient waits longer than 52 weeks.	5.2
4.11 From April 2016, all urgent diagnostic tests should be reported on within two days.	5.2
4.12 From April 2016, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	5.11
4.13 From April 2016, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).	5.6
Desired outcome 5: People, including those with disabilities or long term conditions, or who are frail, are supported to recover from periods of ill health and are able to live independently and at home or in a homely setting in the community.	
5.1 From April 2016, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.	5.6/5.7
5.2 By March 2017, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions.	5.6/5.7/5.8/5.12
5.3 By March 2017, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional	5.2
5.4 By March 2017, secure a 10% increase in the number of direct payments to all service users.	5.6/5.7/5.8
5.5 By March 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.	4.1.1/5.6/5.7/5.8
Desired outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being	
6.1 By March 2017, secure a 10% increase in the number of carers' assessments offered to carers for all service users.	5.6/5.7/5.8
6.2 By March 2017, secure a 5% increase in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	5.6/5.7/5.8
6.3 By March 2017, establish a baseline of the number of carers who have had a carers assessment completed and: • the need for further advice, information or signposting has been identified; • the need for appropriate training has been identified; • the need for a care package has been identified; • the need for a short break has been identified; • the need for financial assistance has been identified.	5.6/5.7/5.8
Desired outcome 7: Resources are used effectively and efficiently in the provision of health and social care services.	
7.1 By March 2017, reduce by 20% the number of hospital-cancelled consultant-led outpatient appointments.	4.4.2
7.2 From April 2016, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.	5.1

7.3 By March 2017, attain efficiencies totalling at least £20m through the Pharmacy Efficiency Programme, separate from PPRS receipts.	5.9.4
7.4 By March 2017, to reduce the percentage of funded activity associated with elective care service that remains undelivered.	4.4.2
Desired outcome 8: People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide	
8.1 By December 2016 ensure at least 40% of Trust staff have received the seasonal flu vaccine.	4.4
8.2 By March 2017, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2015/16 figure.	4.4
8.3 During 2016/17, HSC employers should ensure that they respond to issues arising from the 2015 Staff Survey, with the aim of improving local working conditions and practices and involving and engaging staff.	N/R
8.4 By March 2017, Trusts are required to develop operational Workforce Plans, utilising qualitative and quantitative information that support and underpin their Trust Delivery Plans.	4.4.3
8.5 By March 2017, 10% of the HSC workforce should have achieved training at Ievel in the Q2020 Attributes Framework.	N/R
8.6 By March 2017, to have reduced the number of patient and service user complaints relating to attitude, behaviour and communication by 5% compared to 2015/16. This will require renewed focus on improving the Patient and Client Experience Standards.	N/R

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the DHSSPS in N Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / long term conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the HSCB and PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction – A document published by the Minister on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not publicly funded. Also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, pharmacists, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector as well as service users and carers.

Lesbian, Gay, Bisexual & Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the HSCB arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Palliative Care – The active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of N Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) – these pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Reablement - range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Transforming Your Care – Published in 2011 the Review of Health and Social Care in NI "Transforming Your Care", sets out a model of care for health and social care which makes recommendations about how we change our services to enhance prevention, early intervention, care closer to home, and greater choice and access. The HSCB is taking forward the implementation of around 70 of the 99 proposals sets out in the TYC Report.

Trust Delivery Plans – In response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Ministerial targets, key themes and objectives outlined for the year ahead.

DEPARTMENT OF HEALTH

MEMORANDUM
TEMPORARY AMENDMENT OF THE HEALTH AND SOCIAL CARE FRAMEWORK DOCUMENT FOR THE PERIOD JUNE 2020 TO May 2022

MEMORANDUM

Introduction

This memorandum describes temporary amendments made by the Department of Health to the Health and Social Care Framework Document (the Framework Document) which the Department has introduced for a period of up to 2 years with effect from June 2020. The amendments will be initially reviewed in January 2021 and thereafter kept under regular review by the Department. The two years period will be followed by a consultation on substantive and longer term changes to the Framework Document, reflecting both learning from this period, and the dissolution of the Health and Social Care Board (HSCB) which we anticipate to coincide with this timescale.

The temporary amendments are made under the following Sections in the Health and Social Care (Reform) Act (Northern Ireland) 2009.

Department's general power

3.-(1) The Department may-

(a) provide, or secure the provision of, such health and social care as it considers appropriate for the purposes of discharging its duties under section 2; and,

(b) do anything else which is calculated to facilitate, or is conducive or Incidental, to the discharge of that duty.

Department's priorities and objectives

4.–(1) The Department shall determine, and may from time to time revise, its priorities and objectives for the provision of health and social care in Northern Ireland.

(2) Before determining or revising any priorities or objectives under this section, the Department must consult such bodies or persons as it thinks appropriate.

(3) Where the Department is of the opinion that because of the urgency of the matter it is necessary to act under subsection (1) without

consultation–
(a) subsection (2) does not apply; but
(b) the Department must as soon as reasonably practicable give notice to such bodies as it thinks appropriate of the grounds on which the Department formed that opinion.

The framework document
5. (3) The Department–
(a) shall keep the framework document under review; and
(b) may from time to time revise it.

Section 5. (5) In preparing the framework document, or any revision of it which appears to the Department to be significant, the Department must consult–
(a) each health and social care body as respects its functions (or persons considered by the Department to represent that body); and
(b) any other bodies or persons the Department considers appropriate.
(6) Each health and social care body shall have regard to the framework document in carrying out its functions.

In relation to Section 4(2) and Section 5(5) given the grave situation that Health and Social Care (HSC) is facing and the need therefore to move swiftly to begin the rebuilding of services, commencing from June 2020, the Department is engaging in an initial time limited sounding of the relevant bodies on the proposed temporary amendments and the establishment of the Management Board, to be followed by a 12 week consultation as soon as possible. While our normal practice would be to allow for a 12 weeks consultation period on such matters we are of the view that this two stage approach to engagement is reasonable and proportionate given the enormous rebuilding task that lies ahead and the need to implement this urgently.

Background

The Covid-19 pandemic has presented unprecedented challenges for the planning and delivery of HSC services in Northern Ireland, which prior to Covid-19 were already facing major strategic challenges in the form of an ageing population, increasing demand for services, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments. At the end of March 2020 there were some 307,000 patients on the outpatient waiting list, more than 93,000 waiting for inpatient and day case admissions and more than 131,000 patients waiting for diagnostic tests. The existing challenges confronting the social care sector, as described in the 'Power to People' report, have also been compounded by the pandemic.

Due to the need to redirect HSC resources to managing the Covid-19 pandemic, elective and diagnostic services have had to be curtailed with adverse impacts on the existing excessive waiting lists. The Department has collated a comprehensive assessment of the impact of Covid-19 covering the six weeks period from 9 March to 17 April 2020 across screening, primary care, community services, secondary care, and a wide range of programmes and projects. This detailed assessment indicates that the impact of the pandemic across HSC services, programmes and projects has been devastating, as resources have rightly been focused on the required emergency response. Further loss of service capacity is expected in the period from 18 April to 31 May 2020.

The impact of Covid-19 on HSC will be profound and long lasting. Covid-19 will be with us for some time and will continue to constrain service delivery across the HSC sector. Services will not be able to fully resume pre-Covid-19 delivery levels for some time due to the continued need to adhere to social distancing and for Personal Protective Equipment at volumes not required prior to the pandemic. In addition, the resilience of the HSC workforce is likely to have been eroded and will continue to be impacted with pressures particularly from the social care sector, which continues to be in the 'surge period'.

In the context of the situation described above, the HSC's overarching mission will be to incrementally increase HSC service capacity as quickly as possible across all programmes of care, within the prevailing Covid-19 conditions. The aim will be to maximise service activity within the context of managing the ongoing Covid-19 situation; embedding innovation and transformation; incorporating the Encompass programme; prioritising services; developing contingencies; and planning for the future all at the same time.

In order to achieve this mission the Department, through the temporary amendments to the Framework Document, and the establishment of a new Management Board, will give clear direction to the Health and Social Care Board (HSCB), Public Health Agency (PHA), Health and Social Care Trusts and the Business Services Organisation (BSO) of the Minister's priorities over the next two years to rebuild HSC services. To guide these bodies in this task the Department will publish a 'Strategic Framework for Rebuilding Health and Social Care Services' (the Strategic Framework). The Strategic Framework will address the adverse impact on the downturn of normal service delivery arising from the emergency plans that were introduced in March 2020 by HSC Trusts to respond to the surge in Covid-19 patients. The Strategic Framework will provide a basis on which to stabilise and restore service delivery as quickly as possible by requiring the above bodies to achieve the right balance between delivering Covid-19 and non-Covid-19 activity. The Department believes that it will take at least 2 years to achieve this, subject to the necessary investment being available and the effective management of Covid-19 during this period.

The temporary amendments to the Framework Document are therefore necessary to facilitate the optimum implementation of the Strategic Framework. In pursuance of this the Department re-commits to its statutory obligations for personal and public involvement and consultation while respecting the need for co-production with service users and the HSC workforce.

Amendments to the HSC Framework Document

The Department has produced the Framework Document to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department. The Department has made the following temporary changes to the Framework Document.

Insertion of new paragraph 2.4 (all subsequent paragraphs are renumbered)

2.4 The Department has created a new temporary management board, the 'Management Board for Rebuilding HSC Services' which will come into being in June 2020 for a period of two years to be reviewed thereafter. The Management Board will report directly to the Minister and will be responsible for providing oversight and direction to the Health and Social Care Board (HSCB), the Public Health Agency (PHA), the Health and Social Care Trusts and the Business Services Organisation (BSO) on the implementation of the Department's 'Strategic Framework for Rebuilding HSC Services'. The Management Board will not exercise any other authority in relation to the statutory duties, roles and responsibilities, as specified in the Framework, Document which the Department has delegated to the HSCB, PHA and a number of other HSC bodies. The Management Board will be chaired by the Department's Permanent Secretary and its membership will be drawn from the Department's senior officials and other senior staff from across the HSC. The Minister's Special Adviser will attend meetings of the Management Board. The Minister and the Management Board will obtain advice from experts working in health and social care fields to inform its work in the rebuilding of HSC services as required.

Insertion of new paragraph 2.38 (all subsequent paragraphs are renumbered)

2.38 The Minister directs the HSCB, PHA, HSC Trusts and BSO that for the two year period commencing in June 2020 they are to prioritise their service planning, delivery and deployment of resources to stabilise and restore service delivery as quickly as possible by achieving the right balance between

delivering Covid-19 and non-Covid-19 activity. In pursuance of this priority the Commissioning Plan Direction (CPD), Commissioning Plan and associated Service and Budget Agreements (SBAs) for the 2019/20 financial year will be rolled forward into the years 2020/21 and 2021/22 and updated to reflect Departmental budget allocations in each of these years. Individual Trust Delivery Plans (TDP) for 2020/21 and 2021/22 should also prioritise activity designed to stabilise and restore service delivery as quickly as possible at the level of local commissioning and through regional collaboration with other Trusts guided by the Department's 'Strategic Framework for Rebuilding HSC Services'. The performance targets set out in the CPD, SBAs and TDPs for the financial year 2019/20 will be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the period of the Covid-19 emergency during the years 2020/21 and 2021/22.

Insertion of new paragraph 3.7 (all subsequent paragraphs are renumbered)

3.7 Paragraph 2.38 provides the overarching context for the implementation of the requirements in paragraphs 3.1 to 3.6 during the two year period commencing in June 2020.

Department of Health (NI)
June 2020

MAHI - STM - 120 - 2257

FROM THE MINISTER OF HEALTH

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

HSC Chief Executives

Castle Buildings
Stormont Estate
BELFAST, BT4 3SQ
Tel: [redacted]
Email: private.office@health-ni.gov.uk

Your Ref:

Our Ref: SUB-0308-2022

Date: 7 March 2022

Dear Colleagues,

COMMISSIONING PLAN DIRECTION (CPD)/COMMISSIONING PLAN 2022/23

As you will be aware, a temporary amendment was made to the HSC Framework in June 2020 which saw the roll forward of the 2019/20 CPD and Commissioning Plan for a two-year period. This enabled the Health and Social Care Board and Public Health Agency to meet their statutory obligations in terms of planning and securing the provision of health and social care and other related interventions.

More recently the Health and Social Care Bill 2022, enabling the closure of the HSCB and the ending of the statutory requirement to produce an annual Commissioning Plan, achieved Royal Assent.

A significant programme of work is now underway to develop a new way of planning and managing our services based on an integrated approach. ICS NI will be underpinned by an outcomes based approach and a new Strategic Outcomes Framework is being developed which will outlines the priorities and the outcomes the system will be required to deliver.

Taking these factors into account alongside the ongoing COVID-19 pressures and the need for an agreed budget, I am writing to inform you the 2019/20 CPD and Commissioning Plan will be carried over into next year also. This will allow for the work on the Strategic Outcomes Framework and the associated planning processes to be finalised which alongside an agreed budget position will enable the development of a plan which will be outcomes focused and will articulate how services will be delivered within the resources available.

In the meantime, the process for Trust Rebuild Plans should continue and refreshed guidance will be issued on how these should be developed.

As always, I thank you and all your staff who are working to provide the best possible care to the people of Northern Ireland under difficult circumstances.

MAHI SEM 120 2258

Yours sincerely

Robin Swann MLA
Minister of Health

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

Reference: HSC (SQSD) 64/16

Date of Issue: 28 November 2016

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive PHA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents: N/A

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue the guidance and Early Alert notification to advise staff of the procedures to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

    i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
    ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
    iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
    iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: [redacted]
qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Dir of Performance Management & Service Improvement, HSCB
Dir of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts

Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Prof. Sam Porter, Head of Nursing & Midwifery, QUB
Prof. Pascal McKeown, Head of Medical School, QUB
Prof. Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

ANNEX A

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

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Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) .....

Mobile (work or home) ..... Telephone (work or home) .....

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....

MAHI - STM - 120 - 2265

SAI Process – For DROs

SAI Notification received:

- Included in a 'Daily Report' shared with Directors and relevant colleagues
- Circulated to Professional Colleagues for the respective Programme of Care:
  - Level 1 – Circulated to all members of SAI Professional Group (no longer to individual DROs)
  - Level 2/3 – Circulated to DRO and Chair of SAI Professional Group
- Listed for Weekly Incident Review Group - each Wednesday the previous week's incidents are reviewed to identify any immediate action required, correspondence received from colleagues will be considered. Actions will be taken forward by the Governance Team, the DRO for Level 2/3 Reviews will be copied into all correspondence.

Await submission of Terms of Reference (ToR) and Final Review Report

As a DRO unless you are contacted there is no action required at the stage of the process

The Governance Team will follow up on all outstanding information from Reporting Organisations. Monthly Touchpoint and Quarterly Performance Meetings also take place with Trust Governance Leads highlighting outstanding information / areas of concern.

ToR Received (Level 2 & 3 Reviews only):

ToR to be approved by the DRO – Professional opinion can be sought if required

In line with the S&Q Improvement Plan ToR & Team Membership should be approved within 2 weeks of receipt

Final Review Report Received:

- Level 1 – report saved to Network Folder for review by all members prior to the SAI Professional Group Meeting.
- Level 2 / 3 - report forwarded to DRO and saved to Network Folder for review by all members prior to the SAI Professional Group Meeting.

If any member of the Group / DRO has queries for the Reporting Organisation they can be forwarded at any stage, there is no requirement to wait until the SAI Professional Group Meeting. The Governance team will follow up until the response is received, the report will then be listed for discussion.

- Final Review Report is considered at the SAI Professional Group Meeting:
  - Agreement is made as to whether Regional Learning is required and if the SAI can be closed based on the robustness of review report, engagement and any other information provided (process for taking forward Regional Learning is outlined below).
  - All SAIs are coded using generic themes/trends upon closure.

In line with the S&Q Improvement Plan review reports should be considered, learning identified and SAI closed within 8 weeks from receipt of report.

Regional Learning Identified:

Appropriate method of dissemination agreed by Group – support will be provided by the Assistant Governance Manager:

<u>Learning Letter / RoBP Letter:</u>

- Lead assigned within SAI Professional Group to draft learning
- Draft learning shared with SAI Professional Group to be finalised
- Final draft shared with Safety Alerts for formatting
- Final Learning listed for weekly Incident Review Group for final approval
- Final Learning listed for Safety Brief for signature

<u>Newsletter Article:</u>

- Learning Matters - Group to complete Learning Matters Template – forward to LearningMatters@hscni.net
- DoIC – correspondence re learning required forwarded to Assistant Business Support Manager, Integrated Care

<u>Referred to another Group:</u>

- Information shared with relevant Group as required.

In line with the S&Q Improvement Plan learning letters should be disseminated within 6 weeks from identification

and Newsletter Articles within 8 weeks from identification

Health and Social Care Board

Public Health Agency

Protocol for the Role of a HSCB/PHA Designated Review Officer (DRO) allocated to a Serious Adverse Incident (SAI)

Revised: March 2017

Version 1.0

Contents

1.0 Background

The requirement on HSC organisations to routinely report Serious Adverse Incidents (SAIs) to the Department of Health (DoH) ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA). During 2012/13 the HSCB, working with the PHA, undertook a review of the Procedure, issued in 2010, and issued revised guidance in September 2013.

A further review was undertaken in November 2016 and issued to all Arm's Length Bodies (ALBs) for full implementation on 1 January 2017. The procedure provides guidance to all Arms Length Bodies in relation to the reporting and follow-up of SAIs arising during the course of business of a HSC organisation/Special Agency or commissioned service.

2.0 Role of the HSCB/PHA in the SAI Process

- Responsible for the effective implementation of the procedure for the reporting and follow up of SAIs across the region;

- Ensuring there are mechanisms in place for SAIs to be reviewed by relevant professionals/senior officers;

- Ensuring there are adequate safety and quality structures within the HSCB/PHA so that trends, best practice and learning is identified, disseminated and implemented in a timely manner in order to prevent recurrence;

- Identify any immediate/medium/long term strategic issues which contributed to the incident and that need to be addressed, and communicate these to the relevant commissioning service;

- Maintain a high quality of information and documentation within a time bound process.

3.0 What are the HSCB/PHA Safety and Quality Structures relating to SAIs?

It is important that when a SAI occurs, that there is a systematic process for reviewing the incident and identify potential learning. The key aim being to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across health and social care as a whole.

The HSCB and PHA therefore have developed a safety and quality structure that provides an effective mechanism for identifying and disseminating regional learning across the province.

- **Quality Safety and Experience (QSE) Group**

QSE is a jointly chaired, group that provides an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

A Regional SAI Review Subgroup reports to, and supports the work of the QSE Group.

- **Regional Serious Adverse Incident Review Sub-Group (RSAIRSG)**

The RSAIRSG is chaired by the HSCB Governance Manager and the PHA Senior Manager for Safety, Quality and Patient Experience. Membership comprises of professional representatives from the HSCB and PHA; RQIA are also in attendance.

The RSAIRSG has responsibility to ensure that trends, examples of best practice and learning in relation to SAIs are identified and disseminated in a timely manner.

- **SAI Professional Groups**

A number of professional groups from individual programmes of care have recently been established which allow DROs who share the same area of expertise to meet and discuss SAI reviews and where relevant identify regional learning prior to closure of the SAI. These professional groups also provide support to DROs when they may require advice in relation to specific SAIs.

The groups benefit from:

- Multi-professional input / wider circle of experience;
- Group sign off, decisions not focused on one individual;
- More complete understanding of the range of SAI issues within these service areas leading to the identification of regional trends.

- **Safety Quality and Alerts Team (SQAT)**

SQAT, which is closely aligned to the work of QSE, is responsible for performance managing the implementation and assurance of Regional Safety and Quality Alerts / Learning Letters / Guidance issued by HSCB/PHA in respect of SAIs.

SQAT is a multidisciplinary group with representatives from the HSCB and PHA and is chaired by the PHA Medical Director/ Director of Public Health. The Group meet fortnightly to co-ordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DoH, HSCB, PHA and other organisations. This provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation.

An overview of the Safety and Quality Structures is outlined in Appendix 1.

- **HSCB Governance Team**

The HSCB Governance Team provides the co-ordination, administrative support to all of the above groups and to individual DROs in relation to the management of SAIs from notification to closure of a SAI.

4.0 What is a DRO?

A DRO is a senior professional/officer within the HSCB / PHA who has a degree of expertise in relation to the programme of care / service area where a SAI has occurred.

5.0 What is the role of a DRO?

The DRO has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI;
  - where a DRO believes the SAI review is not being undertaken at the appropriate level.

- Agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- Reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for Level 2 and 3 RCA Reviews, including service user/family/carer engagement and liaising with other professionals (where relevant);

- Liaising with reporting organisations via the Governance Team, where:

  - More information is required in relation to a Level 1 summary report. (Whilst the HSCB will not routinely receive the full Level 1 SEA report, these can be requested.)

  - There may be concerns regarding the robustness of the Level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented.

- Identification of regional learning, where relevant;

- Surveillance of SAIs to identify patterns/clusters/trends.

- Escalate concerns/issues as necessary to the Director and onwards to the respective Chief Executive as required.

6.0 Process

The following details the systematic approach in relation to the nomination of a DRO to a SAI and the process that follows until such time as the SAI can be closed. (A flowchart reflecting each step of the SAI process is detailed in Appendix 2.)

Step 1 - Notification of SAI

- SAI notified to Governance Team by Reporting Organisation;

- Governance Team.
  - Records SAI on the Datix Risk Management System;
  - Forward SAI Notification to DRO as per Regional DRO Listing or Allocation Flowchart and copy to relevant Directors/Senior Managers (current listing and flowcharts available via the following Link http://insight.hscb.hscni.net/resources/safety/);
  - Where the DRO is not automatically allocated from a Flowchart the Regional Lead/s will assign a DRO (this may be a Regional Lead or another member of staff from within their programme of care / area of specialism). Governance Team will forward SAI Notification to the assigned DRO;

- Acknowledge receipt of SAI Notification to reporting organisation and advise on date for submission of learning summary/review report.

Step 2 - Immediate Actions

- DRO will consider SAI and if they decide it to be of major concern they will liaise immediately with their Director with a view to bringing it to the attention of the Chief Executive;
- If required, the DRO will liaise with the Reporting Organisation regarding any immediate actions required. This will be carried out in conjunction with the Governance Team;
- Governance Team will update DATIX accordingly.

Step 3 - Submission of Learning Summary/Review Report/Additional Information

- Governance Team will liaise with Reporting Organisation with regard to review report deadlines i.e. reminders, DRO queries etc;
- Reporting Organisation submit learning summary/review report to serious.incidents@hscni.net (Governance Team);
- Governance Team forward learning summary/review report to DRO;
- DRO will liaise with other professional leads, including RQIA (where relevant) on receipt of learning summary/review report. For those SAIs that are medication related, the DRO may wish to liaise with the Secondary Care Medicines Governance Team (refer to appendix 2)
- If DRO and professional leads (where relevant) are not satisfied with learning summary/review report, DRO will request additional information from the Reporting Organisation until adequate assurance is provided.
- When a DRO has received all the information it is expected the reporting organisation will be informed within a period of 12 weeks that the SAI has been closed.

Step 4 - Closure of SAI

- When a DRO is satisfied with learning summary/review report, and where relevant any additional information that has been requested, he/she informs the HSCB Governance Team they are content to close the SAI in line with HSCB/PHA 'Criteria for Closing SAIs' (Appendix 3);

- The HSCB Governance Team refers the SAI to the relevant SAI Professional Group;

  - Acute;
  - Maternal and Child Health (Including Acute Paediatrics);
  - Elderly Services and Physical Disability and Sensory Impairment;
  - Mental Health and Learning Disability Services;
  - Prison Health;
  - Integrated Care;
  - Corporate Services;
  - Childrens Services – Social Care;
  - Adult Services – Social Care.

- SAI discussed at SAI Professional Group meeting and the following agreed:
  - SAI closed with regional learning and referred to RSAIRG and/or QSE Group either for noting or discussion;
  - SAI closed without regional learning.

- Governance Team closes SAI on DATIX and informs the Reporting Organisation (and RQIA where applicable) that SAI has been closed.

Step 5 – Regional Learning Identified

- Once regional learning has been identified by the Professional Group a DRO may be required to:
  - Refer learning to Network or Group that has already been established;
  - Draft an article for inclusion within a newsletter or draft a reminder or best practice or learning letter;
  - Attend a meeting of the RSAIRG or QSE group to discuss proposed learning;
  - Be involved in a Thematic Review or Task and Finish Group.

  A flowchart outlining the approval process and dissemination of regional learning can be accessed via the following link.

  http://insight.hscb.hscni.net/resources/safety/

7.0 Supporting the DRO Process

7.1 Datix

In order to ensure Statutory Information Governance requirements are adhered to, all communication for each stage in the process should be communicated by the DRO to the HSCB Governance Team. This ensures the Corporate Record for each SAI is fully documented on the Datix Risk Management System.

7.2 DROs Supporting Information

Appendix 4 provides DROs with some supporting information which they may wish to consider on receipt of SAI notifications and learning summary/review reports**.**

7.3 Escalation Process for DRO Requests

Throughout the process there may be occasions where the reporting organisation does not agree with a DRO request. Examples include:

- escalate a SAI to a higher level review;
- amend a review report;
- issues around family engagement;
- requests for additional information are withheld;
- request for a SAI following notification of an Early Alert;
- where a DRO/Professional has been made aware of an incident that they feel should be reported as a SAI.

On these occasions, DROs should follow the escalation process as detailed below:

Stage 1 – Reporting organisation notifies the DRO that they do not agree with their request

- DRO discusses the SAI at the next relevant SAI Professional Group and if agreed the reporting organisation is notified via the Chair of the Professional Group.

Stage 2 - If the reporting organisation does still not agree:

- The DRO informs the relevant HSCB/PHA Director;
- Relevant HSCB/PHA Director discusses this with the relevant Director within the Reporting Organisation.

Stage 3 – If the Reporting Organisation is still not in agreement:

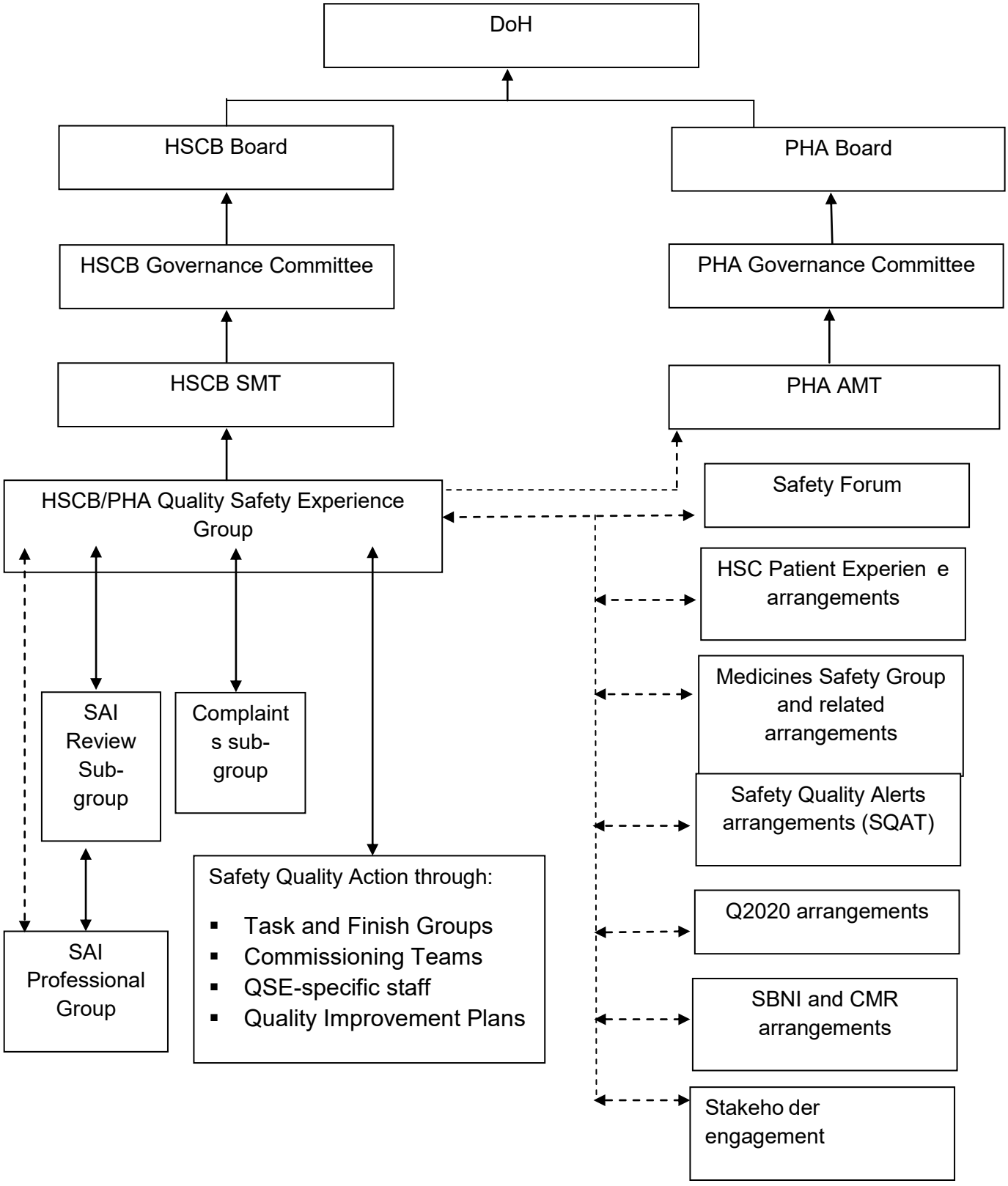
- This should be listed for consideration at QSE.

7.4 Interface Incidents Process

The HSCB/PHA process for the management of interface incidents notified to the HSCB can be accessed via the following link:
http://insight.hscb.hscni.net/resources/safety/

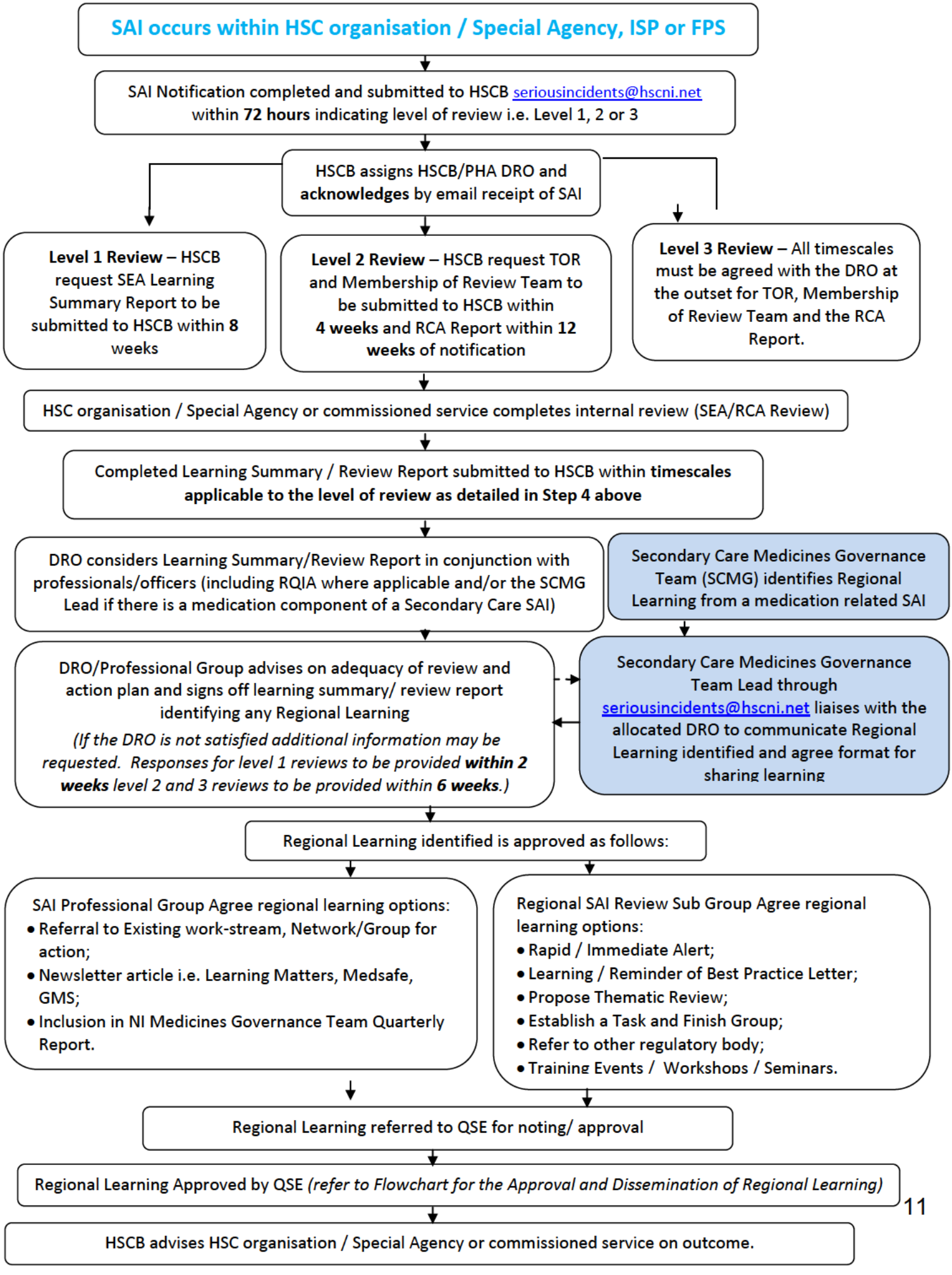
Appendix 1

HSCB/PHA SAFETY AND QUALITY STRUCTURES



Appendix 2

SAI PROCESS AND IDENTIFICATION OF REGIONAL LEARNING FLOW CHART – KEY STAGES



Appendix 3

CRITERIA FOR CLOSURE OF SAIs

A DRO can close an SAI when it meets one of the following three criteria:

1. An independent evaluation of the learning summary/review report received from the reporting organisation has been undertaken by a nominated HSCB/PHA Designated Review Officer (DRO) in conjunction with other officers/professionals (including RQIA) where relevant.

   Prior to closure the DRO must be satisfied that:

   - Format and content of the learning summary/review report is in line with regional templates for Level 1 and level 2/3 Reviews;

   - Review has been carried out appropriately by the reporting organisation (this is only applicable for level 2/3 reviews as the quality assurance of Level 1 reviews is the responsibility of the reporting organisation);

   - All reasonable steps have been taken to prevent recurrence;

   - Recommendations and actions are appropriate and where required there are performance mechanisms in place via the HSCB Governance Team to monitor these;

   - Any queries arising from the learning summary/review report have been resolved including confirmation of how local learning has been disseminated and regional learning identified;

   Other specifics of independent evaluation/review DRO may wish to consider are the Reporting Organisation:

   - has confirmed that it has discharged all statutory requirements;
   - has confirmed that all necessary safeguarding requirements associated with the incident are in place;
   - confirms details of any disciplinary action arising from the incident.

2. DRO has been informed the SAI has transferred to another relevant investigatory process i.e.

    - Case Management Review;
    - Public Inquiry;
    - Independent Expert Inquiry.

3. Following initial notification DRO is advised by reporting organisation that following preliminary reviews, incident is no longer considered a SAI. DRO will consider in conjunction with other officers/professionals, requesting additional information from reporting organisation if necessary; prior to de-escalating SAI and closure.

Appendix 4

Supporting Information for Designated Review Officers

1) At the time the SAI is notified

Immediate Actions

- Is the DRO satisfied that the Trust have taken reasonable actions to reduce the risk of recurrence pending the full review report. HSCB/PHA recognise that this cannot prejudge the outcome of the full review and that what appear to be the circumstances at the time of reporting, may not be substantiated through review;
  - The DRO should also consider if the HSCB/PHA have previously issued regional learning in relation to a similar type incident. In those circumstances, it may be appropriate to ask the Trust whether or not they have:
- Brought the incident to the attention of individual(s) staff involved to ensure that all are aware and to do an immediate review of the circumstances that led to the incident;
- Provided training/refresher training on relevant policies/procedures for the staff involved
- Informed other staff in the unit of the incident.

Level of Review

Do you agree with the level of review the Trust has proposed to undertake?

The nature, severity and complexity of serious incidents vary on a case-by-case basis and therefore the level of response should be dependent on and proportionate to the circumstances of each specific incident. The appropriate level of investigation will be proposed by the provider and agreed by the DRO upon notification, however the level of review may change as new information or evidence emerges as part of the review process.

- **Level 1 Review – Significant Event Audit (SEA)**

  Concise, internal review which is suited to less complex incidents which can be managed by individuals involved in the incident at local level.

- **Level 2 Review - Root Cause Analysis (RCA)**

  A comprehensive internal review which includes an independent element and is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors.

- **Level 3 Review - Root Cause Analysis (RCA)**

  This level of review is suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist advisors. It is required where the integrity of the review is likely to be challenged or where it will be difficult for an organisation to conduct an objective review internally.

  The HSC Regional Risk Matrix (Appendix 5) assist organisation to determine the level of seriousness and subsequently the level of review to be undertaken. DROs can similarly use this matrix to determine if they agree with the level of review being undertaken.

2) At the time the SAI Review Report is received

In your best professional judgment and from the information available to you:

- Has the family been involved appropriately?

- Where appropriate, has the Coroner been notified?

- Was membership of the Review Team appropriate for the level of review undertaken?
- From the information in the report, does it appear that the Review Team identified and reviewed the factors that led to the incident correctly and thoroughly?

- Do the conclusions reflect the facts of the incident?

- Do the recommendations address the underlying contributing factors?

- Is the Action Plan a reasonable set of actions to address the issues/recommendations identified by the review?

- Is there regional learning and if yes, what is that and how should it be handled
  - Learning Matters newsletter article
  - Learning Letter
  - Bespoke piece of work
  - Other?

- To the best of your knowledge, are you aware of other SAIs where the factors have been similar to this SAI?

- Can the SAI be closed – yes/no?

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HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

Appendix 5

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment • Any patient safety incident that required extra observation or minor treatment e g first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days duration) • Emotional distress (recovery expected within days or weeks)	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year) • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days) • Any patient safety incident that resulted in a moderate increase in treatment e g surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma) • Increase in length of hospital stay/care provision by >14 days	• Permanent harm/disability (physical/ emotional trauma) to more than one person • Incident leading to death
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues	• Single failure to meet internal professional standard or follow protocol • Audit/Inspection – recommendations can be addressed by low level management action	• Repeated failure to meet internal professional standards or follow protocols • Audit / Inspection – challenging recommendations that can be addressed by action plan	• Repeated failure to meet regional/ national standards • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities • Audit / Inspection – Critical Report	• Gross failure to meet external/national standards • Gross failure to meet professional standards or statutory functions/ responsibilities • Audit / Inspection – Severely Critical Report
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern • Local press < 1day coverage • Informal contact / Potential intervention by Enforcing Authority (e g HSENI/NIFRS)	• Local public/political concern • Extended local press < 7 day coverage with minor effect on public confidence • Advisory letter from enforcing authority/increased inspection by regulatory authority	• Regional public/political concern • Regional/National press < 3 days coverage Significant effect on public confidence • Improvement notice/failure to comply notice	• MLA concern (Questions in Assembly) • Regional / National Media interest >3 days < 7days Public confidence in the organisation undermined • Criminal Prosecution • Prohibition Notice • Executive Officer dismissed • External Investigation or Independent Review (eg, Ombudsman) • Major Public Enquiry	• Full Public Enquiry/Critical PAC Hearing • Regional and National adverse media publicity > 7 days • Criminal prosecution – Corporate Manslaughter Act • Executive Officer fined or imprisoned • Judicial Review/Public Enquiry
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m • Loss of assets due to damage to premises/property • Loss – £1K to £10K • Minor loss of non-personal information	• Commissioning costs (£) 1m – 2m • Loss of assets due to minor damage to premises/ property • Loss – £10K to £100K • Loss of information • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m • Loss of assets due to moderate damage to premises/ property • Loss – £100K to £250K • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m • Loss of assets due to major damage to premises/property • Loss – £250K to £2m • Loss of or corruption of sensitive / business critical information • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m • Loss of assets due to severe organisation wide damage to property/premises • Loss – > £2m • Permanent loss of or corruption of sensitive/business critical information • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care • Insignificant unmet need • Minimal disruption to routine activities of staff and organisation	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care • Minor unmet need • Minor impact on staff, service delivery and organisation, rapidly absorbed	• Loss/ interrup ion 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care • Moderate unmet need • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resul ing in major damage or loss/impact on service. • Major impact on public health and social care • Major unmet need • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care • Catastrophic unmet need • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisations
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release	• On site release contained by organisation	• Moderate on site release contained by organisation • Moderate off site release contained by organisation	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc)	• Toxic release affecting off-site with detrimental effect requiring outside assistance

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

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SAI Process – For DROs

SAI Notification received:

- Included in a 'Daily Report' shared with Directors and relevant colleagues
- Circulated to Professional Colleagues for the respective Programme of Care:
  - Level 1 – Circulated to all members of SAI Professional Group (no longer to individual DROs)
  - Level 2/3 – Circulated to DRO and Chair of SAI Professional Group
- Listed for Weekly Incident Review Group - each Wednesday the previous week's incidents are reviewed to identify any immediate action required, correspondence received from colleagues will be considered. Actions will be taken forward by the Governance Team, the DRO for Level 2/3 Reviews will be copied into all correspondence.

Await submission of Terms of Reference (ToR) and Final Review Report

As a DRO unless you are contacted there is no action required at the stage of the process

The Governance Team will follow up on all outstanding information from Reporting Organisations. Monthly Touchpoint and Quarterly Performance Meetings also take place with Trust Governance Leads highlighting outstanding information / areas of concern.

ToR Received (Level 2 & 3 Reviews only):

ToR to be approved by the DRO – Professional opinion can be sought if required

In line with the S&Q Improvement Plan ToR & Team Membership should be approved within 2 weeks of receipt

Final Review Report Received:

- Level 1 – report saved to Network Folder for review by all members prior to the SAI Professional Group Meeting.
- Level 2 / 3 - report forwarded to DRO and saved to Network Folder for review by all members prior to the SAI Professional Group Meeting.

If any member of the Group / DRO has queries for the Reporting Organisation they can be forwarded at any stage, there is no requirement to wait until the SAI Professional Group Meeting. The Governance team will follow up until the response is received, the report will then be listed for discussion.

- Final Review Report is considered at the SAI Professional Group Meeting:
  - Agreement is made as to whether Regional Learning is required and if the SAI can be closed based on the robustness of review report, engagement and any other information provided (process for taking forward Regional Learning is outlined below).
  - All SAIs are coded using generic themes/trends upon closure.

In line with the S&Q Improvement Plan review reports should be considered, learning identified and SAI closed within 8 weeks from receipt of report.

Regional Learning Identified:

Appropriate method of dissemination agreed by Group – support will be provided by the Assistant Governance Manager:

<u>Learning Letter / RoBP Letter:</u>

- Lead assigned within SAI Professional Group to draft learning
- Draft learning shared with SAI Professional Group to be finalised
- Final draft shared with Safety Alerts for formatting
- Final Learning listed for weekly Incident Review Group for final approval
- Final Learning listed for Safety Brief for signature

<u>Newsletter Article:</u>

- Learning Matters - Group to complete Learning Matters Template – forward to LearningMatters@hscni.net
- DoIC – correspondence re learning required forwarded to Assistant Business Support Manager, Integrated Care

<u>Referred to another Group:</u>

- Information shared with relevant Group as required.

In line with the S&Q Improvement Plan learning letters should be disseminated within 6 weeks from identification

and Newsletter Articles within 8 weeks from identification

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

SAFETY AND QUALITY ALERTS TEAM (SQAT)

1.0 Introduction

The Health and Social Care Board (HSCB) and Public Health Agency (PHA) are responsible for the co-ordination and implementation of regional safety and quality alerts (SQAs), letters and guidance issued by the Department of Health (DoH), HSCB, PHA, Regulation and Quality Improvement Authority (RQIA) and other organisations.

The Safety and Quality Alerts Team (SQAT) was formed in April 2012 to co-ordinate the implementation of regional safety and quality alerts, letters and guidance. A subsequent procedure which outlines the management of the process was established and endorsed by the DoH in July 2013 and is reviewed on an annual basis.

2.0 Accountability of the Group

The SQA Team shall report to the HSCB/PHA Quality and Safety Experience Group (QSE).

3.0 Objectives of the SQA Team

The SQA Team provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation. The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

4.0 Membership of the Group

Core membership of the SQA Team will consist of the following officers, or their nominated representative, from the HSCB and the PHA: (see annex 2 which details the current membership as at March 2017)

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- Assistant Director Nursing, Safety & Quality & Patient Experience
- Assistant Director Service Development & Screening
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Safety, Quality and Patient Experience Nurse, PHA

- Assistant Governance Manager, Safety and Quality, HSCB
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care, Head of GMS, HSCB when required
- Social Care and AHP input for Alerts relevant to those professions

5.0 Quorum

The SQA Team shall be quorate by the attendance of three members of the group; usually including representation of two professional areas. Where meetings proceed without relevant professionals present this can be endorsed at the next meeting.

6.0 Administration

- The Action log shall be taken by the Chair of the group (or nominated deputy)
- The agenda and papers will be developed by the Assistant Governance Manager and circulated by the PA to the Chair.
- The Assistant Governance Manager will oversee the process, maintain an up-to-date log, prepare for and support team meetings, and prepare an annual report. They will be supported by the Governance Support Manager and a Governance Support Officer.

7.0 Relationship/Links with Other Groups

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SQA Team will work in conjunction with various groups which include the following list of groups which is not definitive:

- HSCB / PHA Regional SAI Review Sub Group
- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Child Protection Committee (RCPC)

- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board
- Medicines Safety Sub-Group (MSSG)
- PHA/HSCB SAI Professional Groups

8.0 Frequency of Meetings

Meetings of the Team will be fortnightly.

9.0 Review of Terms of Reference

The SQA Team will review its Terms of Reference on a biennial basis or earlier as required.

Health and Social Care Board / Public Health Agency

Regional Procedure for Safety and Quality Alerts

Reference	Responsible Officer/s	Review Frequency
SQAT-09.07.18	• Head of Corporate Services, HSCB • Director of Nursing, Midwifery and Allied Health Professionals, PHA	Annual
Approved by HSCB SMT	**Approval Date:** 10 July 2018	**Next review due** June 2019
Superseded documents (if applicable) HSCB/PHA Protocol for Implementation of SQAs (April 2012) HSCB/PHA Protocol for Implementation of SQAs (August 2013) HSCB/PHA Protocol for Implementation of SQAs (May 2015) HSCB/PHA Protocol for Implementation of SQAs (July 2016) HSCB/PHA Protocol for Implementation of SQAs (March 2017)		

Version 1.0

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HSCB/PHA Regional Procedure for Safety and Quality Alerts
Date commenced: 1 April 2012
Last updated: June 2018

1.0 Introduction

The Department of Health (DoH), Health and Social Care Board (HSCB), Public Health Agency (PHA) and other organisations issue a variety of correspondence collectively referred to as Safety and Quality Alerts (SQAs).

SQAs focus on the dissemination of regional learning for the health and social care system within Northern Ireland and are issued to service providers to support improvement in practice.

The learning identified in SQAs may arise from information provided from a variety of sources for example, Serious Adverse Incidents (SAIs), Adverse Incidents (AIs), Complaints, reviews by the Regulation and Quality Improvement Authority (RQIA), legislative changes, medicines regulators, equipment or device failures, national safety systems, independent reviews and Learning Notifications.

There are already procedures in place for the management, reporting and identification of learning from a range of sources including:

- SAIs
- Complaints
- Post Fall Reviews, and
- Early Alerts.

Appendix 1 provides an overview of these established processes and links to the relevant procedures.

This revised procedure enables any HSC organisation who may have identified learning from another source, other than those identified above, and wish it to be considered for a Safety Quality Alert.

The learning may originate from one of the following sources and which the referring organisation consider significant and would benefit other Providers.

- Improved practice;
- Learning from:
    - An Adverse Incident or incident trends;
    - Mortality and Morbidly Review;
    - Patient, Client Experience;
    - Coroner's Inquests;
    - Audit or other reviews;
- Any other concern.

This new addition to the Safety Quality Alerts process is referred to as a **'Learning Notification'**.

2.0 What are Safety Quality Alerts?

Safety and Quality Alerts are the regional process which the Health and Social Care Board (HSCB) and Public Health Agency (PHA) oversee the identification, co-ordination, dissemination and implementation of learning.

Safety Quality Alerts (SQAs) are subdivided into a number of categories detailed below:

Category 1 SQAs include:

- Department of Health (DoH) Safety Quality & Standards (SQS) guidance and letters/circulars and Patient Safety Alerts (PSAs);

- Learning Letters (including other professional related letters) or Reminder of Good Practice Letters arising from established processes as outlined in Appendix 1;
- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports and equivalent robust other national enquiries/audits;
- Learning notifications.

Category 2 SQAs include:

- Medicines and Healthcare products Regulatory Agency (MHRA) notices;
- Safety Alert Broadcast System (SABS) notifications;

A separate process is in place for:

- NICE guidance.
- Drug alerts and recalls;
- Professional In-Confidence alerts regarding individual practitioners.

However in conjunction with the NICE co-ordinating process and where there are specific safety concerns in relation to commissioning issues, these will be considered by the SQA Team and referred where relevant to QSE. (***Refer to appendix 1*** – ***Overview of processes that link into the arrangements for the issuing of HSCB/PHA SQAs***)

3.0 Application of Procedure

3.1 Who does this procedure apply to?

The procedure applies to the following HSC organisations:

HSC organisations (HSC)

- Health and Social Care Board *(including the Directorate of Integrated Care on behalf of Primary Care providers i.e. GPs, Community Pharmacists, Dentists and Opticians)*
- Public Health Agency

- Business Services Organisation
- Belfast Health and Social Care Trust
- Northern Health and Social Care Trust
- Southern Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Western Health and Social Care Trust
- Northern Ireland Ambulance Service
- Regulation & Quality Improvement Authority
- Other ALBs/Special Agencies (SA)
    - Northern Ireland Blood Transfusion Service
    - Patient Client Council
    - Northern Ireland Medical and Dental Training Agency
    - Northern Ireland Practice and Education Council
    - Northern Ireland Guardian Ad Litem Agency (NIGALA)
    - Northern Ireland Social Care Council (NISCC)

4.0 Management Arrangements for SQAs

To ensure that learning is shared in a prompt, targeted and effective way, the HSCB and PHA have two key groups:

- The Quality, Safety and Experience Group;
- The Safety and Quality Alerts (SQA) Team.

4.1 Role of HSCB/PHA Quality, Safety and Experience Group

The QSE group co-ordinates and supports the activities related to safety, effectiveness and patient client focus within the HSCB and PHA. Membership and Terms of Reference are detailed at Appendix 2.

A key function of this group is to promote and share learning a component of which is the identification of learning and approval of SQAs.

The group meet monthly and is chaired by the PHA Executive Director of Nursing, Midwifery and Allied Health Professionals or nominated deputy.

An Assistant Governance manager will oversee the process, maintain an up-to-date log, prepare for and support QSE Team meetings.

4.2 Role of HSCB/PHA Safety Quality Alerts Team

The Safety Quality Alerts Team (SQAT) is responsible for the dissemination, implementation and assurance of all Category 1 SQAs and some Category 2 SQAs (as required)

The SQA Team Terms of reference and membership are detailed at Appendix 3 with membership including HSCB and PHA representatives from professional groups, and Corporate Services.

The SQA Team is chaired, by the Medical Director/Director of Public Health (DPH) or nominated deputy.

To ensure timely co-ordination and implementation of regional safety and quality alerts, the Team will meet every 2 weeks. HSCB/PHA has arrangements in place to ensure that any immediate issues that need to be addressed are processed immediately.

An Assistant Governance manager will oversee the process, maintain an up-to-date log, prepare for and support SQA Team meetings.

4.3 Role of the HSCB Alerts Office

All SQAs will be logged by the Alerts office which is managed by the Governance Team within HSCB Corporate Services.

All correspondence in relation to alerts will be channelled through the HSCB Alerts mailbox at Alerts.HSCB@hscni.net. The Alerts Office will maintain a system to track progress on implementation.

4.4 Learning Notifications – The Process

Trusts and ALBs can advise the HSCB/PHA of potential regional learning via established processes as detailed in Appendix 1 or through the completion and submission of a Learning Notification (Appendix 4 – Learning Notification Template).

In completing the Learning Notification Template organisations should consider the Trigger Tool at Appendix 5.

It is important to note that it's the responsibility of Trusts / ALBs / Special Agencies as individual organisations to undertake their own risk assessments of the issue and to take steps to mitigate the risk within their own organisation and in advance of any further regional advice, guidance or solution i.e. do not delay acting to assess and mitigate risk until a regionally agreed solution is in place.

Completed templates should be forwarded to Alerts.HSCB@hscni.net.

The Notifications will be added to the SQAT database as a category 1 alert, circulated to SQAT members and automatically listed for the next SQAT fortnightly meeting.

SQAT will also consider the following in conjunction with the trigger tool referred to in appendix 6:

- regional learning and the timeliness of this learning
- the most effective method of regional learning
- are assurances required
- is it already being considered as part of another process e.g. SAI, Complaint etc.

Where an organisation has indicated a Learning Notification requires immediate action, the Alerts office will seek confirmation from the Chair of SQAT or their nominated deputy if an immediate SQA is to be issued. If a decision is made not to issue an immediate SQA, feedback will be provided to the referring organisation.

If the Learning Notification has been determined as requiring an immediate SQA, the Chair of SQAT will assign a lead officer to develop the SQA for issue, in liaison with the Assistant Governance Manager and Chair of QSE or their nominated deputy.

The target for issuing an immediate SQA is 3 working days.

Each Trust / ALB / Special Agency is required to identify a first point of contact for queries regarding SQAs (Appendix 7 – Trust Contact points).

Appendix 8 illustrates the process used to submit learning to the HSCB/PHA

4.5 Alerts Relating to Independent Sector Providers and Primary Care Providers

Independent / primary care providers are required to respond to many types of Alerts covered by this procedure. The DoH or HSCB/PHA will send Alerts that they issue to RQIA for dissemination to relevant independent providers and to the HSCB Directorate of Integrated Care for dissemination to relevant primary care providers.

RQIA can also alert the HSCB/PHA of any regional learning they may identify in the discharge of their functions which would support improvement in the health and social care service, via a Learning Notification.

The HSCB Directorate of Integrated Care will alert the HSCB/PHA of any regional learning via the internal safety and quality structures within the HSCB/PHA.

4.6 Interface with other Safety/Quality-related organisations (not ALBs)

To ensure coordinated action across the wider system, the HSCB/PHA SQA Team will also seek input from the range of organisations and bodies that contribute to safety and quality of health and social care (Appendix 9), as required.

4.7 Process for Sharing Regional Learning from Northern Ireland with England, Wales, Scotland and Ireland

A process for sharing regional learning from Northern Ireland has been put in place whereby points of contact (named individuals) have been identified for England, Wales, Scotland and Ireland in the event of learning needing shared more widely. Arrangements have been established with NHS Improvement to allow participation in an observatory capacity on the monthly National Patient Safety Response Advisory Panel.

5.0 Process

5.1 Process prior to dissemination of SQAs

The Department of Health (DoH) issues a variety of correspondence collectively referred to as Safety Alerts. These are issued to service providers to identify those actions which providers should undertake to

assure patient and client safety and best practice. The following describes the process prior to finalisation and dissemination of SQAs.

The DoH, HSCB and PHA share certain SQAs between their respective organisations for comment prior to dissemination to the HSC. These include:

- All Patient Safety Alerts (PSAs) issued by DoH;
- Learning Letters issued by PHA/HSCB.

For SQAs developed by the DoH these will be sent to the HSCB Alerts mailbox at Alerts.HSCB@hscni.net for issue to relevant health and social care professionals within HSCB and PHA, to seek comment prior to issue by the DoH to the HSC.

For SQAs developed by the PHA / HSCB these will be sent to the DoH Safety, Quality and Standards mailbox at qualityandsafety@health-ni.gov.uk for issue to relevant Policy Leads for review to ensure compatibility with DoH policy prior to issue by the HSCB/PHA.

At this stage the level of assurance may be also considered as outlined in section 5.3.

This approach is intended to ensure that the actions required of organisations are clear through a single communication.

5.2 Dissemination of SQAs

5.2.1 Dissemination of SQAs issued by DoH

SQAs from the DoH will be issued to the Chief Executive's office of relevant organisations, and copied to the HSCB/PHA Alerts mailbox at Alerts.HSCB@hscni.net, the first point of contact in Trusts for

alerts, Governance Leads in Trusts and other relevant Directors of Trusts / ALBs / SAs.

5.2.2 Dissemination of Learning Letters/Reminder of Good Practice Letters issued by PHA/HSCB

When regional learning is identified a learning letter / reminder of good practice letter may be issued to the appropriate organisations for wider circulation, application of learning and where identified assurance that learning has been embedded.

These SQAs will be disseminated via the HSCB Alerts Office to the Chief Executive's office of relevant organisations, the first point of contact in Trusts for alerts, Governance Leads in Trusts and other and other relevant Directors of Trusts / ALBs / SAs using the standard distribution list. (see Appendix 10)

5.3 Process for Determining Assurances

Category 1 Alerts will be reviewed by the Safety Quality Alerts Team to make an initial determination on:

- Whether or not regional action is required to assist Trusts or primary care with implementation, and
- The nature of the assurance required regarding implementation.

If regional action is required, the proposed actions may be discussed where necessary with Trusts and/other relevant organisations to agree the precise task.

It is important to note that any regional actions do not in any way negate the responsibilities of Trusts or other organisations to take necessary actions to implement the Alert locally; immediate necessary action should not be delayed. However, it is recognised that some aspects of

implementation may be more efficient, and may ensure a better outcome for patients, clients, staff and the public if they are developed in a standard way across the region.

To take forward work for the region, the principle of using existing systems as much as possible, will apply. However, if necessary, a Task and Finish Group may be established, including all relevant professionals and managers from relevant providers, and as appropriate, service users and/or the public.

Category 2 Alerts will be implemented primarily through existing systems. If on occasion explicit assurance or other action is required, it will be identified by the Safety Quality Alerts Team and described to Trusts and primary care providers as outlined for Category 1 Alerts.

Appendix 11 provides an overview of the HSCB/PHA Process for the Management of Safety and Quality Alerts.

5.3.1 Criteria for Identifying Regional Action and Assurance Levels

The PHA/HSCB SQA Team will determine the detail of the method of assuring implementation of an Alert. This will be proportionate to the assessed level of risk associated with the issue covered by the Alert. It will work on the principle of using existing systems of assurance as much as possible. Options for assurance methods include:

- Level 1 – material risks which cannot be managed within normal Trust clinical and social care governance arrangements;
- Level 2 – explicit assurance by Trusts, and where appropriate, other organisations, that key actions have been implemented; the key actions may be specified by the HSCB/PHA;
- Level 3 – completion of an audit specified by HSCB/PHA.

The following criteria will be used to assess whether or not regional action is required to assist implementation, and to determine the level of assurance required:

- The risk to an individual patient, client, staff member or member of the public, is high (impact);
- The number of patients, clients, staff or public who may be exposed to the risk is high (likelihood);
- Aspects of implementation are complex and outside the control of Trusts or relevant organisations (complexity);
- A regional approach is achievable (deliverability & stakeholder agreement);
- Regional action will not introduce undue delay (timeliness);
- The Alert relates to an issue with a high public/political profile (public confidence);
- Other reasons (professional judgment).

In making its decisions, the HSCB/PHA SQA Team will take account of:

- Other Alerts relating to the service area in question;
- Common themes within a range of Alerts;
- Learning from Serious Adverse Incidents and Complaints;
- Existing safety and quality initiatives in health and social care.
- Audits

5.3.2 Informing of Regional Action/Assurances Required

On completion of the processes outlined above, if regional action or assurance is required, the Chair of the Safety Quality Alerts Team will inform Trusts, primary care, and other relevant providers or stakeholders of the next steps or requirements. Communication will be to the Trust Chief Executive's office, copied to the nominated Trust Governance Lead.

5.3.3 Reviewing Compliance of SQAs

The Safety and Quality Alert Team will consider responses to SQAs and 'close' the Alert when it is assured that actions have been implemented, or there is an existing robust system in place to ensure implementation.

In addition bi-annual progress reports to Governance Committee will be prepared by the SQA Team for the following:

- Regulation and Quality Improvement Authority (RQIA) Reports and other independent reviews;
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) reports and equivalent robust other national enquiries/audits;

These reports will detail the progress on implementation of report recommendations and provide the necessary appropriate assurance mechanism that all HSCB/PHA actions contained within reports are implemented.

6.0 Annual Reporting of SQAs

An annual report will also be prepared for the HSCB/PHA SQA Team, HSCB Senior Management Team, Local Commissioning Group (LCG) Chairs, HSCB Governance Committee, HSCB Board, DoH, Trusts and others as required.

7.0 Review of this procedure

This procedure will be refined on an on-going basis and not less than annually.

Appendix 1

Overview of established processes for identification of Regional Learning

National Patient Safety Alerts and other guidance

DoH Alerts
- SQS Guidance
- Letters/circulars inc RQIA Reports, NCEPOD & other confidential enquiries
- PSAs
- MHRA Notices
- SAB Notifications

(Received by HSCB Alerts Office & Co-ordinated via SQAT)

- NICE Guidance

HSCB/PHA (NICE Coordinating process via Commissioning Directorate)

(Safety/Quality Issues Flagged)

ALB identifies potential regional learning via one of the following regional reporting arrangements

- HSCB/PHA Regional Procedure for Safety & Quality Alerts
- HSCB Policy for the Management of Complaints
- HSCB Procedure for the Reporting and Follow-Up of SAIs
- PHA Post Falls Review Process
- HSCB Protocol for the reporting and follow up of Early Alerts
- Child Death Notification Process

Potential regional learning referred onto QSE for consideration

HSCB/PHA Quality Safety Experience Group

- Approve regional learning
- Agree method of dissemination

HSCB/PHA Safety Quality Alert (SQA)

*The **SQA Team** will take forward the co-ordination, dissemination and follow up of assurances where required*

Other form of Regional Learning to be taken forward
(i.e. via Regional Newsletter/Event etc.)

Links to relevant procedures that link into the HSCB/PHA Regional Procedure for SQAs

Please click on the links below to access other relevant procedures/policies:

Procedure For the reporting and Follow Up of SAIs 2016

HSCB-PHA Protocol for the reporting and follow up of Early Alerts 2017

Falls Shared Learning Template

HSCB Policy for the Management of Complaints

Complaints in HSC - Standards and Guidelines for Resolution and Learning

DoH circular HSS(MD) 01 2016 - Process for Reporting Child Deaths

DoH circular - HSS(MD) 04 2017 - Process for Reporting Child Deaths

Appendix 2

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY
TERMS OF REFERENCE
QUALITY SAFETY AND EXPERIENCE GROUP (QSE)

1.0 Introduction

The Health and Social Care Board (HSCB) and the Public Health Agency (PHA) receive information and intelligence from a wide range of sources in relation to safety, quality and patient experience of services commissioned.

The purpose of the Quality, Safety and Experience Group is to identify themes, patterns and areas of concern emerging from all existing sources; and agree the actions to be taken to address these in order to improve the safety and quality of services commissioned. A diagrammatic overview of the Quality, Safety Experience Internal co-ordination arrangements for the PHA/HSCB is attached in annex 1.

2.0 Objectives of the QSE Group

2.1 To streamline and further enhance current arrangements in relation to Safety, Quality and Patient Experience;

2.2 To consider learning, patterns, themes or areas of concern from all sources of information and to agree appropriate actions to be taken, and follow up of agreed actions;

2.3 To provide an assurance to the Senior Management Team of the HSCB, the Agency Management Team of the PHA and the Governance Committees and Boards of both organisations that the QSE Group has an overview of all sources of information in relation to the safety, quality and patient experience of services and is co-ordinating appropriate action in response.

3.0 Working Arrangements between Existing Groups/Information Flow to QSE

3.1 The Regional Serious Adverse Incident Review Group (SAI) and the Regional Complaints Group (RCG) will be reconstituted as a Serious Adverse Incident Sub Group and a Regional Complaints Sub Group of the QSE Group.

3.2 The Complaints and SAI Sub Groups, which will be multi-disciplinary groups, will meet on a monthly basis, prior to each QSE group, to consider in detail issues emerging from SAIs and complaints and agree issues which require to be referred to the QSE, together with a recommendation for consideration.

3.3 Other existing groups relating to the Patient Experience, Medicines Management, SQAT, Safeguarding Board and Case Management Reviews and Quality 2020 will refer matters on an agreed basis to the QSE Group with an appropriate recommendation for consideration.

4.0 Membership of the QSE

Joint Chairs: **Director of Nursing, Midwifery and Allied Health Professionals;**

Director of Public Health/Medical Director;

Director of Performance and Corporate Services;

Director of Social Care;

Assistant Director of Social Care (Safety and Quality Lead);

Representative for General Medical Services/Safety and Quality;

Head of Pharmacy and Medicines Management;

Assistant Director of Public Health Medicine (Safety and Quality)

Clinical Director, Safety Forum;

Governance Manager;

Head of Nursing, Quality and Patient Safety;

Safety, Quality and Patient Experience Nurse, PHA;

Pharmacy Lead – Medicines Governance and Public Health;

Complaints/Litigation Manager;

Head of Dental Services (co-opt as required);

Head of Optometry (co-opt as required);

Assistant Director of Allied Health Professionals (co-opt as required);

In Attendance:

Deputy Complaints Manager

Assistant Governance Manager

Senior Nurse (Safety, Quality and Patient Experience)

5.0 Frequency of Meetings

Meetings of the Group will be monthly

6.0 Administrative Support to the QSE Group

6.1 The Action log shall be taken by the Director of Nursing Midwifery and Allied Health Professionals (or her nominated deputy).

6.2 The agenda and papers will be developed and circulated by Corporate Services staff.

6.3 Agreed actions will be followed up by Corporate Services staff.

6.4 Agenda items and papers should be forwarded to qse.team@hscni.net

7.0 Review of Terms of Reference

These Terms of Reference will be reviewed in 12 months.

Appendix 3

HEALTH AND SOCIAL CARE BOARD/PUBLIC HEALTH AGENCY

TERMS OF REFERENCE

SAFETY AND QUALITY ALERTS TEAM (SQAT)

1.0 Introduction

The Health and Social Care Board (HSCB) and Public Health Agency (PHA) are responsible for the co-ordination and implementation of regional safety and quality alerts (SQAs), letters and guidance issued by the Department of Health (DoH), HSCB, PHA, Regulation and Quality Improvement Authority (RQIA) and other organisations.

The Safety and Quality Alerts Team (SQAT) was formed in April 2012 to co-ordinate the implementation of regional safety and quality alerts, letters and guidance. A subsequent procedure which outlines the management of the process was established and endorsed by the DoH in July 2013 and is reviewed on an annual basis.

4.0 Accountability of the Group

The SQA Team shall report to the HSCB/PHA Quality and Safety Experience Group (QSE).

5.0 Objectives of the SQA Team

The SQA Team provides a mechanism for gaining regional assurance that alerts and guidance have been implemented or that there is an existing robust system in place to ensure implementation. The Team 'closes' an Alert when it is assured that an Alert has been implemented, or there is an existing robust system in place to ensure implementation.

6.0 Membership of the Group

Core membership of the SQA Team will consist of the following officers, or their nominated representative, from the HSCB and the PHA:

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services
- Assistant Director Service Development & Screening
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Governance Manager, Safety and Quality, HSCB
- GP Input via Assistant Director of Integrated Care, Head of GMS, HSCB when required

- Social Care and AHP input for Alerts relevant to those professions

7.0 Quorum

The SQA Team shall be quorate by the attendance of three members of the group; usually including representation of two professional areas. Where meetings proceed without relevant professionals present this can be endorsed at the next meeting.

8.0 Administration

- The Action log shall be taken by the Chair of the group (or nominated deputy)
- The agenda and papers will be developed by the Assistant Governance Manager and circulated by the PA to the Chair.
- The Assistant Governance Manager will oversee the process, maintain an up-to-date log, prepare for and support team meetings, and prepare an annual report. They will be supported by the Governance Support Manager and a Governance Support Officer.

7.0 Relationship/Links with Other Groups

There are a range of other quality and safety groups across the HSCB/PHA where learning and best practice can be identified and shared. To ensure continuity of learning the SQA Team will work in conjunction with various groups which include the following list of groups which is not definitive:

- HSCB / PHA Regional SAI Review Sub Group
- HSCB / PHA Regional Complaints Sub Group
- Patient and Client Experience Steering Group
- Promoting Good Nutrition Implementation Steering Group
- Regional Falls Prevention for Acute Services Group
- Regional Pressure Ulcer Prevention Advisory Group
- Regional Project Steering Group Evidencing Care through key nursing performance indicators
- Medicines Governance Advisors Groups
- Regional Child Protection Committee (RCPC)
- Regional Governance Officers Group
- HSC Safety Forum Strategic Partnership Group
- Northern Ireland Quality Network
- Regional Emergency Service Collaborative Group
- Safeguarding Board
- Medicines Safety Sub-Group (MSSG)

- PHA/HSCB SAI Professional Groups

8.0 Frequency of Meetings

Meetings of the Team will be fortnightly.

9.0 Review of Terms of Reference

The SQA Team will review its Terms of Reference on a biennial basis or earlier as required.

Appendix 4

LEARNING NOTIFICATION TEMPLATE

Subject / Learning	*Self- explanatory*			
Organisation / Trust	*Self- explanatory*			
Organisation / Trust ref no.	*Self- explanatory*			
Service Area / Speciality	*Self- explanatory*			
Contact Person	*Self- explanatory*			
Please indicate if the propsoed Regional Learning is considerded Immediate ***select as appropriate (✓)***	Yes		No	

SUMMARY OF EVENT

Guidance Notes:

*Provide a **brief factual description** of what has happened and a summary of the facts leading up to the event.*

*Where relevant include D.O.B, Gender and Age. **All should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

LOCAL ACTION TAKEN BY REPORTING ORGANISATION

Guidance Notes:

Based on the understanding of why the event happened and the identification of learning, outline the action(s), agreed and implemented locally within your organisation. This should include immediate and ongoing action.

REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA

Guidance Notes:
Please list learning points you feel should be considered by the HSCB/PHA to share regionally indicating the programmes of care where the learning is applicable.

Please refer to appendix 5 - 'Trigger tool for submission of a Learning Notification Template' to determine if regional learning should be issued i.e. is one or more of the following criteria met:

No.	Criteria ***select as appropriate (✓)***	Yes	No
1	New or under-recognised Risk identified.		
2	Action is outside the remit of the reporting organisation		
3	Likelihood of this happening again and the potential for harm has been identified;		
4	There is a requirement for more robust barriers to be developed for regional implementation;		
5	Relevant to a specialist service		

LEARNING SOURCE

Please identify the source of this proposed regional learning and any other relevant information as appropriate (✓)

Example of good practice		Audit or other review	
Adverse Incident (AI)		Coroner's inquest	
Mortality and Morbidity (M&MR)		Litigation Claim	
Patient Client Experience (PCE)		Incident trends	
Other (please specify below)			

Additional Information:

SUGGESTED METHOD OF REGIONAL LEARNING

If your organsiation has a suggested method for dissemination of the propsoed regional learning please select as appropriate and include narrative (✓)

Rapid / Immediate Alert		Learning Letter ***(new learning where there is no existing guidance or policy)***	
Reminder of Best Practice Guidance Letter ***(where there already is regional guidance or policy in place)***		Professional Letter	
Regional Newsletter Article i.e. Learning Matters / GMS / Med Safe Newsletter etc.		Existing Work stream or Network	
Propose Thematic Review		Establish a task and finish group	
Refer to other regulatory body		Training Event/ Workshop / Seminar	
ECHO videoconference session		Other	

Additional Information:

Approved by:	*This must be approved by the designated point of contact within your organisation for quality and safety communication.*
Designation:	*Self- explanatory*
Date approved:	*Self- explanatory*

Please note it remains the responsibility of your organisation to have undertaken your own risk assessment of the issue and steps to mitigate the risk in advance of any further regional advice.

On completion please submit to Alerts.HSCB@hscni.net

Appendix 5

TRIGGER TOOL FOR SUBMISSION OF A LEARNING NOTIFICATION TEMPLATE

This is an aide to Provider organisations when considering the submission of a Learning Notification.

The action we take as a result of what we learn from incidents/events is vital in protecting patients/clients across the HSC from harm and ensures we continue to improve the health and social care service.

To identify if a Learning Notification Template should be submitted to the HSCB/PHA for consideration of regional action the following criteria should be considered.

1. **New or under-recognised Risk** - Talk to experts, patients and their families, and frontline staff to confirm the risk is **new or under-recognised**; these groups may have different perspectives.

2. **Outside the remit of the reporting organisation** - Check whose **remit** an issue falls under, as some aspects of patient safety are handled by other organisations and can be passed to them for action.

3. **Likelihood of this happening again and the potential for harm** - Look for up-to-date detail about the issue, research studies and other published material, and seek advice from specialists and frontline staff to help identify the **likelihood of this happening again and the potential for harm**.

4. **Requirement for more robust processes to be developed for regional implementation**- Explore whether organisations can do something more **constructive** than simply raising awareness and warning people to be vigilant against error, and the options for these actions (including interim actions while more robust barriers to error are developed).

5. **Relevant to a specialist service** - If your Trust is responsible for a s**pecialist service**, it is still important to report any safety concerns in order to identify potential regional learning across the system.

Note: The above trigger list has been based on the NHS Improvement Patient Safety Review and Response Report (April to September 2017) which has been adopted for the purposes of this procedure.

Submission of a Learning Notification

Each notification must be submitted by the agreed point of contact within each organisation (see appendix 4) and sent to Alerts.HSCB@hscni.net

Appendix 6

TRIGGER TOOL FOR THE ISSUE OF A HSCB/PHA REGIONAL SAFETY AND QUALITY ALERT

This aid is used by the HSCB/PHA in the decision making process for issuing a Safety Quality Alert (SQA). A SQA is typically issued to make providers organisations aware of and share any substantial new regional learning that will help to improve patient/client safety or to share or remind of best practice guidance.

The HSCB/PHA consider the following questions before planning or issuing a SQA:

By issuing a SQA will it…		Why is this important?
	Address an issue that causes, or has potential to cause, severe harm or death or significantly improve care?	This helps providers implement improvement or target resources where they are most needed.
	Detail new learning, or will it include some new or under-recognised content?	SQAs have their greatest impact if they are part of an overall plan to support uptake and implementation of improvement.
	Reinforce information published by one or more national bodies, professional or patient organisations or networks, bearing their logo and hosted on their website?	This ensures the SQAs are developed with the necessary specialist expertise to give them credibility, and ensures they remain updated.

	Be substantial, in relation to a patient/client safety issue or area of good practice?	This question relates to whether the SQA addresses a substantial part of a patient/client safety or improvement issue.
	Practical and helpful?	SQAs must support Provider organisations to improve their services.
	Focused on patient/client safety or a key aspect of improvement?	Public health messages and other aspects of quality (such as clinical effectiveness guidelines from the National Institute for Health and Care Excellence (NICE), have their own communication routes.
	Relevant to most health and social care providers	If SQAs apply only to a specialist service provided by the minority of providers in a sector, their communication can be directly targeted instead.

Note: If a decision is reached not to issue a SQA, learning can also be shared through the other identified routes:

- Newsletter article
- Learning Event
- Thematic Review/Audit
- Shared with an existing network/forum
- Establish a Task and Finish Group

Once it has been determined to issue a SQA it is important to ensure the actions are specific and defined. Therefore the HSCB/PHA should consider the following:

Are the actions:		Why is this important?
	Developed and tested to the point we can be confident are the sole or best current approach to improving safety, are practical and do not introduce new risks?	In complex health and social care systems, even with the best possible proactive risk assessment, a change that is expected to make an improvement can have unintended effects.
	Provides an effective barrier to error **or** requires standardisation to a single consistent approach across the HSC?	Where no strong or moderately strong barrier has been identified to avoid error addressing less serious issues can be shared through other routes.
	Acceptable without wider public consultation?	For actions where the HSCB/PHA is concerned about adverse impacts or costs, or has conflicting views on which of two or more current approaches to adopt as standard, a wider public consultation may be needed.
	Relevant to most health and social care providers?	If the actions apply only to a specialist service provided by the minority of providers in a sector, their communication can be directly targeted instead.
	Is the cost proportionate to the reduction in harm the actions can be expected to achieve?	Calculating the scale and cost of current harm and the impact of the intervention is not straightforward for most patient safety issues, but we work within the principles of cost per year of quality-adjusted life used by NICE, so that finite NHS resources are directed at the patient safety issues where they have the greatest impact. For some issues, potential to reduce costs of litigation may also need to be factored in.

Note: The above trigger list has been based on the NHS Improvement Patient Safety Review and Response Report (April to September 2017) which has been adopted for the purposes of this procedure.

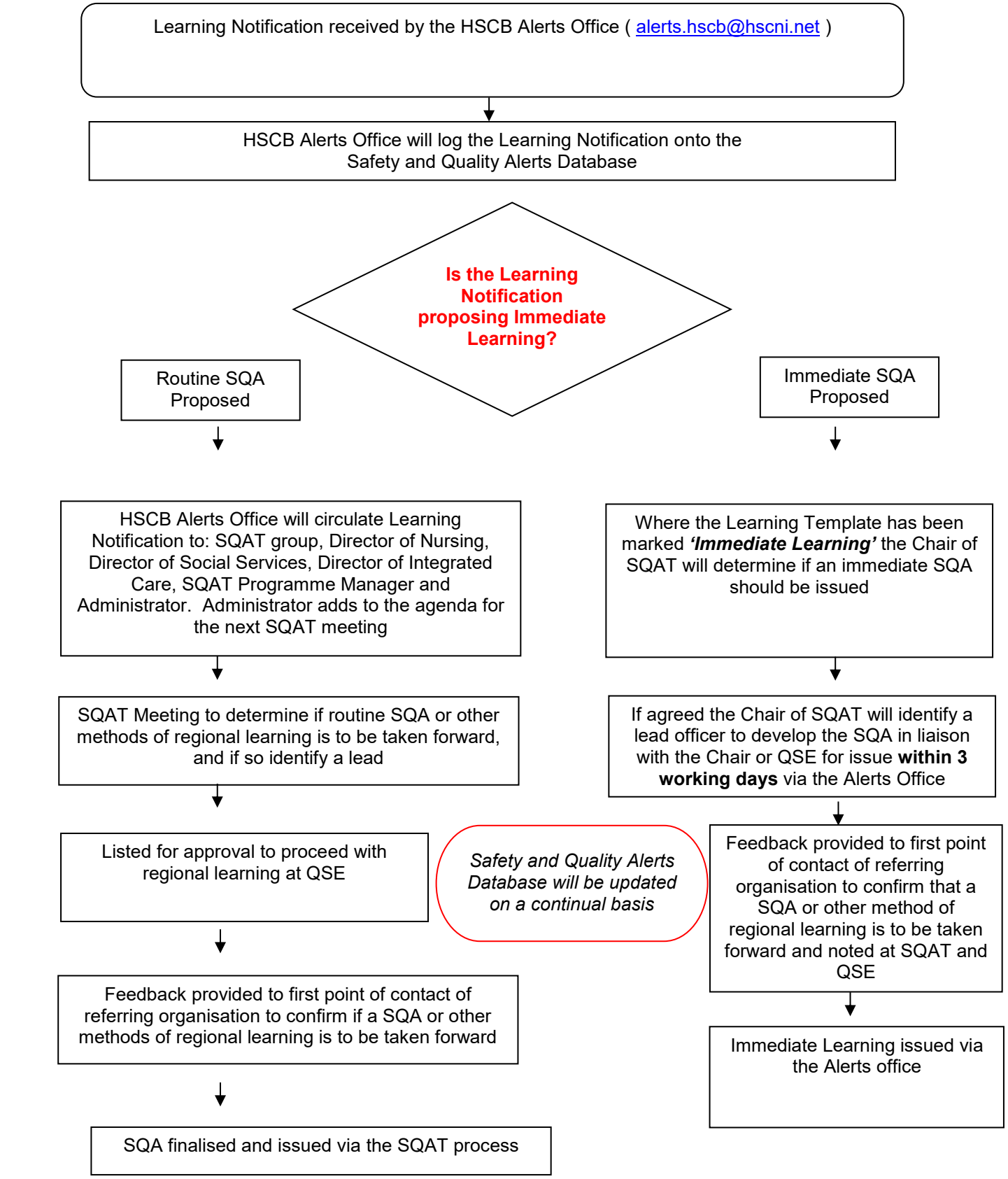
Appendix 7

HSC Trust Contacts

HSC Trust	Medical Director	Governance Lead	SQA First Point of Contact	Contact point for responses to assurances
BHSCT	Dr Cathy Jack	Claire Cairns	trusthq@belfasttrust.hscni.net	Jill Shaw O'Doherty **Copy:** • Martine McNally • trusthq@belfasttrust.hscni.net
NHSCT	Mr Seamus O'Reilly	Sinead O'Kane	Ruth McDonald **Copy:** quality.safety@northerntrust.hscni.net	Ruth McDonald **Copy:**quality.safety@northerntrust.hscni.net
SEHSCT	Dr Charlie Martyn	Irene Low	Liz Campbell **Copy:** Irene Low Linda Kelly	Liz Campbell **Copy:** Irene Low Linda Kelly
SHSCT	Dr Ahmed Khan	Margaret Marshall	Nicole O'Neill **Copy:** • StandardsAndGuidelines@southerntrust.hscni.net • Caroline Beattie	Nicole O'Neill **Copy:** • StandardsAndGuidelines@southerntrust.hscni.net • Caroline Beattie
WHSCT	Dr Dermot Hughes	Therese Brown	Therese Brown	Teresa Murray
NIAS	Dr Nigel Ruddell	Katrina Keating	Katrina Keating **Copy:** • Dr Nigel Ruddell	Katrina Keating **Copy:** • Dr Nigel Ruddell

Appendix 8

HSCB/PHA Internal Process for Managing Learning Notifications from HSC Trusts & other ALBs



Note: This appendix should be read in conjunction with the flow chart in appendix 11

Appendix 9

Safety Quality Alerts Team Membership and Links with other Safety/Quality-related organisations

HSCB/PHA Safety Quality Alerts Team Membership

- Medical Director/DPH, PHA (Chair)
- Director of Performance and Corporate Services, HSCB
- Assistant Director Nursing, Safety & Quality & Patient Experience, PHA
- Safety, Quality and Patient Experience Nurse, PHA
- Assistant Director Service Development & Screening, PHA
- Pharmacy Lead – Medicines Governance and Public Heath, HSCB
- Consultant in Public Health, PHA
- Clinical Director for Safety Forum, PHA
- GP Input via Assistant Director of Integrated Care (Head of GMS) HSCB - when required
- Social Care and AHP input for Alerts relevant to those professions
- Assistant Governance Manager, Safety and Quality, HSCB

SQA Team Roles

- Chair – Dr Carolyn Harper
- Lead Performance – Lisa McWilliams
- Lead Nurse – Mary McElroy / Christine Armstrong
- Lead Service Development & Screening – Dr Brid Farrell
- Lead Pharmacist – Matthew Dolan
- Lead Public Health Doctor / Safety Forum – Dr Jackie McCall
- Lead AHP – through Michelle Tennyson
- Lead GP – Dr Margaret O'Brien
- Lead Social Worker – through Cecil Worthington
- Assistant Governance Manager / Programme Manager – Margaret McNally
- Admin Support – Christine Thompson / Elaine Hyde

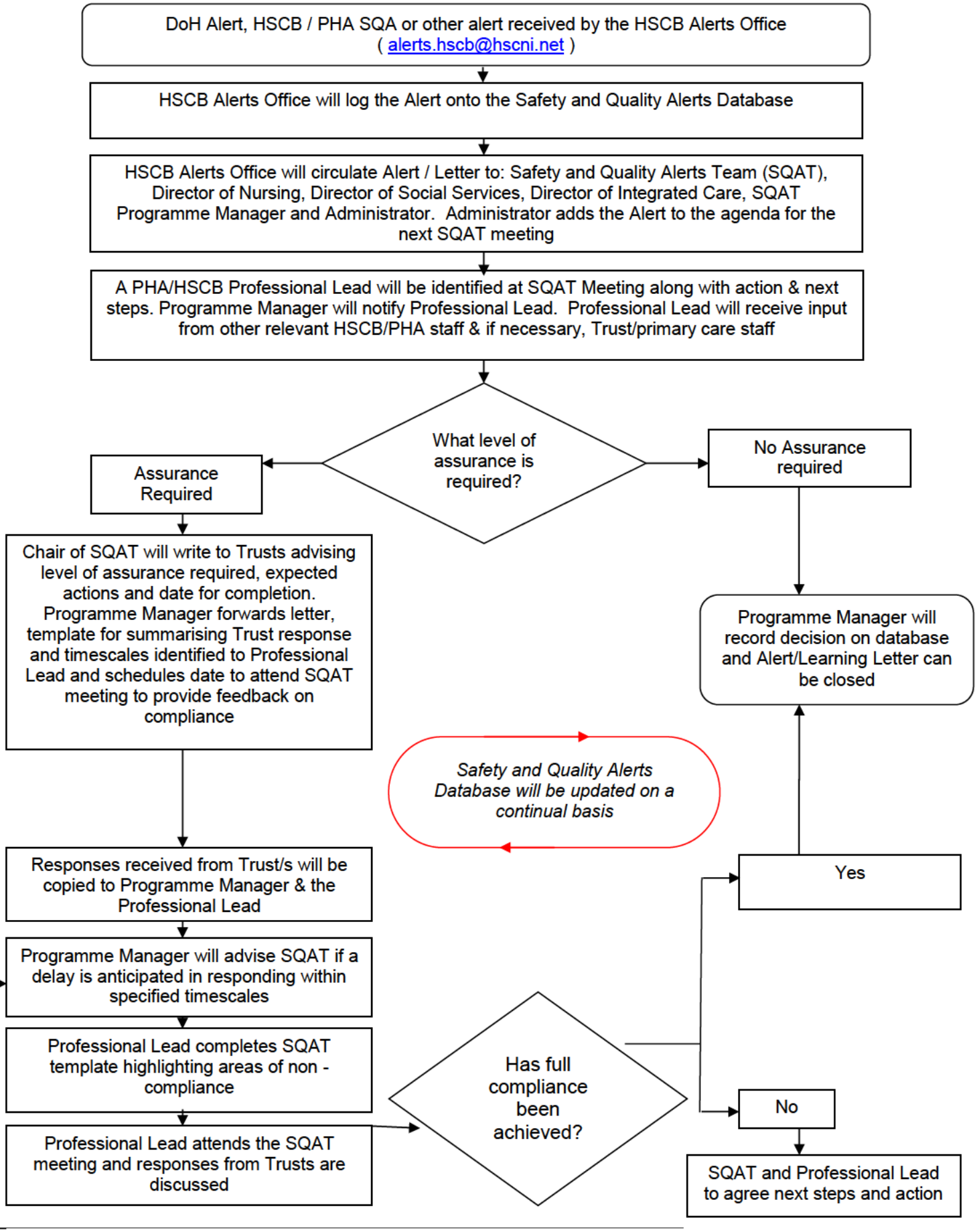
Link as required with the following **Safety/Quality-related organisations**

- NI Social Care Council
- Safeguarding Board NI
- NI Adult Safeguarding Partnership
- Trust Leads for professional education
- Under and postgraduate training bodies
- NIAC, DoH
- NHS Improvement
- Healthcare Improvement Scotland
- NHS Wales
- Health Service Executive, RoI

Template Distribution List **Appendix 10**

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs			CEX		
Medical Director			Medical Director/Director of Public Health		
Directors of Nursing			Director of Nursing/AHPs		
Directors of Social Services			PHA Duty Room		
Governance Leads			AD Health Protection		
Directors of Acute Services			AD Service Development/Screening		
Directors of Community/Elderly Services			AD Health Improvement		
Heads of Pharmacy			AD Nursing		
Allied Health Professional Leads			AD Allied Health Professionals		
Directors of Human Resources			Clinical Director Safety Forum		
NIAS			**HSCB**		
CEX			CEX		
Medical Director			Director of Integrated Care		
RQIA			Director of Social Services		
CEX			Director of Commissioning		
Director of Quality Improvement			Alerts Office		
Director of Quality Assurance			Dir PMSI & Corporate Services		
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean			GPs		
QUB			Community Pharmacists		
Dean of Medical School			Dentists		
Head of Nursing School			**BSO**		
Head of Social Work School			Director of Human Resources		
Head of Pharmacy School			**Open University**		
Head of Dentistry School			Head of Nursing Branch		
UU			**DoH**		
Head of Nursing School			CMO office		
Head of Social Work School			CNO office		
Head of Pharmacy School			CPO office		
Head of School of Health Sciences (AHP Lead)			CSSO office		
Clinical Education Centre			CDO office		
NIPEC			Safety, Quality & Standards Office		
NICPLD			**NI Social Care Council**		
NI Medicines Governance Team Leader for Secondary Care			**Safeguarding Board NI**		
Coroners Service for Northern Ireland			**NICE Implementation Facilitator**		

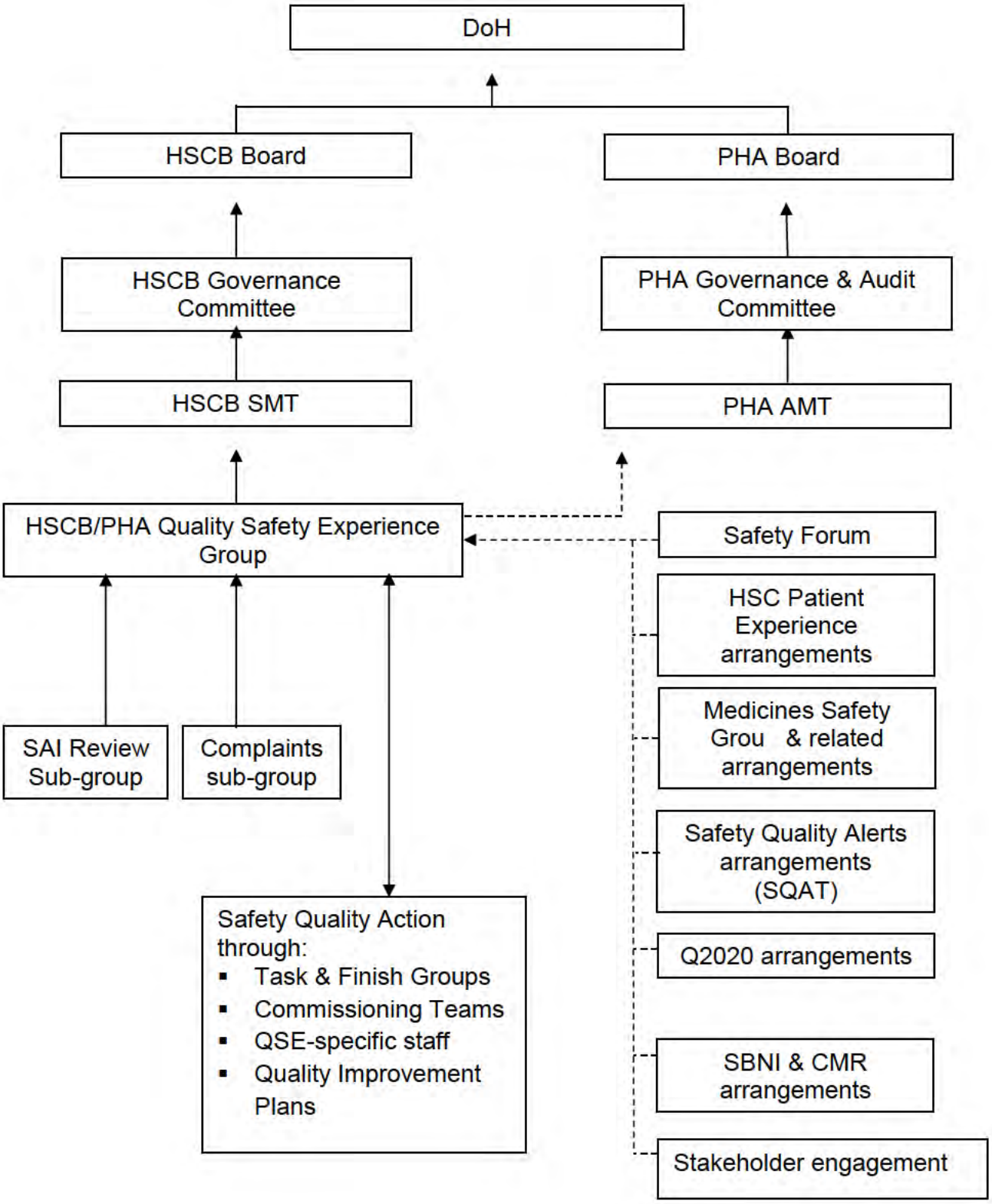
HSCB/PHA Internal Process for the Management of Safety and Quality Alerts



Note: Category 2 Alerts are not automatically listed for SQAT meetings. These are received and logged by the Alerts Office. The Lead Public Health Doctor/Safety Forum reviews these on receipt and escalates to SQAT as required.

Annex 1

Diagrammatic Overview of Quality Safety Experience Internal Coordination Arrangements – HSCB/PHA



Terms of Reference

Incident and Learning Review Group

1.0 Purpose of the Group

The purpose of the Incident Review Group is to provide assurances that all notifications submitted to the HSCB's Serious Incidents mailbox are reviewed and managed in line with guidance for the:

- Procedure for the Reporting and Follow up of Serious Adverse Incidents (November, 2016)
- HSCB/PHA Protocol for the reporting and follow up of the DoH Early Alert System (February, 2017)
- HSCB/PHA Regional Procedure for Safety and Quality Alerts (July, 2018)

The Group ensures collective, multidisciplinary decision making on the management of all notifications received into the SAI mailbox in a timely manner. Any urgent action required is identified and areas of concern or importance are highlighted to Safety Brief each week.

In line with the above procedures, the Group also reviews safety and quality alerts that have either been issued to the HSC by DoH or due to be issued by HSCB/PHA as a result of learning from SAIs, AIs and complaints.

2.0 Objectives of the Group

- All notifications, including SAIs, Early Alerts, Interface Incidents and Shared Learning Notifications are reviewed to ensure:

    - Immediate action is taken forward, if required
    - Appropriate allocation to DRO / POC
    - Appropriate level of Review for SAIs is undertaken
    - A SAI is requested following an Early Alert / Interface Incident notification if required
    - Early Alerts / Interface Incidents are closed where appropriate
    - Shared Learning Notifications are reviewed and forwarded to the relevant Professional Group for action

- Apply a set of regional codes which can be used in conjunction with CCS2 Coding to identify regional recurring themes / trends.

- Review all Safety and Quality Alerts upon receipt, identifying if any immediate action is required and assign a Lead.

- Consider and approve draft professional, learning and reminder of best practice letters prior to noting at Safety Brief and final signature of relevant Directors.

- Escalate areas of concern as appropriate to Safety Brief on a weekly basis.

- By exception, the Group will review / discuss any issues escalated from the SAI Professional Groups if an urgent issue requires discussion before the next meeting of Professional Group.

3.0 Accountability of the Group

The Incident Review Group provides assurance to safety brief on a weekly basis that any urgent action is taken following the receipt of notifications and that any areas of concern are promptly escalated.

4.0 Group Membership

Jointly Chaired	Assistant Director of Nursing, Quality and Safety Governance Lead
Members	Deputy Governance Lead
	Nursing Representative
	Medical Representative
	Social Care Representative (Children's and Elderly)
	Mental Health Nursing Representative
	Integrated Care Representative (Pharmacy)
	HSCB Assistant Governance Manager
	AHP representative
	Project manager Safety and Quality

5.0 Frequency of Meeting

The group will meet weekly.

6.0 Quorum

The Incident Review Group shall be quorate by the attendance of three members of the Group, with a minimum of two professions.

6.1 Revision of Terms of Reference

The Terms of Reference will be reviewed in twelve months (January 2023) or earlier as required.

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

GUIDANCE IN RELATION TO THE

HEALTH AND SOCIAL CARE COMPLAINTS PROCEDURE

Updated April 2023

REVISIONS TO HSC COMPLAINTS PROCEDURE

Title	Update/Action	Date Effective
Guidance in relation to the Health and Social Care Complaints Procedure	Updated to reflect the closure of the Health and Social Care (HSC) Board and migration of functions to Strategic Planning and Performance Group (SPPG), DoH.	01 April 2022
Guidance in relation to the Health and Social Care Complaints Procedure	Introduced in place of: Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning.	01 April 2019
Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning	Introduced in place of: (HPSS) Complaints Procedure 1996.	01 April 2009
Health and Personal Social Services (HPSS) Complaints Procedure 1996	Revoked and replaced with new Guidance.	31 March 2009

AMENDMENTS TO COMPLAINTS DIRECTIONS

Directions	Details	Date Effective
Health and Social Care Complaints Procedure Directions	The Main Directions were amended for the third time at: • Paragraph 2 (Interpretation) of the principal Directions: ▪ omit the definition of "HSC Board". ▪ in the definition of "HSC Body" omit "HSC Board". ▪ in the definition of "Serious Adverse Incident" omit "HSC Board's". [1]	28 October 2022 **2022 No. 4**

([1]) Also refers to the 2013 Amendment Directions

Directions	Details	Date Effective
	• Paragraph 7 (No investigation of complaint): ▪ in sub-paragraph (1)(d) for "the Data Protection Act 1988" substitute "the Data Protection Act 2018([2])". ▪ in sub-paragraph (4A) for "Serious Adverse Incident investigation" substitute "Serious Adverse Incident review". • In paragraph 15(4) (Monitoring), for "HSC Board" at each place it occurs, substitute "Department of Health" and for the "Data Protection Act 1998" substitute "Data Protection Act 2018". • In paragraph 16(2) (Learning), for "HSC Board" substitute "Department of Health". • In paragraph 17 (Annual Reports) omit sub-paragraph (2).	
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The Directions to the Health and Social Care Board on Procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers 2009 are revoked.	28 October 2022 **2022 No. 4**

([2]) 2018 c. 12

Directions	Details	Date Effective
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The **PHA Directions** were amended for the second time at: • In paragraph 2 (Interpretation) in the definition of "Serious Adverse Incident" omit "HSC Board's". • In paragraph 7 (No investigation of complaint): ▪ in sub-paragraph (1)(d) for "the Data Protection Act 1998" substitute "the Data Protection Act 2018([3])". ▪ in sub-paragraph (4A) for "Serious Adverse Incident investigation" substitute "Serious Adverse Incident review".	28 October 2022 **2022 No. 5**
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The **BSO Directions** were amended for the second time at: • In paragraph 2 (Interpretation), in the definition of "Serious Adverse Incident" omit "HSC Board's". • In paragraph 7 (No investigation of complaint): ▪ in sub-paragraph (1)(d) for "the Data Protection Act 1998" substitute "the Data Protection Act 2018([4])". ▪ in sub-paragraph (4A) for "Serious Adverse Incident investigation" substitute "Serious	28 October 2022 **2022 No. 3**

([3]) 2018 c. 12
([4]) 2018 c. 12

Directions	Details	Date Effective
	Adverse Incident review".	
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The **BSO Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman. • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	01 April 2019 **2019 No. 4**
Directions to the Regional Agency for Public Health and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints	The **PHA Directions** were amended for the first time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	01 April 2019 **2019 No. 3**

Directions	Details	Date Effective
	• Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol	
Directions to the Health and Social Care Board on procedures for dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the third time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions—the definition of vulnerable adults policy or procedures was updated to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as “honest	01 April 2019 **2019 No. 2**

Directions	Details	Date Effective
	broker" to the complainant and Practice/Practitioner in the resolution of the complaint.	
Health and Social Care Complaints Procedure Directions	The **Main Directions** were amended for the second time at: • Paragraph 2 (Interpretation) of the principal Directions (a) update to Northern Ireland Public Services Ombudsman • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs. • Paragraph 7 (No investigation of complaint) of the principal Directions— update to adult safeguarding procedures or protocol • Paragraph 12 (Referring a complaint) of the principal Directions, for sub-paragraph (5)(b) substitute(b) The HSC Board Complaints Manager acts impartially as "honest broker" to the complainant and Practice/Practitioner in the resolution of the complaint.	01 April 2019 **2019 No. 1**

Directions	Details	Date Effective
	• Paragraph 14 (Response) of the principal Directions omit sub-paragraph (7).	
Complaints about Family Health Services Practitioners and Pilot Scheme Providers **(Amendment)** Directions (Northern Ireland) 2013	The **HSC Board Directions** were amended for the second time in regard to the handling of complaints under paragraph 12(5)(b) at: • Paragraph 18(c) (Response) was amended to include sub-paragraph 18(c)(i) to respond to the complainant within 20 days when the HSC Board has been asked to act as 'honest broker'; and • Sub-paragraph 18(c) (ii) to respond to the complainant within 10 days in all other cases.	02 September 2013 **2013 No. 12**
Health and Social Care Complaints Procedure Directions **(Amendment)** (Northern Ireland) 2009	The **Main Directions** were amended for the first time at: • Paragraph 2 (Interpretation), where the definition of an SAI was added; • Paragraph 7(1) (No investigation of complaint) where sub-paragraph 7(1)(m) was added in regard to SAIs; and • Paragraph 7(4) where paragraph 7(4A) was added in regard to SAIs.	02 September 2013 **2013 No. 11**
Directions to the Regional Business Services Organisation on Procedures for dealing with Health and Social Care Complaints	The Directions were introduced. Known as **BSO Directions**	26 July 2010
Directions to the Regional Agency for Public Health	The Directions were introduced. Known as **PHA Directions**	26 July 2010

Directions	Details	Date Effective
and Social Well-Being on Procedures for Dealing with Health and Social Care Complaints		
Amendment Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The **HSC Board Directions** were amended for the first time in respect to monitoring and the requirement by the Family Practitioner Services or pilot scheme provider to obtain consent from the complainant was removed at: Paragraph 21(2)(a) in regards to what the practitioner must send to the HSC Board and the timescale: and Paragraph 21(2) (b) in regards the practitioner sending the HSC Board quarterly complaints.	01 October 2009
Directions to the Health and Social Care Board on procedures for dealing with complaints about Family Health Services Practitioners and Pilot Scheme Providers	The Directions were introduced. Known as **HSC Board Directions**	01 April 2009
Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009	The Directions were introduced. Known as **Main Directions**	01 April 2009

BACKGROUND

The HSC Complaints Procedure*, 'Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning'* was developed and published in 2009*.* It replaced the former Health and Personal Social Services (HPSS) Complaints Procedure 1996 and provided a streamlined health and social care (HSC) complaints process that applies equally to all HSC organisations. As such it presented a simple, consistent approach and set out complaints handling procedures with clear standards and guidance for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

The HSC Complaints Procedure (published 2009) was developed in conjunction with HSC organisations and publically consulted on before being finalised and published. It reflected the changing culture across HSC services and demonstrated an increased emphasis regarding the promotion of and need for **safety and quality** in service provision as well as the need to be open and transparent; and to learn from complaints and take action in order to reduce the risk of recurrence.

On the 1st April 2019 revised guidance was introduced and incorporated a number of legislative changes. The document was renamed, '*Guidance in relation to the Health and Social Care Complaints Procedure' or 'HSC Complaints Procedure'* for short.

The HSC Complaints Procedure presents HSC organisations with detailed, yet flexible, complaints handling arrangements designed to:

- provide effective local resolution and learning;
- improve accessibility;
- clarify the options for pursuing a complaint;
- promote the use and availability of support services, including advocacy;
- provide a well-defined process of investigation;
- promote the use of a range of investigative techniques;
- promote the use of a range of options for successful resolution, such as the use of independent experts, lay persons and conciliation;
- resolve complaints quickly and efficiently;
- provide flexibility in relation to target response times;

- provide an appropriate and proportionate response within reasonable and agreed timescales;
- provide clear lines of responsibility and accountability;
- improve record keeping, reporting and monitoring; and
- increase opportunities for shared learning across the region.

The standards for complaints handling are designed to assist HSC organisations in monitoring the effectiveness of their complaints handling arrangements locally and build public confidence in the process. The eight specific standards of HSC are:

Standard 1: Accountability
Standard 2: Accessibility
Standard 3: Receiving complaints
Standard 4: Supporting complainants and staff
Standard 5: Investigation of complaints
Standard 6: Responding to complaints
Standard 7: Monitoring
Standard 8: Learning

More details on each of the standards are provided in Annex 1 of this document.

It is recognised that sometimes, and even in despite of the best efforts of all concerned, there will be occasions when local resolution fails. Where this happens the complainant will be advised of their right to refer their complaint to the Ombudsman. The HSC Organisation also reserves the right to refer complaints to the Ombudsman.

Update – 01 April 2022

As a result of the migration of the HSC Board to the Department of Health (DoH) this guidance has been amended to reflect the transfer of the HSC Board functions in respect of HSC Complaints to the Strategic Planning and Performance Group (SPPG) in the Department.

SPPG will on behalf of the Department of Health assume the roles and responsibilities previously undertaken by the HSC Board. This updated guidance is effective from 01 April 2022.

SECTION 1 – INTRODUCTION

Purpose of the HSC Complaints Procedure

1.1 This document is an updated version of the HSC Complaints Procedure which was first published in 2009 and sets out how HSC organisations should deal with complaints raised by people who use or are waiting to use their services. It replaces any previous or existing guidance with effect from 01 April 2022 and continues to provide a streamlined complaints process which applies equally to all HSC organisations, including the HSC Trusts, Business Services Organisation (BSO), Public Health Agency (PHA), NI Blood Transfusion Service (NIBTS), Family Practitioner Services (FPS), Out of Hours services, pilot schemes and HSC prison healthcare. As such, it presents a simple, consistent approach for both HSC staff who handle complaints and for the public who may wish to raise a complaint across all HSC services.

1.2 The HSC Complaints Procedure continues to promote an organisational culture in health and social care that fosters openness and transparency for the benefit of all who use it or work in it. It is designed to provide ease of access, simplicity and a supportive and open process which results in a speedy, fair and, where possible, local resolution. The HSC Complaints Procedure provides the opportunity to put things right for service users as well as learning from the experience and improving the safety and quality of services. Dealing with those who have made complaints delivers an opportunity to re-establish a positive relationship with the complainant and to develop an understanding of their concerns and needs.

Local resolution

1.3 The purpose of local resolution is to enable the complainant and the organisation to attempt a prompt and fair resolution of the complaint.

1.4 HSC organisations should work closely with service users to find an early resolution to complaints. Every opportunity should be taken to resolve complaints as close to the source as possible, through discussion and negotiation. Where possible, complaints should be dealt with immediately. Where this is not possible, local resolution should be completed within 20 working days of receipt of a complaint (10 working days within FPS settings). The expectations of service users should be

managed by HSC staff and any difficulties identified in being able to resolve a complaint within 20 days by local resolution should be communicated to the service user immediately.

1.5 Local procedures should be easily accessible, open, fair, flexible and conciliatory and should encourage communication on all sides. They should include a well-defined process for investigating and resolving complaints. Complainants must be advised of their right and be signposted to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the HSC Complaints Procedure.

Principles of an effective Complaints Procedure

1.6 The HSC Complaints Procedure has been developed around four key principles:

- **openness and accessibility** – flexible options for pursuing a complaint and effective support for those wishing to do so;
- **responsiveness** – providing an appropriate and proportionate response;
- **fairness and independence** – emphasising early resolution in order to minimise strain and distress for all; and
- **learning and improvement** – ensuring complaints are viewed as a positive opportunity to learn and improve services.

Learning

1.7 Effective complaints handling is an important aspect of clinical and social care governance arrangements. Lessons learned during the complaints resolution process will assist organisations to make changes to improve the quality of their services and safeguard high standards of care and treatment. Increased efforts should be made to promote a more positive culture of not just resolving complaints but also learning from them. Furthermore, by highlighting the potential added value of complaints and subsequent quality and safety improvements made within HSC organisations the process becomes more acceptable and amenable to all.

1.8 Complaints are seen as a significant source of learning within health and social care and provide opportunities to improve:

- outcomes for services users;
- the quality of services; and
- service user experiences.

1.9 How HSC organisations handle complaints is an indicator of how responsive they are to the concerns of service users and/or their representatives. An increase in the number of complaints is not in itself a reason for thinking the service is deteriorating. The important point is to handle complaints well, take appropriate action and use the lessons learned to improve quality and safety.

What the HSC Complaints Procedure covers

1.10 The HSC Complaints Procedure deals with complaints about care or treatment, or about issues relating to the provision of health and social care. Complaints may, therefore, be raised about services provided by, for example:

- HSC Trusts
  - hospital and community services
  - registered establishments and agencies where the care is funded by the HSC
  - HSC funded staff or facilities in private pay beds
  - HSC prison healthcare
- Business services organisation (BSO)
  - services provided relevant to health and social care
- Public Health agency (PHA)
- Northern Ireland Blood Transfusion Service (NIBTS)
- Family practitioner Services (FPS)

1.11 The HSC Complaints Procedure may be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased patients under the Access to Health Records (NI) Order 1993[5] as an alternative to making an application to the courts.

[5] Access to Health Records (NI) Order 1993 applies only to records created since 30 May 1994.

What the HSC Complaints Procedure does not cover

1.12 Complaints about private care and treatment or service; which includes private dental care[6] or privately supplied spectacles are not dealt with in this guidance. In addition those services which are not provided or funded by the HSC, for example, provision of private medical reports are also not covered under the HSC Complaints Procedure.

1.13 Complaints may be raised within an HSC organisation which need to be addressed, but the complaint or aspects of it may not fall within the scope of the HSC Complaints Procedure. When this occurs, the HSC organisation should ensure that there are other processes in place which can be referred to in order to deal with these concerns. For example:

- staff grievances
- an investigation under the disciplinary procedure
- an investigation by one of the professional regulatory bodies
- services commissioned by DoH
- requests for information under Freedom of Information or access to records under the UK General Data Protection Regulation (GDPR) and Data Protection Act 2018
- independent inquiries and criminal investigations
- the Children Order Representations and Complaints Procedure
- adult safeguarding
- child protection procedures
- Coroners cases
- legal action
- Serious Adverse Incidents (SAIs)
- Whistleblowing[7]

1.14 Complaints received that appear to indicate the need for referral under any of the processes listed above should be immediately transferred to the Complaints

[6] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints and can be contacted via the General Dental Council at http://www.gdc-uk.org/
[7] Public Interest Disclosure (Northern Ireland) Order 1998

Manager for onward transmission to the appropriate department. Where a complaint is referred to any of these other processes it will be the responsibility of the officers involved to ensure that information is given to complainants on the reason for the referral; how the new process operates; their expectations for involvement in the process; anticipated timescales and the named officer/organisation the complainant can contact for ongoing communication. If any aspect of the complaint is not covered by the referral it will continue to be investigated under the HSC Complaints Procedure. In these circumstances, investigation will only be taken forward if it does not, or will not, compromise or prejudice the matter being investigated under any other process.

Staff Grievances

1.15 HSC organisations should have separate procedures for handling staff grievances.

Disciplinary Procedure

1.16 Disciplinary matters are not covered under the HSC Complaints Procedure. Its purpose is to focus on resolving complaints and learning lessons for improving HSC services. It is not for investigating disciplinary matters though these can be investigated by the HSC organisation and may be referred to a Professional Regulatory Body (see paragraph 1.20 below). The purpose of the HSC Complaints Procedure is not to apportion blame, but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

1.17 Where a decision is made to embark upon a disciplinary investigation, action under the HSC Complaints Procedure on any matter which is the subject of that investigation must cease. Where there are aspects of the complaint not covered by the disciplinary investigation, they may continue to be dealt with under the HSC Complaints Procedure.

1.18 The Chief Executive (or designated senior person[8]) must advise the complainant in writing that an investigation is being dealt with under appropriate Trust staff procedures. They also need to be informed that they may be asked to take part

[8] A designated Senior Person should be a Director (or Nominee)

in the process and that any aspect of the complaint not covered by the investigation will continue to be investigated under the HSC Complaints Procedure.

1.19 In drafting these letters, the overall consideration must be to ensure that when investigation is required the complainant is not left feeling that their complaint has only been partially dealt with.

Investigation by a Professional Regulatory Body

1.20 A similar approach to that outlined above should be adopted in a case referred to a professional regulatory body (Annex 3). The Chief Executive (or designated senior person) must inform the complainant in writing of the referral. This should include an indication that any information obtained during the complaints investigation may need to be passed to the regulatory body. The letter should also explain how any other aspect of the complaint not covered by the referral to the regulatory body will be investigated under the HSC Complaints Procedure.

Services Commissioned by the DoH

1.21 Correspondence raising an issue on the availability, commissioning and/or the purchasing of services arising as a result of a decision taken by the Department, should be addressed directly to the Department of Health.

Requests for Information/Access to Records

1.22 Although use and disclosure of service user information may be necessary in the course of handling a complaint, the complainant, or indeed any other person, may at any time make a request for information which may, or may not, be related to the complaint. Such requests should be dealt with separately under the procedures set down by the relevant HSC organisation for dealing with requests for information under the Freedom of Information Act 2000[9] and requests for access to health or social care records under the UK General Data Protection Regulation (GDPR)[10] and Data Protection Act 2018.

[9] Freedom of Information Act 2000: http://www.legislation.gov.uk/ukpga/2000/36/contents
[10] General Data Protection Regulation (GDPR): https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

Independent Inquiries and Criminal Investigations

1.23 Where an independent inquiry into a serious incident or a criminal investigation is initiated, the Chief Executive (or designated senior person) should immediately advise the complainant of this in writing. As the HSC Complaints Procedure cannot deal with matters subject to any such investigation, consideration of those parts of the original complaint must cease until the other investigation is concluded.

1.24 When the independent inquiry or criminal investigation has concluded, consideration of that part of the original complaint on which action was suspended may recommence if there are outstanding matters remaining to be considered under the HSC Complaints procedure.

Children Order Representations and Complaints Procedure

1.25 Arrangements for complaints raised under the Children Order Representations and Complaints Procedure are outlined in Annex 14. The HSC Trusts should familiarise themselves with Part IV of, and paragraph 6 of Schedule 5 to, the Children (NI) Order 1995[11].

Adult Safeguarding

1.26 Where it is apparent that a complaint relates to abuse, exploitation, or neglect of an adult at risk of harm then the regional '*Adult Safeguarding Operational Procedures*' (September 2016[12]) and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases'* (August 2016[13]) should be activated by contacting the Adult Protection Gateway Service at the relevant HSC Trust[14]. The HSC Complaints Procedure should be suspended pending the outcome of the adult safeguarding investigation and the complainant advised accordingly. However, if there are aspects of the complaint that do not cause the aforementioned Operational Procedures and associated Protocol to be activated, then these should continue to be investigated under the HSC Complaints Procedure. However, only those aspects of the complaint

[11] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[12] Adult Safeguarding Operational Procedures: Adult Safeguarding (hscni.net)
[13] Protocol for Joint Investigation of Adult Safeguarding Cases: DRAFT (hscni.net)
[14] Information about and contact details for HSC Trusts can be accessed at the following link - https://www.nidirect.gov.uk/articles/who-contact-if-you-suspect-abuse-exploitation-or-neglect

not falling within the scope of the safeguarding investigation will continue via the HSC Complaints Procedure.

Child Protection Procedures

1.27 Any complaint about individual agencies should be investigated through that agency's complaints procedure. Appeals which relate to decisions about placing a child's name on the Child Protection Register should be dealt with through the Child Protection Registration Appeals Process. The Safeguarding Board for Northern Ireland (SBNI) Child Protection procedures manual outlines the criteria for appeal under that procedure. These include when the:

- ACPC procedures in respect of the case conference were not followed;
- information presented at the case conference was inaccurate; incomplete or inadequately considered in the decision making process;
- threshold for registration/deregistration was not met;
- category for registration was not correct.

Coroners Cases

1.28 With the agreement of the Coroner's Office, where there are aspects of the complaint not covered by the Coroner's investigation they will continue to be dealt with under the HSC Complaints Procedure. Once the Coroner's investigation has concluded, any issues that are outstanding in relation to the matters considered by the Coroner may then be dealt with under the HSC Complaints Procedure.

Legal Action

1.29 Even if a complainant's initial communication is through a solicitor's letter it should not be inferred that the complainant has decided to take formal legal action.

1.30 If the complainant has either instigated formal legal action, or advised that he or she intends to do so, the complaints process should cease. The Chief Executive (or designated senior person) should advise the complainant and any person/member of staff named in the complaint of this decision in writing. However, those aspects of the complaint not falling within the scope of the legal investigation will continue via the HSC Complaints Procedure.

1.31 It is not the intention of the HSC Complaints Procedure to deny someone the opportunity to pursue a complaint if the person subsequently decides **not to take legal action**. If he/she then wishes to continue with their complaint via the HSC Complaints Procedure and requests this, the investigation of their complaint should commence or resume. However, any matter that has been through the legal process to completion cannot also be investigated under the HSC Complaints Procedure.

Serious Adverse Incidents (SAI)

1.32 Complaints may indicate the need for a Serious Adverse Incident (SAI) review. When this occurs, the Chief Executive (or designated senior person), must advise the complainant and any person/staff member named in the complaint in writing that an SAI review is under way. They must also indicate to all concerned that the HSC Complaints Procedure may still continue during the SAI review. However, only those aspects of the complaint not falling within the scope of the SAI review will continue via the HSC Complaints Procedure.

1.33 The overall consideration must be to ensure that when the review is through the SAI process, the complainant is not left feeling that their complaint has only been partially dealt with.

Whistleblowing

1.34 The Department of Health has a framework and model policy in place for HSC organisations on Whistleblowing[15]. All HSC organisations should have their own separate procedures in place.

[15] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-whistleblowing.PDF

SECTION 2 – MAKING A COMPLAINT

What is a complaint?

2.1 A complaint is "**an expression of dissatisfaction that requires a response**". Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments that are actually complaints and therefore need to be handled as such.

Promoting access

2.2 Standard 2: *Accessibility* provides the criteria by which organisations should operate (Annex 1 refers). Service users should be made aware of their right to complain and given the opportunity to understand all possible options for pursuing a complaint. Complainants must, where appropriate, have the support they need to articulate their concerns and successfully navigate the system. They must also be advised on the types of help available, for example, through front-line staff, the Complaints Manager and the Patient and Client Council (PCC). HSC organisations should promote and encourage more open and flexible access to the HSC Complaints Procedure and other less formal avenues in an effort to address barriers to access.

Who can complain?

2.3 Any person can complain about any matter connected with the provision of HSC services. Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using HSC services and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

Consent

2.4 Complaints by a third party should be made with the written consent of the individual concerned. There will be situations where it is not possible to obtain consent, such as when the:

- individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- individual is incapable (for example, rendered unconscious due to an accident; judgement impaired as a result of a learning disability, mental illness, brain injury or serious communication problems);
- subject of the complaint is deceased; and
- delay in the provision of consent may result in a delay in the resolution of the complaint.

2.5 Where a person is unable to act for him/herself, his/her consent shall not be required.

2.6 The Complaints Manager, in discussion with the Chief Executive (or designated senior person), will determine whether the complainant has sufficient interest to act as a representative. The question of whether a complainant is suitable to make representation depends, in particular, on the need to respect the confidentiality of the patient or client. If it is determined that a person is not suitable to act as a representative, the Chief Executive (or designated senior person) must provide them with information in writing outlining the reasons the decision has been taken. More information on consent can be found in the DoH good practice in consent guidance[16].

2.7 Third party complainants who wish to pursue their own concerns can bring these to the HSC organisation without compromising the identity of the patient/client. The HSC organisation must consider the matter then investigate and address the issue and any concerns identified fully. A response will be provided to the third party on any issues which may be addressed without breaching patient/client confidentiality.

[16] https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care

Confidentiality

2.8 HSC staff should be aware of their legal and ethical duty to protect the confidentiality of the service user's information. The legal requirements are set out in the UK General Data Protection Regulations (GDPR) and Data Protection Act 2018 which controls how personal information is used by organisations, businesses or the government. Additional requirements are detailed in the Human Rights Act 1998 (HRA) which requires public authorities to act in a way which is compatible with the list in the European Convention on Human Rights (the Convention). The Common Law Duty of Confidentiality must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required if their personal information is to be disclosed. More detailed information can be found in the DoH guidance entitled *Code of Practice on Protecting the Confidentiality of Service User Information*[17] published January 2012.

2.9 It is not necessary to obtain the service user's express consent to the use of their personal information to investigate a complaint. Even so, it is good practice to explain to the service user that information from his/her health and/or social care records may need to be disclosed to the complaint investigators, but only if they have a demonstrable need to know and for the purposes of investigating. If the service user objects to this, it should be explained to him/her that non-disclosure could compromise the investigation and his/her hopes of a satisfactory outcome to the complaint. The service user's wishes should always be respected, unless there is an overriding public interest in continuing with the matter.

Third Party Confidence

2.10 The duty of confidence applies equally to third parties who have given information or who are referred to in the service user's records. Particular care must be taken where the service user's records contain information provided in confidence, by, or about, a third party who is not a health or social care professional. Only information which is relevant to the complaint should be considered for disclosure, and then only to those *within* the HSC who have a demonstrable 'need to know' in

[17] DoH Code of Practice:
https://www.health-ni.gov.uk/publications/dhssps-code-practice-protecting-confidentiality-service-user-information

connection with the complaint investigation. Third party information must not be disclosed to the service user unless the person who provided the information has expressly consented to the disclosure.

2.11 Disclosure of information provided by a third party outside the HSC also requires express consent. If the third party objects, then information they provided can only be disclosed where there is an overriding public interest in doing so.

Use of Anonymised Information

2.12 Where anonymised information about a patient/client and/or third parties would suffice for investigation of the complaint, identifiable information should be omitted. Anonymising information does not of itself remove the legal duty of confidence but, where all reasonable steps are taken to ensure that the recipient is unable to trace the patient/client or third party identity, it may be passed on where justified by the complaint investigation. Where a patient/client or third party has expressly refused permission to use certain information, then it can only be used where there is an overriding public interest in doing so.

How can complaints be made?

2.13 Complaints may be made in a variety of formats including verbally, written or electronic. Should a verbal complaint be made the complainant should be asked to formalise their complaint in writing. If the complainant is unable to put their complaint in writing then Trust staff or the Patient Client Council can provide assistance. It is helpful to establish at the outset what the complainant wants to achieve in order to avoid confusion or dissatisfaction and subsequent complaints. HSC organisations should be mindful of technological advances specifically in regard to email communications and must adhere to their relevant Information Technology (IT) policies and procedures. Complaints Managers should also consider local arrangements to ensure there is no breach of patient/client confidentiality in the management of information surrounding complaints.

2.14 Complaints may be made to any member of staff, for example receptionists, clinical or care staff. In many cases complaints are made orally and front-line staff may either resolve the complaint “on the spot” or pass it to the Complaints Manager.

It is important that front-line staff receive the appropriate complaints handling training including refresher training according to extant local procedures. They must also be supported to respond sensitively to the comments and concerns raised and be able to distinguish those issues which would be better referred elsewhere for more detailed investigation. Front line staff should familiarise themselves with Section 75 of the Northern Ireland Act 1998 which changed the practices of government and public authorities so that equality of opportunity and good relations are central to policy making, policy implementation, policy review and service delivery[18]. (See Flowchart page 45)

Options for pursuing a complaint

2.15 Some complainants may prefer to make their initial complaint to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, they should be advised to address their complaint to the Complaints Manager, an appropriate senior person or, if they prefer, to the Chief Executive. All HSC organisations have named Complaints Managers. The following paragraphs outline the options available to complainants who want to raise complaints in relation to:

- Family Practitioner Services;
- Regulated Establishments and Agencies; and
- Independent Sector Providers.

Family Practitioner Services (family doctors, dentists, pharmacists, opticians)

2.16 Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure which forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

2.17 Alternatively, the complainant has the right to lodge his/her complaint with the SPPG Complaints Team[19], if he/she does not feel able to approach immediate staff (see flowchart page 46).

[18] Section 75 of the Northern Ireland Act 1998 https://www.legislation.gov.uk/ukpga/1998/47/section/75
[19] SPPG Complaints Team acting on behalf of the DoH.

2.18 Where requested, the SPPG Complaints Team will act impartially as "honest broker" to the complainant and Practice/Practitioner in either the resolution of a complaint or by assisting all parties in reaching a position of understanding. The objective for the SPPG Complaints Team should be, wherever possible, to restore the trust between the patient and the Practice/Practitioner staff. This will involve an element of mediation on the part of the SPPG Complaints Team or the offer of conciliation services where they are appropriate. The SPPG Complaints Team should seek with the complainant's agreement to involve the FPS Complaints Manager as much as possible in resolving the issues. The SPPG Complaints Team is also available to Practice/Practitioner staff for support and advice.

2.19 The SPPG Complaints Team has a responsibility to record and monitor the outcome of complaints lodged with them.

2.20 The SPPG Complaints Team will provide support and advice to FPS in relation to the resolution of complaints. It will also appoint Independent Experts, Lay Persons or Conciliation Services, where appropriate.

2.21 Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the practice-based complaints procedure.

Regulated Establishments and Agencies

2.22 All regulated establishments and agencies[20] must operate a complaints procedure that meets the requirements of applicable Regulations, relevant Minimum Standards and the HSC Complaints Procedure. This includes:

- Effectively publicising the arrangements for dealing with complaints and ensuring service users, clients and families are aware of such arrangements;
- Ensuring that any complaint made under the complaints procedure is investigated;
- Ensuring that time limits for investigations are adhered to;

[20] Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.

- Advising complainants regarding the outcomes of the investigation; and
- Maintaining a record of learning from complaints that is available for inspection.

2.23 Complainants must also be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the HSC Complaints Procedure. It is for the Ombudsman to determine whether or not a case falls within that office's jurisdiction.

2.24 Complaints may be made by service users or persons acting on their behalf providing they have obtained the service user's consent. Complaints relating to contracted services provided by the registered provider or agency may be received directly by the service provider or by the contracting Trust. Complainants should be encouraged to raise their concerns, at the outset, with the registered provider or agency. The registered provider is required by legislation to ensure the complaint is fully investigated. The general principle in the first instance would be that the registered provider or agency investigates and responds directly to the complainant.

2.25 However, individuals placed in a regulated establishment or who have their service provided by a regulated agency may, if they prefer, raise their concerns through the HSC Trust that commissioned the care on their behalf (see flowchart on page 47) as the commissioning Trust has a continuing duty of care to the service user and should participate in local resolution as necessary.

2.26 Where complaints are raised with the HSC Trust, the Trust must establish the nature of the complaint and consider how best to proceed. For example, the complaint may be about an aspect of the "care plan" and can, therefore, only be fully dealt with by the Trust. The complaint may also trigger the need for an investigation under child protection or protection of vulnerable adults' procedures or indeed, might highlight non-compliance with statutory requirements. It is not the intention to operate parallel complaints procedures, however, if the RQIA is notified of a breach of regulations or associated standards it will review the matter and take whatever appropriate action is required. It is important, therefore, that Trusts work closely with the registered

providers, other professionals and the RQIA to enable appropriate decisions to be made.

2.27 HSC Trusts must assure themselves that regulated establishments and agencies that deliver care on their behalf are effective and responsive in complaints handling. Service users may approach the Ombudsman if they remain dissatisfied. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the registered provider without HSC Trust participation in local resolution will be referred to the HSC Trust by the Ombudsman for action.

2.28 Copies of all correspondence relating to regulated sector complaints should be retained. The RQIA will use this information to monitor all regulated services including those services commissioned by the HSC Trust.

2.29 Voluntary Adoption Agencies became regulated by the RQIA in 2010 and in due course, these arrangements will extend to Fostering Agencies services which will also be regulated by the RQIA.

Independent Sector Providers

2.30 This section of the guidance has been developed for use in complaints against Independent Service Providers (ISP) in contract with HSC Trusts. Complaints against regulated establishments and agencies, such as, residential and nursing homes should be handled in accordance with paragraphs 2.22 to 2.28 above. On occasions HSC organisations contract with ISPs to provide services for patients/clients. An example where this may be the case is in the maintenance of waiting lists for elective forms of treatment.

2.31 Such contracts are agreed and managed by HSC Trusts and procured in accordance with public procurement law. ISPs may have their own premises or may be permitted to use Trust premises, equipment and facilities.

2.32 Trusts must be assured that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints. This should include the appointment of designated

officers of suitable seniority to take responsibility for the management of the in-house complaints handling procedures, the investigation of complaints and the production of leaflets, or other literature (available and accessible to patients/clients) that outline the provider's complaints procedure.

2.33 Complaints relating to contracted services provided by ISPs may be received directly by the ISP or by the contracting Trust. The general principle in the first instance would be that the ISP investigates and responds directly to the complainant. Independent Sector Providers are required to notify Trusts of any complaints received without delay and in any event within 72 hours. Trusts can then determine how they wish the complaints to be investigated (see flowchart on page 48).

2.34 Where complaints are raised directly with the Trust, it must establish the nature of the complaint and consider how best to proceed. The Trust may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where it raises serious concerns or where the Trust deems it in the public interest to do so. This may also be considered preferable should the Trust premises and/or staff have been involved (see flowchart on page 48).

2.35 In all cases, appropriate communication should be made with the complainant to inform them which organisation is leading the investigation into their complaint.

2.36 In complaints investigated by the ISP:

- A written response will be provided by the ISP to the complainant and copied to the Trust;
- Where there is a delay in responding within the target timescales the complainant will be informed and where possible provided with a revised date for conclusion of the investigation; and
- The letter of response must advise the complainant that they may progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and, if so, will confirm who should be responsible for conducting it. The Trust will work closely with the ISP to enable appropriate decisions to be made.

2.37 The complainant must also be informed of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

2.38 It is possible that referrals to the Ombudsman, where complaints are dealt with directly by the ISP without Trust participation in local resolution, will be referred to the Trust by the Ombudsman for action.

2.39 Trusts should have agreed arrangements in place to ensure that ISPs regularly provide information relating to all complaints received and responded to directly by them. This information should be made available to the Trust for monitoring purposes. The ISP must keep a record of complaints, the subsequent investigation and its outcome and any action taken as a result. This record must be submitted to the Trust no longer than 10 working days after the end of each quarter for complaints closed in the period. This should include details of the number, source and type(s) of complaint, action taken and outcome of investigation.

2.40 The ISP should also indicate if the learning from complaints has been disseminated to all relevant staff. The ISP must review their complaints procedure on an annual basis and in this annual review shall include a review of the outcome of any complaints investigations during the preceding year to ensure that where necessary any changes to practice and procedure are implemented. This annual review must be available for inspection by Trust staff on request.

What information should be included in the complaint?

2.41 A complaint need not be long or detailed, but it should include:

- contact details;
- who or what is being complained about, including the names of staff if known;
- where and when the events of the complaint happened; and
- where possible, what remedy is being sought – e.g. an apology or an explanation or changes to services.

Supporting complainants and staff

2.42 Standard 4: *Supporting complainants and staff* provides the criteria by which organisations should operate (Annex 1 refers). Advice and assistance is available to complainants and staff at any stage in the complaints process from the Complaints Manager. Independent advice and support for complainants is available from the PCC (detailed in Section 5 – Roles and responsibilities). Independent advocacy and specialist advocacy services are also available (Annex 7 refers).

What are the timescales for making a complaint?

2.43 A complaint should be made as soon as possible after the action giving rise to it, normally within six months of the event. HSC organisations should encourage those who wish to complain to do so as soon as possible after the event. Investigation is likely to be most effective when memories are fresh and the relevant evidence such as records of treatment will be easier to source.

2.44 If a complainant was not aware that there was potential cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is the earlier.

2.45 There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier and where it is still possible to investigate the facts of the case. This discretion should be used with sensitivity and impartiality. The complainant should be advised that with the passage of time the investigation and response will be based largely on a review of records.

2.46 In any case where a Complaints Manager has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant should be advised of the options available to pursue this further.

2.47 The Complaints Manager must consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety

and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

SECTION 3 – HANDLING COMPLAINTS

Accountability

3.1 Standard 1: *Accountability* provides the criteria by which organisations should operate (Annex 1 refers). Accountability for the handling and consideration of complaints rests with the Chief Executive (or Clinical Governance Lead in FPS settings). The HSC organisation must designate a senior person within the organisation:

- to take responsibility for the local complaints procedure;
- to ensure compliance with the regulations; and
- to ensure that action is taken in light of the outcome of any investigation.

In the case of HSC Trusts, a Director (or a Clinical Governance Lead in FPS setting) should be designated. All staff must be aware of, and comply with, the requirements of the complaints procedure. These arrangements will ensure the integration of complaints management into the organisation's governance arrangements.

3.2 Where care or treatment is provided by an independent provider, for example residential or nursing home care, the commissioning body must ensure that the contract includes entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

Performance Management

3.3 Complaints provide a rich source of information and learning from complaints should be considered a vital part of the HSC organisation's performance management strategy. HSC organisations need to be able to demonstrate that positive action has been taken as a result of complaints and that learning from complaints is embedded in the organisation's governance and risk management arrangements.

3.4 Complaints should be used to inform and improve the standard of service provision. HSC organisations should aim for continuous change and improvement in their performance as a result of complaints. Where something has gone wrong or fallen below standard the organisation has the opportunity to improve and avoid a

recurrence. By making sure that lessons from complaints are taken on board and followed up appropriately, services and performance can be greatly improved for the future.

Co-operation

3.5 Local arrangements must ensure that a full and comprehensive response is given to a complainant and that there is the necessary co-operation in the handling and consideration of complaints between:

- HSC organisations;
- Regulatory authorities e.g. professional bodies, DoH, Medicines Regulatory Group (MRG);
- The Ombudsman; and
- The RQIA.

3.6 This general duty to co-operate includes answering questions, providing information and attending any meeting reasonably requested by those investigating the complaint.

Complaints Manager

3.7 HSC organisations must appoint:

- A senior person within the organisation to ensure compliance with the relevant Complaints Directions[21] and to ensure that action is taken in light of the outcome of any investigation; and
- A Complaints Manager to co-ordinate the local complaints arrangements and manage the process.

3.8 The Complaints Manager or whoever is designated on their behalf must be readily accessible to both the public and members of staff. The Complaints Manager should:

- deal with complaints referred by front-line staff;
- be easily identifiable to service users;

[21] DoH Complaints Directions: https://www.health-ni.gov.uk/publications/hsc-complaints-directions

- be available to complainants who do not wish to raise their concerns with those directly involved in their care;
- provide advice and support to vulnerable adults;
- consider all complaints received and identify and appropriately refer those falling outside the remit of the complaints procedure;
- provide support to staff to respond to complaints;
- be aware of and advise on the role of the Medical Defence Organisations (MDOs)[22] to assist staff requiring professional indemnity[23];
- have access to all relevant records (including personal medical records);
- take account of all evidence available relating to the complaint e.g. witness to a particular event;
- identify training needs associated with the complaints procedure and ensure those needs are met;
- ensure all issues are addressed in the draft response, taking account of information obtained from reports received and providing a layman's interpretation to otherwise complex reports;
- compile a summary of complaints received, actions taken and lessons learnt;
- maintain and appropriately store records;
- assist the designated senior person in the examination of trends, monitoring the effectiveness of local arrangements and the action taken (or proposed) in terms of service improvement; and
- assist the designated senior person in ensuring compliance with standards, identifying lessons and dissemination of learning in line with the organisation's governance arrangements.

3.9 Complaints Managers should involve the complainant from the outset and seek to determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options available in seeking complaint resolution. Throughout the process, the Complaints Manager should

[22] There are 3 MDOs, the Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS), and Medical Protection Society (MPS).
[23] Since 16 July 2014 and the introduction of the Health Care and Associated Professions (Indemnity Arrangements) Order 2014, all registered healthcare professionals are legally required to have adequate and appropriate insurance or indemnity to cover the different aspects of their practice in the UK.

assess what further action might best resolve the complaint and at each stage keep the complainant informed.

Publicity

3.10 HSC organisations must ensure that the complaints process is well publicised locally. This means that service users should be made aware of:

- their right to complain;
- all possible options for pursuing a complaint, and the types of help available; and
- the support mechanisms that are in place.

3.11 Ready access to information can make a critical difference to the service user's experience of HSC services. Information about services and what to expect, the various stages involved in the complaints process, response targets and independent support and advice should be available. Clear lines of communication are required to ensure complainants know who to communicate with during the lifetime of their complaint. The provision of information will improve attitudes and communication by staff as well as support and advice for complainants.

3.12 Local information should:

- be visible, accessible and easily understood;
- be available in other formats or languages as appropriate;
- be provided free of charge; and
- outline the arrangements for handling complaints, how to contact complaints staff, the availability of support services, and what to do if the complainant remains dissatisfied with the outcome of the complaints process.

Training

3.13 All staff should be trained and empowered to deal with complaints as they occur. Appropriately trained staff will recognise the value of the complaints process and, as a result will welcome complaints as a source of learning. HSC staff have a responsibility to highlight training needs to their line managers. Line managers, in turn, have a responsibility to ensure needs are met to enable the individual to function

effectively in their role and HSC organisations have a responsibility to create an environment where learning can take place. It is essential that staff recognise that their initial response can be crucial in establishing the confidence of the complainant.

Actions on receipt of a complaint

3.14 Standard 3: *Receiving Complaints* provides the criteria by which organisations must operate (Annex 1 refers).

3.15 All complaints received should be treated with equal importance regardless of how they are submitted. Complainants should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they may say will be treated with appropriate confidence and sensitivity. Complainants should be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. The first responsibility of staff is to ensure that the service user's immediate care needs are being met. This may require urgent action before any matters relating to the complaint are addressed.

3.16 The involvement of the complainant throughout the consideration of their complaint will provide for a more flexible approach to the resolution of the complaint. Complaints staff should discuss individual cases with complainants at an early stage and an important aspect of the discussion will be about the time it may take to complete the investigation especially if it is likely to exceed the 20 working day target for any reason. Early provision of information and an explanation of what to expect should be provided to the complainant at the outset to avoid disappointment and subsequent letters of complaint. Each complaint must be taken on its own merit and responded to accordingly. It may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive way.

3.17 Where possible, all complaints should be registered and discussed with the Complaints Manager in order to identify those that can be resolved immediately, those that require formal investigation, or those that should be investigated and managed outside of the HSC Complaints Procedure by other means. Front-line staff will often find the information they gain from complaints useful in improving service quality. This

is particularly so for complaints that have been resolved “on the spot” and have not progressed through the formal HSC Complaints procedure. Mechanisms for achieving this are best agreed at organisational level.

Acknowledgement of Complaint

3.18 A complaint should be acknowledged in writing within **2 working days** of receipt. FPS complaints should be acknowledged within **3 working days** in line with legislative requirements (see Legal Framework at Annex 2). The acknowledgement letter should always thank the complainant for drawing the matter to the attention of the organisation. A copy of the complaint and its acknowledgement should be sent to any person involved in the complaint unless there are reasonable grounds to believe that to do so would be detrimental to that person’s health or well-being.

3.19 There should be a statement expressing sympathy or concern regarding the issue that led to a complaint being made. This is a statement of common courtesy, not an admission of responsibility.

3.20 It is good practice for the acknowledgement letter to be conciliatory, and indicate that a full response will be provided within **20 working days**. FPS acknowledgement should indicate that a full response will be provided within **10 working days**. As soon as the HSC organisation becomes aware that the relevant response timescale is not achievable they must provide the complainant with an explanation. The complainant must be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

3.21 The acknowledgement should:

- seek to confirm the issues raised in the complaint;
- offer opportunities to discuss issues either with a member of the complaints staff or, if appropriate, a senior member of staff; and
- provide information about the availability of independent support and advice.

3.22 Complaints Managers should provide the complainant with further information about the complaints process. This may include locally produced information leaflets or those provided by the Ombudsman's Office or the RQIA. It is also advisable to include information about the disclosure of patient information at this stage.

Joint Complaints

3.23 Where a complaint relates to the actions of more than one HSC organisation the Complaints Manager should notify any other organisations involved. The complainant's consent must be obtained before sharing the details of the complaint across HSC organisations. In cases of this nature there is a need for co-operation and partnership between the relevant organisations in agreeing how best to approach the investigation and resolution of the complaint. It is possible that the various aspects of the complaint can be divided easily with each organisation able to respond to its own area of responsibility. The complainant must be kept informed and provided with advice about how each aspect of their complaint will be dealt with and by whom.

Out of Area Complaints

3.24 Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the DoH or HSC Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. HSC contracts must include entitlement, by the HSC organisation, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the Departmental or the HSC Complaints Procedure.

Investigation

3.25 Standard 5: *Investigation* provides the criteria by which organisations must operate (Annex 1 refers). HSC organisations should establish a clear system to ensure an appropriate level of investigation. The purpose of investigation is not only "resolution" but also to:

- ascertain what happened or what was perceived to have happened;
- establish the facts;
- learn lessons;

- detect misconduct or poor practice; and
- improve services and performance.

3.26 An investigation into a complaint may be undertaken by a suitable person appointed by the HSC organisation. Investigations should be conducted in a manner that is supportive to all those involved, without bias and in an impartial and objective manner. The investigation must uphold the principles of fairness and consistency. The investigation process is best described as listening, learning and improving. Investigators should be able to seek advice from the Complaints Manager/senior person, wherever necessary, about the conduct or findings of the investigation.

3.27 Whoever undertakes the investigation should seek to understand the nature of the complaint and identify any issues not immediately obvious. Complaints must be approached with an open mind, being fair to all parties. The complainant and those identified as the subject of a complaint should be advised of the process, what will and will not be investigated, those who will be involved, the roles they will play and the anticipated timescales. Everyone involved should be kept informed of progress throughout. Staff involved in the investigation process should familiarise themselves with Section 75 of the Northern Ireland Act 1998.

Assessment of the complaint

3.28 It is unrealistic to suggest that all complaints should be investigated to the same degree or at the same level. HSC organisations must ensure that a robust risk assessment process is applied to all complaints to allow serious complaints, such as those involving unsafe practice, to be identified. The use of assessment tools to risk assess and categorise a complaint may be helpful in determining the course of action to take in response. It can help ensure that the process is proportionate to the seriousness of the complaint and the likelihood of recurrence.

Investigation and resolution

3.29 The HSC organisation should use a range of investigating techniques that are appropriate to the nature of the complaint and to the needs of the complainant. Those

responsible for investigation should be empowered to choose the method that they feel is the most appropriate to the circumstances.

3.30 The investigator should establish the facts relating to the complaint and assess the quality of the evidence. Depending on the subject matter and complexity of the investigation the investigator may wish to call upon the services of others. There are a number of options available to assist HSC organisations in the resolution of complaints. These should be considered in line with the assessment of the complaint and also in collaboration with the complainant and include the involvement of:

- senior managers/professionals at an early stage;
- honest broker;
- independent experts;
- lay persons; and
- conciliators.

3.31 It is not intended that HSC organisations utilise all the options outlined above as not all these will be appropriate in the resolution of the complaint. Rather HSC organisations should consider which option would assist in providing the desired outcome. The SPPG Complaints Team on behalf of DoH will provide the necessary support and advice to FPS in relation to access and appointment of these options, where appropriate.

Completion of Investigation

3.32 Once the investigator has reached their conclusion they should prepare the draft report/response. The purpose is to record and explain the conclusions reached after the investigation of the complaint. The Department's *HSC Regional Template and Guidance for Incident Investigation/ Review Reports*[24] will assist HSC organisations in ensuring the completeness and readability of such reports.

3.33 Where the complaint involves clinical/ professional issues, the draft response must be shared with the relevant clinicians/ professionals to ensure the factual

[24] https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2034-07_0.pdf

accuracy and to ensure clinicians/ professionals agree with and support the draft response.

3.34 All correspondence and evidence relating to the investigation should be retained. The Complaints Manager should ensure that a complete record is kept of the handling and consideration of each complaint. Complaints records should be kept separate from health or social care records, subject only to the need to record information which is strictly relevant to the service user's on-going health or care needs.

3.35 HSC organisations should regularly review their investigative processes to ensure the effectiveness of these arrangements locally.

Circumstances that might cause delay

3.36 Some complaints will take longer than others to resolve because of differences in complexity, seriousness and the scale of the investigative work required. Others may be delayed as a result of circumstance, for example, the unavailability of a member of staff or a complainant as a result of holidays, personal or domestic arrangements or bereavement. Delays may also be as a result of the complainant's personal circumstances at a particular time e.g. a period of mental illness, an allegation of physical injury or because a complaint is being investigated under another procedure (as outlined in paragraphs 1.12 to 1.14).

Periods of acute mental illness

3.37 If a service user makes a complaint during an acute phase of mental illness, the Complaints Manager should register the complaint and consideration should be given to delaying the complaint until his/her condition has improved. A delay such as this will need either the agreement of the complainant or someone who is able to act on his/her behalf including, where appropriate, consultation with any advocate. The decision about whether a complainant is well enough to proceed with the complaint should be made by a multi-disciplinary team, and the Complaints Manager should refer regularly to this team to establish when this point has been reached.

Physical Injury

3.38 Where a complainant is alleging physical injury, a physical examination should be arranged without delay and with the consent of the injured person. Medical staff undertaking the physical examination should clearly report their findings. If a person refuses a physical examination, or if his or her mental state (for example, degree of agitation) makes this impossible, this should be clearly documented.

3.39 Whatever the reason, as soon as it becomes clear that it will not be possible to respond within the target timescales, the Complaints Manager should advise the complainant and provide an explanation with the anticipated timescales. While the emphasis is on a complete response and not the speed of response, the HSC organisation should, nevertheless, monitor complaints that exceed the target timescales to prevent misuse of the arrangements. The complainant must also be updated every 20 working days on the progress of their complaint by the most appropriate means. All contact with the complainant must be recorded by the HSC organisation.

Responding to a complaint

3.40 Standard 6: *Responding to complaints* provides the criteria by which organisations must operate (Annex 1 refers). A response must be sent to the complainant within **20 working days of receipt** of the complaint (**10 working days within FPS**) or, where that is not possible, the complainant must be advised of the delay (as per paragraph 3.39 above).

3.41 Where appropriate, HSC organisations must consider alternative methods of responding to complaints whether through an immediate response from front-line staff, a meeting, or direct action by the Chief Executive (or senior person). It may be appropriate to conduct a meeting in complex cases, in cases where there is serious harm/death of a patient, in cases involving those whose first language is not English, or, for example in cases where the complainant has a learning disability or mental illness. Where complaints have been raised electronically the HSC may reply electronically whilst ensuring they adhere to the relevant Information Technology (IT) policies and procedures and maintain appropriate levels of confidentiality according to Trust policies and procedures

3.42 Where a meeting is scheduled it is more likely to be successful if the complainant knows what to expect and can offer some suggestions towards resolution. Complainants have a right to choose from whom they seek support and should be encouraged to bring a relative or friend to meetings. Where meetings do take place they should be recorded and that record shared with the complainant for comment.

3.43 The Chief Executive (or Clinical Governance Lead) may delegate responsibility for responding to a complaint, where, in the interests of a prompt reply, a designated senior person may undertake the task (or the governance lead within FPS settings). In such circumstances, the arrangements for clinical and social care governance must ensure that the Chief Executive (or Clinical Governance Lead) maintains an overview of the issues raised in complaints, the responses given and be assured that appropriate organisational learning has taken place. HSC organisations should ensure that the complainant and anyone who is a subject of the complaint understand the findings of the investigation and the recommendations made.

3.44 The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:

- address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
- include an apology where things have gone wrong;
- report the action taken or proposed to prevent recurrence;
- indicate that a named member of staff is available to clarify any aspect of the letter;
- advise of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure; and
- advise of the availability of the Patient and Client Council to provide assistance in making a submission to the Ombudsman.

Concluding Local Resolution

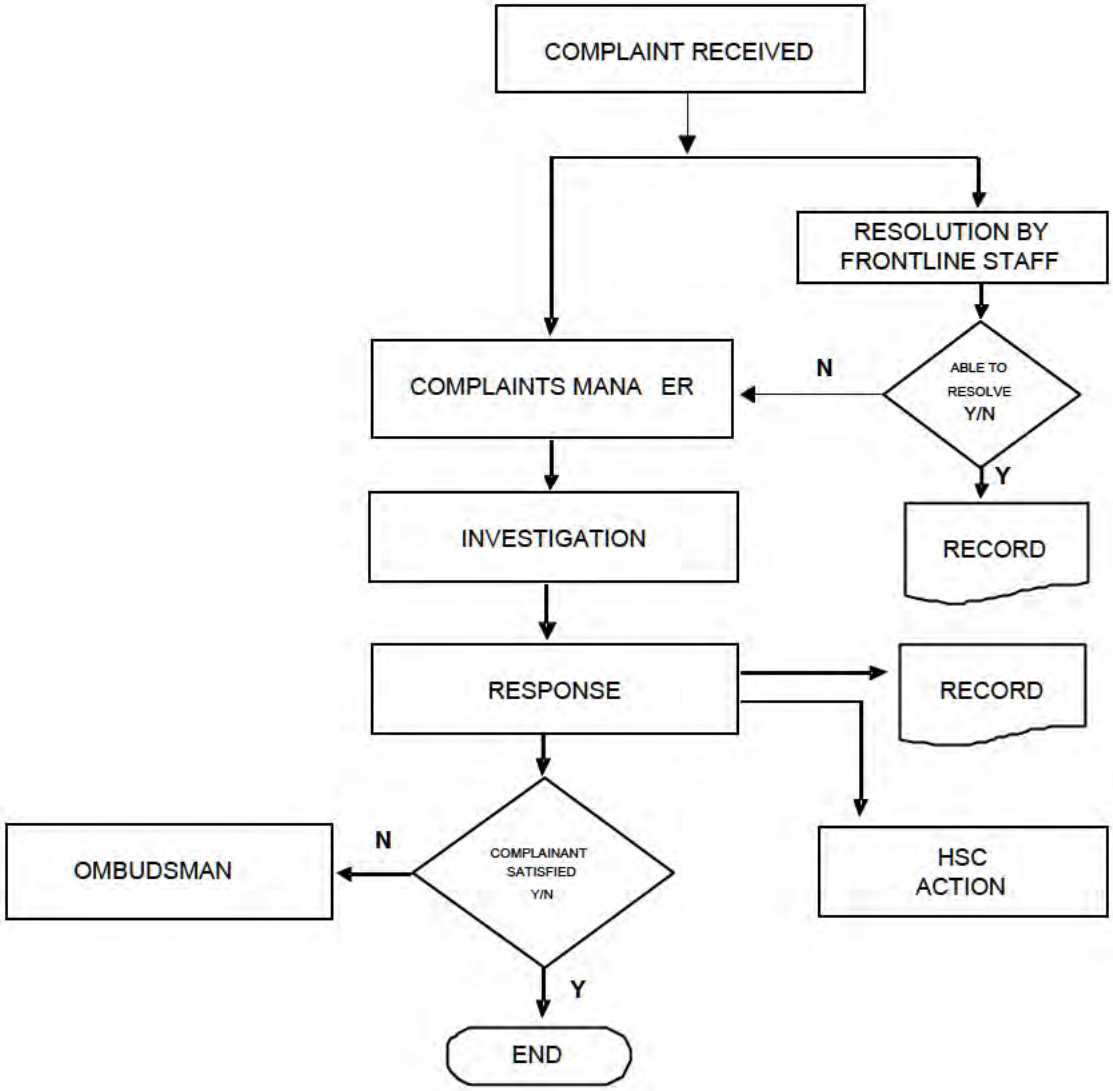
3.45 The HSC organisation should offer every opportunity to exhaust local resolution. While the final response should offer an opportunity to clarify the response this should not be for the purposes of delaying "closure". Complainants should contact the organisation within one month of the organisation's response if they are dissatisfied with the response or require further clarity[25]. There is discretion for the Complaints Manager to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

3.46 Once the final response has been signed and issued, the Complaints Manager, on behalf of the Chief Executive/Clinical Governance Lead, should liaise with relevant local managers and staff to ensure that all necessary follow-up action has been taken. Arrangements should be made for any outcomes to be monitored to ensure that they are actioned. Where possible, the complainant and those named in the complaint should be informed of any change in system or practice that has resulted from the investigation into their complaint.

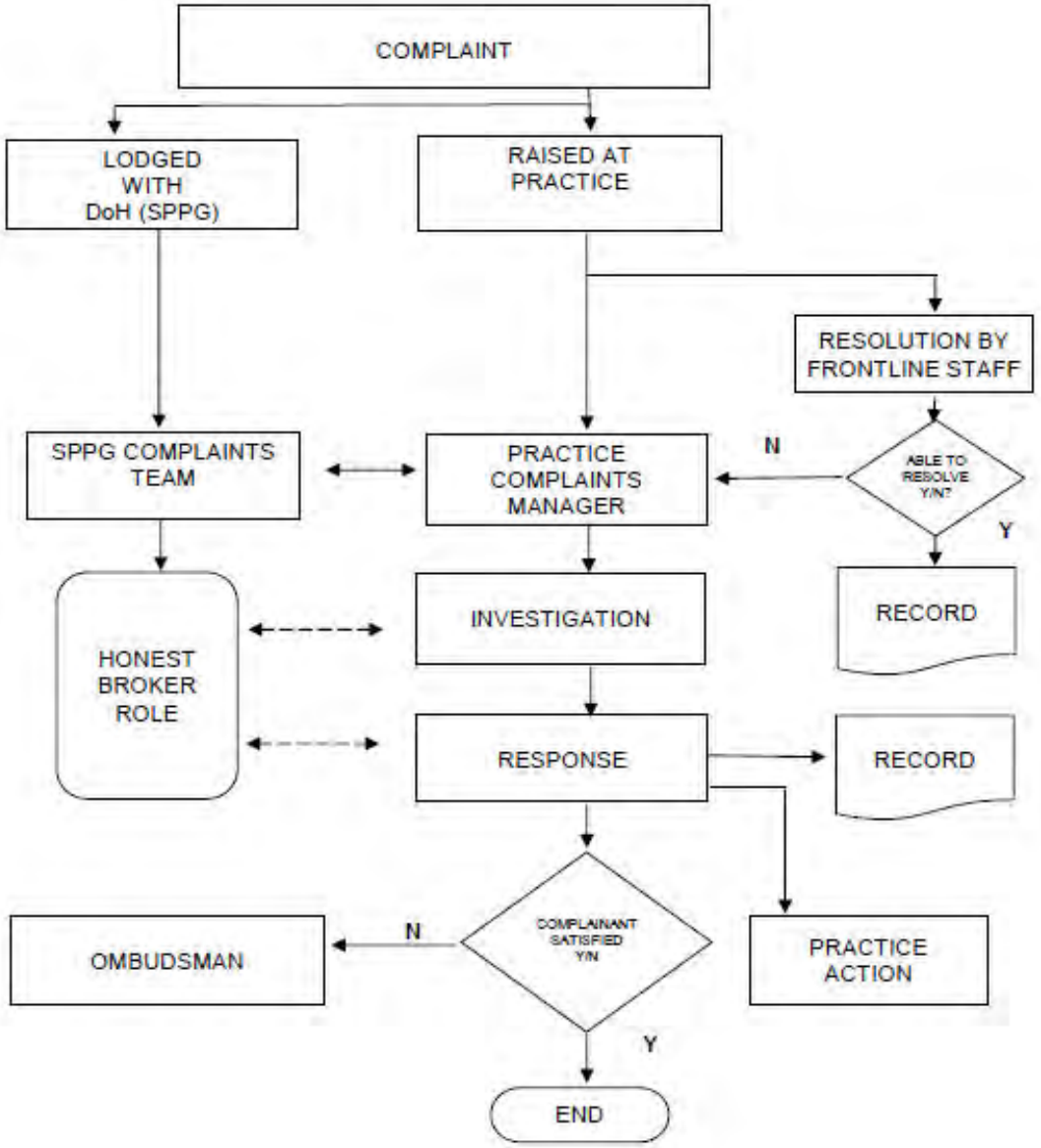
3.47 This completes the HSC Complaints Procedure. There is a statutory obligation on all HSC organisations to signpost to the Ombudsman upon completion of the complaints procedure. Please refer to Annex 5 for details on the requirements for signposting.

[25]Inserted 5th June 2013 per letter from Director of Safety, Quality & Standards Directorate

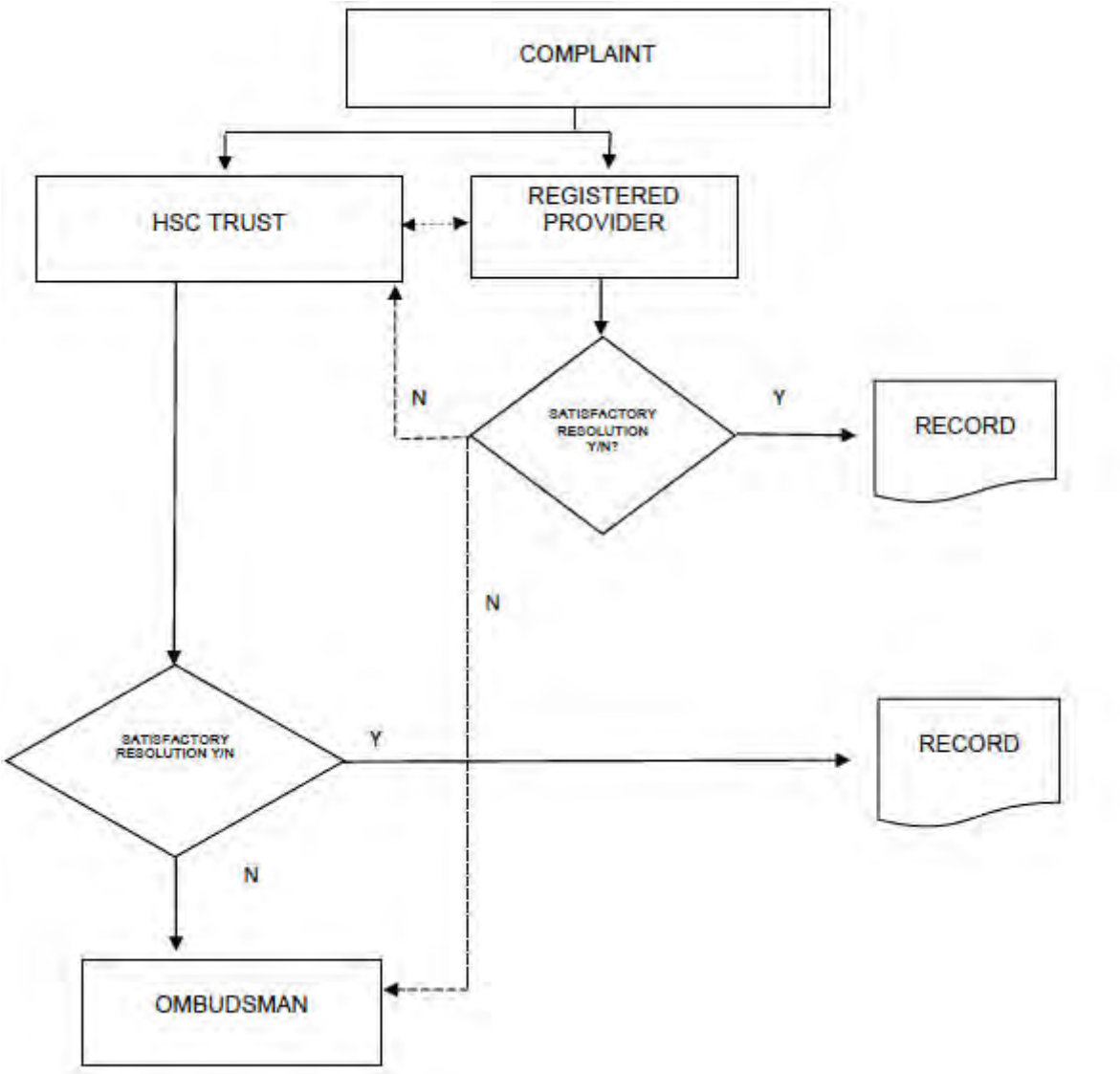
HOSPITAL OR COMMUNITY COMPLAINTS FLOWCHART



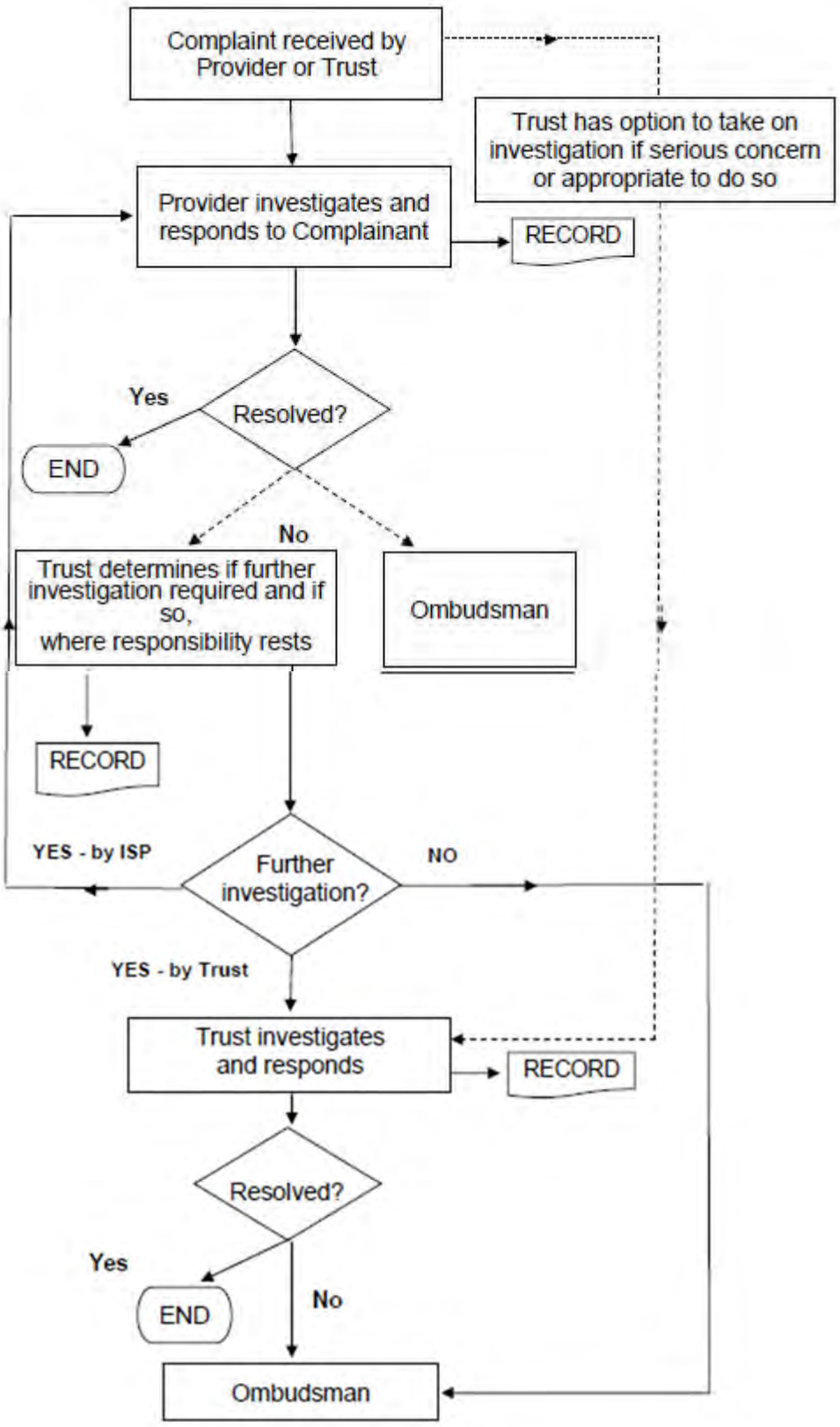
FAMILY PRACTITIONER SERVICE COMPLAINTS FLOWCHART



REGULATED ESTABLISHMENTS & AGENCIES FLOWCHART
(Services commissioned by HSC - Residential and nursing homes as well as Voluntary Adoption Agencies are examples of regulated establishments and agencies.)



INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



SUMMARY OF TARGET TIMESCALES

EVENT	TIMESCALE
Making a complaint	within 6 months of the event, or 6 months after becoming aware of the cause for complaint, but no longer than 12 months from the event
Acknowledgement Family Practitioner Services	within 2 working days* of receipt within 3 working days
Response Family Practitioner Services	within 20 working days within 10 working days (20 working days if lodged with the SPPG Complaints Team)
Should complainant wish to seek clarity in relation to response or express continued dissatisfaction	within 1 months of the organisation's response

*** A working day is any weekday (Monday to Friday) which is not a local or public holiday.**

SECTION 4 – LEARNING FROM COMPLAINTS

Reporting and Monitoring

4.1 Each HSC organisation has a legal duty to operate a complaints procedure and is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with governance arrangements and monitoring the effectiveness of the procedure locally. The HSC organisation must:

- regularly review its policies and procedures to ensure they are effective;
- monitor the nature and volume of complaints;
- seek feedback from service users and staff to improve services and performance; and
- ensure lessons are learnt from complaints and use these to improve services and performance.

4.2 HSC organisations are also required to keep a record of all complaints received, including copies of all correspondence relating to complaints. HSC organisations must have effective processes in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared. HSC organisations must ensure regular and adequate reporting on complaints in line with agreed governance arrangements.

4.3 The *Standards for Complaints Handling* (Annex 1 refers) provide the criteria by which organisations must operate and will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally. HSC organisations should also involve service users and staff to improve the quality of services and effectiveness of complaints handling arrangements locally

4.4 The HSC must ensure they have the necessary technology/information systems to record and monitor all complaints. For the purposes of measuring the effectiveness of the procedures, HSC organisations must maintain systems as described below.

DoH

4.5 The SPPG Complaints Team on behalf of DoH will maintain an oversight of all FPS and HSC Trust complaints received (including HSC prison healthcare) and be prepared to analyse any patterns or trends of concern or clusters of complaints against individuals, practices, or organisations.

4.6 The SPPG Complaints Team will produce an annual report on complaints outlining the number of FPS and, where appropriate, out-of-hours services complaints received, the categories to which the complaints relate and the response times. The annual report should also include the number of FPS complaints in which the SPPG Complaints Team acted as "honest broker". Copies should be sent to the PCC, the RQIA and the Ombudsman. Reports must not breach patient/ client confidentiality.

4.7 The DoH will continue to collect statistics on the number, type and response times of complaints made to HSC organisations. A regional breakdown of complaints statistics will be provided via the Departmental website on an annual basis.

HSC Trusts

4.8 All HSC Trusts must provide the Department with quarterly statistical returns on complaints.

4.9 HSC Trusts must provide their Management Boards and the DoH with quarterly complaints reports outlining the number and types of complaints received, the investigation undertaken and actions as a result including those relating to regulated establishments and agencies, and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare. The reports must summarise the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.10 HSC Trusts must also produce an annual complaints report to include the number of complaints received, the categories to which the complaints relate, the response times and the learning from complaints. Copies should also be made available to the PCC, RQIA, the Ombudsman and the DoH. Reports must not breach patient/ client confidentiality.

Quarterly reports

4.11 The management boards of the HSC Trusts should receive quarterly reports summarising the categories, emerging trends and the actions taken (or proposed) to prevent recurrence in order to:

- monitor arrangements for local complaints handling;
- consider trends in complaints; and
- consider any lessons that can be learned and shared from complaints and the result in terms of service improvement.

4.12 HSC Trusts' quarterly reports to their management board should include a breakdown of all complaints received including those received by, or on behalf of, residents in statutory or independent residential care and nursing homes and, where appropriate, out-of-hours services, pilot schemes and HSC prison healthcare.

Family Practitioner Services

4.13 Family Practitioner Services must provide the SPPG Complaints Team with anonymised copies of all written complaints received and responses provided by the Practice within 3 working days of the response being issued.

4.14 Arrangements should be in place to ensure that the complainant is aware and agrees to his/her complaint being forwarded to the SPPG Complaints Team.

4.15 The SPPG Complaints Team will record and monitor the outcome of all FPS complaints lodged with them.

Other HSC organisations

4.16 All other HSC organisations must publish an annual report on complaints handling. Copies should be sent to the PCC and the DoH. Reports must not breach patient/client confidentiality.

Regulated establishments and agencies

4.17 All regulated establishments and agencies are required if requested to provide the RQIA with a statement containing a summary of complaints made during the preceding 12 months and the action that was taken in response. The RQIA will record and monitor all outcomes and will report on complaints activity within the regulated sector.

Learning

4.18 All HSC organisations are expected to manage complaints effectively, ensuring that appropriate action is taken to address the issues highlighted by complaints and making sure that lessons are learned, to minimise the chance of mistakes recurring and to improve the safety and quality of services. Learning should take place at different levels within the HSC organisation (individual, team and organisational) and the HSC organisation must be able to demonstrate that this is taking place[26].

4.19 Learning is a critical aspect of the HSC Complaints Procedure and provides an opportunity to improve services and contribute to and learn from regional, national and international quality improvement and patient safety initiatives. All HSC organisations, the RQIA and Ombudsman must share the intelligence gained through complaints.

4.20 The SPPG Complaints Team on behalf of the DoH will have in place regional-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints and must ensure they are used to improve service quality. HSC Trusts and FPS should be encouraged to share learning and seek feedback from service users for further improvement.

[26] The Quality Standards for Health and Social Care, Theme 5 (8.3 (k)) - https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/the-quality-standards-for-health-and-social-care.pdf

SECTION 5 - ROLES AND RESPONSIBILITIES

DoH

5.1 The SPPG on behalf of DoH is required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. This will include monitoring complaints processes, outcomes and service improvements. The S*tandards for Complaints Handling* provides a level against which HSC service performance can be measured (Annex1 refers).

5.2 The SPPG Complaints Team will maintain an oversight of all FPS and HSC Trust complaints received and, where appropriate, out-of-hours services. The SPPG Complaints Team must be prepared to investigate any patterns or trends of concern or clusters of complaints against individual clinicians/ professionals.

5.3 The SPPG Complaints Team on behalf of the DoH will have in place area-wide procedures for collecting and disseminating learning and sharing intelligence.

5.4 The SPPG Complaints Team will provide a vital role in supporting FPS complaints that includes:

- providing support and advice;
- the role of “honest broker” between the complainant and the service provider;
- providing independent experts, lay persons, conciliation services, where appropriate;
- recording and monitoring the outcome of all complaints;
- addressing breaches of contractual arrangements; and
- sharing complaints intelligence with appropriate authorities e.g. the DoH Medicines Regulatory Group (MRG).

HSC Organisations

5.5 HSC organisations must:

- make arrangements for the handling and consideration of complaints and publicise these arrangements locally;
- appoint a Complaints Manager with responsibility for co-ordinating the local complaints arrangements and managing the process;
- appoint a senior person to take responsibility for delivering the organisation's complaints process and ensuring that all necessary organisational learning takes place;
- ensure that all staff who provide services on their behalf are aware of, and trained in, the procedures to be followed when dealing with complaints;
- ensure that complainants and staff are supported and made aware of the availability of support services;
- ensure that there is full co-operation between organisations/bodies in the handling and consideration of complaints;
- integrate complaints management into the organisation's clinical and social care governance and risk management arrangements;
- monitor the effectiveness of local complaints handling arrangements;
- have in place area-wide procedures for collecting and disseminating the information, themes and good practice derived from complaints; and
- where appropriate, publish annually a report on complaints handling.

The Patient and Client Council (PCC)

5.6 The PCC is an independent non-departmental public body established on 1 April 2009 to replace the Health and Social Services Councils. Its functions include:

- representing the interests of the public;
- promoting involvement of the public;
- providing assistance to individuals making or intending to make a complaint;
- promoting the provision by HSC bodies of advice and information to the public about the design, commissioning and delivery of health and social care services; and

- undertaking research into best methods and practices for consulting and engaging the public.

5.7 If a person feels unable to deal with a concern alone, the staff of the PCC can offer a wide range of advocacy, assistance and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services; and
- help in accessing medical/social services records.

5.8 All advice, information and assistance with complaints is provided free of charge and is confidential. Further information can be obtained from: pcc-ni.net or Freephone 0800 917 0222

Where can I get support

If you wish to raise a concern or issue relating to a Health or Social Care service the PCC can provide advocacy to support and assist you.

You can contact the PCC in the following ways

Free phone number 0800 91702222

Or email the PCC on

info@pcc.ni.net

The PCC can support and assist you through our advocacy service to seek a resolution to the concern you have. You can view the PCC website for additional information on the PCC.

www.pcc-ni.net

ANNEX 1: STANDARDS FOR COMPLAINTS HANDLING

Standards for complaints handling

1. The following standards have been developed to address the variations in the standard of complaints handling across HSC organisations. These will assist organisations in monitoring the effectiveness of their complaints handling arrangements locally and will build public confidence in the process by which their complaint will be handled. These are the standards to which HSC organisations are expected to operate for complaints handling:

STANDARD 1: ACCOUNTABILITY

HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.

Rationale:

HSC organisations will demonstrate that they have in place clear accountability structures to ensure the effective and efficient investigation of complaints, to provide a timely response to the complainant and a framework whereby learning from complaints is incorporated into the clinical, social care and organisational governance arrangements.

Criteria:

1. Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Lead in FPS settings);
2. HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;
3. HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;
4. HSC organisations will include complaints handling within its performance management framework and corporate objectives;
5. Each HSC organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;
6. All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;
7. Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure; and
8. Each HSC organisation is responsible for quality assuring its complaints handling arrangements.

STANDARD 2: ACCESSIBILITY

All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.

Rationale:

Those who wish to complain will be treated impartially, in confidence, with sensitivity, dignity and respect and will not be adversely affected because they have found cause to complain. Where possible, arrangements will be made as necessary for the specific needs of those who wish to complain, including provision of interpreting services; information in a variety of formats and languages; at suitable venues; and at suitable times.

Criteria:

1. Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;
2. Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;
3. Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable; and
4. All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.

STANDARD 3: RECEIVING COMPLAINTS

All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.

Rationale:

All complaints are welcomed. Effective complaints handling is an important aspect of the HSC clinical and social care governance arrangements. All complaints, however or wherever received, will be recorded, treated confidentially, taken seriously and dealt with in a timely manner.

Criteria:

1. Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;
2. Complaints from a third party must, where possible, have the written consent of the individual concerned;
3. HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;
4. Attempts to resolve complaints are as near to the point of contact as possible, and in accordance with the complainant's wishes;
5. Where possible, the complainant should be involved in decisions about how their complaint is handled and considered; and
6. Complaints are appropriately recorded and assessed according to risk in line with agreed governance arrangements.

STANDARD 4: SUPPORTING COMPLAINANTS AND STAFF

HSC organisations will support complainants and staff throughout the complaints process.

Rationale:

The HSC will support service users in making complaints and will encourage feedback through a variety of mechanisms. Information on complaints will outline the process as well as the support services available. Staff will be trained and empowered to deal with complaints as they arise.

Criteria:

1. HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;
2. The HSC organisation's Complaints Manager will offer assistance in the formulating of a complaint;
3. HSC organisations will promote the use of independent advice and advocacy services;
4. HSC organisations will facilitate, where appropriate, the use of conciliation;
5. HSC organisations will adopt a consistent approach in the application of DoH guidance on responding to unreasonable or abusive complainants;
6. HSC organisations will ensure that staff receive training on complaints, appropriate to their needs; and
7. HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.

STANDARD 5: INVESTIGATION OF COMPLAINTS

All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.

Rationale:

HSC organisations will establish a clear system to ensure an appropriate level of investigation. Not all complaints need to be investigated to the same degree. A thorough, documented investigation will be undertaken, where appropriate, including a review of what happened, how it happened and why it happened. Where there are concerns, the HSC organisation will act appropriately and, where possible, improve practice and ensure lessons are learned.

Criteria:

1. Investigations are conducted in line with agreed governance arrangements;
2. Investigations are robust and proportionate and the findings are supported by the evidence;
3. A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;
4. Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;
5. People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;
6. All HSC providers/commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;
7. The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised; and
8. All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements.

STANDARD 6: RESPONDING TO COMPLAINTS

All complaints will be responded to as promptly as possible and all issues raised will be addressed.

Rationale:

All complainants have a right to expect their complaint to be dealt with promptly and in an open and honest manner.

Criteria:

1. The timescales for acknowledging and responding to complaints are in line with statutory requirements;
2. Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;
3. HSC organisations must consider alternative methods of responding to complaints;
4. Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;
5. The Chief Executive may delegate responsibility for responding to a complaint where, in the interests of a prompt reply, a designated senior person may undertake this task (or a clinical governance lead in FPS settings);
6. Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint; and
7. Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.

STANDARD 7: MONITORING

HSC organisations will monitor the effectiveness of complaints handling and responsiveness.

Rationale:

HSC organisations are required to monitor how they, or those providing care on their behalf, deal with and respond to complaints. Monitoring performance is essential in determining any necessary procedural change that may be required. It will also ensure that organisations have taken account of the issues and incorporated improvements where appropriate.

Criteria:

1. HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;
2. HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;
3. HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;
4. HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;
5. HSC organisations must review the arrangements for complaints handling and responsiveness; and
6. HSC organisations must be assured, that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints.

STANDARD 8: LEARNING

HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.

Rationale:

Complaints are viewed as a significant source of learning within HSC organisations and are an integral aspect of its patient/client safety and quality services ethos. Complaints will help organisations to continue to improve the quality of their services and safeguard high standards of care and treatment. HSC organisations must have effective structures in place for identifying and minimising risk, identifying trends, improving quality and safety and ensuring lessons are learnt and shared.

Criteria:

1. HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;
2. HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;
3. Learning will take place at different levels within the HSC (individual, team and organisational);
4. HSC organisations will ensure that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;
5. HSC organisations will incorporate learning arising from any review of findings of an investigation;
6. HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives; and
7. HSC organisations will include learning from complaints within its Annual Report on Complaints.

ANNEX 2: LEGAL FRAMEWORK

HPSS Complaints Procedure Regulations:

- The Health and Personal Social Services (General Medical Services Contracts) Regulations (NI) 2004;
- Health and Personal Social Services General Dental Services (Amendment) Regulations (NI) 2008;
- The General Ophthalmic Services (Amendment) Regulations
- (Northern Ireland) 2014The Pharmaceutical Services Regulations (NI) 1997.

The Children (NI) Order 1995:

- The Representations Procedure (Children) Regulations (NI) 1996.

HSC Complaints Procedure Directions:

- The Health and Social Care Complaints Procedure Directions (NI) 2009;
- Health and Social Care Complaints Procedure Directions (NI) 2009 (Amended 2013);
- Complaints about Family Health Services Practitioners and Pilot Scheme Providers (2009) (Honest Broker Timescales) (Amended 2013);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (2010);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (2010);
- Health and Social Care Complaints Procedure Directions (Amended 2019);
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) (Amended 2019);
- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (Amended 2019);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (Amended 2019);
- Directions to the Regional Business Services Organisation on Procedures for Dealing with Health and Social Care Complaints (Amended 2022);

- Directions to the Regional Agency for Public Health and Social Well-being on Procedures for Dealing with Health and Social Care Complaints (Amended 2022);
- Directions to the Health and Social Care Board on Procedures for Dealing with Complaints about Family Health Services Practitioners and Pilot Scheme Providers (NI) (Revoked 2022);
- Health and Social Care Complaints Procedure Directions (Amended 2022).

The Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003:

- The Residential Care Homes Regulations (NI) 2005;
- The Nursing Homes Regulations (NI) 2005;
- The Independent Health Care Regulations (NI) 2005;
- The Nursing Agencies Regulations (NI) 2005;
- The Adult Placement Agencies Regulations (NI)2007;
- The Day Care Settings Regulations (NI) 2007;
- The Residential Family Centres Regulations (NI) 2007;
- The Domiciliary Care Agencies Regulations (NI) 2007.

ANNEX 3: PROFESSIONAL REGULATORY BODIES

General Chiropractic Council (GCC) Chiropractors Phone: [redacted] www.gcc-uk.org	**Nursing and Midwifery Council (NMC)** Nurses, midwives and specialist community public health nurses Phone: [redacted] www.nmc-uk.org
General Dental Council (GDC) Dentists, dental therapists, dental hygienists, dental nurses, dental technicians, clinical dental technicians and orthodontic therapists Phone: [redacted] www.gdc-uk.org	**Royal Pharmaceutical Society of Great Britain (RPSGB)** Pharmacists, pharmacy technicians (on the voluntary register) and pharmacy premises Phone: 08452572570 https://www.rpharms.com
General Medical Council (GMC) Doctors Phone: 01619236602 www.gmc-uk.org	**Pharmaceutical Society of Northern Ireland** Pharmacists and pharmacy premises in Northern Ireland Phone: [redacted] www.psni.org.uk
General Optical Council (GOC) Opticians Phone: [redacted] www.optical.org **General Osteopathic Council (GOsC)** Osteopaths Phone: [redacted] www.osteopathy.org.uk	**Professional Standards Authority for Health and Social Care (the Authority)** aims to protect the public, promote best practice and encourage excellence among the nine regulators of healthcare professionals listed. Phone: [redacted] http://www.professionalstandards.org.uk
Health and Care Professions Council (HCPC) Arts therapists, biomedical scientists, chiropodists, podiatrists, clinical scientists, dieticians, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, prosthetists and orthotists, radiographers, speech and language therapists Phone: 03005006184 www.hpc-uk.org	**Northern Ireland Social Care Council (NISCC)** Social care workers, qualified social workers, and social work students on approved degree courses in Northern Ireland Phone: [redacted] www.niscc.info

ANNEX 4: HSC PRISON HEALTHCARE

1. HSC prison healthcare is commissioned by the DoH. The South Eastern HSC Trust has responsibility for providing or securing the provision of health and social care services for prisoners.

2. Complaints raised about care, treatment or issues relating to the provision of prison healthcare will be dealt with under the HSC Complaints Procedure.

ANNEX 5: THE NI PUBLIC SERVICES OMBUDSMAN

1. The Ombudsman[27] can carry out independent investigations into complaints about poor treatment or service or the administrative actions of HSC organisations. If someone has suffered because they have received poor service or treatment or were not treated properly or fairly, and the organisation or practitioner has not put things right where they could have, the Ombudsman may be able to help. The Ombudsman powers have also been extended to include the power to investigate complaints about social care decisions.

All listed authorities within the Ombudsman's jurisdiction have a statutory obligation to signpost complainants to the Ombudsman's office where the listed authority's complaints handling procedure is exhausted.

Section 25 of the Public Services Ombudsman Act (Northern Ireland) 2016 states:

25. (1) This section applies where a listed authority's complaints handling procedure is exhausted.
(2) The authority must, within 2 weeks of the day on which the complaint handling procedure is exhausted give the person aggrieved a written notice stating –
(a) that the complaints handling procedure is exhausted, and
(b) that the person aggrieved may, if dissatisfied, refer the complaint to the Ombudsman.
(3) A notice under subsection (2) must –
(a) inform the person aggrieved of the time limit for referring the complaint to the Ombudsman; and
(b) provide details of how to contact the Ombudsman.

[27] With effect from 1 April 2016 the statutory office of "NI Commissioner for Complaints" was abolished and the new statutory office of "Northern Ireland Public Services Ombudsman" was created as a result of the Public Services Ombudsman Act (Northern Ireland) 2016 coming into operation.

2. The Ombudsman's contact details are:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

Freepost: Freepost NIPSO
Telephone: [redacted]
Freephone: (0800) 34 34 24
Email: nipso@nipso.org.uk

3. Additional information on the jurisdiction and powers under the Public Services Ombudsman Act (NI) 2016 can be accessed at:
www.nipso.org.uk

ANNEX 6: THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

1. The RQIA is an independent non-departmental public body. The RQIA is charged with overall responsibility for regulating, inspecting and monitoring the standard and quality of health and social care services provided by independent and statutory bodies in Northern Ireland.

2. The RQIA has a duty to assess and report on how the HSC and the regulated sector handle complaints in light of the standards and regulations laid down by the DoH. The RQIA will assess the effectiveness of local procedures and will use information from complaints to identify wider issues for the purposes of raising standards.

3. The RQIA has a duty to encourage improvement in the delivery of services and to keep the DoH informed on matters concerning the provision, availability and quality of services.

4. The RQIA may be contacted at:

James House
2-4 Cromac Avenue
Belfast
BT7 2JA
Tel: [redacted]

http://www.rqia.org.uk

ANNEX 7: ADVOCACY

1. Some people who might wish to complain do not do so because they do not know how, doubt they will be taken seriously, or simply find the prospect too intimidating. Advocacy services are an important way of enabling people to make informed choices. Advocacy helps people have access to information they need, to understand the options available to them, and to make their views and wishes known. Advocacy also provides a preventative service that reduces the likelihood of complaints escalating. Advocacy is not new. People act as advocates every day for their children, for their elderly or disabled relatives and for their friends.

2. Within the HSC sector, advocacy has been available mainly for vulnerable groups, such as people with mental health problems, learning disabilities and older people (including those with dementia). However, people who are normally confident and articulate can feel less able to cope because of illness, anxiety and lack of knowledge and be intimidated by professional attitudes.

3. HSC organisations should encourage the use of advocacy services and ensure complainants are supported from the outset and made aware of the role of advocacy in complaints, including those services provided by the PCC. Advocacy in complaints must be seen to be independent to retain confidence in the complaints process.

ANNEX 8: CONCILIATION

1. Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. He/she will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but it may be helpful in situations:

- where staff or practitioners feel the relationship with the complainant is difficult;
- when trust has broken down between the complainant and the Practice/ Practitioner/HSC organisation/SPPG on behalf of the DoH and both parties feel it would assist in the resolution of the complaint;
- where it is important, e.g. because of ongoing care issues, to maintain the relationship between the complainant and the Practice/Practitioner/HSC organisation/SPPG on behalf of the DoH; or
- when there are misunderstandings with relatives during the treatment of the patient.

2. All discussions and information provided during the process of conciliation are confidential. This allows staff to be open about the events leading to the complaint so that both parties can hear and understand each other's point of view and ask questions.

3. Where a complainant is considered unreasonable or abusive under the *Unacceptable Action Policy* (Annex 13 refers) then conciliation would NOT be an appropriate option.

4. Conciliation is a voluntary process available to both the complainant and those named in the complaint. Either may request conciliation but both must agree to the process being used. In deciding whether conciliation should be offered, consideration must be given to the nature and complexity of the complaint and what attempts have already been made to achieve local resolution. The decision to progress to conciliation must be made with the agreement of both parties. The aim is to resolve difficulties, for example, if there is a breakdown in the relationship between a doctor or practitioner and their patient.

5. Conciliation may be requested by the complainant, the Practice/Practitioner/HSC organisation/SPPG on behalf of the DoH. In FPS complaints it may be suggested by the SPPG Complaints Team.

FPS arrangements

6. The Practitioner/Practice/Pharmacy Manager (respondent) should approach the SPPG Complaints Team for advice.

7. Where a request for a conciliator is received the SPPG Complaints Team will liaise with the relevant FPS lead to consider the best way forward. Where it is considered that conciliation would aid resolution then the SPPG Complaints Team will advise the FPS Practice/Practitioner. In some cases the SPPG Complaints Team may consider an alternative to conciliation, such as, an honest broker.

Agreement by parties involved

8. The FPS Practice/Practitioner/HSC organisation must contact the complainant and discuss the rationale for involving a conciliator and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. It is important that all parties involved are aware of the confidentiality clause attached to conciliation services. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

9. Where it has been agreed that the intervention of a conciliator is appropriate, the HSC organisation or SPPG Complaints Team (on behalf of FPS) should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand what conciliation involves;
- agreeing the timescales;
- agreeing when conciliation has ended; and
- explaining what happens when conciliation ends.

10. The conciliator must advise the Practice/Practitioner/ HSC organisation when conciliation has ceased and whether a resolution was reached. No further details should be provided. The Practice/Practitioner must then notify the SPPG Complaints Team of the outcome.

11. Using conciliation does not affect the right of a complainant to pursue their complaint further through the HSC organisation or the SPPG Complaints Team (for FPS) if they are not satisfied. Neither does it preclude the complainant from referring their complaint to the Ombudsman should they remain dissatisfied.

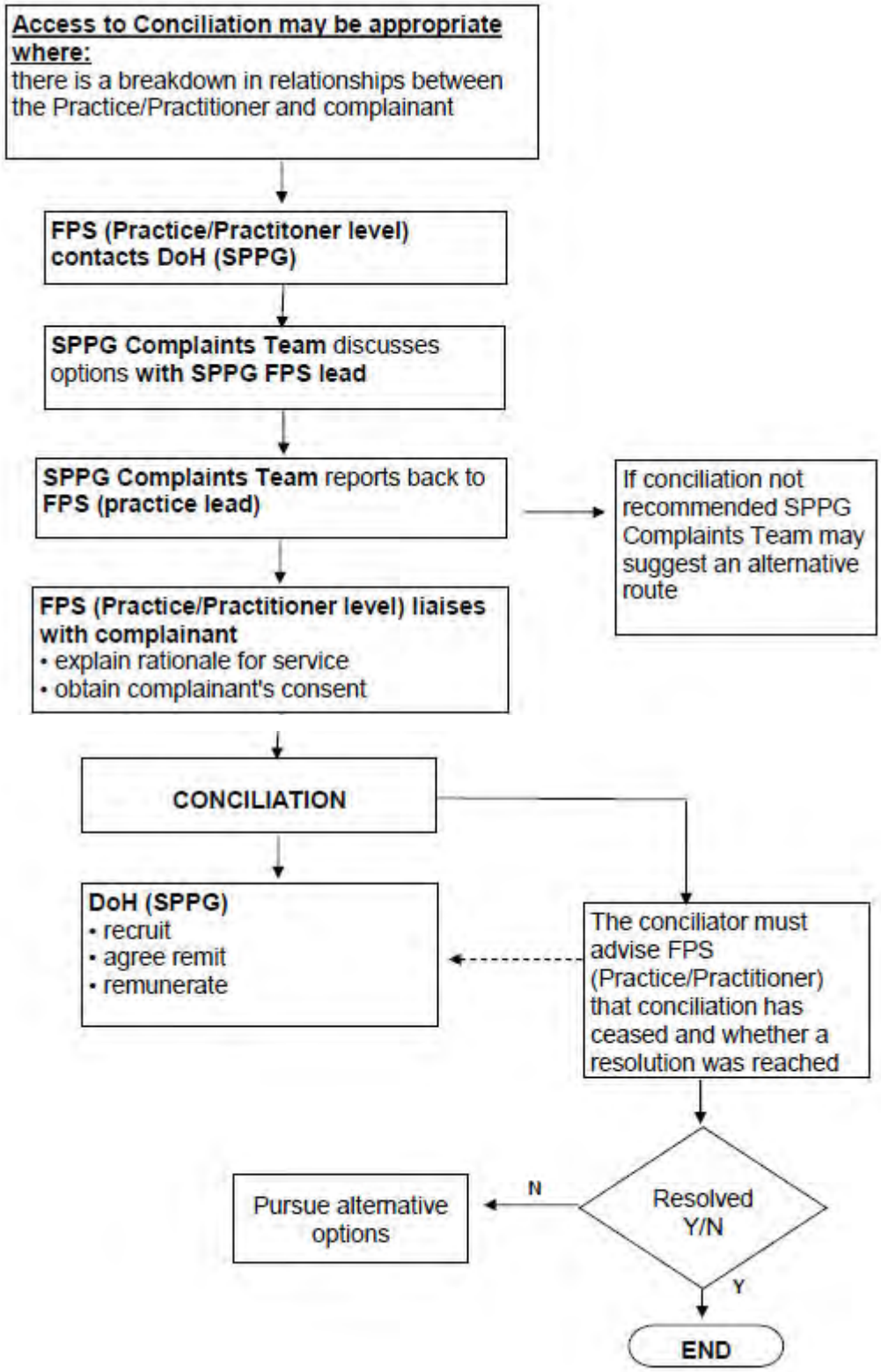
Appointment of conciliators

12. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate conciliation service. In addition it is responsible for all other arrangements, including remuneration.

Monitoring

13. The SPPG Complaints Team will monitor the effectiveness and usage of conciliation arrangements within HSC Trusts and FPS.

Conciliation – FPS



ANNEX 9: INDEPENDENT EXPERTS

1. The use of an Independent Expert in the resolution of a complaint may be requested by the complainant, the Practice/Practitioner/ HSC organisation. In FPS complaints it can also be suggested by the SPPG Complaints Team on behalf of the DoH. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at resolution. Input will not be required in every complaint but it may be considered beneficial where the complaint:

- cannot be resolved locally;
- indicates a risk to public or patient safety;
- could give rise to a serious breakdown in relationships, threaten public confidence in services or damage reputation; and
- to give an independent perspective on clinical issues.

FPS arrangements

2. The Practice/Practitioner should approach the SPPG Complaints Team for advice.

3. Where a request for an Independent Expert is received the SPPG Complaints Team **may** wish to liaise with the relevant FPS lead to consider the best way forward. Where it is considered that independent expert advice would aid resolution then the SPPG Complaints Team will advise the FPS practice. In some cases the SPPG Complaints Team may consider an alternative to an Independent Expert.

Agreement and consent

4. The FPS Practice/Practitioner/HSC organisation/SPPG Complaints Team must contact the complainant and discuss the rationale for involving an Independent Expert and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once agreement is received, the HSC organisation or the SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

5. The HSC organisation or SPPG Complaints Team may decide to involve an Independent Expert in a complaint without the complainant's consent, outside the complaints procedure, for the purposes of obtaining assurances regarding health and social care practice.

6. Where it has been agreed that an Independent Expert will be involved the Practice/Practitioner/HSC organisation/SPPG Complaints Team should clearly define the remit of the appointment for the purposes of:

- explaining and agreeing the issue(s) to be reviewed;
- ensuring all parties understand the focus of the issue(s);
- agreeing the timescales;
- agreeing to the provision of a final report; and
- explaining what happens when this process is complete.

7. The Independent Expert's findings/report will be forwarded to the Practice/Practitioner/HSC organisation/SPPG Complaints Team (if acting as contact point). A full report of the findings should be made available by the practice/pharmacy/HSC organisation to:

- the complainant; and
- the SPPG Complaints Team (for FPS only).

8. The letter of response to the complainant is the responsibility of the Practice/Practitioner/ HSC organisation.

Appointment of Independent Experts

9. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate Independent Expert. In addition, it is responsible for all other arrangements, including remuneration and indemnity.

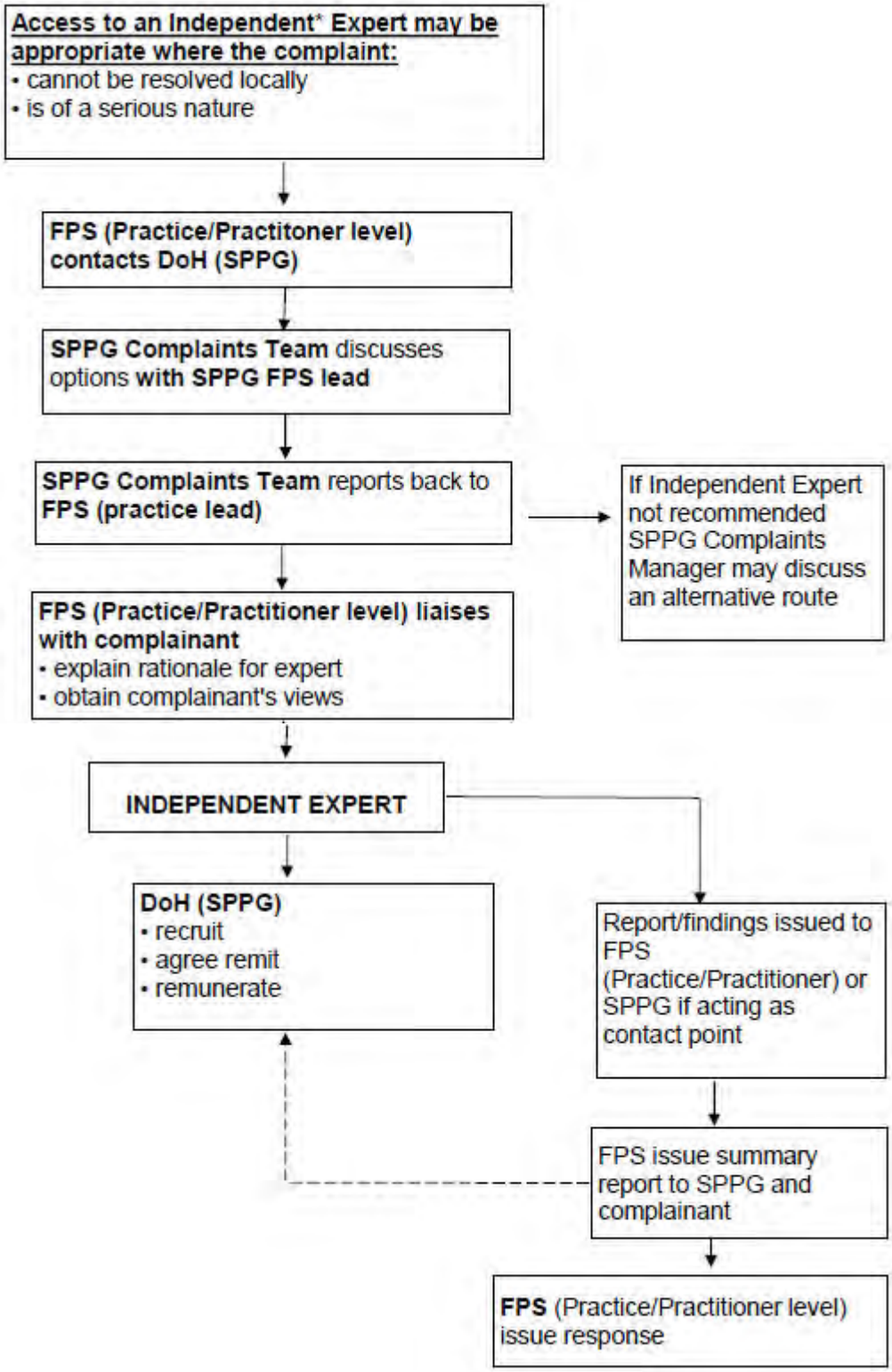
10. Independent Experts must be impartial, objective and independent of any parties to the complaint. Independent Experts should be recruited from another Local Commissioning group (LCG) area to ensure this impartiality (and in certain circumstance may be recruited from outside Northern Ireland).

Monitoring

11. The SPPG Complaints Team will monitor the effectiveness and usage of Independent Expert arrangements within HSC Trusts and FPS including the implementation of any recommendations in FPS.

12. A flowchart outlining the process for FPS is shown overleaf.

Independent Experts – FPS Access



*Definition of "Independent" = an Independent Expert must be recruited from another LCG area (and in certain circumstances outside Northern Ireland) and must have no connection with any of the parties to the complaint to avoid calling into question their objectivity and independence.

ANNEX 10: LAY PERSONS

1. Lay persons may be beneficial in providing an independent perspective of non-clinical/ technical issues within the local resolution process. Lay persons are NOT intended to act as advocates, conciliators or investigators. Neither do they act on behalf of the provider or the complainant. The lay persons involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. For example, the lay person could accompany the investigator during the investigation process where the complainant is considered unreasonable (Annex 13 refers).

2. Input from a lay person may be valuable to test key issues that are part of the complaint, such as:

- communication issues;
- quality of written documents;
- attitudes and relationships; and
- access arrangements (appointment systems).

3. It is essential that both the provider and the complainant have agreed to the involvement of a lay person.

4. Lay persons should have appropriate training in relation to the HSC complaints procedure and have the necessary independence and communication skills.

FPS arrangements

5. The Practice/Practitioner should approach the SPPG Complaints Team for advice.

6. Where a request for a lay person is received the SPPG Complaints Team **may** liaise with the relevant FPS lead to consider the best way forward. Where it is considered that a lay person's involvement would aid resolution then the SPPG Complaints Team will advise the FPS practice. In some cases the SPPG Complaints Team **may** consider an alternative to a lay person.

Agreement and consent

7. The FPS Practice/ Practitioner/ HSC Organisation/SPPG Complaints Team must contact the complainant and discuss the rationale for involving a lay person and provide an opportunity to allow the complainant to agree to such an approach and consent to share information. Once received, the HSC organisation/SPPG Complaints Team (on behalf of FPS) will make the necessary arrangements.

8. Where it has been agreed that a lay person will be involved the Practice/Practitioner/HSC Organisation/SPPG Complaints Team should clearly define the remit of the appointment for the purposes of:

- explaining the issue(s) to be resolved;
- ensuring all parties understand the focus of the issue(s);
- ensuring all parties understand what lay person involvement means;
- agreeing the timescales;
- agreeing to the provision of a final report, and
- explaining what happens when this process is complete.

9. The layperson's findings/report will be forwarded to the Practice/Practitioner/HSC Organisation/SPPG Complaints Team. The full report will be made available by the Practice/ Practitioner/HSC Organisation/SPPG Complaints Team (for FPS only) and to the complainant.

10. The letter of response to the complainant is the responsibility of the Practice/Practitioner/HSC Organisation/SPPG Complaints Team.

Appointment of lay persons

11. The HSC organisation or SPPG Complaints Team (on behalf of FPS) is responsible for communicating with, ascertaining the availability of and formally appointing an appropriate lay person. In addition it is responsible for all other arrangements, including training, performance management and remuneration.

Monitoring

12. The SPPG Complaints Team will monitor the effectiveness and usage of lay person arrangements within HSC Trusts and FPS.

ANNEX 11: HONEST BROKER ROLE

1. "Honest broker" is the term used to describe the role of the SPPG Complaints Team in supporting and advising FPS on the handling of complaints. The complainant or the Practice/Practitioner can ask the SPPG Complaints Team to act in this role at any point in the complaints process. It is expected that the SPPG Complaints Team will not carry out the investigation but it is also expected that it will add value to the process by providing support and advice to FPS.

2. It is not an alternative to local resolution. Neither is it an opportunity for the SPPG Complaints Team to take over an investigation. Rather it is about facilitating communications and building relationships between the Practice/Practitioner and the complainant or reaching positions of understanding. The honest broker will act as an intermediary and is available to both, the complainant or Practice/Practitioner staff throughout the complaints process. For example, the honest broker may:

- provide advice to both the complainant and the Practice/Practitioner;
- act as a link between both parties and/ or negotiate with them; and
- facilitate and attend meetings between/with both parties together or separately.

3. Paragraphs 2.16 to 2.21 outline the options available to complainants when pursuing FPS complaints. This includes an option to lodge their complaint directly with the SPPG Complaints Team. Where the complainant contacts the SPPG Complaints Team the options available to resolve the complaint will be explained:

- that the complaint can be copied to the relevant practice/pharmacy for investigation, resolution and response; or
- that the SPPG Complaints Team can act as honest broker between the complainant and the Practice/Practitioner.

4. FPS co-operation in complaints of this type is essential for the role of honest broker to effectively assist in the successful local resolution of complaints. FPS will be asked for their agreement should the complainant prefer the SPPG Complaints Team's involvement.

5. Where the SPPG Complaints Team has been asked to act as honest broker they will:

- act as intermediary between the complainant and the practice/ pharmacy;
- make arrangements for independent expert advice, conciliation, lay person assistance, where appropriate;
- provide advice to the complainant and the Practice/Practitioner on target timescales[28]; and
- where there is a delay, ensure the complainant is advised as set out in paragraph 3.39.

6. Whichever process is used it is important to note that the Practice/Practitioner are responsible for the investigation and the response. The SPPG Complaints Team, however, must ensure that:

- a written response is provided by the Practice/Practitioner to the complainant and any other person subject to the complaint (whether this is direct from the Practice/Practitioner or from the SPPG Complaints Team after receiving a report from the Practice/Practitioner;
- the response is of sufficient quality and addresses the complainant's concerns;
- the written response is provided within target timescales and where this is not possible that the complainant is informed; and
- the response notifies the complainant of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure.

7. The complainant may contact the SPPG Complaints Team for further advice and support.

[28] For 'honest broker' this is 20 working days from receipt of the complaint: for FPS, this is 10 working days from receipt of the complaint.

ANNEX 12: ADULT SAFEGUARDING

Definition of vulnerable adult

1. The regional policy 'Adult Safeguarding – Prevention and Protection in Partnership' defines the terms 'adult at risk of harm' and 'adult in need of protection[29]'.

2. The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

3. An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain.

Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

[29] 'Adult Safeguarding – Prevention and Protection in Partnership' (July 2015) (https://www.health-ni.gov.uk/publications/adult-safeguarding-prevention-and-protection-partnership-key-documents), p10

4. An '**adult in need of protection**' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

AND

d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

5. In order to meet the definition of an 'adult in need of protection' either (a) or (b) must be present, in addition to both elements (c), and (d).

6. The decision as to whether the definition of an 'adult in need of protection' is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Reportable offences and allegations of abuse

7. Very careful consideration must be given to complaints alleging offences that could be reportable to the police, and there should be explicit policies about the arrangements for such reporting. Where it is apparent that a complaint relates to abuse, exploitation or neglect of an adult at risk then the regional *'Adult Safeguarding Operational Procedures' (September 2016)* and the associated *'Protocol for Joint Investigation of Adult Safeguarding Cases' (August 2016)* should be activated (see paragraph 1.26).

ANNEX 13: UNREASONABLE OR ABUSIVE COMPLAINANTS

1. HSC staff must be trained to respond with patience and empathy to the needs of people who make a complaint, but there will be times when there is nothing further that can reasonably be done to assist them. Where this is the case and further communications would place inappropriate demands on HSC staff and resources, consideration may need to be given to classifying the person making a complaint as an unreasonable, demanding or persistent complainant.

2. In determining arrangements for handling such complainants, staff need to:

- ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of a complaint is overlooked or inadequately addressed;
- appreciate that even habitual complainants may have grievances which contain some substance;
- ensure a fair approach; and
- be able to identify the stage at which a complainant has become habitual.

3. The following *Unacceptable Actions Policy*[30] should only be used as a last resort after all reasonable measures have been taken to resolve the complaint.

Unacceptable Actions Policy

4. People may act out of character in times of trouble or distress. There may have been upsetting or distressing circumstances leading up to a complaint. HSC organisations do not view behaviour as unacceptable just because a complainant is forceful or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the HSC organisation or unreasonable behaviour towards HSC staff to be unacceptable. It is these actions that HSC organisations aim to manage under this policy.

[30] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

Aggressive or abusive behaviour

5. HSC organisations understand that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards HSC staff, it will consider that unacceptable. Any violence or abuse towards staff will not be accepted.

6. Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of behaviours grouped under this heading include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. HSC organisations will judge each situation individually and appreciate individuals who come may be upset. Language which is designed to insult or degrade, is racist, sexist or homophobic or which makes serious allegations that individuals have committed criminal, corrupt or perverse conduct without any evidence is unacceptable. HSC organisations may decide that comments aimed at third parties are unacceptable because of the effect that listening or reading them may have on staff. HSC organisations also consider that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

7. HSC organisations expect its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and staff should refer to the Zero Tolerance campaign launched in 2007 to clarify the HSC position in relation to attacks on the workforce. HSC staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards HSC staff.

Unreasonable demands

8. HSC organisations consider these demands become unacceptable when they start to (or when complying with the demand would) impact substantially on the work of the organisation.

9. Examples of actions grouped under this heading include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; and
- repeatedly changing the substance of a complaint or raising unrelated concerns.

10. An example of such impact would be that the demand takes up an excessive amount of staff time and in so doing disadvantages other complainants.

Unreasonable levels of contact

11. Sometimes the volume and duration of contact made to the HSC organisation by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when a complainant repeatedly makes long telephone calls to the organisation or inundates the organisation with copies of information that has been sent already or that is irrelevant to the complaint.

12. The HSC organisation considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone, or dealing with emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

Unreasonable use of the complaints process

13. Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about an organisation with which they have a continuing relationship, if subsequent incidents occur.

14. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the organisation from pursuing a legitimate aim or implementing a legitimate decision. The HSC organisation considers access to a complaints system to be important and it will only be in exceptional circumstances that

it would consider such repeated use is unacceptable, however it reserves the right to do so in those exceptional circumstances.

Unreasonable refusal to co-operate

15. When the HSC organisation is looking at a complaint, it will need to ask the individual who has complained to work with them. This can include agreeing with the HSC organisation the complaint it will look at; providing it with further information, evidence or comments on request; or the individual summarising the concerns or completing a form for the HSC organisation.

16. Sometimes, an individual repeatedly refuses to cooperate and this makes it difficult for the HSC organisation to proceed. The HSC organisation will always seek to assist someone if they have a specific, genuine difficulty complying with a request. However, the HSC organisation consider it is unreasonable to bring a complaint to it and then not respond to reasonable requests.

Examples of how the HSC manage aggressive or abusive behaviour

17. The threat or use of physical violence, verbal abuse or harassment towards HSC staff is likely to result in a termination of all direct contact with the complainant. All incidents of verbal and physical abuse will be reported to the police.

18. HSC organisations will not accept any correspondence (letter, fax or electronic) that is abusive to staff or contains allegations that lack substantive evidence. The HSC organisation will tell the complainant that it considers their language offensive, unnecessary and unhelpful and ask them to stop using such language. It will state that it will not respond to their correspondence if the action or behaviour continues.

19. HSC staff will end telephone calls if they consider the caller aggressive, abusive or offensive. The staff member taking the call has the right to make this decision, tell the caller that their behaviour is unacceptable and end the call if the behaviour persists. In extreme situations, the HSC organisation will tell the complainant in writing that their name is on a “no personal contact” list. This means that it will limit contact with them to either written communication or through a third party.

Examples of how the HSC deal with other categories of unreasonable behaviour

20. The HSC organisation has to take action when unreasonable behaviour impairs the functioning of its office. It aims to do this in a way that allows a complainant to progress through its process. It will try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

21. Where a complainant repeatedly phones, visits the organisation, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the HSC organisation may decide to:

- limit contact to telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of staff who will deal with the future calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact from the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; and
- take any other action that the HSC organisation considers appropriate.

22. Where the HSC organisation considers correspondence on a wide range of issues to be excessive, it may tell the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly.

23. In exceptional cases, the HSC organisation will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further.

24. The HSC organisation will always tell the complainant what action it is taking and why.

The process the HSC follows to make decisions about unreasonable behaviour

25. HSC staff who directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the organisation are only taken after careful consideration of the situation by a more senior member of staff. Wherever possible, the HSC organisation will give the complainant the opportunity to change their behaviour or action before a decision is taken.

How the HSC lets people know it has made this decision

26. When a HSC member of staff makes an immediate decision in response to aggressive or abusive behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[28] why a decision has been made to restrict future contact, the restricted contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

The process for appealing a decision to restrict contact

27. It is important that a decision can be reconsidered. A complainant can appeal a decision to restrict contact. If they do this, the HSC organisation will only consider arguments that relate to the restriction and not to either the complaint made to the organisation or its decision to close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable, the restrictions were disproportionate; or that they will adversely impact on the individual because of personal circumstances.

28. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They

must advise the complainant in writing[31] that either the restricted contact arrangements still apply or a different course of action has been agreed.

How the HSC record and review a decision to restrict contact

29. The HSC organisation records all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact as described above, may be reconsidered if the complainant demonstrates a more acceptable approach. A member of the Senior Management Team reviews the status of all complainants with restricted contact arrangements on a regular basis.

[31] Unacceptable Actions Policy based on best practice guidelines issued by the Scottish Public Services Ombudsman-Updated 18 January 2017

ANNEX 14: CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

1. Under the Children (NI) Order 1995[32] (the Order) HSC Trusts are statutorily required to establish a procedure for considering:

- any representations (including any complaint) made to it about the discharge of its functions under Part IV of, and paragraph 4 of Schedule 5 to, the Order, and
- matters in relation to children accommodated by voluntary organisations and privately run children's homes, and
- those personal social services to children provided under the Adoption Order (NI) 1987[33].

2. HSC Trusts functions are outlined in Article 45 of, and paragraph 6 of Schedule 5 to, the Order and in the Representations Procedure (Children) Regulations (NI) 1996[34].

3. Departmental guidance on the establishment and implementation of such a procedure is included at Chapter 12 of the Children Order Guidance and Regulations, Volume 4 (a flowchart to aid decision making is attached).

4. The HSC Trusts should familiarise themselves with these requirements.

[32] Children (NI) Order 1995: http://www.legislation.gov.uk/nisi/1995/755/contents
[33] Adoption Order (NI) 1987: http://www.legislation.gov.uk/nisi/1987/2203/contents
[34] Representations Procedure (Children) Regulations (NI) 1996: http://www.legislation.gov.uk/nisr/1996/451/contents/made

CHILDREN ORDER REPRESENTATIONS AND COMPLAINTS PROCEDURE

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1. Complaint: Does it fit the definition of a Children Order complaint as below?

"…Any representation (including any complaint) made to the Trust … about the discharge of any of its functions under Part IV of the Order in relation to the child."
(Children (NI) Order 1995, Article 45(3))

OR

"A written or oral expression of dissatisfaction or disquiet in relation to an individual child about the Trust's exercise of its functions under Part IV of, and para 6 of Schedule 5 to, the Children Order."
(Guidance & Regulations – Vol. 4, Para 12.5 – DHSS)

If **YES** to **EITHER** of above

If **NO** to **EITHER** of above → Progress via HSC Complaints Procedure

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2. Does it meet the criteria of what may be complained about under Children Order?

"… about Trust support for families and their children under Part IV of the Order."
(Vol. 4, Para 12.8)

a. Day care;
b. Services to support children within family home;
c. Accommodation of a child;
d. After care;
e. Decisions relating to the placement of a child;
f. The management or handling of a child's case (in respect of Part IV services);
g. Process involved in decision making (in respect of Part IV services);
h. Denial of a (Part IV) service;
i. Exemptions to usual fostering limit;
j. Matters affecting a group of children (receiving a Part IV service);
k. Issues concerning a child subject to Adoption Services.

If **YES** to **ANY** of above

If **NO** to **ALL** of above → Progress via HSC Complaints Procedure

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3. <u>Complainant</u>: Does he/she fit the definition of a Children Order complainant?

a. **Any child** who is being looked after by the Trust;

b. **Any child** who is not being looked after by the Trust, but is in need;

c. A parent **of his**;

d. Any person who is not a parent of his but who has **parental responsibility for him**;

e. Any Trust foster parent;

f. Such other person as the Trust considers has a sufficient interest in **the child's welfare** to warrant his representations being considered by the Trust, i.e.

- the person who had the day to day care of the child within the past two years;
- the child's Guardian ad Litem;
- the person is a relative of the child (as defined by Children Order, Article 2(2));
- The person is a significant adult in the child's life, and where possible, this is confirmed by the child;
- a friend;
- a teacher;
- a general practitioner.
  (Children (NI) Order 1995 Article 45(3))

If **<u>YES</u>** to **ANY** of above

If **<u>NO</u>** to **ALL** of above → Progress via HSC Complaints Procedure

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Progress via Children Order Procedure

<u>NB</u>: In order for a complaint to be eligible to be considered under the Children Order Procedure, the answer to 1 <u>and</u> 2 <u>and</u> 3 MUST all be YES.

Consent: *The (Trust) should always check with the child (subject to his understanding) that a complaint submitted reflects his views and that he wishes the person submitting the complaint to act on his behalf.* (Where it is decided that the person submitting the complaint is not acting on the child's behalf, that person may still be eligible to have the complaint considered).

Definitions of Key Terms

Throughout the standards and guidelines the following terms have the meanings set out below:

Complaint	"an expression of dissatisfaction that requires a response"
Complainant	an existing or former patient, client, resident, family, representative or carer (or whoever has raised the complaint)
Chief Executive	the Chief Executive of the HSC organisation
Complaints Manager	the person nominated by an HSC organisation to handle complaints
DoH[35]	Department of Health in Northern Ireland
Family Practitioner Service (FPS)	family doctors, dentists, pharmacists and opticians
Honest Broker	this is the term used to describe the role of the SPPG on behalf of DoH in FPS complaints
HSC Organisation	an organisation which commissions or provides health and social care services and for the purpose of this guidance includes HSC Trusts, the Northern Ireland Ambulance Service (NIAS), the Business Services Organisation (BSO), the Public Health Agency (PHA), Family Practitioner Services (FPS), Out-of-Hours Services, and pilot scheme providers
Local Resolution	the resolution of a complaint by the organisation, working closely with the service user

[35] Formally the Department for Health, Social Services and Public Safety (DHSSPS)

NIBTS	Northern Ireland Blood Transfusion Service
NIPSO	Northern Ireland Public Services Ombudsman (NIPSO, known as 'the Ombudsman')
Out of-Hours services	refers to immediate necessary treatment provided by FPS 6.00 pm to 8.00 am Monday – Friday, weekends and local holidays
PCC	Patient and Client Council
Pilot Scheme	a small-scale experiment or set of observations undertaken to decide how and whether to launch a full-scale project (refers to personal dental services provided by an HSC Trust in this case)
Pilot Scheme Complaints Procedure	is a complaints procedure established by the pilot scheme
Practice based complaints procedure	is an FPS complaints procedure established within the terms of the relevant regulations
Registered Provider	person carrying on or managing the establishment or agency
RQIA	Regulation, Quality and Improvement Authority which is the organisation responsible for regulating, inspecting and monitoring the standard and quality of health and social care services provision by independent and statutory bodies in Northern Ireland
Registered Establishments and Agencies	for example, residential care homes, nursing homes, children's homes, nursing agencies, independent clinics/hospitals, etc. registered with and regulated by the RQIA
Regulated Sector	refers to registered establishments and agencies

Senior Person	means the person designated to take responsibility for delivering the organisation's complaints process e.g. a Director in the HSC Trust
Service User	means a patient, client, resident, carer, visitor or any other person accessing HSC services
Special Agency	For example the NI Blood Transfusion Service (NIBTS)
SPPG	Strategic Planning and Performance Group, DoH (formerly HSC Board)

MAHI - STM - 120 - 2432

Health and Social Care Board and Public Health Agency

Annual Quality Report 2017/18

HSC Health and Social Care Board

HSC Public Health Agency

QUALITY 2020

MAHI - STM - 120 - 2433

Foreword

I am very pleased to present the fifth Annual Quality Report of the Health and Social Care Board (HSCB) and Public Health Agency (PHA).

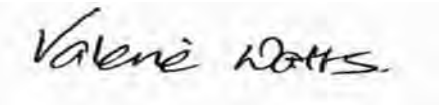
This report highlights a variety of work that has taken place over the last year, demonstrating our firm commitment to driving improvements in safety, outcomes, access, efficiency and patient satisfaction. While it is impossible to include information about every service the HSCB and PHA provide, nevertheless it is my hope that this report goes some way to reassure our patients, clients and the public of our commitment to continuous improvement and delivering high quality treatment and care.

During 2017/18 there was an important focus on quality improvement and improving outcomes for patients/clients within each of our directorates. I am particularly pleased to note the range of improvements which have been implemented as a result of, for example, the Dementia Together NI project. With the extensive public information campaign #STILL ME, the delivery of a range of training and education programmes and the recruitment of dementia champions and navigators across the HSC, the project has far exceeded all expectations.

Regionally, we have seen continuous progress in the management of clinical networks and I am delighted to share the work of the imaging services accreditation scheme, which, through the modernising radiology clinical network, has been commended as an exemplar model for collaborative working. Similarly, measuring improvement has remained an key area of focus and last year we continued to provide support to HSC Trusts and other HSC bodies on a range of key quality improvement priorities, which collectively resulted in, for example, a reduction in moderate to major/ catastrophic falls across the region.

Our commitment to the co-production of services has been evident through the various improvements implemented as a result of 10,000 More Voices and the continuous growth of recovery colleges across the region. Similarly, through the integration of care we have seen a range of transformed and enhanced services being delivered, +exhibiting strong inter-professional communication links between both primary and secondary care.

Finally, I would like to thank all the staff for their continuing efforts over the past year and I am particularly proud of what we have achieved together. As the HSC continues to face financial and operational pressures, the HSCB/PHA will focus on continually improving quality of care for people using their services and to put our patients, clients and staff at the heart of everything we do.



Transforming the culture

361 Serious Adverse Incident Reviews Completed

Regional learning methods approved:

- 12 reminder of best practice guidance letters
- professional letters
- 2 newsletter articles
- 56 specialist group referrals
- featured at the regional SAI learning event
- thematic reviews commissioned

5 Recovery Colleges fully operational

Top 3 categories of complaints

1. Quality of treatment & care
2. Staff attitude & behaviour
3. Communication /information

10,000 TEN THOUSAND MORE VOICES

2,422 Stories Collected

Overall Total **12,720**

Strengthening the workforce

HSC staff...

32% trained at level 1 of the **Q2020 Attributes Framework**

2,826 trained in the use of the **Delirium Assessment & Management Tool**

Personal and Public Involvement (PPI)

23% completed the Engage & Involve PPI Training Programme

The Q Community in NI up to **123 members**

Q is an initiative which connects people who have quality improvement expertise across the United Kingdom

Roll out of Project ECHO®

in 30 clinical areas

Project ECHO is a tele-monitoring programme designed to address the growing demand for secondary care services

Measuring improvements

Regional Quality Improvement Plan priority areas focused on:

- Pressure ulcer prevention
- Falls prevention
- National Early Warning Scores
- Mixed gender accommodation

59 Technology Appraisals issued

Continued monitoring the implementation of

170 Clinical Guidelines

Raising the standards

MAHI - STM - 120 - 2436

Regional Clinical Networks implemented to achieve regional consistency in care & drive quality improvement, including:

- Critical Care Network
- Neonatal Network
- Cancer Network
- Pathology Network
- Diabetes Network
- Stroke Network
- Paediatric Network
- Trauma Network
- Radiology Network
- Pain Forum Network
- Lymphoedema Network

Development of 'Quality Improvement Collaboratives', including:

- Maternity collaborative
- Sepsis collaborative
- Mental Health collaborative
- Paediatric Collaborative

8 antenatal, newborn & adult screening programmes commissioned & quality assured:

1. Antenatal infection
2. Newborn blood spot
3. Newborn hearing
4. Abdominal Aortic Aneurysm
5. Bowel cancer
6. Breast cancer
7. Cervical cancer
8. Diabetic eye

1,407 downloads of the Learning Disability Hospital Passport from the PHA website

6,000 Learning Disability Hospital Passports & guidance notes distributed

69%

As a result of the **Developing Eyecare Partnership** 69% fewer patients were referred for suspect ocular hypertension

Mental Health 1+1 Project

Project launched with 3 bi-lingual staff - 4-year pilot programme supporting the **mental health & wellbeing needs of Black & Minority Ethnic communities**

Integrating the care

A-Z Health Conditions

The A-Z Health Conditions Platform was developed providing a suite of health information, supporting people to make decisions in relation to their personal illness & chronic conditions

3,464 key information summaries successfully completed by GPs enabling important accurate information to be quickly identified in an unscheduled care setting

26% increase

26% increase in Health Service patients receiving specialist oral surgery care within primary care compared to the previous year, as a direct result of the Oral Surgery Personal Dental Services Pilot

3,656 patients

In April 2018, **3,656 patients** received a home oxygen concentrator via the home oxygen service

22% increase

22% increase in the number of children whose language development was age appropriate, as a direct result of the supporting speech, language & communication programme in Sure Start

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Theme one

Transforming the culture

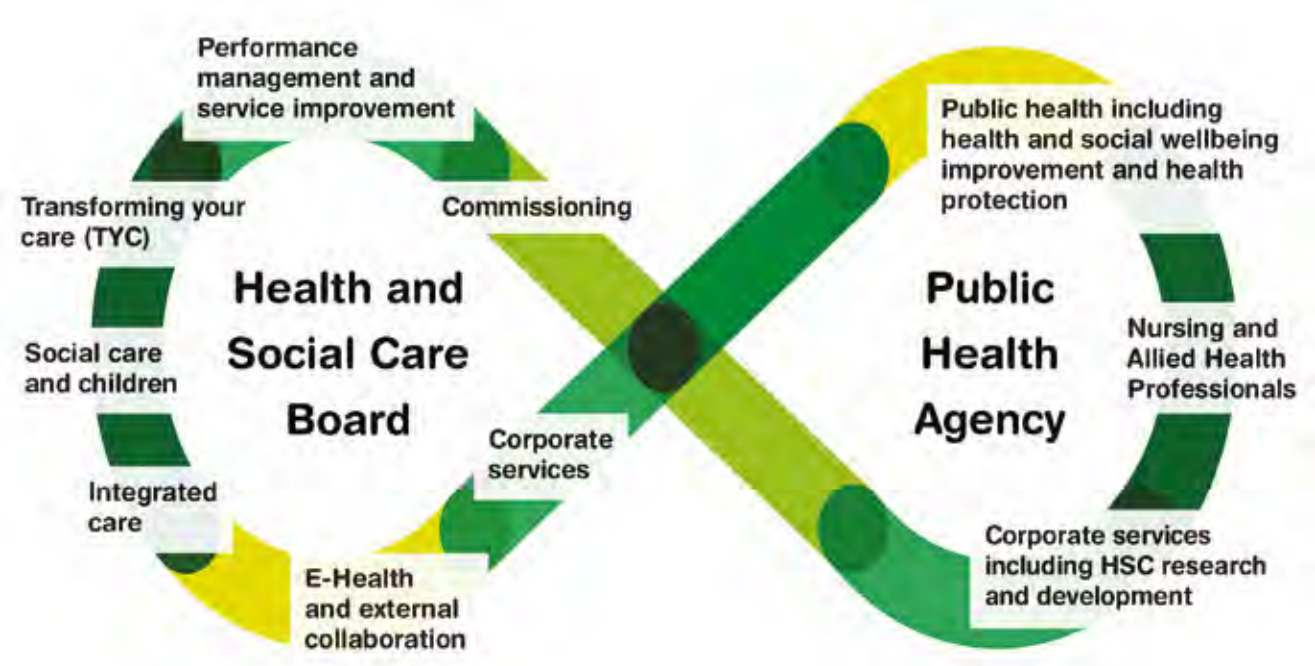
Transforming the culture

1.1 Introduction

The HSCB and PHA both recognise that for the quality of care and services to be of the highest standard, the culture of an organisation must be open, honest, transparent and, in particular, patient and client focused. Key to transforming organisational culture is the willingness of the senior team to lead from the front in motivating staff and, prioritising patient and client care, while embracing change in the rapid moving climate of Health and Social Care (HSC).

1.2 Who we are

The HSCB and PHA are considered arm's-lengths bodies within HSC. The organisations have a different range of roles and responsibilities, as reflected in their directorate structure. Ensuring that HSC services are safe, high quality, effective and meet people's needs is a core function of the HSCB and PHA. The two organisations work collaboratively to improve the quality of services delivered and work towards the Quality 2020 vision "to be recognised internationally, but especially by the people of Northern Ireland, as a leader for excellence in Health and Social Care".

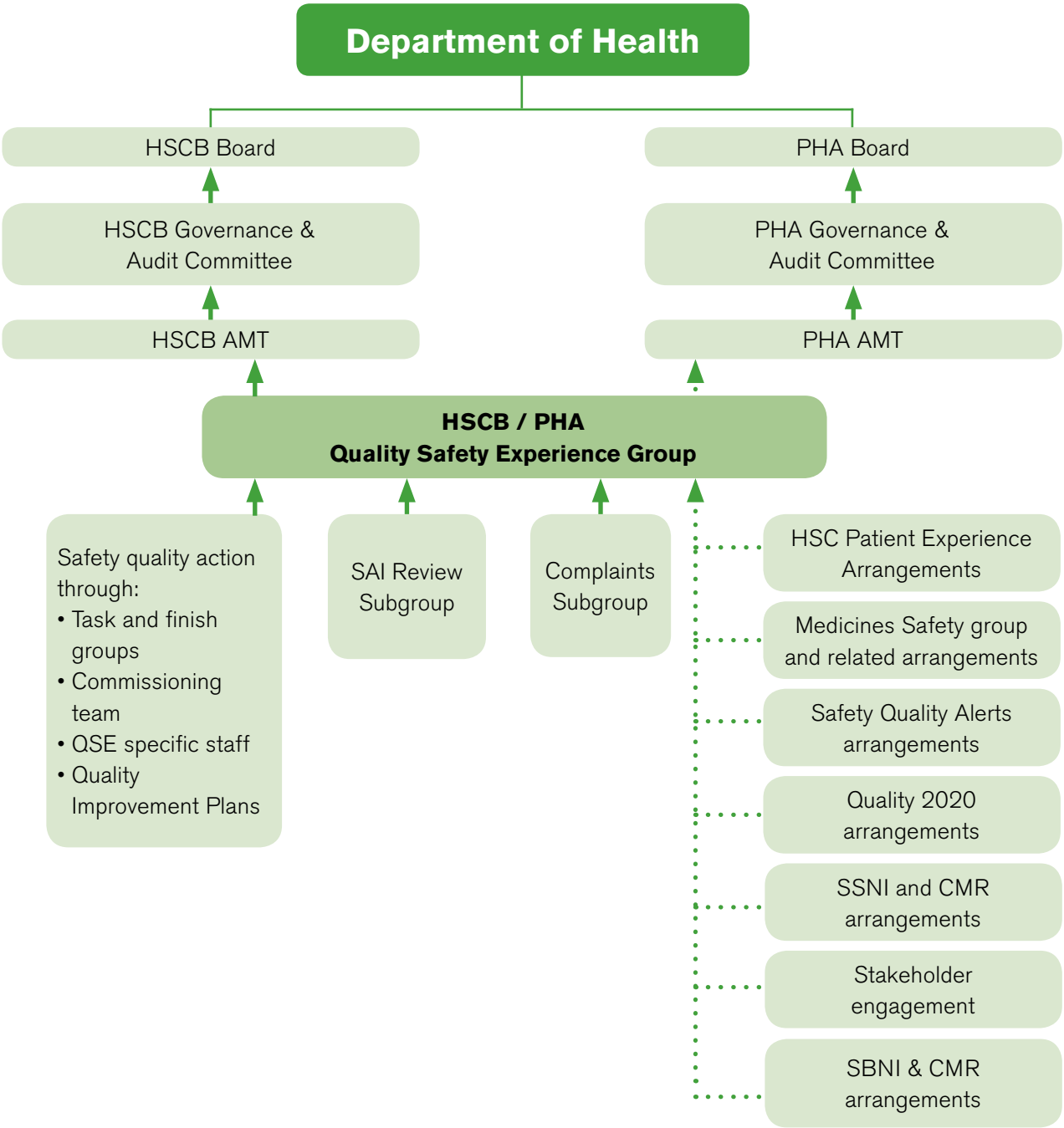


Transforming the culture

1.3 Leadership & governance

Within the HSCB and PHA, the **Quality, Safety and Experience (QSE) Group** monitors and reports on safety, effectiveness and the patient client experience. A number of other groups contribute to the work of improving the safety and quality of services as shown in the overview of the PHA/HSCB QSE governance and assurance structure.

The Safety Quality Alerts Team, Regional Complaints Group, Serious Adverse Incident Group, Designated Review Officer (DRO) professional groups, and the Safety Forum, report to, and support the work of QSE.



Transforming the culture

1.4 Learning

Regional learning from serious adverse incidents

The key aim of the Serious Adverse Incident (SAI) process is to improve patient and client safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC.

For the majority of SAIs reported, local learning will be identified and actioned by the reporting organisation. However, as the HSCB/PHA have a role in reviewing all SAIs they may also identify regional learning for dissemination across the HSC through a number of mechanisms.

During the reporting period 361 SAIs were closed by the HSCB/PHA following review. The following methods of regional learning were approved from SAIs closed in 2017/18:

12	**reminders of best practice guidance letters**
8	**professional letters**
42	**newsletter articles were identified**
56	**were referred to other specialist groups**
2	**thematic reviews were commissioned**
9	**were featured at learning events (SAI learning event)**

Listed below are four examples of regional learning identified last year:

- **Management of needlestick injuries in patients presenting to emergency departments**

This SAI related to a community pharmacy staff member who sustained a needlestick injury during the course of their duties. As a result, a reminder of best practice guidance letter was issued to the HSC and the HSCB and PHA worked with Trusts to ensure:

- Emergency departments within Trusts have a clear policy on managing people who present with needlestick injuries;
- All members of staff who may be involved in the management of patients presenting with a needlestick injury are aware of, and have received training in the Trust policy.

- **Acute management of diarrhoea related to cancer treatment**

A number of SAIs occurred in which people receiving systemic anti-cancer therapy were admitted to hospital with diarrhoea and subsequently died. A common feature in the incidents reported was that the seriousness of the patient's diarrhoea was not necessarily recognised and appropriate inpatient treatment was consequently delayed.

As a result, a reminder of best practice guidance letter was issued reminding Trusts of the requirements under current guidance and requesting this be brought to the attention of relevant staff.

Transforming the culture

• Choking on food

Last year a thematic review of choking on food led by the HSCB/PHA in conjunction with key stakeholders was distributed to the HSC. The themes identified through analysis reinforce a need for co-ordinated efforts to facilitate learning and inform future quality improvement work with an aim of prevention or reduction of risk of choking in future. A number of key messages relating to the areas below are identified within the report. These include:

- Raising awareness
- Communication to staff delivering care directly
- Terminology
- Roles and responsibilities
- Education and training
- Reporting
- Support to staff

In response to the choking on food thematic review, a multidisciplinary and multiagency Adult Swallowing Difficulties Regional Steering Group has been established. The group uses a co-production approach and has four workstreams including awareness, identification; assessment and management and International Dysphagia Diet Standardisation Initiative (IDDSI) implementation.

Funding has been agreed to support a number of specific actions within the work. Engagement activities have taken place to inform the work going forward. These include:

• Focus groups / workshops

Two focus groups & a regional workshop have been held to listen to issues from nursing/ residential homes, domiciliary care sector and Trust staff in relation to the identification and management of adults with dysphagia, including staff training needs.

• Public awareness raising

Information stands were held across the region in hospitals on European Swallow Awareness Day on 14th March 2018. Speech and language therapists (SLT) and SLT students provided information on swallowing difficulties and catering departments provided samples of a dysphagia diet. A short survey was also completed to gain information on the public's knowledge of dysphagia.

Transforming the culture

• Fire risk associated with use of product to treat head lice

This case involved a child treated for head lice who suffered severe burns following application of a treatment product and subsequent exposure to a source of ignition. Unfortunately due to the combustible nature of the treatment product the child's face and scalp. The child suffered 3rd degree burns to the face and neck. Although there are written warnings included with the product, these may not have been brought to the attention of the recipient by pharmacy staff.

As a result a Reminder of Best Practice Guidance letter was issued to the HSC with specific actions for Trusts, HSCB, GP practices, community pharmacies and the Regulation and Quality Improvement Authority (RQIA).

For further information on learning from SAIs please see following link **http://www.hscboard.hscni.net/publications/sai-learning-reports/**

Regional learning from complaints

The HSCB/PHA review complaints received from Trusts, family practitioner services (FPS), and those received directly by HSCB and PHA. For the majority of complaints, local learning will be identified and actioned by the reporting organisation. In some cases, the HSCB/PHA may also identify regional learning.

Areas of concern, patterns and trends from complaints are shared with relevant professional groups. This ensures that issues raised by complaints inform key areas of work on the quality of patient experience and safety, including thematic reviews and strategy and policy development.

Setting the context: during 2017/18
- **Trusts received 5814 complaints**
- **HSCB received 240 complaints regarding Family Practitioner Services**
- **HSCB acted as 'honest broker' in 54 complaints regarding Family Practitioner Services.**

Top 3 categories of complaints
1) **Quality of treatment and care**
2) **Staff attitude/behaviour**
3) **Communication/information**

During 2017/18, the HSCB hosted its fourth annual Learning From Complaints event, which focused on the themes of palliative care and the coordination of discharge packages. Both issues consistently feature in a significant number of complaints across primary and secondary care.

Transforming the culture

Palliative care is appropriate for people with a progressive or life limiting condition, regardless of age. Dame Cicely Saunder quote – *How people die remain in the memories of those who live on.* Therefore complaints regarding palliative care is appropriate for people with a progressive or life limiting condition. Timely communication of information between patients, families, carers and HSC providers is therefore paramount in improving patient and carer experience of palliative and end of life care. The timing of discharge also needs appropriate consideration, with referrals to district/palliative care made in a timely fashion.

Key messages from the day included; recommendations identified by the Patient Client Council (PCC) to improve interactions between clinicians, patients and their families; how complaints have influenced the discharge policies across the WHSCT emergency departments; how complaints have made a difference to the Regional Palliative Care Programme and consideration given to the theme of "moral distress" within intensive care and the associated impact this has on relatives, doctors and nurses.

To raise awareness of these issues and to highlight learning and good practice, feedback from this event was compiled and disseminated to the HSC.

For further information relating to complaints can be accessed at **http://www.hscboard.hscni.net/publications/complaints-publications/**

Learning from experience:

Learning from patient and client experience is a key indicator of quality of care and is integral to the implementation of Q2020 across the region. The HSCB/PHA lead the implementation of the 10,000 More Voices initiative for Northern Ireland. The rich source of information from the stories received through the 10,000 More Voices initiative continues to provide opportunities for learning , reflection and informing improvement work, for example:

- Stories from the individual 10,000 More Voices projects are reviewed on a weekly basis – this provides an opportunity for the relevant staff to highlight areas of good practice as well as considering any immediate learning or action that needs to be taken.

- Findings and results from 10,000 More Voices projects are presented at analysis and interpretation workshops at which key stakeholders, including service users work collaboratively to themes and trends. Following this, recommendations are developed, alongside local and regional action plans.

Transforming the culture

- Stories are used to inform education and training, including local induction programmes as well as pre and post registration education for medical, nursing and allied health professional students.

- 10,000 More Voices is now an integral part of quality improvement, informing 'Always Events' and quality improvement programmes within HSC Trusts.

To date over **12,000** stories have been collected, across a broad range of service areas, including: eye care services, hospital discharge, delirium and adult safeguarding.

Further information and completed project reports can be accessed at: **http://10000morevoices.hscni.net/**

10,000 More Voices Team at their celebration event in March 2018

"When I heard about 10,000 More Voices I felt it was important to tell our story, I hope that by doing so other families will be listened to or receive better explanations in these circumstances…… If as you say our story is used to shape future healthcare, improve services and educate staff then I am content that this opportunity is available."

Thank you for taking time to listen to 10,000 Voices or even me."

Transforming the culture

Personal and Public Involvement (PPI) Involving you, improving care

PPI is the active and effective involvement of service users, carers and the public in the commissioning, development and delivery of HSC services. Co-production is considered the pinnacle of such involvement. The PHA leads on the implementation of PPI in Health and Social Care. Recognising that core to quality improvement work is the involvement of service users and carers, a number of initiatives have been progressed in 2017/18. These include:

1.5 Involvement & co-production

Personal and public involvement (PPI)

- **Improving involvement in transformation -** Working closely with a number of the transformation workstreams, the PHA has provided guidance to ensure service users and carers are effectively and meaningfully involved in transforming HSC at all levels.

- **Improving access to information to improve involvement practices -** The PHA lead the co-production of the Engage website and e-learning resource for service users and carers. This has led to a significant improvement in the quality, availability and consistency of PPI information available. The PHA was also a partner in the quality improvement community of practice for PPI which has developed checklists for staff undertaking improvement work alongside service users and carers getting involved in this work.

- **Improving knowledge and skills –** The PHA continues to promote and deliver the Engage and Involve training programme, elements of which are now being delivered as part of quality improvement training in some HSC Trusts**.** In addition, innovative and high quality training for involvement, including an involvement leadership programme and specialist training for consultation has been commissioned.

- **Improving HSC performance for PPI -** The PHA continue to undertake performance monitoring for PPI across HSCT which focuses on what is working well and what can be improved. The HSCB / PHA were also subject to external PPI monitoring during this period.

- **Improving involvement standards – leading the way -** The PPI standards, developed by the PHA, have been used as the pathfinder for National Research Standards. The PHA has been working with the National Institute of Health Research (NIHR) and PPI leads from England, Scotland, Wales on this initiative.

Meaningful involvement across our services remains critical improvements in safety and quality. The PHA will continue to advance these core areas of responsibility in partnership with service users and carers.

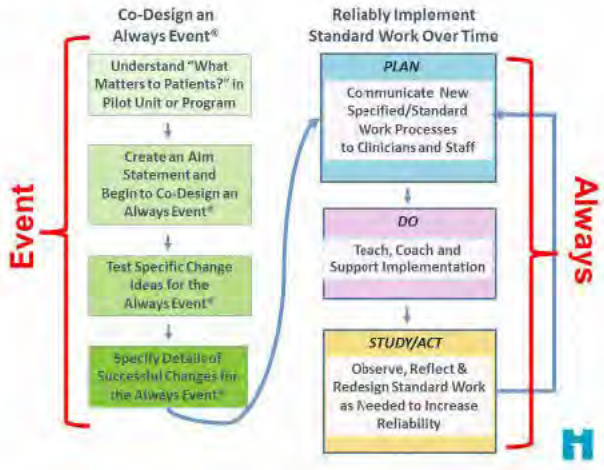
Further information on PPI is available at **http://engage.hscni.net/**

Transforming the culture

Implementation of Always Events in Northern Ireland

Always Events are defined as those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health and social care delivery system.

During 2017/18, the HSCB/PHA, through the regional Patient Client Experience Steering Group, have led the implementation of Always Events in each HSC Trust.



Using feedback from 10,000 More Voices, each Trusts identified a key area and pilot wards in which to test the methodology. A number of key improvements have been noted during the testing.

Belfast Health and Social Care Trust (BHSCT) will ALWAYS meet the World Health Organisation's Noise at Night recommendation

- Trust has linked with estates/labs department to review the use & frequency of the pneumatic chute system, replacing the foam padding on existing pods.
- Noise at night checklists have been introduced into the pilot wards.
- A traffic light noise monitor has been introduced into pilot wards.
- Apps were made available for staff to measure noise levels on ongoing basis.
- Posters & leaflets have been developed to remind people of human noise that can be reduced – building on the Trust animation "there is nothing like a good night sleep".

Northern Health and Social Care Trust (NHSCT) Mealtime matters: our pledge - we will ALWAYS protect patients mealtimes

- Core components of what should **always** happen at mealtimes have been established.
- A mealtimes bundle poster has been designed detailing the roles and responsibilities of nursing and catering staff at every mealtime.
- Electronic menu system has been introduced.
- A scale and spread plan was been developed with a view to total Trust-wide implementation by March 2019.

Transforming the culture

Southern Health and Social Care Trust (SHSCT) - I will ALWAYS be supported to communicate at the Outpatients Department Ramone Ward, Craigavon Area Hospital.

- Yellow with black writing signage introduced in outpatients department and at front entrance to Craigavon Area Hospital.
- Sensory awareness training for all staff has been co-produced by deaf service users and staff. This will also be co-delivered by the deaf service users.
- Yellow name badges introduced in the department and for eye care clinic staff.
- 'I am deaf' card has been introduced to increase awareness of a deaf patient awaiting appointment with details of interpreter services on the reverse.
- Sonido digital hearing system is now in place – posters and leaflets have been developed to raise awareness.

South Eastern Health and Social Care Trust (SEHSCT) - *To improve pain management satisfaction to 90% or greater throughout the inpatient setting.*

- ABCDE approach to pain assessment and management developed / pathway & logo 'Prioritise Pain' developed.
- Launch of project in pilot wards. Promotional posters, pens, balloons were used and information was shared using social media and staff newsletters etc.
- Pain score standardised in pilot wards.
- Successful pain study day for registered nurses hosted by Trust pain team. Some initial results indicate:
  - 76% increase compliance in recording of pain score on revised NEWS chart;
  - 93.4% of patients reported that they were always/frequently asked about their pain;
  - 18% increase in staff knowledge in relation to pain management in pilot wards following the project;
  - Increase in number of referrals to the hospital acute team.

Western Health and Social Care Trust (WHSCT) Family presence: promoting a shared person centred approach to visiting times and participation within the hospital.

- Standardisation of core information to promote family presence which includes information on how to best support patients and clients, information relating to illnesses, helping with food and drink, car parking, and visiting times.
- Personalised ward based posters & leaflets designed and distributed.
- The Trust has linked closely with the *John's Campaign: for the right to stay with people with dementia in hospital* and promotes dementia friendly wards.

Transforming the culture

You in Mind 'Your Experience Matters' Sensemaker Re-Audit Report

In June 2017 the HSCB / PHA launched the 'You in Mind – Your Experience Matters' report on the re-audit of experience relating to mental health services. The survey, used to gather experience, was developed by service users and carers from each HSCT area using story telling methodology, enabling a more person centred / co-produced approach to improving experience.

Overall, the re-audit data suggests that there was a positive shift in how people perceive mental health care services. Approximately one third of all respondents said that they are hopeful for the future. For the majority of respondents, recovery focused practice was identified as an important part of their treatment.

Although it is recognised that there is still much to do, it is important to celebrate and acknowledge the positive work which has taken place across Northern Ireland. The launch event provided an opportunity to demonstrate the significant and valuable changes that have taken place in services across the region since the first report was published in 2012. Some examples of service/organisational change being implemented as a direct result of the Sensemaker re-audit findings include:

- SEHSCT - Developing an outcomes framework for the Recovery College.
- NHSCT - Maternal mental health and wellbeing workshop.
- BHSCT - Physical health care pathway in acute wards.
- WHSCT - Service user involvement in planning their care and treatment.
- SHSCT - Transforming the workforce & employment of peer support workers.

Regionally, Recovery services continue to improve within mental health with minimal financial investment. This is a result of the Trusts undertaking the journey together, initially with facilitation from Implementing Recovery Through Organisational Change (ImROC) and continues with a regional steering group lead by the PHA.

The full report is available here **http://www.publichealth.hscni.net/publications/you-mind-your-experience-matters%E2%80%99-sensemaker-re-audit-2015).**

Transforming the culture

Recovery newsletter

The PHA in collaboration with HSCB continues to work with Recovery Colleges and the ImROC Regional Group to co-produce a bi-annual newsletter. There have been five newsletters published providing a snapshot of peer support working, co-production, Recovery College activities and articles and poems from service users about their recovery journey.

The latest newsletter (Issue 5) was published at the end of March 2018 and highlights the establishment of the regional peer support workers into statutory mental health services. Also included in the newsletter is the launch of the European Union (EU) investment of €7.6 million in mental health recovery secured by the Co-operation and Working Together (CAWT) health and social care partnership.

Copies of the Recovery newsletters can be accessed on the following link: **http://www.publichealth.hscni.net/publications/recovery-newsletter**


Recovery

Promoting hope, choice and opportunity

Regional Peer Support Workers Forum – embedding and developing the peer support worker role across the region

Service framework for Mental Health and Wellbeing 2018-21 (public consultation stage)

The draft service framework for Mental Health and Wellbeing 2018-21 is the regionally agreed model for mental health care in Northern Ireland. It sets out the standards of care and treatment that individuals, their carers and wider family can expect to receive from HSC. The HSCB/PHA are leading the development of this service framework which reflects the principles and values of the 'You In Mind' Regional Mental Health Care Pathway, launched in 2014. The pathway recognises that all treatment and care needs to be highly personalised and recovery orientated.

The 'You In Mind' care pathway explains how people can access mental health care and details the quality of service they can expect from the point of referral to the point that services are no longer required. It describes how mental health professionals will work in partnership with people to access mental health services, though assessment, diagnosis, care and treatment, self-management, and recovery. It outlines how care decisions are made with and for people. It places people, families, partners and nominated friends at the heart of all decision-making.

Transforming the culture

#EndPJparalysis

PHA is leading, supported by the HSCB, Northern Ireland's participation in the nationwide 70 day, #EndPJparalysis challenge. The campaign has been endorsed by Professor Charlotte McArdle and aims to get people up, dressed and moving about, thus giving patients back one million days of their time that would otherwise be spent in a bed in hospital gowns or PJs. #EndPJparalysis is a means of valuing patients' time so they return sooner to loved ones staff may never meet, to homes staff will never visit, to spend more of their last 1000 days in a place that is not a hospital. The challenge is about embedding that into normal practice.

At the midway point of the campaign there are a variety of areas from all Trusts taking part in the campaign with almost 5000 patients up dressed and moving. PHA has secured repeat visits from #EndPJParalysis creator Professor Dolan in June 2018. Professor Dolan will deliver his TODAY programme which further highlights why we should focus on time being the most important currency in Healthcare. This follows on from five similar workshops held across Northern Ireland in January 2018 with very positive feedback.

Benefits of #endPJparalysis include:

- Reduced length of stay (< 1.5 days in Nottingham University Hospital Trauma and Orthopaedic Ward)
- Reduced loss of mobility, deconditioning and risk of falls (37% in same Nottingham University Hospital Trauma and Orthopaedic Ward)
- Reduced food wastage due to greater patient mobility and energy need
- Reduced risk of needing institutional care on discharge
- Enhanced wellbeing of patients and staff

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Theme two

Strengthening the workforce

Strengthening the workforce

2.1 Introduction

The HSCB and PHA, who collectively employ over 800 staff, are determined to invest in the development of their staff and the creation of a working environment that enables everyone to make their best contribution. The organisations' diverse range of responsibilities, coupled with current demographic changes and economic climate, requires a sustained focus on improving quality. The HSCB/PHA recognise the importance of the workplace as a setting to promote health and wellbeing. Similarly, the process of working together across all divisions has been important in understanding complexities and developing a commitment from staff to embed improvement techniques in daily activities.

HEALTH
WORK
WELLBEING

2.2 Supporting HSCB/PHA staff

Promoting health and wellbeing in the HSCB/PHA as a workplace

During 2017/18 the HSCB/PHA have led the implementation of a number of programmes to assist in promoting health and wellbeing for staff such as:

(a) Lesbian, Gay, Bisexual and Transgender (LGBT) Forum

A forum for lesbian, gay, bisexual and transgender staff continues to provide confidential support for LGBT staff and students in the HSC workplace. An e-learning module has been developed and widely promoted within HSC settings, The dedicated website to support LGBT staff in HSC now includes an online gallery of staff who are 'out at work'.

For more info - **http://www.lgbtstaff.hscni.net/**

Strengthening the workforce

(b) My Mood Matters/Living Life to the Full

Staff in the HSCB/PHA have been offered the opportunity to attend the My Mood Matters and Living Life to the Full programmes. Staff evaluation of both programmes has been very positive.

(c) Physical activity

Staff are encouraged to increase their physical activity during the working day by promoting the use of stairs, lunchtime walks and gym facilities. An upgrade to the gym facilities in Linenhall Street, Belfast and the introduction of the 'take the stairs' initiative also helped boost opportunities for physical activity. This was further rolled out to Tower Hill, Armagh and County Hall Ballymena sites HSCB/PHA sites. The 'take the stairs' initiative; saw an increase in upward journeys using the stairs by 81% and an increase in downward journeys by 86%. A toolkit has now been developed that can help other workplaces introduce this simple, effective and low cost measure. A short video was developed to raise awareness of the scheme.

(d) Staff wellness day

A wellness day for staff was held in February 2018. This event proved to be highly popular with a range of activities and advice available including: cookery demonstrations; Belfast City Council bike scheme; active travel; Tapestry Staff Disability Forum; trade unions; Pure Gym; Here NI and the Rainbow Project.

(e) HSC Healthier Workplaces Network

The PHA in conjunction with the HSCB has established a HSC Healthier Workplaces Network. This Network aims to develop improved and consistent workplace health programmes aligned to HR and other policies and which bring increased focus to valuing staff and the advantages that a diverse workforce can bring to organisations. The Network's four subgroups are now addressing the following areas: common measures and indicators; ageing workforce; a healthy workplaces charter; and on-line tools and apps.

For further information and access to the materials see **http://www.choosetolivebetter.com/content/getting-active**

2.3 Project ECHO – innovation & learning for the HSC

What is ECHO?

ECHO (Extension for Community Healthcare Outcomes) is a pioneering tele-monitoring programme designed to address growing demand for secondary care services. Using video-conferencing technology, participants benefit by sharing evidence-based best practice guidance and case-based learning. The model provides an affordable solution to addressing growing need in the UK for training and support. The approach is seen as an effective way of® improving access to specialist supported care and ultimately improving patient outcomes.

Project ECHO

Project ECHO seeks to develop clinician capacity to safely and effectively treat common, chronic, complex diseases. The HSCB/PHA in partnership with Hospice UK, are currently rolling out the ECHO model in 30 clinical areas to include **elective care, prison health, optometry/ophthalmology and dementia**. The model is a method to help improve the reach and availability of a wide range of under pressure health care services across Northern Ireland.

It is hoped that, through working with Integrated Care Partnerships (ICPs) and associated networks, new ways of delivering service which better fit the need for more chronic care irrespective of postcode will be developed, thus freeing up capacity for more complex issues in our acute centres.

Project ECHO

"Moving Knowledge not People"

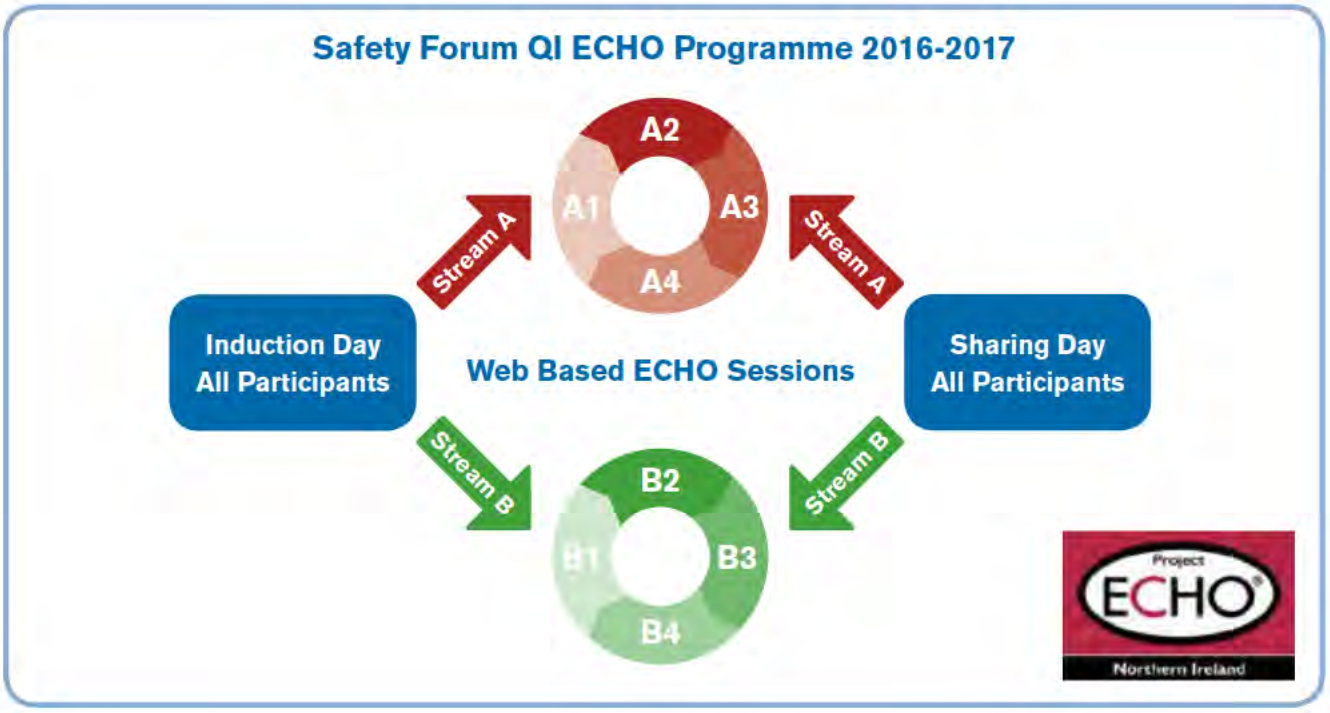
Strengthening the workforce

Quality improvement ECHO

Last year the HSC Safety Forum led its first quality improvement (QI) ECHO programme which provided Trusts with training in QI methodology, supporting the development and success of current or proposed Trust-based QI projects.

The range a range of quality improvement projects within the programme included:

- Learning disability project aimed to increase time spent on physical activity and fun opportunities to improve health and wellbeing. Activity levels increased from 48 minutes per child per week to 200 minutes.
- An outpatient team that aimed to reduce inappropriate urine sampling achieved a reduction in testing by 80%,
- A podiatry team exceeded their initial aim of increasing clinical capacity by increasing appropriate discharges from 5%-25%
- A mental health project aimed to increase the uptake and offer of carers' assessments in the community. The project demonstrated a 70% increase in carers' assessments completed



Strengthening the workforce

2.4 Sharing quality improvement

Q Community

Q is an initiative connecting people who have HSC improvement expertise across the United Kingdom. It is being led by the Health Foundation supported locally by the HSC Safety Forum based in the PHA.

The Q community is made of up a diverse range of people including those at the front line of health and social care, patient leaders, managers, commissioners, researchers, policymakers and others.

In 2017/18 a recruitment programme was undertaken in Northern Ireland. This programme was successful in attracting over 90 new members far exceeding initial expectations. New and existing members (123 in total) were invited to a welcome event in Titanic Belfast to learn from each other and from invited guests. This was followed up by a networking event in March 2018. In addition members have had access to a range of online resources, specialist training, networks and site visits across the United Kingdom. Members attended the national Q event in Liverpool, a site visit to explore artificial intelligence and problem solving and specialist patient experience training. Learning from these visits has been shared with the wider Q community through a series of reflective blogs.

PHA Safety Forum Awards 2017

The PHA, through the HSC Safety Forum invited organisations to nominate individuals or teams for the 3rd Northern Ireland Safety Forum Awards. The annual awards recognise and showcase the excellent work undertaken across the HSC system to drive improvement in quality of care and to strengthen patient safety

Four teams from across HSC were presented with their awards at a quality improvement event at the end of March. An award was made in each of four categories:

- Partnership working/co-production
- Innovation/transformation in care
- Integrated care
- Building reliable care

From the four categories, one overall winner was chosen. The winners covered a breadth of subjects, showed clear evidence of teamwork and tangible improvements to care.

Strengthening the workforce

2.5 Education and training for HSC

Primary care

Nursing: Last year the HSCB/PHA funded a bespoke foundation course, delivered by the HSC Clinical Education Centre (CEC), in line with the GP Nursing Framework, for general practice nurses (GPN) and healthcare assistants (HCA). The training was designed to meet the complex and changing service needs of patients in primary care settings. In total 141 GPN and HCAs accessed and positively evaluated the training. It is planned to roll out these regional training programmes in 2018.

Additional resources were secured to facilitate GPNs accessing post registration courses in local universities. In addition, courses were made available for general practice nurses via the Royal College of Nursing (RCN) and CEC. Additional courses included transformational leadership and cervical cytology.

In 2017/18, five Advanced Nurse Practitioners (ANP) have been working successfully in the Down GP Federation. Numbers are expected to increase over the next two years. This supports the career pathway of GPN to ANP level in primary care.

A regional network for GPNs has been established across Northern Ireland. A series of network events took place focusing on the management of long term conditions. Communication strategies for sharing correspondence, information on training and professional updates have been successfully re-established via the primary care intranet, the websites and social media.

Following a workforce review, a proposal has been developed that identifies the need for additional GPNs and HCAs to meet the increasing demands and pressures faced in general practice.

GP training numbers: The HSCB lead on the development of business cases to evidence the requirement to increase the GP training numbers. In response to workforce capacity concerns the number of GP training places has been increased from 65 (2015/16) to 95 (2017/18).

In a move to support retention of qualified GPs, there were 25 places on a two year retainer scheme covering 2016/17 and 2017/18. These GPs are attached to a practice and also commit to a number of out of hours sessions. In total 28 GPs took part in the scheme. Of the nine who left the scheme before their two year attachment was complete, five left to take up permanent GP jobs, either salaried or as a partner. A new cohort of retainer places will be available starting in 2018/19.

Strengthening the workforce

Dementia

As part of the implementation of the Dementia Together NI strategy a variety of training and education programmes have been delivered throughout Northern Ireland. These include:

- Development of the Dementia Learning and Development Framework has been used by local universities to inform course development / content for social workers and nurses
- A number of stand-alone training resources have been developed. in collaboration with the Northern Ireland Social Care Council (NISCC) including the development of a training app for domiciliary care staff and an online training resource for adult residential / nursing and day care staff on dementia, delirium and palliative care.
- In total 260 staff from across the statutory and independent sectors completed the dementia champion programme. This six month programme which included direct teaching and on-line learning required participants to complete a service improvement project within their area of work.
- One thousand copies of a training pack entitled 'Barbara's Story' were issued to HSC facilities, GPs, pharmacists, opticians, dentists, prison staff, PSNI and the Northern Ireland Ambulance Service (NIAS).
- More than 500 copies of a training pack entitled 'Supporting Derek' were issued to HSC staff working with people with learning disabilities.
- Development of a range of other bespoke training programmes for HSC staff including CLEAR (a model to assess and address unmet need) and the virtual dementia bus.
- HSC staff trained in the use of the delirium assessment and management tool totalled 2826. Forty staff have completed the relevant *train the trainer* programme.

Strengthening the workforce

Staff working with older people

• Regional multi-professional educational awareness programme for the identification and management of frailty

Frailty is a condition in which multiple body systems gradually lose their in-built reserves. Older people with frailty are at substantially increased risk of adverse outcomes including falls, disability, hospitalisation, nursing home admission and mortality. Early recognition of frailty and targeted interventions and management can significantly improve health outcomes for frail older adults. Staff knowledge and skills in relation to the identification and management of frailty is fundamental to achieving best outcomes. In order to improve HSC staff awareness in relation frailty the PHA commissioned the CEC to:

- Develop and pilot a face to face multi-disciplinary Frailty Educational Awareness Training programme.
- Develop an ELearning Frailty Educational Awareness Training programme.

This regional multi-professional educational awareness programme was designed to enhance health professional's knowledge and understanding of frailty with a view to improving prevention, identification, management and therefore outcomes for these older adults. Ninety three health professionals from across all disciplines attended this training with excellent feedback. The plan going forward is to roll this training out across the HSC.

• Loneliness aide-memoire for older people

It is recognised that loneliness in older people is a public health issue affecting their health and well-being. A recent Age NI survey highlighted that:

- One in three older people in Northern Ireland said that they are lonely
- 100,000 older people in Northern Ireland say that television is their main form of company
- 26,000 older people in Northern Ireland feel trapped in their own homes

As a result of these facts, Allied Health Professionals (AHPs) across Northern Ireland have worked with Age NI to develop an aide-memoire for HSC staff to raise awareness of older people and loneliness. The aim is to make a difference to an older person who is lonely by looking, listening and asking to see if they are lonely. In this way people can be directed towards agencies who can help. Some reasons for loneliness may include bereavement, retirement, living alone, lack of money, not having transport to get out and about. The aide memoire encourages staff to be aware of these factors in their daily interactions with older people.

Strengthening the workforce

Age NI engaged with older people to hear their views on the development of the aide memoire, through a workshop at which older people, AHPs, representatives from PHA, Age NI, HSCB and Translink had the opportunity to contribute to table and larger group discussions. The aide-memoire provides useful contact details including:

- Age NI the leading charity for older people in Northern Ireland;
- Silverline helpline for older people for information, friendship and advice; and
- Translink for practical advice on transport queries.

Staff are also advised to approach appropriate Trust contacts for local information.

"An older person in Northern Ireland described loneliness as "An ache in your heart so bad that it physically hurts. Longing for someone who cares."

• Rethinking Frailty Symposium

The PHA held a 'Rethinking Frailty' Symposium which provided an opportunity for the first time in Northern Ireland to bring together a wide range of stakeholders to look at and discuss all aspects of frailty and consider how best to take forward work in this area that would enable healthier and more fulfilling lives.

More than 100 people attended the event with representation from HSC, HSCB voluntary and community organisations, other statutory organisations and most importantly people with lived experience of frailty. Presentations addressed current regional and national perspectives in relation to the identification and management of frailty. This work captured the views of older people on frailty and what matters to them. This symposium has marked the beginning of significant work across Northern Ireland which aims to engage with all relevant stake holders to agree a common understanding of frailty and to improve the experience and health outcomes for all individuals who are frail or at risk of frailty.

Adult learning disability

In line with the Learning Disability Service Framework, the HSCB/PHA aim to ensure that services for adults with a learning disability provide the opportunity for people to enjoy personal and sexual relationships while protecting vulnerable adults from abuse. They have led the development of the operational protocol: 'Adults with Learning Disabilities: Personal and Sexual Relationships' which is being implemented by the Trusts. Last year, the HSCB/PHA commissioned the Family Planning Association (FPA) to provide training to support Trust staff with the implementation of the operational protocol. To date over 300 HSCT staff have received awareness raising (level 1) training from FPA. Approximately 30 Trust staff from across Northern Ireland have received Level 2 Peer Educator training to provide support and guidance to peers and colleagues on how to implement the protocols within their Trust. Year three of the training is currently been implemented by FPA.

Strengthening the workforce

Nursing

Following obtaining a grant award for 2017/18 from the Burdett Trust for Nursing, the PHA is leading a regional initiative that aims to improve nurse retention and recruitment in care of older people's settings in Northern Ireland. This innovative and collaborative approach is delivering a programme of development activities including team coaching, practice support, supervision and professional and personal effectiveness. The PHA leads for the project have successfully participated in national events associated with the Burdett Trust stipulations for the grant award. The evaluation of the project has seen very positive results to date.

Implementation groups are now established within each of the Trusts to provide support and guidance. In addition to quantitative information including staffing levels, vacancies, absence rates etc, qualitative baseline information has also been obtained including:

Values Clarification Exercise (VCE)- Understanding the values, beliefs and views that staff hold about working with older people including what staff think is important, and what staff feel should happen. This has been used to verify or inform local ward mission statements and develop training programmes.

- **Workplace Culture Critical Analysis Tool (WCCAT) -** The WCCAT has been developed to help people involved in the development of practice to undertake observational studies of work place settings in order to inform changes in practice. Examples of good and not so good practices have been observed and results shared with the ward managers and some of the other ward staff.

- **Nursing Workplace Satisfaction Questionnaire (NWSQ) -** used to evaluate nurse satisfaction with a new team model of nursing care delivery.

In addition, a bespoke training programme for staff in the 11 pilot wards commenced in January 2018. This programme has been tailored to meet the individual needs of staff. The programme includes: induction and preceptorship programmes, delivery of action learning sets by AGE NI peer facilitators, use of specialist nurses, training on resilience, assertiveness and coaching. The sustainability of this project will be further reviewed as part of the transformation agenda in nursing homes next year.

2.6 Delivering Care: A policy framework for nursing & midwifery workforce planning

Delivering Care is a policy framework aimed to support the provision of high quality care which is safe and effective in hospital and community settings. Initiated in 2012, it has used a phased approach to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities. The PHA and HSCB, in partnership with Trusts and other key stakeholders lead the implementation of the eight phases underway.

Workforce Phase	Staffing Model	Status
Phase 1: Acute medical and surgical wards	Staffing range	Funding for this phase has been secured and is in the process of phased implementation across designated wards in all HSCTs
Phase 1A: Elective care treatment care environments	Recommended range for 24/7 wards including day and short stay wards	Guidelines currently being scoped in HSCT 2018
Phase 2: Type 1 emergency departments	Nurse to annual attendance ratio	Recommendations endorsed by CNO. 1st phase of implementation due in 2018.
Phase 3: District nursing	Population based model	1st phase of implementation due in 2018 dependent on resources
Phase 4: Health visiting	Population based model – caseload weighting	1st phase of implementation due in 2018.
Phase 5: Mental health	Acute – nurse/bed ratio community – caseload and population based model	Phase 5A completed for acute inpatient mental health facilities. A number of workshops have been facilitated by the PHA and the expert reference group. The proposed recommendations around the staffing ranges for the category of inpatient environments have been shared for endorsement with the CNO. Phase 5b community staffing model to be progressed mid-2018
Phase 6: Neonatal nursing	Based on level of activity	Final proposals underway
Phase 7: Primary care nursing	Population based model from the GPN framework 2016	Finalised and with the CNO for endorsement 2018
Phase 8	Independent sector nursing homes	This phase is underway in 2018.

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Theme three

Measuring Improvement

Measuring Improvement

3.1 Introduction

The HSCB and PHA recognise that gathering information and examining data is important in assessing performance. They also recognise that it is vital that lessons from the information are learned, areas of high performance are duplicated and areas of lower performance are supported to improve. Last year the HSCB and PHA continued to promote the use of accredited improvement techniques to drive improvements and have worked with Trusts and other HSC bodies to provide support to improve outcome measurements in a range of quality indicators.

3.2 Quality improvement plans

The quality improvement plans (QIPs) focus on key priority areas to improve outcomes for patients and service users. The HSCB and PHA support Trusts on a range of initiatives to assist with the achievement of the QIP targets and facilitate a regional platform to enable good practice to be shared throughout Northern Ireland.

In 2017/18 QIP target areas were:

- **Pressure ulcer prevention;**
- **Falls prevention;**
- **National Early Warning Scores (NEWS);**
- **Mixed gender accommodation.**

Pressure ulcer prevention

The PHA along with HSCB supports Trusts through the Regional Pressure Ulcer Prevention Group to implement SKIN (an evidenced based collection of interventions proven to prevent pressure ulcers) in all hospitals in Northern Ireland. This group provides advice and support and shares regional learning across Northern Ireland. It focuses on strategies for pressure ulcer prevention and management across the Trusts.

Last year the focus was on the prevention of avoidable grade 3 & 4 pressure ulcers. These create deeper cavity wounds which can result in increased pain and suffering to patients.

Regionally a variation in the rate of avoidable grade 3 and 4 pressure ulcers was noted with a range of 0.01 to 0.33 between Trusts. For the purpose of quality improvement work, Trusts continually review their data to compare improvement over time and to learn from local variation.

In recognition of the need for continual evaluation and improvement, and to ensure that potential regional variation in recording and reporting of data across Northern Ireland is minimised, the PHA, in collaboration with the HSCB and Trusts are:

- Undertaking an improvement project in relation to measurement, display and interpretation of improvement data;
- Reviewing the current operational definitions including current regional application of same;

Measuring Improvement

- Reviewing the process for root cause analysis and process for obtaining bed day figures which reflect exactly the wards & clinical areas within which pressure ulcer data is collated and submitted to PHA;
- Developing a regionally agreed schedule for validation of data;
- Working with Trusts to ensure local and regional learning is identified and shared.

Falls prevention

During 2017/18 the PHA and HSCB through the Regional Falls Prevention Group have supported Trusts to implement and spread the Royal College of Physicians 'Fallsafe' bundle, an evidence based collection of interventions proven to reduce falls; in inpatient settings.

Trusts measure compliance against the Falls Safe Bundle and report to the PHA and HSCB on a quarterly basis. The Regional Falls Prevention Group provides advice, support and shares regional learning across Northern Ireland and focuses on strategies for falls prevention and management across the Trusts.

The Business Services Organisation (BSO) internal audit team carried out an audit of learning from serious adverse incidents (SAIs) and from falls across HSC organisations. This audit found that definitions were not consistent with the Trusts' classifications of falls and recommended that the current definitions should be brought into line with the regional incident grading matrix. There was regional agreement that this should commence from April 2017.

During 2017/18 the focus was on prevention of the number and rates of falls incidents classified as causing moderate to major/ catastrophic.

Regionally, for this period there has been a reduction in falls incidents resulting in moderate to major/catastrophic, the rate during 2017/18 is between **0.08** and **0.09** per 1,000 bed days.

NEWS (National Early Warning Scores)

As part of its leadership role, the HSC Safety Forum has led the regional implementation of NEWS in Trusts, including appropriate escalation arrangements to improve care of the deteriorating patient. This tool helps professional staff identify early deterioration in a patient's condition. Abnormal scores prompt specific actions and/or referral to greater expertise. Part of this work involved facilitating Trusts to clearly define their expectations regarding intervention when NEWS are abnormal. Trusts are committed to ensuring escalation of NEWS is a priority and have worked with the HSCB and PHA to measure compliance with accurately completed NEWS charts.

Measuring Improvement

Mixed gender accommodation (MGA)

HSC is committed to the delivery of person centred care. International and national evidence has highlighted that the provision of single gender accommodation has been identified by patients and relatives/carers as having significant impact on maintaining privacy and dignity whilst in hospital. There is therefore an expectation that men and women will not be required to sleep in the same area.

In line with the DoH Guiding Principles for Mixed Gender Accommodation, each Trust has developed a policy for the management of MGA in hospital. During 2017/18 the PHA has engaged with Trusts to review the current processes for recording MGA to agree operational definitions and develop a regional monitoring template for reporting occurrences. Trusts have been using the Institute for Healthcare Improvement (IHI) improvement methodology to test and evaluate the revised monitoring process. Initially on a small scale within a small number of wards per hospital site, with view to scale and spreading during 2018/19.

3.3 Key performance indicators (KPI)

A regional group has led the development of high level KPIs for nursing and midwifery to measure, monitor and evidence the impact and unique contribution the nursing has on the quality of patient and client care. There are three domains which many Trusts are currently presenting via dashboard systems, which allow data sets to be viewed collectively across all wards and departments.

Examples of indicators

Organisational: absence rates; normative staffing ranges and vacancy rates.

Safe and effective care: incidence of falls, pressure ulcers, omitted or delayed medications, absconding etc.

Patient experience: consistent delivery of care against identified need; involvement of the person receiving care in decisions made about their nursing care; time spent by nurses with the patient.

Measuring Improvement

Below are two examples of KPIs which are measured within mental health and learning disability services:

- **Anti-absconding KPI**

Research evidence has demonstrated that patients who abscond from inpatient mental health settings have increased risk of harm to self and others, suicide, self-harm, and self-neglect.

The anti-absconding intervention draws on empirical research into patient and staff experience of absconding and outlines effective practice based activities that can be employed by staff to reduce episodes of absconding.

In May 2014, the South Eastern Health and Social Care Trust (SEHSCT) initiated a pilot of the East London and City Mental Health Trust Anti-Absconding Work Book. The results from the pilot were extremely encouraging, showing a reduction in absconding rates of 70% as compared to the base line audit. Following the success of the pilot, the PHA/HSCB worked with all Trusts to develop the first regional mental health KPI, focused on the anti-absconding intervention.

Data is collated using an agreed audit tool and reported quarterly to the HSCB/PHA. Year two data is now complete and Trusts are working on increasing compliance with all elements of the KPI Intervention with evidence suggesting that compliance with the KPI is having an impact on reducing incidents of absconding.

The PHA working closely with the HSCB hosted a regional learning event in October 2017. The event facilitated the sharing of learning from year one of the implementation of the Anti-Absconding KPI intervention and reflection on the experiences of front line staff, service users and carers.

Following presentations from each Trust participants had an opportunity to take part in group activity designed to encourage staff to think about what it is like for patients, who are often admitted without having had the time to prepare for the admission, and the impact this can have on them. Participants were then asked to discuss how they could facilitate home and social contact for patients which might help reduce the risk of absconding. Feedback from those who attended the event was very positive and the regional learning identified has been used to inform the ongoing implementation of the KPI.

Measuring Improvement

- **Review of Psychological Therapy Training in Nursing**

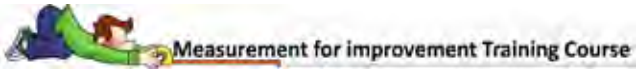
The provision of evidence based psychological therapies is fundamental in enabling psychological and personal recovery.

As set out in the 'You In Mind' Regional Mental Health Care Pathway, and other relevant guidance, mental health nurses are required to embed evidence based psychological therapies and recovery practice in the provision of all treatment and patient centred care.

In order to establish a baseline of psychological therapy practice across mental health nursing an audit tool was developed to test the psychological therapies KPI. Two cycles of data collection were completed as a pilot. This identified the need to establish the accredited training of registered in mental nursing across NI.

In October 2017, the PHA commissioned the HSC Clinical Education Centre (CEC) to carry out an audit which included training record audits and an online survey with staff working across all mental health settings and facilities in Northern Ireland. The findings of the audit have informed the next stages for the KPI.

3.4 Measurement for improvement masterclasses



During 2017/18 the HSC Safety Forum hosted a series of "Measurement for Improvement" masterclasses, facilitated by Paul Rafferty. These interactive sessions challenged participants to ask the following questions:

- Why measure?
- Is there an art to measurement?
- How can we illustrate and analyse variation?
- What are the steps for effective measurement?

Participants had the opportunity to explore the functionality of Excel and to bring along their own data to discuss and improve presentation. The technical skills were balanced with the clear message that data can win or lose hearts depending on how it is used to engage people. Feedback from the 50 participants, who were from a range of clinical and administrative positions, was extremely positive and further sessions are planned for 2018/19.

3.5 Implementation of National Institute for Health and Care Excellence (NICE) guidance

NICE is a non Departmental Public Body responsible for providing national guidance and advice to improve health and social care.

NICE
National Institute for Health and Care Excellence

NICE produces different types of guidance, including:

- Technology Appraisals (new drugs, medical treatments and therapies);
- Clinical Guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions); and
- Public Health Guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health).

The HSCB/PHA have put in place processes to take forward the implementation of Technology Appraisals, Clinical Guidelines and Public Health Guidance published by NICE and endorsed by the DoH.

During 2017/18, the HSCB/PHA issued 59 Technology Appraisals to the HSC and continues to monitor the implementation of 170 Clinical Guidelines which have been issued to the service.

The implementation of NICE guidance can often be the driver for change in a wide range of areas, as it provides commissioners, clinicians and other health care professionals with evidence based methodologies to improve and sustain higher quality outcomes for patients and clients.

More information about the Technology Appraisals and Clinical Guidelines that are being implemented can be found on the HSCB NICE webpage. **(http://www.hscboard.hscni.net/nice/)**

Measuring Improvement

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Theme four

Raising the standards

Raising the standards

4.1 Introduction

The HSCB and PHA have established a framework of clear evidence-based standards and best practice guidance which is used in the planning, commissioning and delivery of services in Northern Ireland. The HSCB and PHA are continuously striving for excellence and raising the standards of care and the quality of services delivered. Below are examples of outcome quality improvement secured, through a number of interventions.

4.2 Managed clinical networks

The purpose of a managed clinical network is to provide a regional platform to achieve consistency in care and drive quality improvement within the network and beyond with a family centred approach. The HSCB/PHA lead the implementation of a number of clinical networks, some of which include:

- **Paediatric Network**
- **Critical Care Network**
- **Neonatal Network**
- **Pathology Network**
- **Stroke Network**
- **Cancer Network**
- **Trauma Network**
- **Diabetes Network**
- **Radiology Network**
- **Pain Forum Network**
- **Lymphoedema Network**

Below are two examples of how standards of health and social care have been improved through the work of the Northern Ireland Trauma Network.

Northern Ireland Major Trauma Network

The Northern Ireland Major Trauma Network supports the coordination of regional trauma services enabling patients with serious injury to receive timely, skilled, high quality hospital care, including rehabilitation and repatriation. In collaboration with all HSC, the Network is taking a whole system approach to developing processes and services to reduce mortality and morbidity rates for patients assessed as 'major trauma'.

In 2017/18 the Network Manager, Regional Clinical Lead and Local Clinical Leads (representing each HSCT) were appointed, as were a team of Trauma Audit Data Coordinators. Monthly meetings of the Network Board have provided strategic direction to the Network in line with its aims and objectives and the HSC Chief Executives' Forum supported the principle of a regional bypass and repatriation protocol.

A model for a designated Major Trauma Centre (MTC) has been agreed that includes a consultant-led trauma ward with additional intensive care beds that will support the introduction of a regional bypass protocol. This protocol has been developed in conjunction with the Belfast Health and Social Care Trust and HSCB/PHA and reflects NICE guidance for major trauma services and National Trauma Quality Indicators (TQUINS).

Raising the standards

Over 80 colleagues from trauma related specialties within the Trusts attended the Major Trauma Network's stakeholder engagement event in 2017. This provided an opportunity for people to learn about the Network and give feedback on suggested priorities to help develop the Network's first annual plan.

A Network Clinical Advisory Group (CAG) has agreed a Major Trauma Triage Tool and regional clinical protocols. This includes protocols for Whole Body Computed Tomography (CT), Traumatic Cardiac Arrest, Massive Blood Loss and a standardised Emergency Department Trauma document.

The Network's Nursing & AHP group provide multidisciplinary input and has undertaken a review of trauma training across Northern Ireland and developed a programme to support ward-based staff involved in providing care to patients following repatriation from the MTC's trauma ward.

In late 2017/18 service user representatives from the HSCB's Unscheduled Care Clinical Reference Group were engaged on the development of guidance and patient information relating to the Network's bypass and repatriation protocols.

A workshop on Supporting the Concept of Damage Control Surgery was held for surgical colleagues with expert speakers providing perspectives from various specialties on this subject. This supports regional preparedness for a mass casualty response as well as individual trauma cases. Future work on this will be to encourage clinical skills training for surgical colleagues.

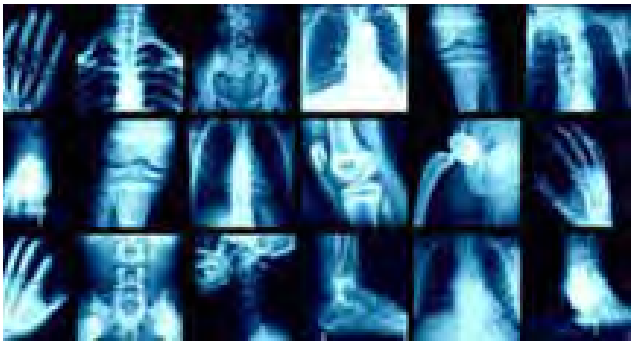
Important work commenced in 2017/18 to submit trauma data to the national database of the Trauma Audit Research Network (TARN). TARN monitors and measures standards of care and patient outcomes for trauma in the region and by hospital site. Two Northern Ireland TARN clinical reports were received providing core data on trauma, a focus on head and spinal injuries and abdominal and thoracic injuries. This information will be used for service improvement and to underpin the Network's programme of work to improve standards of care and reduce mortality and morbidity for seriously injured patients.

Raising the standards

Modernising Radiology Clinical Network (MRCN)

The HSCB/PHA established the MRCN in 2013 following the 2011 RQIA investigations into unreported plain film examinations. The Network's primary role was to oversee implementation of the recommendations outlined in the reports. The Network currently functions as a clinical advisory and implementation collaborative aimed at ensuring high quality, safe and sustainable diagnostic imaging services for the people of Northern Ireland. It is led by a Network Manager from the HSCB, supported by a Consultant in Public Health.

Diagnostic imaging is an integral part of modern healthcare and provides approximately 1.8million investigations in Northern Ireland each year. Imaging services play a role in diagnosing and screening for virtually all major illnesses and contribute to the planning of treatment. There is increasing recognition of the need to place imaging early in care pathways to reduce the time to diagnosis and treatment and to improve efficiency and effectiveness.



Some of the key achievements in 2017/18 include:

- Continued collaboration with the DoH in the recently published review of imaging services. The MRCN was represented at all of the public consultation events for the review.
- Detailed workforce review of radiologists, radiographers and assistant practitioners which will inform the regional workforce exercise being led by the DoH.
- Securing annual increases in the number of training places for consultant radiologists, which has seen the scheme recurrently expanded from 37 to 49.
- Development of a new regional pathway to expedite CT staging of new known cancers.
- Continued collaboration with other cancer / clinical reference groups.
- Appointment of the first consultant radiographer in Northern Ireland to the breast service in the Western Health and Social Care Trust.
- Continued investment in training radiographers to optimise the skills of advanced practice radiographers.
- Collaboration with colleagues from the University of Ulster to inform the undergraduate training requirements for advanced nurse practitioners in radiation protection for referring rights.
- Fully operational regional programme of Imaging Services Accreditation Scheme (ISAS) accreditation outlined below.

Raising the standards

Imaging Services Accreditation Scheme (ISAS)

The Society and College of Radiographers (SCoR) and Royal College of Radiologists (RCR) have worked together to develop ISAS to provide assurance that diagnostic imaging services offer patients consistently high quality services, delivered by competent staff, working in safe environments.

ISAS is based on current professional guidance updated annually and is independently assessed by the United Kingdom Accreditation Service (UKAS).

The ISAS scheme focuses primarily on the patient and their pathway through the imaging system. This includes how they access care, how they are cared for after their discharge and the quality of the services provided for them.

The Modernising Radiology Clinical Network (MRCN) considers ISAS to be fundamentally important for the future safe, effective provision of quality imaging services for the people of Northern Ireland.

A regional approach to deliver ISAS has been agreed in order to optimise opportunities for sharing learning across Trusts. A lead ISAS radiographer and lead ISAS radiologist have been appointed in each Trust and a regional lead from the HSCB oversees the programme.

A special interest group for diagnostic imaging has also been established which will consider relevant clinical guidance, audits and standards relating to diagnostic imaging as well as actively contribute to future revisions of the ISAS standard itself. This is a positive development for Northern Ireland and a real opportunity to participate and contribute to clinical development across the UK.

The regional ISAS programme has been commended as an exemplar model for collaborative working and a number of heath economies in England are now adopting the network approach to ISAS based on the Northern Ireland model.

4.3 Collaborative working

Mental Health Collaborative

The Mental Health Quality Improvement Collaborative, led by the HSC Safety Forum, continues to grow in strength. Since 2016 the work of the Collaborative has been focusing on the learning from the Thematic Review of Mental Health SAI Reports relating to Patient Suicides.

Templates have been developed by Trusts for safety briefings and the use of structured communication tools such as SBARD (Situation, background, assessment, recommendation, decision). These are now being tested, embedded and spread across mental health facilities in the Trusts.

The Collaborative also developed a core set of principles for reflective practice along with self-assessment questions and measures and Trusts are reporting success with these sessions.

To measure improvement in the overall culture, a Staff Safety Climate Survey was adopted. This was carried out in 2016 (baseline) and in 2017. In the 2017 survey more than 50% of the survey questions demonstrated positive increases in responses given.

Further developing the work of the Collaborative, the next topic will focus on communication with carers and, whilst in the early stages, there is already strong user and carer involvement.

Maternity Collaborative

PROMPT
Making Childbirth Safer, Together

In 2017/18 the Maternity Collaborative, led by the HSC Safety Forum has continued to support improvements in maternity services across Northern Ireland. The focus of the work has been safety in the intrapartum period of care. To support this work the HSC Safety Forum facilitated bringing the UK Practical Obstetric Multi-Professional Training (PROMPT) team to Northern Ireland to deliver the PROMPT programme in 2017. PROMPT is an evidence based multi-professional training package for obstetric emergencies. It is associated with direct improvements in perinatal outcome and has been proven to improve knowledge, clinical skills and team working.

In total there were 52 participants from Northern Ireland joined by 24 colleagues from the Republic of Ireland.

To reduce variation and improve patient safety, the Collaborative have continued work on cardiotocography (CTG) evaluation and management of sepsis. The Collaborative has also agreed a regional dosing regimen for the administration of oxytocin, for use in the induction or augmentation of labour. This has now been incorporated into all Trust policies and guidelines.

Raising the standards

The work of the Collaborative has been recognised as an exemplar of good practice in an international publication entitled 'Healthcare Systems Improvement Across the Globe' (Braithwaite 2017). Additionally, the SAI process, which is administered by the HSCB, runs a regional group for maternity SAI's. The learning identified through this process is referred to the HSC Safety forum Maternity Quality Improvement Collaborative to ensure regional consistency when implementing learning.

Sepsis Collaborative

Improving sepsis care in Northern Ireland has been recognised as a strategic priority by the DoH. A regional quality improvement group has been established to take this forward.

In 2017/18 a new Sepsis Collaborative was established, led by the HSC Safety Forum, to scale and spread implementation of the Sepsis Six care bundle. Sepsis Six is the name given to a collection of medical therapies designed to reduce mortality of patients with sepsis. Sepsis is a life threatening condition that arises when organ failure occurs in the context of infection. The focus of the work is on early recognition and treatment of sepsis in emergency departments, acute medical and surgical, intensive care and high dependency settings. A workshop was held in March 2018 where a range of health professionals from all Trusts had an opportunity to listen to Dr Vida Hamilton, National Clinical Lead for Sepsis, Health Service Executive, discuss the work to improve sepsis care in the Republic of Ireland.

The sepsis work in Northern Ireland is being deliberatively linked to the regional antibiotic governance agenda given how important it is that these two strands of work coexist effectively.

Raising the standards

All Island Collaborative: Enhanced Care Guidelines

An All Island Collaborative Task Group has been set up by the Chief Nursing Officers in Northern Ireland and the Republic of Ireland, to take forward a piece of work to develop key principles for enhanced care that will be applied in both jurisdictions. The PHA has been involved in this collaborative initiative and has provided funding for the progression of the Northern Ireland pilot site. This work has been developed in line with the principles of Quadruple Aim. The Quadruple Aim model suggests that healthcare institutions simultaneously pursue four dimensions of performance. Namely:

- Improving the health of the population;
- Enhancing the patient experience;
- Reducing costs; and
- Improving the work life of healthcare providers, clinicians and staff

Enhanced care refers to the requirement of care outside of normal staffing levels. It is an activity where an allocated member of staff is constantly aware of the precise whereabouts of a patient through visual observation or hearing. Enhanced care should benefit both the patient and the staff involved. It is crucial that therapeutic activities appropriate to the patients' needs are undertaken as part of the enhanced care process.

Through collaborative working and aligning best practice guidance, the All Island Collaborative seeks to:

- Provide information through the development of a national all island guideline on shared key principles and outcome measures based on best practice;
- Provide guidance for the use of enhanced care observations that meets agreed patient needs, is cost effective and justifiable in each jurisdiction;
- Improve quality of care by ensuing that staffing and intervention reflect patient need;
- Support use of enhanced care in acute hospital and continuing care settings across the island of Ireland;
- Ensure decision making processes around assessment, alternative interventions, recording, and reassessment and monitoring of enhanced care are in place;
- Develop, test and implement local guidance to assess need and maintain safe patient care in each jurisdiction;
- Reduce the number of incidents relating to patient safety enhanced observations eg falls, complex behaviours etc.

Raising the standards

4.4 Strategy Implementation

Q2020

The PHA linking closely with HSCB, Trusts and Arm's Length Bodies lead the regional implementation of the Q2020 Strategy on behalf of the DoH. A number of taskgroups have been established to take forward work aligned to the Strategy. The focus for 2017/18 has been in the following areas:

- **Developing Professional Leadership** – this regional task group, chaired by Professor Charlotte McArdle, DoH, last year focused on standardising level 2 & level 3 training programmes aligned to the Q2020 Attributes framework.

- **Supporting staff involved in SAIs and other incidents** – this regional task group was chaired by Dr Cathy Jack, Belfast Health and Social Care Trust and Bob Brown, Western Health and Social Care Trust. Last year the group focused on understanding the level of support that was available to staff following an incident, and explored the concept of Schwartz rounds, in order to inform the development of a model of support for staff.
- **Strengthening our response to adverse incidents** – this task group, lead by Director of Nursing in Southern Health and Social Care Trust, focused on testing models to identify and implement learning following adverse incident within the Trust.
- **Developing a model for the development of Always Events in NI.** Last year the regional group, chaired by Mary McElroy, PHA focused on piloting an Always event in each Trust based on feedback from patient and client experience.
- **Improving patient safety through multi-disciplinary simulation & human factors training.** This regional group, chaired by Dr Mike Morrow, Northern Ireland Medical and Dental Training Agency and Caroline Lee, Clinical Education Centre focused on the development and testing of faculty relating to human factors and de-briefing last year. Additionally, the NI Simulation and Human Factors Network (NISHFN) continued to evolve, establishing specialist interest groups pertaining to human factors and paediatrics.

- Last year work began, led by Dr Mark Roberts, Safety Forum which aimed to ultimately **reduce the reoccurrence of the 3 main categories of Never Events**. This work will be progressed during 2018/19.

The PHA /HSCB hosted a regional Q2020 Event in November 2017 to coincide with world quality day. The aim of the event was share the work ongoing relating to Q2020 with the HSC. The event provided an opportunity to highlight the positive work which is on-going in relation to Quality 2020 and the wider quality agenda and provided a platform to share, learn and generate new ideas in relation to quality improvement.

Raising the standards

Dementia Together NI

The HSCB and PHA led the regional implementation of the Dementia Together NI (DTNI) project which ended in March 2018. This three year project far exceeded all expectations and targets.

The Dementia Together NI project received a number of prestigious awards and all four strands of the project have been independently evaluated by external evaluators and the findings were very positive.

Awareness raising, information and support

- Development of a public information website.
- Publication and distribution of 11 information booklets covering subjects as diverse as communicating effectively with a person with a dementia and choosing a care home to dental care, sight loss and planning ahead with dementia.
- Appointment of ten (Band 6) dementia navigators and development of operational guidance based on the findings of an external evaluation of the initiative.
- Appointment of 19 dementia companions in acute hospitals
- #STILLME, an extensive and effective public awareness campaign that included TV, radio outdoor, press, online and social advertising.
- Information developed for GPs and available on the GP intranet.

Short-breaks and support to carers

- Design (in collaboration with service users) and delivery of five short break pilot schemes. Schemes included extended domiciliary care services, befriending, night services and the provision of short vacations to 229 individuals.
- One hundred and eighty individual training courses provided information, training and support to 2463 informal carers.

Future of Dementia Together NI

Building on the success of the project, proposals have been submitted to the DoH in relation to the following, all of which are at various stages of development or implementation:]

- Publication (including promotional materials) and implementation of an agreed regional Dementia Care Pathway including the roll out of the Occupational Therapy Cognitive Rehabilitation Model which was initiated through the regional memory services collaborative. All Trusts have begun to look at how this pathway can be implemented and identifying the resources required.

- On-going work of the Delivering Social Change Phase 2 Dementia Project to develop improved e-health and social care systems and the collection and analysis of dementia care data. This project also includes a raft of research programmes over the next three years.

Raising the standards

- Improvements in dementia care in hospitals including implementation of recommendations from the audit of dementia care in acute hospitals and the roll out of John's Campaign.

- Improved locality planning processes to ensure meaningful engagement with local communities to build sustainable models for dementia care as new commissioning structures and processes are established.
- On-going work to embed the Learning and Development Framework and promote staff development within Dementia Care services.

- Promote research in three main areas - *cause*, *cure* and *care*.

Further information in relation to Dementia
http://www.hscboard.hscni.net/dementia/
www.NIDirect.gov.uk/dementia

Promoting Physical and Sensory Disability Strategy

The Physical and Sensory Disability (PSD) Strategy Implementation Group have operated on a co-production model. During 2017/18 a range of improvements which resulted in co-produced support for service users and staff have progressed including:

Regional communication support services

- Following extensive public consultation transition plans commenced in 2017/18 to transfer current communication support services for deaf and hard of hearing people to a regional shared service supplied by the Business Services Organisation

Sensory support service DVD

- Belfast Health and Social Care Trust Sensory Support Team produced a regional DVD on behalf of the PSD Strategy Implementation Group to provide information on sensory disability, possible causes and effects and supports. Service user's co- produced the DVD and shared their experiences of Sensory Support Team services.

Social networking services

- Social networking services were commissioned last year for people with physical and sensory disability. These services enable sustained community engagement for disabled people with the view to helping prevent disabled people needing care and support in the first place or from developing long-term dependencies on health and social care provision. All Trusts have implemented this initiative.

4.5 Improving partnerships

Developing eye-care partnerships

The Developing Eyecare Partnerships (DEP) strategy was launched in 2012 and led to a five year project to improve the commissioning and provision of eyecare services in Northern Ireland. The HSCB/PHA are jointly implementing the strategy. Below are some of the reported impacts of the work of the DEP project.

- **Patient**
  I thought I had to go to the hospital to have my red eye checked but now I can go to my local optometrist.

- **GP**
  Patients had come to me, then the optometrist, back to me, then to the hospital. Now they can go straight to their optometrist and onto the hospital for treatment.

- **The ophthalmologist**
  I can now offer care to more glaucoma patients due to the extension of the roles of allied health professionals.

- **Nurse specialist**
  I can now provide additional care to patients in the macular clinic as I have been trained in giving intravitreal injections.

- **Optometrist**
  I can now view the details of my patients eye problem, straight from their electronic care record so that, like their GP and hospital clinic staff I can involve the patient in their care more.

Raising the standards

- **The sensory support team**
  Patients in Northern Ireland are no longer 'registered blind' so it is easier for us to offer vital support without causing anxiety.

- **The eye casualty team**
  Optometrists now work alongside ophthalmologists in eye casualty which speeds things up for patients.

- **The HSC trust manager**
  Collective management of eye-care services has led to smarter use of resources.

For further information
http://www.hscboard.hscni.net/our-work/integrated-care/ophthalmic-services/developing-eye-care-partnerships/

Palliative Care in Partnership

Palliative Care in partnership

Palliative Care is about improving the quality of life for those with needs and improving the experience of those important to them. The Regional Palliative Care Programme – *Palliative Care in Partnership*, is led by the HSCB/PHA and brings together people with palliative care needs, those who care from them, clinicians and other professions, service providers, planners and DoH to ensure the delivery of a whole system, holistic approach to support and care. Ensuring that "what matters to me" is addressed for each person with palliative care needs, whether the need be physical, psychological, social or spiritual.

> *You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.*
>
> *Dame Cecily Saunders*

Raising the standards

For some people, where they are cared for, matters to them. Given the choice most people would prefer to be cared for in their own home (which include residential and nursing home) at the end of life. In 2016, 47% of all deaths occurred in hospital, compared with 52% on 2010. The Programme aims to support a greater number of people who wish to be supported in their own home. In order to achieve this aim, Palliative Care in Partnership Programme is working to:

- **Raise awareness of palliative care which includes events during palliative care week in September.**
  Last year's theme was 'What have you heard? which aimed to clarify some myths about palliative care.

- **Implement processes to have proactive earlier identification of palliative care need.**
  Currently there are 46 GP practices engaged in an early identification prototype project with plans to expand to all practices in the coming year.

- **Allocate those with identified palliative care need a keyworker to help co-ordinate care across the system.**
  Typically the keyworker will be the persons District Nurse. Some resources have been allocated towards District Nursing. Districts Nurses have also undertaken additional training to enable them support people with palliative care needs and those important to them as part of their role.

- **Provide tools to enable the opportunity for the public to have advance care planning conversations and record them if they wish to do so.**
  In partnership with Macmillan Cancer Support the partnership has developed a free resource for the public to help them understand more about making plans for the future eg such as making a will, funeral plan or their wishes and preferences for care at end of life. In addition approximately 1000 staff have been trained in advance care planning.

- **Improved access to generalist and specialist palliative care services**.
  There has been additional specialist palliative care posts across the region to ensure those with complex palliative and end of life care needs can be supported. Tools and guidance have been developed to support specialist palliative care professions such as the management of symptoms in palliative care & the role of the specialist palliative care professional.

4.6 Population Screening in Northern Ireland

Early diagnosis through screening can lead to improved outcomes for a number of health conditions. The PHA is responsible for commissioning and quality assurance (QA) of eight antenatal, newborn and adult screening programmes:

Antenatal and newborn screening programmes:

- Antenatal infection
- Newborn blood spot
- Newborn hearing

Adult screening programmes:

- Abdominal Aortic Aneurysm
- Bowel cancer
- Breast cancer
- Cervical cancer
- Diabetic Eye

The key aim of population screening programmes in Northern Ireland is the early detection of disease as early detection often produces better outcomes for patients. The programmes demonstrate and reflect the highest levels of service quality as set out in national guidance and specifications. In addition, assuring the quality of screening is a fundamental objective embedded within all population screening programmes. This remained a key task of the PHA within 2017/18. Rigorous checks and measures have, and continue to be, in place. Where necessary, recommendations to improve practice have been provided to HSC providers.

• Cancer screening

Early detection of disease through population screening programmes often produces better outcomes. However, it is recognised that deprivation is associated with lower rates of participation in cancer screening. The PHA awarded a three year contract to the Women's Resource and Development Agency (WRDA) to raise awareness and promote informed choice in uptake of the cancer screening programmes. In 2017/18, peer facilitators delivered 127 educational awareness sessions to participants from disadvantaged, diverse and sometimes remote backgrounds. This included Africa House Women's Group, Kates Bridge Rural Support Group, Rathlin Development and Community Association, and Shankill Sure Start.

Raising the standards

Cervical screening

During 2017/18, the PHA worked with laboratories and primary care colleagues in the HSCB to take forward a number of initiatives to support the quality of the cervical screening service being delivered at primary care level. This included:

- Developing a process which enabled sample takers to record their own unique code against each sample. This improved the process for audit of individual performance, such as activity levels and inadequate rates and will allow audit reports to be generated for each primary care practice or clinic. The PHA also collaborated with primary care colleagues in the HSCB to develop an audit tool to support practices in undertaking audits and to help assure the quality of cervical samples being taken within practices.

- Developing a regional practice protocol for the provision of cervical screening services which was shared with all GP practices. The template may be adapted for use in each general practice and is aligned with current national and regional policy, standards and guidance for cervical screening. The intention is that this protocol will assist in standardising the service delivered at primary care level across Northern Ireland.

Cervical Screening

Abdominal aortic aneurysm screening

Working with service users to explain individual programme aims and to increase uptake is clearly important. Within Abdominal Aortic Aneurysm (AAA) screening, service user engagement is facilitated through a range of recurring and targeted mechanisms. This includes the programme's annual service user event which brings together service users and programme providers to receive updates on programme performance, recent service developments suggested by service users and potential areas for improvement. Three patient representatives contribute to the programme's commissioning group to further support Personal and Public Involvement (PPI) and co-production initiatives related to the continued advancement of AAA screening in Northern Ireland.

AAA Screening

• Training and development for screening

A key element of work has been to support and facilitate the ongoing training and personal development of staff within population screening programmes. For example, within the Diabetic Eye Screening Programme staff have undertaken eye screener-specific training. Likewise, staff within the AAA and Breast Cancer Screening Programmes have benefited from peer review training (professional and clinical advisor training) alongside colleagues from similar English NHS Screening Programmes. This is integral to maintaining excellence and high standards of programme delivery. It also ensures staff are trained and equipped to both undertake and participate in external quality assurance visits - the key benchmark for population-based screening programmes.

For further information on screening programmes please see **http://www.publichealth.hscni.net/directorate-public-health/service-development-and-screening/screening**

4.7 Working with marginalised communities

Black and Minority Ethnic (BME) Groups

The health of migrants and Black and Minority Ethnic groups is an important area of focus, because of the poorer pattern of health experienced by these groups. Whilst many minority ethnic communities have close social networks and strong cultural beliefs and practices which can promote health and social wellbeing, it is also known that their experience has led to patterns of health inequality.

In April 2012, the PHA in collaboration with the HSCB, commissioned the BHSCT to provide the Northern Ireland New Entrant Service (NINES) by building on their existing Tuberculosis (TB) screening and BCG vaccination programme for 'at risk children'.

NINES offer a range of clinics which include:

- an holistic assessment of the health and well-being needs of new entrants
- continuing the TB screening and targeted BCG programmes
- increasing uptake of vaccinations (other than BCG)
- assisting with primary care registration
- supporting transition to mainstream services
- signposting to appropriate health services.

Raising the standards

It has been essential to work closely with BME communities to increase engagement and participation and develop appropriate health promotion and peer education programmes to improve equity of service and the quality of care provided. Housing, poverty, community relations and education have a significant impact upon health and wellbeing and, in order to assist in addressing these issues, the NINES team has developed multi-agency links with other statutory and voluntary organisations.

A new 4 year pilot programme funded by PHA, *'Mental Health 1+1 Project'*, supports the mental health and emotional wellbeing needs of BME communities. Three bi-lingual workers have been appointed to deliver support to local BME communities.

The project also aims to raise awareness within BME communities of wider services available beyond the project, and to make service providers aware of the need to adapt approaches to increase access from BME Communities. The project has highlighted that for European clients (clients predominantly Polish, Portuguese, Lithuanian) with little or no English, the main issue appears to be the language barrier, rather than a significant difference of cultural perspective on mental health. For African and East Timorean clients (predominantly Portuguese speaking) and for Chinese (both Cantonese & Mandarin speakers), a key cultural issue has been familiarising the client with the concept of mental health and emotional wellbeing, as something that they should and could enjoy.

Since 2012, the PHA has funded STEP (South Tyrone Empowerment Programme) to develop, manage and sustain an inclusive, collaborative, regional minority ethnic health and social wellbeing, good practice and information sharing network. A website has been developed which allows members to share good practice and keep up to date with BME activity. This, alongside regular e-alerts, seminars and an annual conference, focuses on members' needs and current issues which impact upon our BME population. This work builds on the strengths of members and has been an important mechanism for developing connections and improving outcomes.

For further information on STEP programme see **www.strongertogetherni.org**

Raising the standards

Travellers

It is difficult to accurately assess how many Travellers are currently living in Northern Ireland. The All Ireland Travellers Health Study (AITHS) carried out in 2010 estimate a population of 3,905 Travellers living in 1,562 families. The study also shows that the age profile of the Traveller community in Northern Ireland is markedly different from that of the general population, with 75% of people under the age of 30 years. Only 1% of Travellers are over 65 years compared to over 15% of non-Travellers. There are significant differences in life expectancy and other health and wellbeing outcomes for Travellers.

Consequently, addressing improvements in the circumstances in which Travellers live, learn and work, as well as improving access to services is essential. The Travelling community experience prejudice and racism in almost every aspect of life. This experience has a very detrimental effect on health and wellbeing.

The PHA and HSCB convened a Travellers Health and Wellbeing Forum in October 2010. The Forum, which includes Trusts, Education Authority, Traveller Support Groups, voluntary sector organisations and the HSCB/PHA, is committed to progress the recommendations outlined within the *All Ireland Travellers Health Study*, particularly with regard to health and wellbeing. This is achieved through the development of a yearly action plan with the Forum meeting four times a year to report on progress and agree new priorities. A particular emphasis has also been given to emotional health and wellbeing and PHA commission *Aware NI* to deliver regional mental health and emotional wellbeing programmes for Travellers. The Forum also works with other agencies and seeks to influence a more coordinated approach to meeting need alongside informing mainstream services so that access is improved.

In addition to the Forum, the PHA commission services from the Southern, Western and Belfast Trusts to deliver a range of programmes to address the needs of Travellers.

Services include:

- community development
- family support
- health programmes
- training and education
- signposting to services such as smoking cessation, cancer screening
- drug & alcohol services
- support to engage in local services e.g. Healthy Living Centres
- cultural awareness training
- support to engage in conflict resolution within families and communities

Raising the standards

Event speakers pictured at the Dementia Together NI celebratory event. Back row (from L-R): Eleanor Ross, PHA, Seamus McErlean, hscb, Chris Matthews, DoH, Tara Collins, Dementia NI, and Professor Assumpta Ryan, Ulster University. Front row (from L-R): Jerome Dawson, DoH, Andrew Dougal, PHA, Lorna Conn, HSCB and Sarah Penney, Ulster University.

Above pictured at the Q2020 Event in November 2017. L-R Dr Carolyn Harper, PHA, Dr Michael McBride, DoH, Carol McCullough, service user representative, Prof Charlotte McArdle, DoH, Mary Hinds, PHA.

Theme five

Integrating the care

Integrating the care

5.1 Introduction

The HSCB and PHA are committed to ensuring the integrated HSC system in Northern Ireland is effective and that there is seamless movement across all professional boundaries and sectors of care. A number of key improvements were led by the HSCB/PHA last year. This made a significant contribution to raising the quality of care and outcomes experienced by patients, clients and their families.

5.2 Centre for Connected Health and Social Care

The Centre for Connected Health and Social Care (CCHSC), located within the HSCB and PHA, promotes the use of technology and innovation in the HSC system in Northern Ireland. The primary purpose of CCHSC is to improve patient/client experience and to provide better quality and more effective care.

During the year the CCHSC continued to contribute to improving health and wellbeing through a number of partnership activities including:

encompass

e-Health and Care strategy

CCHSC has led the implementation of the eHealth and Care Strategy, ensuring that the strategic aims of the HSCB/PHA are fully reflected contributing to all of the workstreams, with a focus on supporting people, sharing information and fostering innovation projects. The CCHSC has also been supporting work on the 'encompass' programme, supporting various engagement activities and developing the Personal Public Involvement model to support involvement of patients, carers and the public.

HSC Online

A health conditions A-Z platform is being developed which will provide a comprehensive suite of health information, supporting people to make decisions in relation to their personal illness and chronic conditions. Hosted by *Nidirect*, the HSCB eHealth initiative developed in conjunction with the PHA will promote self-management where appropriate, and help people decide whether their condition has reached the threshold where advice or clinical assessment is required. It will link to signposting of appropriate services, assisting people in accessing services they require. Links will be provided to GP practices to book appointments online and order prescriptions, where these services have been made available by practices. In parallel, work will continue migrating content currently hosted on HSCB/PHA websites, to the N*idirect* platform.

Integrating the care

eHealth and Data Analytics Dementia Pathfinder Programme

CCHSC has been delivering the eHealth and Data Analytics Dementia Pathfinder Programme of work. The programme can be divided into two distinct areas:

- **eHealth projects** comprising of:
  - a **patient portal** and **app** for people with a diagnosis of dementia and their carers linked to the Northern Ireland Electronic Care Record (NIECR), as well as providing the IT infrastructure and security to support such portals and apps;
  - the development of a new patient care pathway, through the support of "**Project ECHO**" for dementia;
  - a local enhanced service for the completion of **key information summaries (KIS)** in the NIECR for the majority of dementia patients. This will mean that the patients will be recognised and flagged as having dementia across the electronic system.

- **Data analytics** projects comprising of:
  - **Setting up of data analytics platform and team** to undertake a scoping study to develop data analytics capability within health and social care;
  - **Commissioning Queen's University Belfast research** to develop a strong academic research base, ensuring clinical input and data analytics expertise is at the heart of the programme and can link, learn and disseminate information to the data analytics team from international and best practice approaches;
  - **Dementia analytics and research projects** - to commission ten dementia analytics projects exploring issues critical to patient outcomes and service planning and to assist in service development and design.

EU Engagement and projects

CCHSC is a member of DoH-led EU Engagement Forum set up to inform strategic directions and co-ordinate information about EU funding streams and networks. CCHSC led by HSCB / PHA works with Trusts, universities and industry to pursue both UK and EU funding opportunities to support HSCNI's contribution to the work of the European Innovation Partnership on Active and Healthy Ageing (EIP AHA).

5.3 Integrating care at home

24 hour District Nursing care

During 2018, *A District Nursing Framework 2018-2026 - 24 Hour District Nursing Care No Matter Where You Live* was launched. The Framework aims to provide the strategic direction for the provision of district nursing services in Northern Ireland. It paves the way for developing a service that is innovative, collaborative and transformed, available 24 hours a day, seven days a week, no matter where the patient lives. An outcomes based approach has been adopted for the four principles in the framework, which are

- Person centred;
- Efficient and effective;
- Expert;
- Integrated and population based around General Practice.

A number of improvement priorities, actions and indicators of success have been identified for each of the four principles. The PHA will be responsible for taking forward the implementation plan linking closely with HSCB and other stakeholders to progress the outcomes in this Framework, using a collective leadership approach.

Prof Charlotte McArdle, DOH Chief Nursing Officer:

"I believe this Framework sets the way forward for all of us to work together to deliver a world class district nursing service. I am confident that the implementation of the Framework will have a valuable impact on delivering safe and effective person centre care by district nurses and their teams in community settings."

Transformation of the home oxygen service

Oxygen therapy is vital in supporting adults and children with breathing difficulties, including those with long-term medical conditions such as cystic fibrosis and chronic obstructive pulmonary disease (COPD). Access to oxygen at home helps users to manage their symptoms so that they can live effectively in the community, rather than needing to be cared for in hospital.

The provision of oxygen therapy involves a range of health professionals in secondary and primary care settings who contribute to the patient's journey of care from initial clinical assessment to the supply of oxygen at home. Currently there are approximately 4,000 patients on oxygen therapy at home in Northern Ireland.

Integrating the care

Old service model

In Northern Ireland, oxygen therapy can be prescribed by GPs. The GPs assess the clinical needs of patients and determine the appropriate oxygen flow rate and hours of use per day. The service model required a large amount of communication between secondary care to advise GPs on prescribing. The service does not make any provision for the modern modalities to supply long term oxygen, nor does it make provision for a four hour response rate to allow discharge from hospital, offer a tapped install service to allow a safer installation of oxygen, or offer a 24/7 call-out service.

Transformed service model

Advances in oxygen technology, especially portable and transportable concentrators and liquid oxygen mean that patients with high oxygen demands can be supported to live at home, be active and have greater freedom and autonomy in managing their oxygen needs. In April 2017, 3752 patients received a home oxygen concentrator via the specialist oxygen contract. This may have been a standard, portable, transportable or self-fill concentrator. The average number of new patients per month is 210.

Community pharmacy hidden carers pilot

The Community Pharmacy Hidden Carers pilot began in the South Eastern Local Commissioning Group (LCG) area. Evidence shows that many carers become isolated through the demands of their caring role and are twice as likely as those who are not in a caring role to suffer from ill health. The aim of the pilot was to use community pharmacists to identify those carers who were not currently in touch with services and therefore unidentified. The role of the community pharmacist was to promote the Carers Support Service and thereby enable carers presenting at pharmacies to avail of the services.

Forty four pharmacies in the LCG area took part in the pilot and mandatory training sessions were held. An evaluation of the pilot was undertaken and the results showed that there were 61 referrals across the participating pharmacies. Thirteen of the carers were contacted for detailed feedback of the service. Ten of those contracted reported that they would not have known that the Carer Support Service was available if they had not been identified by the pharmacist. The evaluation recognised the value of community pharmacies in identifying hidden carers and recommended continuation of the pilot in the area and consideration of rollout across other areas. The service has been extended for a further six months across the South Eastern LCG. Both the Northern and the Western Trusts have identified funding to commence the project. The Southern Health and Social Care Trust hope to introduce the service and provisional discussions have also been held with Belfast Health and Social Care Trust.

5.4 Local enhanced services

Key Information Summaries

HSCB developed a Northern Ireland local enhanced service to introduce and train GPs in the use of key information summaries in 2017/18. The key information summary (KIS) is a summary of medical history and patient wishes. It allows GPs to record useful data about their patients which is then visible on the electronic care record (ECR) in unscheduled care settings such as GP out-of-hours and emergency departments. The information contained in the KIS helps to ensure improved patient safety and continuity of care. It allows accurate information to be quickly identified in an emergency and avoids key information having to be repeated several times.

Patients with dementia were identified as a group who would particularly benefit from use of the KIS therefore there was a particular focus on this group of patients.

A total of 152 GP practices were contracted to provide the KIS enhanced service in 2017/18 and have all completed the relevant training. The contracting GP practices are expected to have completed 5781 KIS assessments by the end of June 2018 with KIS assessments completed on 50% of their registered dementia patients. This will equate to 3374 assessments on dementia patients by the end of June 2018. By 31st March 2018 a total of 3464 KIS assessments had been successfully completed by GPs.

Oral Surgery - Personal Dental Services Pilot 2017/18

In 2017/18 an oral surgery Personal Dental Services (PDS) pilot was established to improve patient access to specialist oral surgery treatment within primary care and to reduce demand on secondary care. Within primary care in Northern Ireland there are six specialist high street oral surgery (HSOS) practices which treat health service patients on referral from general dental practitioners. However, in recent years HSOS activity under the health service has declined dramatically with providers citing economic reasons.

The oral surgery contractual arrangement being piloted offers HSOS practices a more viable business model but at the same time requires from them a greater commitment to health service provision. The pilot benefits the wider HSC through reduced pressure on secondary care, more effective use of Trust resources, increased value for money and greater financial control and predictability.

Integrating the care

Outcomes are positive for patients as well as overall waiting times are reduced.
Although in its infancy and still being evaluated, the pilot has clearly been successful in reversing the downward trend in the high street oral surgery service.

Additional key 2017/18 pilot outcomes include:

- Approximately 3000 more patients in 2017/18 received specialist oral surgery care within primary care than during 2016/17 (an increase of 26%).
- Equity in patient access has improved as service provision has increased across all five LCG areas.
- 1271 fewer oral surgery referrals were made to secondary care during the pilot period than in the same months of the previous year (a reduction of 12%).

A second phase of the oral surgery pilot is currently ongoing to allow for continued primary care oral surgery service provision, more extensive pilot evaluation and potential further refinements to the future service model.

Management of *Clostridium difficile* in the independent sector care and residential home setting

Laboratories in Northern Ireland notify the PHA of all *clostidium difficile* infections. On notification a reporting proforma is completed which contains information about the patient and associated risk factors, including antibiotic history in the last four weeks. Following completion of the proforma prompt Infection Prevention and Control (IPC) is given in relation to isolation of those infected, hand hygiene, appropriate use of personnel protective equipment, environmental and equipment cleaning and decontamination.
A guidance pack containing the advice is also emailed to the facility.

A twice weekly risk assessment review of all notifications is completed where they are risk assessed and decisions are made about the ongoing management. These meetings aim to provide assurance about IPC practice and can include;

- The provision of further expert advice and support via telephone or through the completion of support visits to the facility. The visit can also be used to gather information about IPC practice.

- Sharing of audit tools to help provide assurance of IPC and control practice such as hand hygiene and equipment audit.
- Support through teaching sessions for staff in relation to IPC – including the theory and practice.
- Providing a link between independent sector care home, GPs, Trusts and the Regulation Quality Improvement Authority (RQIA). These links ensure the direct dialogue of all stakeholders, continuity of approach will enhance resident safety.
- Encourage compliance with antimicrobial stewardship through awareness of Northern Ireland primary care guidance and through direct access to HSCB pharmacy colleagues.

A root cause analysis is carried out where appropriate, following a confirmed case of *clostridium difficile* infection. This analysis can identify factors that may have contributed to the person acquiring the infection. Learning is then shared with the relevant agencies.

5.5 Criminal Justice Healthcare

The DoH and Department of Justice (DoJ) consulted on a draft joint healthcare/criminal justice strategy in 2017/18. The PHA and HSCB were instrumental in driving forward a number of recommendations for the regional action plan. Progress has included:

- An associated services multidisciplinary team for prison healthcare has been reconstituted; a mandate and work plan has been agreed.
- As part of commissioning team, work has been ongoing to formulate a plan to outline the requirements for the future service.
- As part of a ten point plan, proposals have been made to the DoH to take forward a number of transformation proposals to build on and progress the health needs assessment in prison environments.

During 2017/18 a multidisciplinary workforce review has been initiated and this will be evaluated in line with the service requirements, demand and supply of the recommended workforce for prison healthcare.

Joint PHA and PSNI Police Custody Pathfinder

A number of consultations and a regional workshop has taken place with key stakeholders to progress recommendations for the development of a Trust led model for healthcare in custody. The PHA in conjunction with DoH, DoJ and PSNI and the Belfast Health and Social Care Trust is leading work to develop a Trust led model for healthcare in custody. A joint funding envelope has been agreed to progress and test the model through a nurse led pathfinder in 2018.

The specification for the pathfinder has been successfully established with a plan to have this in place by September 2018. In parallel to this the regional roll out for nurse led services in custody suites is being progressed by a regional Task and Finish group co-chaired by PHA and PSNI.

5.6 Integrating the care for Learning disability services

Annual health check: patient pathway to support the development of a health and wellbeing plan

Health and wellbeing plans identify the personal health and wellbeing needs of individuals and describe the actions to empower individuals to make healthy choices to improve their health. Within the learning disability services a core quality indicator specifies that each person with a learning disability who receives an annual health check should have a health and wellbeing plan in place.

A patient pathway has been developed as well as detailed guidance in order to assist Trusts with the implementation of individual health and wellbeing plans for adults with a learning disability. The pathway and guidance will facilitate a consistent regional introduction to the development and implementation of health and wellbeing plans. A multi-disciplinary approach will describe roles and responsibilities and ensure the plans become integral and routine to existing assessment, care planning and review processes.

HSC Hospital passport for people with learning disability

The PHA has worked with HSCB and Trusts, education providers, people with a learning disability and their families and carers, to design the Hospital Passport and guidance notes for staff.

This involved consultations with a wide range of individuals with a learning disability, healthcare staff, voluntary organisations involved in the support and delivery of services to people with a learning disability, and family and carers.

The purpose of the Hospital Passport is to provide important information about the person with a learning disability. This information will help staff in general hospital settings make reasonable adjustments in order to support safe and effective care. This in turn will improve patient/client experience of care and treatment.

The Passport was launched in May 2017, with copies being distributed to each of the Trusts and to a number of the larger community and voluntary sector organisations working with people with learning disabilities across Northern Ireland.

In August 2017 following feedback received from healthcare professionals and carers the Passport was also made available in an accessible format. Individuals can type onto the document, print or save to a mobile device. The PHA has also provided a PPI award to an Association for Real Change (ARC) project called *Telling It Like It Is* (TILII). TILII is an organisation that works with individuals with a learning disability, who assisted with the evaluation of the Passport. TILII has engaged with peers to develop an easy read evaluation tool that can be used as part of the wider PHA evaluation.

Both the Passport and guidance notes are also available to download from the PHA website. **http://www.publichealth.hscni.net/publications/hsc-hospital-passport-and-guidance-notes**

5.7 Quality improvement: babies, children & families

Getting Ready for Baby

The Early Intervention Transformation Programme (EITP) aims to improve outcomes for children and young people across Northern Ireland through embedding early intervention approaches. There are a total of three workstreams within EITP. Workstream one is divided in to two areas

1. Getting Ready for Baby
2. Getting Ready for Toddler.

Getting Ready for Baby is a new way of delivering care and supporting first time parents through pregnancy, labour and birth and preparing for the early days of baby's life. It links antenatal appointments and parenting group support for the first time in Northern

Integrating the care

Ireland. This means that first time mothers will be part of an antenatal parenting group that meet at various points during pregnancy and will also receive antenatal care at this visit.

Getting Ready for Baby helps new parents get to know and develop a relationship with their baby using the Solihull Approach, an evidence based programme focused on emotional health and wellbeing. Getting Ready for Baby is currently only for first-time mothers with no major health issues.

Extensive data collection has been ongoing and the programme has received excellent feedback from a number of sources using questionnaires to evaluate. Feedback comments included:

> "The assurance of knowing others are experiencing the same ups and downs as you makes pregnancy much easier. You will leave armed with knowledge, confidence and a support group for life. The midwives are fantastic and will guide you through this wonderful time".

3+ Review

Work Stream One of EITP has designed an evidence informed approach to the 3+ Health Review using an integrated health and education review for children in their pre-school year. Whilst this is intended to be a holistic review, particular focus is on social, emotional and behavioural development.

As part of the programme the health visiting service will work together with nursery school principals and pre-school leaders to offer a 3+ Health Review for children attending pre-school education. The 3+ Health Review requires the parent/carer to complete a questionnaire and attend a short interview at the pre-school setting with the health visitor. The pre-school leader/nursery school teacher also has the opportunity to highlight any concerns or issues. It is designed to be easy to complete by parents at home or in the pre-school education setting with minimal support.

The 3+ Review has been well received by parents and this has been highlighted in the parent questionnaires.

Integrating the care

EITP Publications

The PHA worked with a number of key professionals across Northern Ireland to standardise child development public health information which was supported by the EITP.

A targeted consultation supported by Parenting NI, was conducted alingside the development of these messages to ensure they were appropriate to service user needs. This information has been distributed to Trusts, GP practices, Early Years settings and libraries to ensure messages are cascaded to help improve the health and well-being of children.

http://www.publichealth.hscni.net/publications/playing-parents-number-one-three-posters

http://www.publichealth.hscni.net/publications/helping-your-baby-learn-talk

http://www.publichealth.hscni.net/publications/helping-your-child-learn-talk

Safe sleeping

As a result of the findings of the Northern Ireland Infant Death Thematic Review (2015) we have a better understanding of sudden and unexpected infant death in Northern Ireland.

The PHA used the findings from the thematic review to highlight the key messages which aimed to prevent further deaths, and improve the health, safety and wellbeing of children. In consultation with practitioners from the key disciplines across the Trusts two new resources have been developed to assist practitioners to provide consistent messages about safe sleeping regularly both in the antenatal period and postnatally. The resources include a Parent Information Card and a Risk Assessment Tool.

Children with Special Educational Needs

The PHA hosted a number of regional workshops with staff from Trusts, the Education Authority and Department of Education to improve health input to the educational statutory assessment process. From these events a number of recommendations and actions have been put in place which will ensure regional standardisation of health advice in the statutory assessment process. This will ensure that children with Special Educational Needs (SEN) are identified and assessed in a timely manner, and advice provided within the statutory assessment process is provided within the specified timeframe. There was a high level of co-operation between health and education in ensuring this work meets the legislative requirements of the Children's Services Co-operation Act (Northern Ireland) 2015 to improve children's wellbeing.

Integrating the care

Supporting speech, language and communication (SLC) in Sure Start

There are 39 Sure Start projects delivering services in the 25% most deprived areas in Northern Ireland. The supporting speech, language and communication (SLC) programme in Sure Start aims to:

- support parents and staff to provide language rich environments;
- support early identification of SLC need; and
- ensure timely access to appropriate additional support.

To achieve the aims of the SLC programme, the PHA, working with key stakeholders, implemented *Wellcomm*, a speech and language screening tool in order to:

- help with the early identification of speech, language and communication needs
- help identify the appropriate type of SLC support
- monitor the SLC progress of the children

The Wellcomm Screening tool uses a red, amber, green scoring system to indicate if a child's language is age appropriate (green), has some difficulties (amber) or is delayed (red). It was administered in Sept/Oct 2016 prior to the SLC development programme being implemented and then re-administered in May/June 2017 following the SLC development programme.

SLC Programme Target	Achieved
100% of eligible children 2-3 year old will be screened using the Wellcomm Screening tool.	96%
Wellcomm Screening will be carried out by Early Years staff in 100% of 2-3 year old.	97%
To ensure consistency in the accuracy of screening, annual regionally agreed Wellcomm training will be delivered by SLTs in 100% of Sure Start projects.	100%
There is consultation with SLT regarding all children who score red on Sept/Oct screen and these children are signposted to appropriate services.	Achieved within each local area

Did the SLC programme improve the outcome for 2 3year old children?

MAHI - STM - 120 - 2506

For further information
please contact

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Q2020
Project Manager
[redacted]

MAHI - STM - 120 - 2508

Health and Social Care Board and Public Health Agency

Annual Quality Report 2018/19

HSC Health and Social Care Board

HSC Public Health Agency

QUALITY 2020

Chief Executive's foreword

Welcome to the sixth Annual Quality Report of the Health and Social Care Board (HSCB) and Public Health Agency (PHA). As Chief Executive I am pleased to share this report which outlines our journey in relation to improving the quality of services across each of our directorates during the year 2018/19.

The publication of annual quality reports are a recommendation of the Department of Health Quality 2020: a 10 year strategy to protect and improve quality in Health and Social Care in Northern Ireland. While it is impossible to include information about every service the HSCB and PHA provide, this report seeks to demonstrate, using the Q2020 strategy as the driver, our commitment to delivering improvements in safety, outcomes, access, efficiency and patient satisfaction throughout health and social care.

During 2018/19 there was an important focus on collaboration and partnership working and I am delighted to share a variety of examples within the report, such as the growth of the Q community within Northern Ireland and the impact this has had on providing opportunities for learning. In addition, projects such as Social Prescribing and Belfast Safer Homes have highlighted inter-agency collaboration and the benefits of working across boundaries have proven to be successful towards the integration of care.

Regionally, we have continued to provide support to measure and identify learning in relation to the key quality improvement indicators such as pressure ulcers and falls. I am particularly pleased to share some examples of new innovative ways of working through, for example the primary care infrastructure project, a hub and spoke approach to delivering primary and community care services.

Our commitment to the co-production of services has been evident through various improvements implemented as a result of, for example, the implementation of the regional hospital passport for people with a learning disability. In addition, through the 10,000 More Voices initiative we have continued to listen and improve our services based on the experience of service users.

Finally, I would like to thank all the staff for their continuing efforts over the past year and I am proud of what we have achieved together. This report demonstrates not only how far we have come, but also our continuing collective drive to achieving the vision of Quality 2020 against a background of increasing demands and a challenging financial position. There will always be areas for improvement and going forward we will continue to aim for the highest quality in the care and services we provide and put our patients and clients at the heart of everything we do.

Valerie Watts

Valerie Watts
Chief Executive

Transforming the culture

247 Serious Adverse Incident Reviews closed

Regional learning methods approved:

- 7 reminder of best practice guidance letters
- 2 learning letters
- 2 professional letters
- 23 newsletter articles
- 14 specialist group referrals

10,000 TEN THOUSAND MORE VOICES

2,035 Stories Collected

Overall total number of stories collected **14,755**

Last year the top 3 categories of HSC complaints were

1. treatment and care
2. staff attitude and behaviour
3. communication

Stengthening the workforce

The HSCB and PHA collectively employ over **800** people

By March 2019 **56%** of HSC staff have completed level 1 Q2020 attributes framework training

Multidisciplinary team programme in place within **57** GP practices across Northern Ireland

66% reduction in vacant nursing posts in care of older people settings

Project Retain

Last year **1,694** of children's services social workers have been trained to implement the Signs of Safety model

Measuring improvements

Last year the Quality Improvement Plan priority areas focused on

1. Falls prevention
2. Pressure Ulcer Prevention
3. National Early Warning Scores
4. Reducing mixed gender accommodation

26 participating units across HSC focusing on improving the recognition of sepsis

NICE National Institute for Health and Care Excellence

45 technological appraisals issued / Monitor the implementation of 190 clinical guidelines

8 antenatal, newborn and adult screening programmes commissioned and quality assured:

1. Antenatal infection
2. Newborn blood spot
3. Newborn hearing
4. Abdominal aortic aneurysm
5. Bowel cancer
6. Breast cancer
7. Cervical cancer
8. Diabetic eye

Raising the standards

Establishment of

Northern Ireland Frailty Network

Regional trauma network

new networks

Q community

has up to 180 members from Northern Ireland. (Q is an initiative which connects people who have quality improvement expertise across the United Kingdom).

Practice based pharmacist evaluation showed savings of approximately

12 hours

per week of other practice staff time (relates to participating practices).

Newly updated parenting resources including:

- Maternity handheld record
- Pregnancy book
- Birth to five book
- Personal child health record

Following the stay well this winter campaign:

Calls to GP out of hours providers were down **16%** from previous year

70% uptake of flu vaccine among those 65 years and older

Integrating the care

A-Z Conditions

– total 152,000 page views (Platform was developed providing a suite of health information, supporting people to make decisions in relation to their personal illness & chronic conditions)

New ways of working resulting in reduced DNA rates, reduced waiting lists and increased capacity through:

- Virtual fracture clinic
- Scoliosis mega clinic
- 'Spoke' premises within primary and community care

Interagency working

24 hour nurse led custody pathfinder operational in Musgrave PSNI custody suite.

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MAHI - STM - 120 - 2514

Theme one

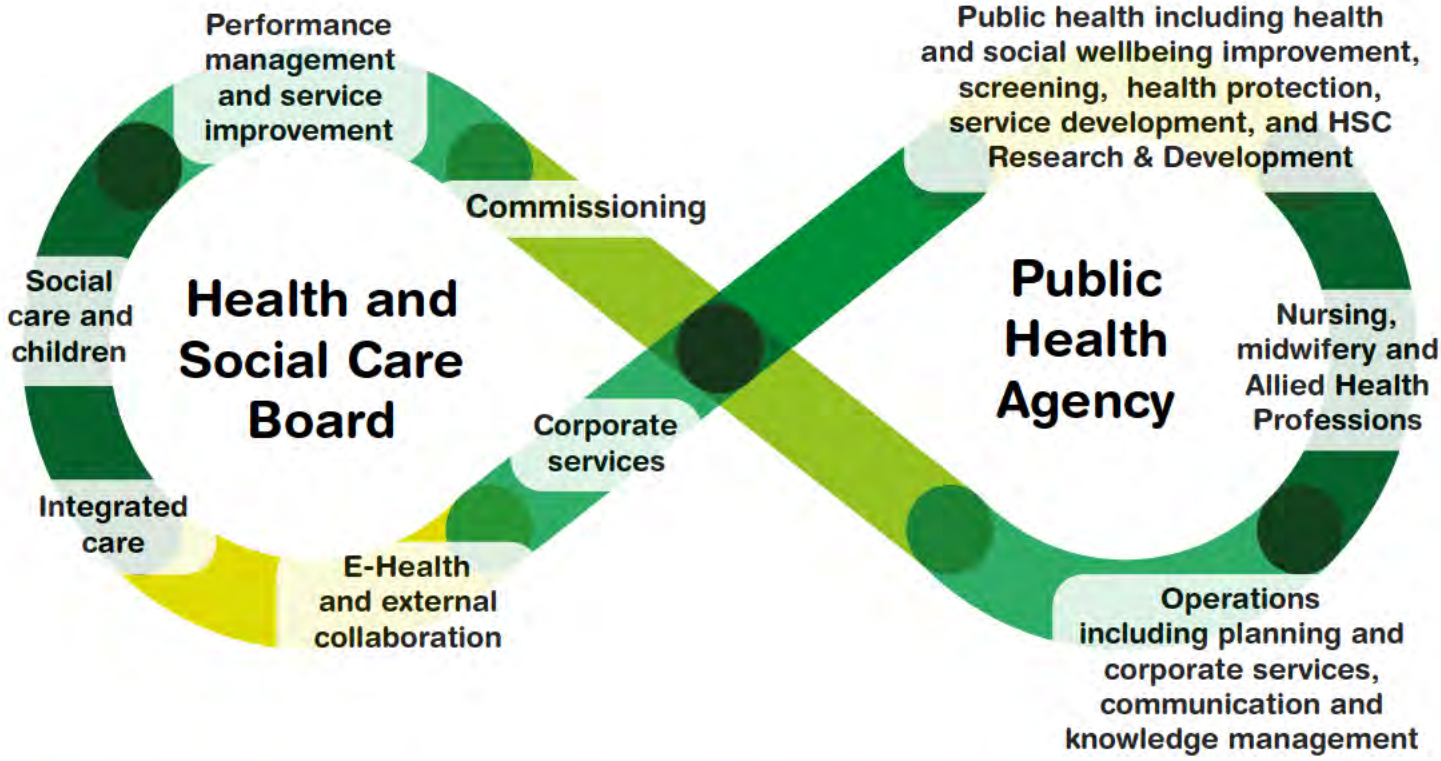
Transforming the culture

1.1 Introduction

The HSCB and PHA both recognise that for the quality of care and services to be of the highest standard, the culture of an organisation must be open, honest, transparent and, in particular, patient and client focused. Key to transforming organisational culture is the willingness of the senior team to lead from the front in motivating staff and, prioritising patient and client care, while embracing change in the rapid moving climate of Health and Social Care (HSC).

1.2 Who we are

The HSCB and PHA are considered arm's-length bodies within HSC. Ensuring that services are safe, high quality, effective and meet people's needs is a core function of both the organisations. They continue to work collaboratively and focus on improving the quality of services delivered.



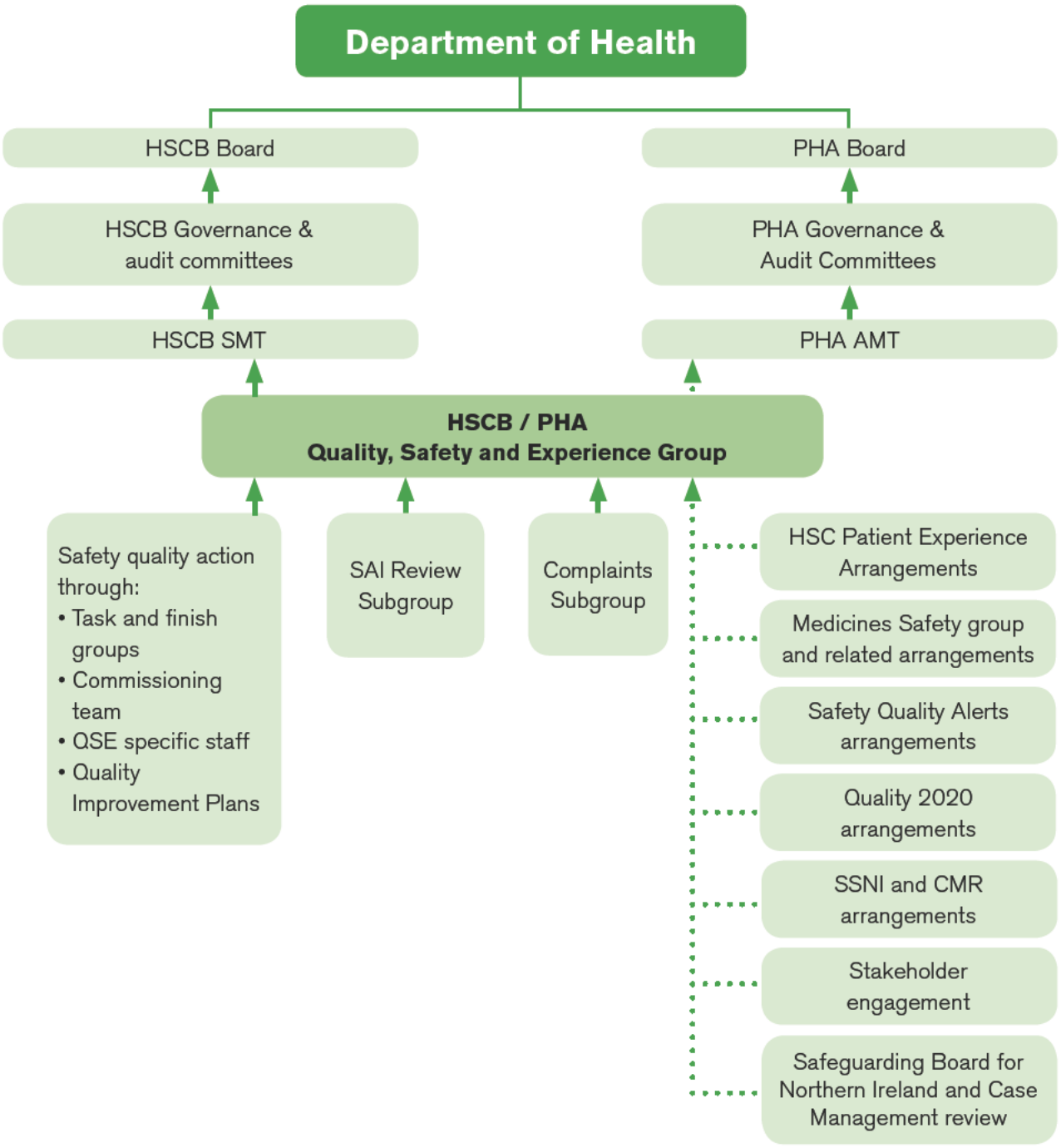
For further information relating to the HSCB and PHA's role, governance structure and the work that we do is available at:

- http://www.hscboard.hscni.net/
- https://www.publichealth.hscni.net/

1.3 Leadership and governance

There are a number of core groups which oversee and provide governance on the quality of services commissioned or delivered by HSCB and PHA, outlined within the diagram.

The **Quality, Safety and Experience (QSE) Group** provides an overarching structure whereby the HSCB and PHA can monitor and report on safety, effectiveness and the patient client experience to the respective Boards and committees. A range of groups such as the Safety Quality Alerts Team, Regional Complaints Group, Serious Adverse Incident (SAI) Group, Designated Review Officer (DRO) professional groups, patient experience team, report to, and support the work of QSE.



Establishment of HSCQI

HSCQI (Health and Social Care Quality Improvement) is a 'movement' in health and social care services in Northern Ireland. It focuses on working together to improve the quality of the services we provide or use, and sharing good practice so that we can all learn from each other and spread improvements.

With the anticipated appointment of a new Director for quality improvement, HSCQI will form a new directorate within the PHA known and the HSCQI hub. During 2018/19, as part of the design phase for HSCQI, five communities of practice (COP), reflecting common areas of interest across the HSC, were established. They COP, which are led by a range of convenors from across the HSC, and during the year they considered areas such as ICT and communication, workforce, PPI engagement in quality improvement, innovation and evaluation of QI training.

The COP carried out a range of activity during 2018/19:

- In April 2018, the ICT COP formally launched the HSCQI website. The website was identified as a core resource required by the HSC to enable the sharing of quality improvement learning, projects, news and events across the region.
- In October 2018, the PPI COP launched the GREAT checklist, a tool designed for engaging service users in quality improvement. The comprehensive tool was co-produced with service users and practitioners, and funded by the PHA.

WWW Further information relating to HSCQI, its activities and resources is available at **qi.hscni.net/about-qi**

1.4 Learning

Regional learning from serious adverse incidents

The key aim of the SAI process is to improve patient and client safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole. For the majority of SAIs reported, local learning will be identified and actioned by the reporting organisation. However as the HSCB and PHA has a role in reviewing all SAIs they may also identify regional learning for dissemination across the wider HSC through a number of mechanisms.

During the reporting period 247 SAIs were closed by the HSCB and PHA following review. The following methods of regional learning were approved from SAIs closed in 2018/19:

- **7** reminders of best practice guidance letters
- **2** professional letters
- **23** newsletter articles
- **14** specialist group referrals
- **2** learning letters
- **11** linked to ongoing work

Listed below are two examples of regional learning identified last year:

- Management of risk for patients with mental health conditions in the general hospital setting This case involved a patient who died following a non-accidental fall within an acute hospital facility. The patient attended the emergency department and was admitted to the acute medical admission ward. The patient left the ward following which, the tragic incident occurred. The patient was also known to the Trust mental health services.

  As a result a Reminder of Best Practice Guidance letter was issued to the wider HSC. The PHA and HSCB worked with Trusts to ensure:

  - the letter was brought to the attention of relevant staff;
  - developed and shared guidelines for the management of people with mental health conditions in general hospital settings. This also included an agreed risk assessment form and PSNI liaison form.

- Milligram and microgram: 1000 times intended dose error at hospital-GP interface In this case a young patient received 1000 times the intended dose of a drug used to bring on puberty (Ethinylestradiol). This would be regarded as a relatively uncommonly encountered indication for the medication in primary care.

A recommendation was made to start the drug at a dose of 2 micrograms by the hospital specialist, but the GP could not find this dose on their computer system and made an assumption the dose was 2 milligrams.

Over a period of approximately 2 years the dose was raised incrementally by the hospital to what should have been 10 micrograms, but at the GP surgery the corresponding dose was raised to 10 milligrams on prescriptions, maintaining the 1000 times dosing error. A HSCB Pharmacy Adviser picked up on the error during a routine prescribing review.

A Reminder of Best Practice Guidance letter was issued to secondary and primary care providers. Secondary care was asked to develop prescribing information to be issued when this regimen is used. The importance of good medicines reconciliation at the hospital-GP interface was reinforced. This includes encouraging patients to bring their medications to outpatient appointments, providing an opportunity to confirm medications they are taking are as intended.

WWW For further information on learning from SAIs please see following link **www.hscboard.hscni.net/publications/sai-learning-reports/**

Regional Learning System (RLS) Project

A regional project commenced in September 2018 to develop a regional system for allowing the HSCB and PHA to have oversight of Adverse Incidents. A Regional Project Board and Project Team were established to take this forward. Last year the HSCB and PHA worked closely with HSC Trusts, DoH and other key stakeholders to:

- upgrade HSCT Datix systems to Datix web, with HSCB upgrade due to be completed by the end of June 2019;
- improve the consistency of reporting across the region through the use of CCS 2 codes:
- deliver Regional DATIX Certified Practitioner training for all Trusts;
- ensure regional Datix searching, reporting and document template training was completed by all Trusts with further training scheduled;
- work towards an agreed means by which Adverse Incident data can be provided to the HSCB and PHA using CSS2 codes using a regional minimum dataset.

The work of the project will continue into 2019/20 to take forward the DoH outline business case.

Regional learning from complaints

The HSCB and PHA review complaints received directly and those from HSCTs and family practitioners (FPS). For the majority of complaints, local learning will be identified and actioned by the reporting organisation. In some instances, the HSCB or PHA may also identify regional learning.

During 2018/19:

- HSCTs received 6,049 complaints.
- HSCB received 177 complaints regarding Family Practitioner Services.
- HSCB acted as 'honest broker' in 115 complaints regarding Family Practitioner Services*.

The top three categories of complaints are:

1. Treatment and care.
2. Staff attitude and behaviour.
3. Communication.

*Of note this year is a significant increase in the number of complaints where the HSCB has acted in the role of 'honest broker', that is in an intermediary capacity between the patient and the FPS practice in an effort to resolve the complaint, or at least to reach an understanding or agreed position on the issues.

Areas of concern, patterns and trends from complaints are shared with relevant professional groups. This ensures that issues raised by complaints inform key areas of work on the quality of patient experience and safety including thematic reviews and strategy and policy development. Some examples include:

- **Atypical presentation of stroke**
  Following a number of complaints regarding patients who had presented to out-of-hours services and emergency departments with atypical symptoms of stroke, it was agreed that to supplement the FAST campaign, an

article would be included in the Learning Matters newsletter, Issue 8 which was published in September 2018.

Atypical Presentation of stroke

Some symptoms of atypical stroke

Neuropsychiatric symptoms	Acute confusional state
Altered level of consciousness	Abnormal movements
Limb shaking transient ischaemic attacks	Seizures
Alien hand syndrome	Localised auditory (flapping tremor)
Isolated hemifacial spasms	Disappearance of previous essential tremor
Acute vestibular syndrome	Other cranial nerve palsies (especially third and seventh cranial nerves)
Tongue numbness or tingling	Acute mono paresis
Cortical hand syndrome	Cortical foot syndrome
Isolated sensory symptoms	Isolated dysarthria
Isolated dysarthria facial paresis syndrome	Isolated visual symptoms
Antioch's syndrome (cortical blindness with denial of deficit)	Bálint's syndrome (type of visual spatial deficit)
Isolated visual field disturbances	Foreign accent syndrome
Isolated dysphagia or stridor	Isolated headache

WWW The full article is available at https://www.publichealth.hscni.net/sites/default/files/2018-11/Learning%20matters%20issue%208_0.pdf

For further information relating to complaints can be accessed at www.hscboard.hscni.net/publications/complaints-publications

Learning from experience: 10,000 More Voices

The 10,000 More Voices initiative seeks to understand the patient client experience across Health and Social Care. Through bespoke tailored surveys the driver for each project is to integrate key learning from patient experience into local service improvement and to further inform commissioning. Under the auspices of co-production each project ensures the patient experience can shape our services from the design of the survey to the analysis and the delivery of the recommendations. 10,000 More Voices is an integral part of quality improvement, informing "Always events" and quality improvement programmes with HSCTs. Stories from each project are reviewed on a weekly basis to support trusts to highlight areas of good practice and consider timely learning to inform service improvement.

Stories are used to inform pre and post registration education for medical, nursing and allied health professional students. The stories are also used in the development of local training programmes within each trust such as organisational induction or local in-house programmes.

In 2018/2019 the 10,000 More Voices team supported a regional roadshow called 'An important piece of the puzzle' exploring the skill of communication, and delivering training to over 600 attendees of all disciplines across all trusts.

Since 2014, over 14,000 stories have been collected over a broad range of service areas. In 2018/2019 projects included the experience of discharge from hospital, the experience of bereavement, the experience of children's audiology services and the experience of mental health services.

WWW Further information and completed project reports can be accessed at www.10000morevoices.hscni.net

1.5 Involvement and co-production

Personal and Public Involvement (PPI) Involving you, improving care

Personal and public involvement (PPI)

PPI is the active and effective involvement of service users, carers and the public in the commissioning, development and delivery of HSC services. Co-production is considered to be the pinnacle of such involvement. The PHA leads on the implementation of PPI in Health and Social Care. Recognising that core to quality improvement work is the involvement of service users and carers, a number of initiatives have been progressed in 2018/19. These include:

Improving involvement in transformation - Working closely with a number of the transformation workstreams, the PHA has provided guidance to ensure service users and carers are effectively and meaningfully involved in transforming HSC at all levels.

- **Improving service delivery – Partnership Working Fund** - The PHA has lead the distribution of Partnership Working funding across HSC Trusts and agencies. This has been allocated to support the recruitment of a partnership working officer in each HSC Trust, and to pilot a service user and carer consultant programme. Funding has also been awarded to progress an involvement and innovation programme. The Patient and Client Council (PCC) were also commissioned to produce a model of service user and carer recruitment to support regional transformation.
- **Improving access to information to improve involvement practices** - The PHA lead the Co-production of the Engage website and e-learning resource for service users and carers. This has led to a significant improvement in the quality, availability and consistency of PPI information available.
- **Improving knowledge and skills** – The PHA continues to promote and deliver the Engage and Involve training programme, elements of which are now being delivered as part of quality improvement training in some HSC Trusts.
- **Improving HSC performance for PPI** - The PHA continue to undertake performance monitoring for PPI across HSC Trusts which focuses on what is working well and what can be improved. The HSCB and the PHA were also subject to external PPI monitoring during this period.
- **Improving evidence base for Involvement and Co-production** – The PHA has commissioned a range of research to further develop evidence that will enable high quality practice in Involvement and Co-production, this included research into the concept of citizen hubs and the reimbursement and remuneration of service users and carers.
- **Improving involvement standards – leading the way** - The PPI standards, developed by the PHA, have been used as the pathfinder for National Research Standards. The PHA has been working with the National Institute of Health Research (NIHR) and

PPI leads from England, Scotland, Wales on this initiative. The standards have been piloted across the UK in 2018/19 and will be launched officially in 2019/20.

Meaningful involvement across our services remains critical to improving safety and quality. The PHA will continue to advance these core areas of responsibility in partnership with providers and service users and carers.

WWW Further information on PPI is available at **engage.hscni.net**

Implementation of Always Events® in Northern Ireland

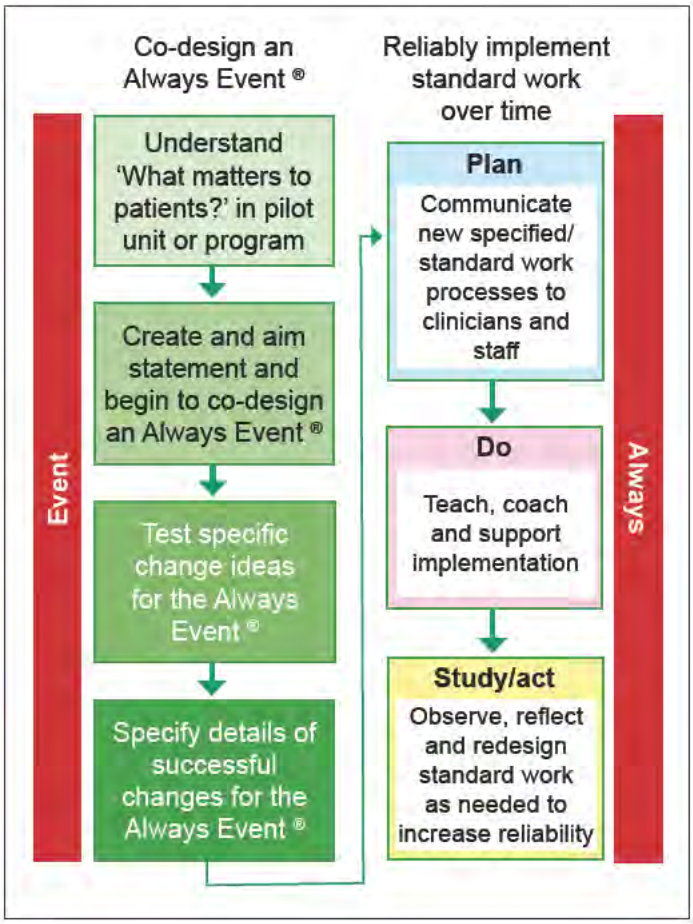
Always Events are defined as those aspects of the care experience that should always occur when patients, their family members or other care partners, and service users interact with health care professionals and the health and social care delivery system.

During 2018/19, the HSCB and PHA, through the regional Patient Client Experience Steering Group, have supported HSCTs to begin to implement, scale and spread plans for two identified Always Events – 'family presence' and 'mealtimes matter'.

Family presence allows family caregivers to be active participants in the patient's care and welcomed at the patient's side, regardless of the time of day. During 2018/19 a regional group was established which focused on building on the Western HSCT family presence model and testing the approach in two wards within each HSCT.

Additionally, each HSCT developed plans to review and standardise their core information relating to family presence using Always Event methodology. These include:

- information on how to best support patients and clients;
- information relating to illnesses;
- helping with meals, food and drink;.
- operating a no smoking policy;
- ensuring proper hand washing.



Mealtimes matter - putting patients first at mealtimes. Last year, each organisation developed plans, building on the Northern HSCT tried and tested model, to agree and test the core components of what should **always** happen at mealtimes. The broad themes include:

- menu ordering;
- before mealtime;
- during mealtime;
- after mealtime.

Recovery college evaluation

The PHA and HSCTs are committed to embedding recovery-focused practice into mental health services using the ImROC (implementing recovery through organisational change) programme. A core aim is to ensure focus remains on supporting individuals in their recovery.

Recovery

Promoting hope, choice and opportunity

Issue 8, Summer 2019

Transforming minds

In this issue we focus on how the recovery colleges play a key role in transforming the minds of not only people using mental health services and their carers, but also the minds of staff and providers of services.

Belfast recovery college wins Aontas award

Belfast recovery college has won a prestigious a l Ireland award for adult learning. Coordinator Helen Anderson said: "We are delighted to get this recognition as it shows that people are engaging in the concept of recovery from mental health issues, and that the journey through recovery is something in which we can all participate."

The Award, presented in Dublin and called The All Ireland Aontas Adu t Learning Award 2019 for Health and Wellbeing Large Organisation, recognises outstanding contributions in the field of adult learning.

The Aontas award convener said at the presentation: "adult and community education is about more than receiving a qual fication. From improved confidence to better hea th, the wider benefits are far reaching and can have a hugely positive impact on a person's l fe, fam ly and wider community. That's why our award categories for 2019 reflect the divers ty of adult learning initiatives taking place across the country."

Since starting in 2015, more than 1,800 people have enro led as individual students in the Belfast recovery college. John Morgan, Senior Peer Educator at the college, said: "Recovery education empowers me. Why not give people hope? Schizophrenia no longer defines me thanks to the recovery college."

In this issue:

HSC Health and Social Care

YOU IN MIND

Recovery colleges were established in Northern Ireland in 2012. Five recovery colleges are in operation in each of the HSCT areas: Belfast, Northern, South Eastern, Southern and Western.

In 2018/19 PHA commissioned qualitative research to:

- evaluate the processes by which recovery colleges are implemented in HSCTs across Northern Ireland;
- explore stakeholders' requirements for a wider evaluation framework that will measure the impact of recovery colleges.

The evaluation report highlights the passion and commitment of the recovery college teams, students, peer trainers and mental health professionals involved and their belief in the positive impact the colleges have. Key strengths, consistencies and variations across the region, were also identified in the evaluation report.

Regional recommendations include taking steps towards a robust evaluation framework for recovery colleges in Northern Ireland. The development of an evaluation framework would be three-fold:

- the data can be used internally to inform the development of recovery college courses;
- the data can be used to widen student targeting and reach and to inform best practice;
- the data can be used externally to demonstrate to key stakeholders and funders the value and impact of the recovery colleges to strengthen the 'business case' for future investment in recovery colleges.

Regional Hospital Passport

The award winning Regional Hospital Passport was designed to help improve the quality of communication between people with learning disabilities, their carers and staff in general hospital settings. During 2018/19 the HSCB, in cooperation with the Southern HSCT, the SHSCT LCG and the SHSCT Carers Forum developed a co-produced animation to support the awareness and possible uptake of the passport. This resource should assist with the regional roll out of the passport.

WWW The resource is available at **https://vimeo.com/323802613/8f46a34a30**

Regional Dementia Care Pathway: supporting each person's individual journey:-

The Care Pathway will assist practitioners in the delivery of high quality dementia care services from initial engagement to the end of life stage of the dementia journey.

This Care Pathway was jointly developed using the expertise of people working in dementia care, the views of people living with a dementia, Dementia NI and the family and carers of people living with a dementia. The HSCB and PHA recognises that engaging with people with a dementia about their experiences is essential when determining service need and helping shape future dementia services in Northern Ireland.

The needs of younger people with a dementia and persons with a learning disability are recognised and addressed in the Regional Dementia Care Pathway. During 2018/19, the HSCB and PHA collaborated with Trust staff and service users from learning disability services in co-designing 5 easy read booklets, complemented by a series of animations. These resources are aimed at raising awareness of dementia for people with a learning disability, building their understanding and informing them of their care and treatment options.

WWW For more information relating to dementia services **www.nidirect.gov.uk/campaigns/dementia**

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Theme two

Strengthening the workforce

2.1 Introduction

The HSCB and PHA, who collectively employ over 800 staff, are determined to invest in the development of their staff and the creation of a working environment that enables everyone to make their best contribution. The organisations' diverse range of responsibilities, coupled with current demographic changes and economic climate, requires a sustained focus on improving quality.

2.2 Supporting our staff within HSCB and PHA

Promoting health and wellbeing in the HSCB and PHA as a workplace

During 2018/19 the PHA and HSCB have led the implementation of a number of programmes to assist in promoting health and wellbeing for staff such as:

(a) Lesbian, Gay, Bisexual and Transgender (LGBT) Forum

A forum for lesbian, gay, bisexual and transgender staff continues to provide confidential support for LGBT staff and students in the HSC workplace. An e-learning module has been developed and widely promoted within HSC settings, The dedicated website to support LGBT staff in HSC now includes an online gallery of staff who are 'out at work'. Staff also participated in a number of the annual PRIDE events and information stalls within HSC settings.

WWW To find out more visit **www.lgbtstaff.hscni.net**

(b) My Mood Matters/Living Life to the Full

Staff in the HSCB and PHA have been offered the opportunity to attend the My Mood Matters and Living Life to the Full programmes. Staff evaluation of both programmes has been very positive.

(c) Physical activity

Staff are encouraged to increase their physical activity during the working day by promoting the use of stairs, lunchtime walks and gym facilities. An upgrade to the gym facilities in Linenhall Street, Belfast and the introduction of the 'take the stairs' initiative also helped boost opportunities for physical activity. This was further rolled out to other HSCB and PHA sites. A toolkit has now been developed that can help other workplaces introduce this simple, effective and low cost measure. A short video was developed to raise awareness of the scheme.

WWW For further information and access to the materials see **www.choosetolivebetter.com/content/getting-active**

Sustrans delivers a workplace programme called Leading the Way, funded by the PHA, across a number of public sector organisations in Belfast and Derry/Londonderry to encourage staff to travel actively on their commute. The Active Travel Challenge also commissioned by the PHA took place from 7 May – 3 June to encourage and support employees to travel actively as part of their working day.

(d) HSC Healthier Workplaces Network

The PHA in conjunction with the HSCB has established a HSC Healthier Workplaces Network. This Network aims to develop improved and consistent workplace health programmes aligned to HR and other policies and which bring increased focus to valuing staff and the advantages that a diverse workforce can bring to organisations. The Network's four subgroups are now addressing the following areas: common measures and indicators; ageing workforce; a healthy workplaces charter; and online tools and apps.

(e) Reflective practice supervision pilot

The PHA introduced a new reflective practice programme for non-clinical staff who work in the challenging areas of suicide and self-harm prevention, mental health promotion and drugs and alcohol. Many of these staff deal with often complex issues around the sudden loss of life, engaging with bereaved families and dealing with challenging media queries.

A new programme was launched in April in collaboration with BSO and Inspire at Work to offer staff a reflective 1-2-1 supervision programme with a qualified clinical supervisor. Update and outcomes will be assessed over the coming year before rolling the opportunity out to other topic areas of work.

NHS@70 Celebrations

To coincide with the National Health Service's 70th birthday, the HSCB and PHA joined in the celebrations highlighting the improvement in the health of the population in Northern Ireland over the past seven decades. A very special birthday event was held for Board members and staff to mark this important milestone.

As part of the celebrations, the campaign 'NHS Standout stars' searching for and awarding staff who had made an exceptional contribution to patient care, services and local communities over the last 70 years. The award was voted by patients, staff and the public. Mary Hinds, the PHA Director of Nursing and Allied Health Professions, PHA was named one of the national health service's standout stars.

2.3 Quality improvement capacity and capability building within the HSC

Developing leadership

Last year the Q2020 Developing Professional Leadership group, supported by the HSCQI Workforce Community of Practice carried out a range of activity focused on implementing the Q2020 Attributes Framework and building capacity and capability for QI across the HSC. This included:

- Revising the level 1 Q2020 e-learning programme to include further information on human factors or situational awareness and person centred framework. The level 1 programme continues to be promoted throughout the HSC and training uptake is monitored by the PHA.

Key principles for the design, content and delivery of learning and development programmes relating to the *Q2020 Attributes Framework for Health and Social Care*.

- The group held a number of workshops in order to standardise the HSC approach to level 2 and level 3 programmes through developing core principles guide for the design, content and delivery of QI training programmes.

- Based on the IHI dosing formula, the group have mapped the current training programmes available, with the numbers of people trained in order to contextualise the QI capacity and capability gap in Northern Ireland.

WWW More information relating to the Attributes Framework and core principles guide is available at https://www.health-ni.gov.uk/publications/quality-2020-ten-year-strategy-protect-and-improve-quality-health-and-social-care

PPI leadership programme

In 2018/19 the PHA Co-produced the 'Leading in Partnership' leadership programme for HSC staff, service users, carers and members of the community and voluntary sector. The aim of this unique programme was to develop the necessary leadership skills to enable continuous and effective involvement of service users and carers across all levels of the HSC whilst supporting the principles of involvement and co-production, collective leadership and partnership working.

A total of 25 people actively participated in the programme. They included a diverse range of HSC staff from across the region such as assistant directors, commissioners, clinical

Personal and Public Involvement (PPI)

professionals, senior managers, support staff. There were also service users, carers and community and voluntary sector representatives.

Regional quality improvement programmes

Scottish Improvement Leader Programme (ScIL)

In order to build capacity and capability in quality improvement science, in line with the attributes framework, HSCQI commissioned the first Northern Ireland regional cohort of the Scottish Improvement Leader Programme. The 30 local participants were nominated from across a range of HSC organisations and came from both clinical and non-clinical backgrounds. The aim of the ScIL Programme is to enable individuals to:

- design, develop and lead improvement projects;
- lead and generate support for change;
- provide expert QI support and advice in their organisations.

The programme commenced in October 2018 and will run over a ten month period.

ScIL
Scottish Improvement Leader

Community Midwives QI Programme – Level 2

To build on the work of the existing maternity collaborative the HSC Safety Forum designed a QI training programme for community midwives. The programme commenced in January 2019 with 24 participants and ran over a six month period including five face-to-face learning sessions. In addition, participants were required to undertake a QI project either as teams or individually. Primary facilitation was led by the HSC Safety Forum with training experts co-opted in on specific topic areas such as data analysis and human factors. The programme was supported by members of the existing maternity collaborative to act as mentors for participants and to assist with a clinical specialty day.

2.4 Sharing quality improvement

PHA Safety Forum Awards 2018

The PHA, through the HSC Safety Forum, invited organisations to nominate individuals or teams for the 4th Northern Ireland Safety Forum Awards. The annual awards recognise and showcase the excellent work undertaken across the HSC system to drive improvement in quality of care and to strengthen patient safety. From the initial 32 applications, 13 were shortlisted and invited to attend for a final interview.

There are four category awards. The winners covered a great breadth of subjects, showed clear evidence of teamwork and tangible improvements to care.

Overall winner (and winner of Partnership working/co-production category) - This work focused on the reduction in the use of oral psychotropic prn medication in young people and also the reduction of incidents and the use of intra-muscular medication.

Building reliable care category - This team were able to demonstrate a reduction in incidents relating to nasal high flow oxygen therapy within three medical wards.

Integrated care category - This team demonstrated an improvement in access to carer events and a reduction in paperwork with increased carer support plans.

Innovation/transformation in care category - The winner of this award demonstrated that 100% of children attending the out-patient clinic had their BMI calculated and plotted in order to identify and address obesity in children.

Cross-border work

During 2018/19 the HSC Safety Forum has continued to build on relationships with HSE Quality Improvement teams in the Republic of Ireland. This included regular cross-border meetings and collaborating with colleagues on microsystem learning events, frameworks and curricula for improvement. We also established a working subgroup to plan the design and delivery of a cross border exhibition stand at the Institute for Healthcare Improvement International Forum held in Glasgow in March 2019. The focus of the stand was on connecting and networking staff who have a passion for improvement.

International Forum on QUALITY & SAFETY in HEALTHCARE

2.5 Education and training for HSC

Primary care nursing

Last year the HSCB and PHA funded a number of different training initiatives delivered by the HSC Clinical Education Centre (CEC) and the Royal College of Nursing (RCN), in line with the GP Nursing Framework, for general practice nurses (GPN) and nursing assistants. The training was designed to meet the complex and changing service needs of patients in primary care settings.

The uptake of this training has been positive with high levels of satisfaction; there were over 400 attendees across 32 courses. These courses focused on areas to improve the clinical skills of nurses in general practice settings as this will ultimately enhance patient quality, safety and experience. The nursing assistants and general practice nurses have provided examples of how they will use their learning to improve practice and have made suggestions for future programmes.

These initiatives provide a consistent regional education plan as part of a regional network system offering access to accredited education, therapeutic clinical updates on core topics and bespoke education programmes for general practice.

A pilot project is underway to implement a phased approach to provide two selected GP Federations with additional registered GPN and unregistered Nursing Assistant posts. The allocations to enable this project are based on the staffing principles and assumptions set out in the General Practice Framework for Northern Ireland 2016. These nurses will be employed by the Federations and the recruitment will be phased in over a number of years as recommended in Phase 7 of Delivering Care.

Signs of safety training

Signs of Safety is an innovative, strengths-based, safety-organised approach to child protection casework. It expands the investigation of risk in child protection work to encompass strengths and 'Signs of Safety' that can be built upon to stabilise and improve a child's and family's situation. It provides a format for undertaking comprehensive risk assessment – assessing both danger and the existing strengths, safety and goals of the family or extended family that can contribute to better planning and achievement of safety for the child or young person.

Within the last year, 1,694 of children's services social workers have been trained to implement the model across the region with support from designated specialist practitioners based within each Trust's Implementation Team. A further 725 staff will be trained by March 2020 and partner agencies are also being offered bespoke training in conjunction with the Safeguarding Board for Northern Ireland (SBNI).

Support programme for staff working in learning disability

Positive behavioural support (PBS) is an ethical and effective way of supporting individuals with learning disabilities who present with behaviours of concern. PBS uses the techniques of applied behaviour analysis, guided by a strong values base, delivered in a person-centred way to meet the needs of individuals who present with behaviours of concern.

In 2018/19 the PHA secured funding to enable staff working in learning disability to avail of the British Institute of Learning Disability (BILD) PBS training. The coaches training involved staff attending three consecutive days and a follow up day held six months later where participants had to present on a project they had implemented to imbed PBS within their area of practice and an action plan to take forward PBS within their workplace. The three day BILD training was delivered in two cohorts. Twelve of the staff who attended the three day coaches programme successfully completed this training and are now accredited British Institute of Learning Disability PBS coaches.

The PBS coaches programme's aim is to develop practice leaders within an organisation. Practice leaders are an essential part of developing PBS culture within services and organisations. They have a direct and positive influence on workplace culture and are able to coach staff and become a role model for PBS approaches. Attendance on the PBS coaches programme and the follow-up support coaches can access will help to drive an action plan that will have a direct impact on the quality of life for the people that your organisation supports.

Feedback received from participants who completed the PBS coaches programme:

Developing services that lead to a better quality of care and a better quality of life for service users.

It will clearly define what is expected of myself and others therefore creating a better working environment.

Useful tools for helping others learn and better understand rationale for PBS.

Having an action plan and assignment will help me focus and prioritise service development projects.

I have been motivated to begin. I will become a strong advocate for Positive Behaviour Support.

Following the success of the programme in 2018–2019 and the positive feedback received from participants who completed the coaches programme, funding has been secured to enable a further 20 staff to be trained as BILD coaches.

Human factors and simulation-based education

As part of the ongoing implementation of Quality 2020, which is led by the PHA and HSCB, the multi-disciplinary Northern Ireland Simulation and Human Factors Network (NISHFN) has been established focusing on promoting and standardising human factors and simulation-based education within Northern Ireland. Last year, the network carried out a range of activity which included:

- Meeting regularly to provide advisory support to human factors and simulation work throughout the region. The network held a successful annual event in October 2018 which enabled sharing of learning relating to human factors with a wide multi-disciplinary audience.

- Developing an 'introduction to human factors' training course, linking closely with the Oxford Nuffield Patient Safety Academy. The course, funded by the PHA, will be customised for Northern Ireland and will be designed to standardise human factors language to ensure consistency of terminolog.

- Developing a storyboard or electronic learning resource using learning from SAIs.

WWW Further information is available at **www.nishfn.org**

2.6 New ways of working to support staff

Delivering Care: A policy framework for nursing and midwifery workforce planning

Delivering Care is a policy framework aimed to support the provision of high quality care which is safe and effective in hospital and community settings. Initiated in 2012, it has used a phased approach to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities. Currently, there are eight phases underway.

Workforce phase	Staffing model	Status
Phase 1: Acute medical and surgical wards	Staffing range	Funding for this phase has been secured and is in the process of phased implementation and monitoring across designated wards in all HSCTs.
Phase 1A: Elective care treatment care environments	Recommended range for 24/7 wards including day and short stay wards	Paper issued for guidance.
Phase 2: Type 1 emergency departments	Nurse to annual attendance ratio	Ongoing.; Portion of recurring funding received to initiate phased implementation
Phase 3: District nursing	Population-based model	Ongoing. Portion of recurring funding received to initiate phased implementation
Phase 4: Health visiting	Population-based model – caseload weighting	Ongoing. Portion of recurring funding received to initiate phased implementation
Phase 5: Mental health	Acute – nurse/bed ratio Community – caseload and population based model	Phase 5a sent to CNO for endorsement. Phase 5b final proposals presented to the working group in early 2019 for approval
Phase 6: Neonatal nursing	Based on level of activity	Final proposals for endorsement with CNO 2019
Phase 7: Primary care nursing	Population-based model from the GPN framework 2016	Endorsed by the CNO – Feb 2019
Phase 8	Independent sector nursing homes	Ongoing. Five HSCT stakeholder workshops have taken place UK Four Country plus Ireland teleconference took place with a commitment to establish a national network relating to nurse staffing in care homes Five Country Care Home Workforce Seminar held 6 March 2019

Project Retain – Improving recruitment and retention of nursing staff in older people's wards

Northern Ireland has experienced significant attrition of nursing staff and over reliance on bank and agency staff which has presented many challenges for us around nurse retention particularly in care of older people settings. The PHA were delighted to secure funding provided by the Burdett Trust to initiate Project Retain which aimed to increase nurse recruitment and retention across 10 hospital wards in five HSCTs across Northern Ireland.

Project Retain

This programme delivered and offered a wide range of activities, programmes, coaching, leadership development and reflective sessions designed to support nurses and nursing assistants in their place of work.

One of the key factors that contributed to the tremendous success of the project was using a co-production model, which ensured that the voice and experience of older people was central to the future of nursing this was achieved in partnership with Age NI.

The project ran for 18 months. On completion of the project we saw a significant reduction (66%) in vacant posts. The culture within the ward and patient-centred environments have seen immense improvements. Staff satisfaction improved uptake of post registration education and collective team working has been highlighted as one of the most positive outcomes of the project. The outcomes of the project have also influenced regional workforce initiatives including an increase of funding senior posts in these wards. The project ethos and approach will now be replicated in other areas in Northern Ireland.

WWW

Further information is available at https://nipec.hscni.net/download/projects/previous_work/professionaldevelopment/career_pathway_for_older_peoples_nursing/documents/Retain-Report-Report-Final-Publication.pdf

Establishment of multi-disciplinary teams (MDT) programme in primary care

The Multi-Disciplinary Team programme started in September 2018 with the initial GP Federation areas of Derry (28 GP practices), Down (13 GP practices) and West Belfast (16 GP practices) commissioned to recruit the required staff. The aim of the MDT programme in primary care is to establish new ways of working for existing GP practice teams, working alongside newly appointed physiotherapists, social workers, social work assistants and mental health professionals. These professions will be embedded in GP practices to provide a practice based response to patient need.

The recruitment of MDT professional teams, embedded in general practice will enhance the practice skills available to better meet the needs of the practice population. This additional staffing capacity is designed to manage patients as an additional option to the traditional GP appointment. This service will support practices and enable GPs to focus on the more complex patients within the practice. It is anticipated that strengthening the workforce within GP practices will make the profession more attractive to enhance recruitment into the profession and primary care.

NI Project ECHO®

Quality Improvement ECHO

The HSC Safety Forum hosted a second Regional Quality Improvement ECHO building on the success of the first QI programme held in 2017. This gave the opportunity to over 54 staff from across HSC Trusts to develop knowledge and skills in quality improvement to drive forward improvements in patient or client care.

From staff feedback, it was demonstrated that staff increased their knowledge of quality improvement methodologies and that they were able to apply them in the frontline setting to demonstrate improvements in care.

There were a total of 13 teams from HSCTs involved and the quality improvement work ranged across a diverse range of themes such as:

- Mental health bed occupancy.
- Increasing mobility of patients in hospital.
- Child and adolescent mental health and improving the flow of young people from referral.
- Reducing times to process complaints in a contracts department and improve the information distributed to staff.
- Increasing the amount of assessments for looked after children.

Social Care ECHO

The first Social Care Project Echo established in Europe was held in early 2019. The 'spoke and hub' design of Project Echo provided the opportunity for a community of learning network to grow for Social Care Managers, with subject specific inputs as well as peer learning and sharing on specific cases or issues.

The Social Care Echo met on a monthly basis between January and March 2019. The programme included inputs and case discussion on: Project Echo introduction; decision making and risk; and, what is domiciliary care? The network will build over time, with 39 participants already registered at the end of March 2019.

Positive Behaviour Support ECHO

The PHA has been successful in securing support from ECHO for a project to support the development of a community of practice for PBS in Northern Ireland. It is anticipated that the ECHO model will be an effective way of ensuring that the PBS coaches are supported to further develop and embed their new skills in their local areas and form the basis of a community of practice across HSC in Northern Ireland.

Clinical staff who involved in the ECHO spokes are from all HSCT areas. The PBS ECHO provides an opportunity to be involved in a network of learning and support which is accessible from their own workplace thus reducing the need for staff to be released for long periods of time from frontline clinical duties.

It also provides a relatively inexpensive way to support and engage specialist expertise and knowledge relating to PBS so that staff can enhance their skills, knowledge and experience and share best practice relating to PBS across the region. It is hoped that participants will take the opportunity to share learning and experience with other likeminded people in a safe and supportive environment, with a view to developing a community of practice across five HSC services in Northern Ireland to further embed this approach regionally.

In December 2018, a group of twenty five staff working in both children and adult learning disability services came together to agree the ECHO programme for the coming year. The first PBS ECHO session started in February 2019 and will continue until January 2020.

Children and Families Programme

The HSCB concluded on the Review of Regional Services for Children and Young people in March 2018. The report's findings and recommendations, endorsed by DoH and DoJ, established a transformation programme of improvement for Childrens Services. A primary recommendation was the introduction of an integrated care and justice campus comprising the current standalone secure care and juvenile justice centres.

In collaboration with the respective Departments and key partner agencies the HSCB has embarked on building foundations to support the implementation of the primary recommendations.

Building blocks being progressed include:

- Funding proposals secured to assist with creating more conducive conditions that will enable change for example the delivery of an accredited coaching programme for frontline managers across residential childcare to strengthen capacity and leadership.

- Appointment of an independent Chair to lead on the establishment of a Regional Multi-Agency Decision Making Panel for applications, in the first instance, to secure care.

- Testing a bespoke peripatetic residential support model for residential childcare which seeks to enhance and strengthen mainstream childrens homes. This will introduce a skills mix service comprising of youth workers, sensory support specialisms and psychology. It will provide young people with high level diversionary strengths based interventions which are intended to better support their integration into local communities, build resilience and enable stable and enduring care placements.

- Introduction and testing of new housing and support solutions for vulnerable young people in a Trust area intended to better meet the complex needs of young people transitioning from care to the community. Underpinned by a partnership with others from the statutory and voluntary sector, the investment proposal is transformational in that it is integrated within a newly innovative housing led service; it eliminates silo working and duplication of effort; provides a rapid person centred support service; and will afford the opportunity to explore the feasibility of redesign of existing homeless provision and resources to better respond to need.

WWW **Further information is available at https://www.health-ni.gov.uk/publications/review-regional-facilities-children-and-young-people-review-report**

MAHI - STM - 120 - 2540

Theme three

Measuring improvements

3.1 Introduction

The HSCB and PHA recognise the importance of measuring progress for safety effectiveness and the patient/client experience in order to improve. We promote the use of accredited improvement techniques when gathering information or examining data, and recognise the importance of ensuring that lessons from the information and data are learned.

3.2 Quality improvement plans

The quality improvement plans (QIPs) focus on key priority areas to improve outcomes for patients and service users. The HSCB and PHA support HSCTs on a range of initiatives to assist with the achievement of the QIP targets and facilitate a regional platform to enable good practice to be shared throughout Northern Ireland.

Last year the QIP target areas were:

- Pressure ulcer prevention;
- Falls prevention;
- National Early Warning Scores (NEWS);
- Mixed gender accommodation.

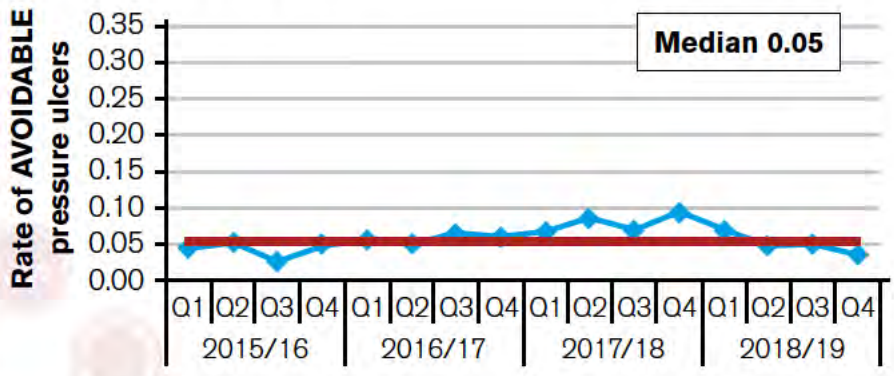
Pressure ulcer prevention

The PHA along with the HSCB supports HSCTs through the Regional Pressure Ulcer Prevention Group to implement SSKIN (an evidenced-based collection of interventions proven to prevent pressure ulcers) in all hospitals in Northern Ireland. This group provides advice and support and shares regional learning across Northern Ireland. It focuses on strategies for pressure ulcer prevention and management across the HSCTs.

A basic principle of quality measurement is: if it can't be measured, it can't be improved. Therefore we recognise that pressure ulcer performance must be counted and tracked as a core component of our quality improvement programme.

At the Regional Pressure Ulcer Prevention Group, HSCTs agreed to focus on reduction of avoidable grade 3 and 4 pressure ulcers, as these create deeper cavity wounds which can result in more pain and suffering to patients. The following graph shows the total regional **rates** of pressure ulcers grade 3 and 4 from April 2015 –March 2019.

Region: Rate of AVOIDABLE grade 3 & 4 pressure ulcers per 1,000 bed days run chart



The data indicates that there has been a decrease regionally in the number of grade 3 and 4 avoidable pressure ulcers.

Shared learning

Last year a number of regional workshops were held, focused on learning and prevention of pressure ulcers. These included:

Regional Pressure Ulcer Prevention workshop – held 10 August 2018 to:

- Consider the international and national guidance.
- Consider current practice in Northern Ireland.
- Review current definitions/categories/ reporting and escalation and gain regional agreement on these.

Pressure Ulcers and Safeguarding Event - held 10 October 2018 to:

- Consider current practice in Northern Ireland.
- Consider *Pressure Ulcers & the interface with a safeguarding enquiry* (Department of Health, England, January 2018) for use in Northern Ireland.
- Contribute to a short proposal relating to adult safeguarding protocol in Northern Ireland.
- Gain regional agreement on the way forward.

Regional Pressure Ulcer Learning Event - held October 2018 to:

- Update on agreed definitions.
- Focus on repositioning.
- Share learning across HSCTs.
- Agree a way forward for the next two years.

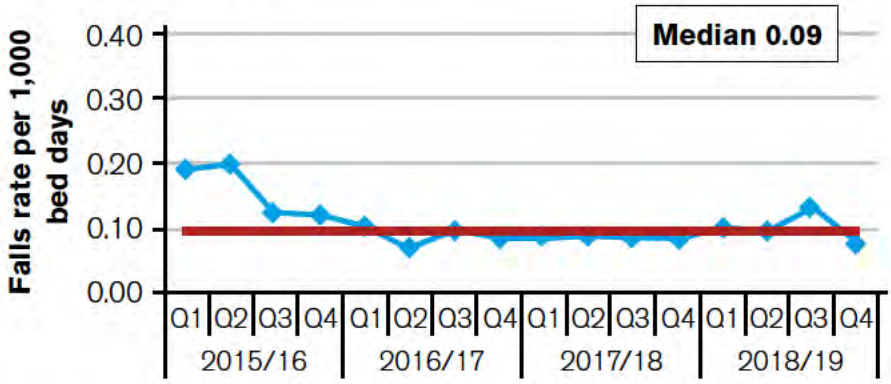
Falls prevention

During 2018/19 the PHA and HSCB, through the Regional Falls Prevention Group, have supported HSCTs to implement and spread the Royal College of Physicians 'Fallsafe' bundle, an evidence-based collection of interventions proven to reduce falls in inpatient settings. HSCTs measure compliance against the fallsafe bundle and report to the PHA and HSCB on a quarterly basis. The Regional Falls Prevention Group provides advice, support and shares regional learning across Northern Ireland and focuses on strategies for falls prevention and management across the HSCTs.

Part A Element	Part B Elements
• Asked about history of falls in past 12 months • Asked about fear of falls • Urinalysis performed • Call bell in sight and reach • Safe footwear on feet • Personal items within reach • No slips or trips hazards	• Cognitive screening • Lying and standing Blood pressure record • Full medication review requested • Bedrails risk assessment

During 2018/19 the focus was on prevention of the number and rates of falls incidents classified as causing moderate to major or catastrophic harm.

Region: Rate of moderate to major/catastrophic falls per 1,000 bed days run chart



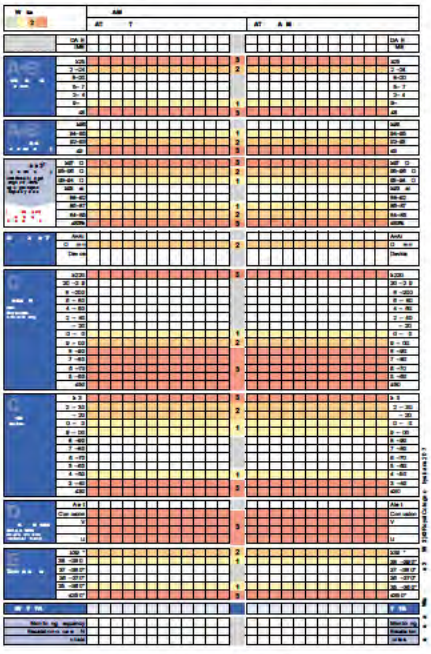
Regionally, there has been no significant trend in the falls rates over the past year.

Shared learning

In addition to the ongoing support relating to falls prevention through the regional falls prevention group, the PHA held a Regional Falls Inpatient Learning Event in March 2019. The purpose of this workshop was to share the regional and local work that has been carried out over the past three years relating to the falls prevention including testing, spread and implementation of the Royal College of Physicians Fallsafe Bundles across all adult inpatient HSC areas in Northern Ireland. A summary of the introduction of a new process for reporting and reviewing all incidents resulting in moderate to severe/catastrophic harm and the results of the evaluation of this process, was presented. This event was positively evaluated with feedback on the benefits of the shared learning being highlighted. The PHA and HSCTs are working with the Clinical Education Centre (CEC) to develop a falls prevention programme, to ensure it is suitable for regional delivery and have a programme plan for roll out.

NEWS (National Early Warning Scores)

As part of its leadership role, the HSC Safety Forum has led the regional implementation of National Early Warning Scores (NEWS) in HSCTs, including appropriate escalation arrangements to improve care of the deteriorating patient. This tool helps professional staff identify early deterioration in a patient's condition. Abnormal scores prompt specific actions and/or referral to greater expertise. Part of this work involved facilitating HSCTs to define their expectations regarding intervention when NEWS are abnormal. During 2018/19 the HSC Safety Forum/HSCQI hub have worked with HSCTs to:



- Facilitate a phased implementation of the new NEWS chart to identify early deterioration and prompt specific action.

- Liaised with the copyright holder the Royal College of Physicians to ensure the integrity and effectiveness of the NEWS chart was maintained whilst allowing for local and regional modifications.

A number of regional meetings have been held with PHA/HSCB and HSCTs to help support the scale and spread of NEWS2 across all clinical areas. The region as a whole has continued to maintain an average percentage compliance of NEWS throughout the 2018/19 years of 92-95%. All HSC Trusts have maintained over 80% compliance during 2018/19.

Mixed gender accommodation

HSC is committed to the delivery of person-centred care. International and national evidence has highlighted that the provision of single gender accommodation has been identified by patients and relatives/carers as having significant impact on maintaining privacy and dignity while in hospital. There is therefore an expectation that men and women will not be required to sleep in the same area.

In line with the DoH Guiding Principles for Mixed Gender Accommodation, each HSCT has developed a policy for the management of mixed gender accommodation in hospital. During 2018/19 the PHA and HSCB supported HSCTs to:

- put in place effective arrangements to adhere to their policy for the provision of safe and effective care and treatment in mixed gender accommodation;
- undertake in a thematic review of mixed gender accommodation in inpatient adult wards, which will help to inform the progression of further improvement in mixed gender accommodation for 2019/20;
- measure and report compliance with their policy for mixed gender accommodation in 100% of inpatient areas.

3.3 Core regional priorities

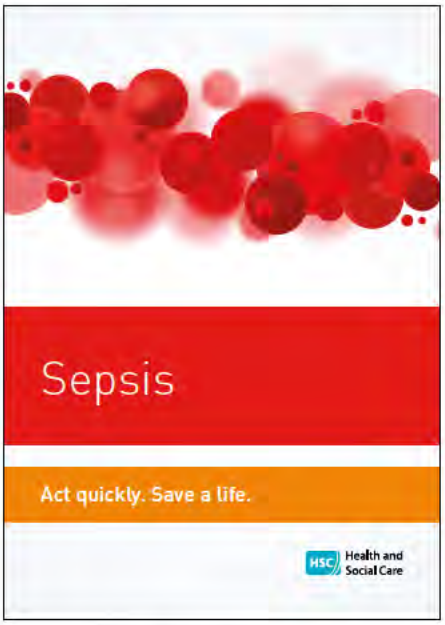
During 2018/19 the HSCB and PHA worked collaboratively with HSCTs and the wider HSC system on a number of key priorities which impact on the safety, quality and experience of care. Below is an example of two key areas which identify measurement as a key component of improvement:

Improving the recognition of sepsis

Sepsis is a life threatening, severe form of infection which leads to organ failure and critical illness. Survival and recovery are heavily dependent on early recognition and treatment, which includes effective antibiotics. Symptoms and signs however are not always straightforward but there are a number of decision tools designed to support frontline clinicians to make the best possible decisions – neither to overtreat (and contribute in part to the growing problem of resistance to antibiotics) nor to undertreat and miss opportunities for effective management.

The Sepsis Regional Steering group is a multi-professional group hosted by the HSC Safety Forum/HSCQI hub at the PHA to guide and support improvement efforts in sepsis

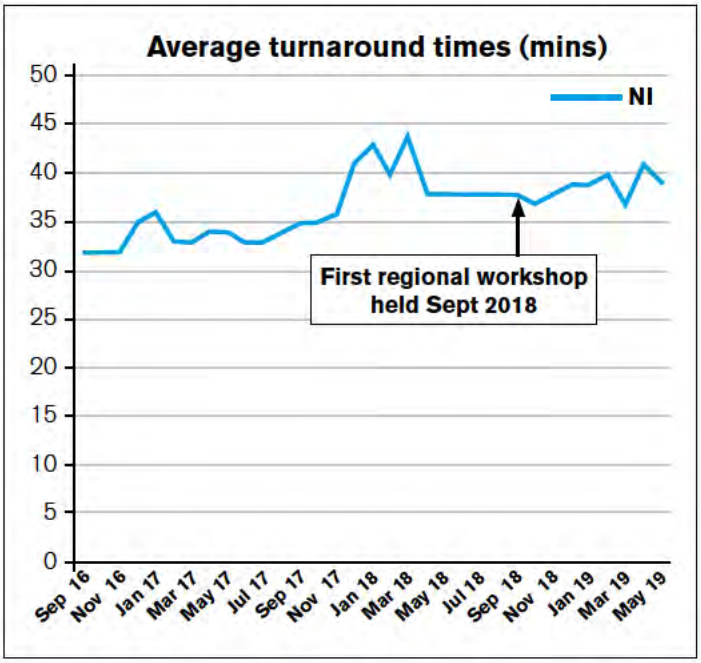
recognition and care. Notable milestones achieved to date include establishing 26 participating units across Northern Irelands' acute hospital network, universally agreed measures to assess progress, a screening tool and patient information leaflets. The group hosts quarterly learning sessions with clinical and support staff working in Northern Ireland's emergency departments, acute medical and surgical units and critical care units. Participants share progress and challenges in improving sepsis care and invited speakers – to date from England and the Republic of Ireland – share their insights to accelerate our learning.



We are currently establishing a network of support staff to collect key measures to aid our collective improvement efforts in a psychologically safe environment that promotes learning rather than judgement. Links have also been established with Antimicrobial Stewardship efforts across Northern Ireland to collaborate on safe and effective use of antibiotics. Sepsis management in the medium and long-term requires effective stewardship of antibiotics, as well as links with the UK Sepsis Trust to raise public awareness of the symptoms and signs to prompt them to ask the question 'could it be sepsis?'

Improving Community Emergency Response

Prompt turnaround times for Northern Ireland Ambulance Service (NIAS) ambulances and crew are an important element of maintaining an effective emergency community response. Over the last 3 years turnaround times have gradually increased from their target time of 30 minutes, in part due to challenges with congestion in our Emergency Departments at times of peak pressure. The HSCB and HSC HSC Safety Forum/HSCQI hub have been involved in providing a neutral, credible platform for Emergency Department and NIAS staff to explore solutions to improving the turnaround times together. Innovations include refreshing the pathway to the ED Reception area, standardising handover processes, improved understanding of the needs of frail older patients and developing a shared aim to improving turnaround times. These efforts are complementary to existing Trust and NIAS initiatives and together with a focus on these metrics it is hoped improvements can be made.



3.4 Implementation of National Institute for Health and Care Excellence (NICE) guidance

NICE is a non-departmental public body responsible for providing national guidance and advice to improve health and social care.

NICE produces different types of guidance, including:

- technology appraisals (new drugs, medical treatments and therapies);
- clinical guidelines (recommendations on the appropriate treatment and care of people with specific diseases and conditions);
- public health guidance (recommendations for populations and individuals on activities, policies and strategies that can help prevent disease or improve health).

NICE National Institute for Health and Care Excellence

The HSCB and PHA have put in place processes to implement technology appraisals, clinical guidelines and public health guidance published by NICE and endorsed by the DoH.

During 2018/19, the HSCB and PHA issued 45 technology appraisals to the HSC and continues to monitor the implementation of 190 clinical guidelines which have been issued to the service.

The implementation of NICE guidance can often be the driver for change in a wide range of areas, as it provides commissioners, clinicians and other health care professionals with evidence based methodologies to improve and sustain higher quality outcomes for patients and clients.

WWW More information about the technology appraisals and clinical guidelines that are being implemented can be found at **www.hscboard.hscni.net/nice**

3.5 Measuring improvement within mental health and learning disability services

The Outcomes Star™

The Outcomes Star™ is an evidence-based tool for both supporting and measuring change. The values that inform the Outcomes Star™ are similar to those of person-centred, strengths-based and co-production approaches. As a result, implementing the Outcomes Star™ can provide an effective way of putting these approaches and values into practice in a service. It is envisaged that use of the Outcome Star™ will empower individuals to take responsibility for their own recovery journey and help demonstrate real tangible outcomes for the individual and the organisations involved in providing the care and support for people with mental health conditions.

Outcomes Star™

Last year the PHA commissioned training for over 100 staff working within mental health services on the use of three Outcome Stars™.

These include:

The Wellbeing Star works by encouraging people with long-term health conditions to consider a range of factors that impact on their quality of life. The overall aim is for the service user to do as much as they can so that the long-term condition impacts on their life as little as possible.

The Recovery Star is a tool for supporting and measuring change when working with adults who experience mental health problems. The Recovery Star focuses on ten core areas that have been found to be critical to recovery; managing mental health, physical health and self-care, living skills, social networks, work, relationships, addictive behaviour, responsibilities, identity and self-esteem and trust and hope.

The Drug and Alcohol Star is designed for use with adults in substance or alcohol misuse services. The Drug and Alcohol Star focuses on areas that have been found to be critical in supporting people to progress towards and maintain a life free from drug misuse and problem drinking.

Feedback received to date from staff working within mental health services has demonstrated that the use of the Outcomes Star™ has a positive impact on their engagement with service users as it provides a tool to help guided conversations about recovery and is an invaluable resource for measuring progress to improve.

Phase one evaluation of the Regional Hospital Passport for People with Learning Disabilities

The Regional Hospital Passport for People with Learning Disabilities (RHPLD) was developed to provide vital information about a person with a learning disability which will help hospital staff to make reasonable adjustments to provide safe and effective care and improve the care experience for the person with learning disability.

The regional learning disability health care and improvement steering group, which includes representation from PHA, HSCB and HSCTs, oversees the implementation of the RHPLD and last year the PHA health intelligence team was commissioned to carry out an evaluation of the implementation of the passport in order to measure its effectiveness and identify improvements which can be taken into consideration for the future. The evaluation methodology included conducting interviews regarding distribution processes and experiences of using the RHPLD, completion of surveys regarding awareness of the RHPLD among the community and voluntary sector, and desktop analysis of downloads of the RHPLD and guidance notes from the PHA website.

In addition, the 'telling it like it is' (TILI) group designed an evaluation form using the 'appreciative inquiry method' which looks at leading with the positives. Members of the

TILII group engaged with 150 people with learning disabilities and their carers across Northern Ireland and asked positive questions to find out the strengths of the passport. By encouraging conversations, TILII identified areas for improvement to help to move towards the dream phase of having the passport embedded into every day practice. This would make sure that each individual gets the care and support they need when going into hospital and that it is not only of a high standard but actually fitting to their individual needs.

As a result of the evaluation the PHA working closely with HSCB and HSCTs have been able to accurately measure the effectiveness of the hospital passport implementation and use this information to learn for the future.

3.6 Population screening in Northern Ireland

Early diagnosis through screening is associated with improved outcomes for a number of health conditions. Population screening programmes in Northern Ireland aim to detect disease at an early stage, usually before they become symptomatic. The PHA is responsible for the commissioning and quality assurance (QA) of eight screening programmes.

These screening programmes must reflect the highest level of service quality as set out within the respective national guidance and service specifications (associated within the individual programmes). This is verified thorough ongoing monitoring and benchmarking exercises undertaken within each programme. An example of the work of some of the screening programmes to increase the uptake of services in order to improve outcomes for patients is outlined below.

Antenatal and newborn screening programmes

- Antenatal infection
- Newborn blood spot
- Newborn hearing

Young person and adult screening programmes

- Diabetic eye
- Bowel cancer
- Breast cancer
- Cervical cancer
- Abdominal aortic aneurysm

Cervical screening

During 2018/19, the PHA worked with Cancer Research UK (CRUK) to support their primary care engagement programme in Northern Ireland. This included the development of an audit tool for primary care practices in relation to the delivery of cervical screening at practice level. The audit tool can be used by practices to self-assess their service and processes against best practice and regional guidance. It can assist practices to identify potential areas for improvement.

The audit tool was launched in March 2019 at a training update event for cervical sample takers, jointly hosted by PHA and CRUK. Over 170 nurse sample takers and GPs attended the event, which was used to promote best practice in cervical screening.

Cervical Screening

The information provided to women on the cervical screening programme is regularly reviewed and updated. In 2018/19, the PHA collaborated with voluntary organisations to develop a new resource for women following the diagnosis of a cervical cancer. The leaflet and additional fact sheet aim to provide women with information on how their previous screening results may be reviewed and to assure them that they will be able to see the findings of this review if they wish. This group, along with HSC clinical staff, also contributed to the development of a framework document for audit of cervical cancers. This has been distributed to all HSCTs and aims to standardise the approach used across Northern Ireland.

Abdominal aortic aneurysm screening

Since the programme's successful implementation in 2012, it has worked with service users and key stakeholders to ensure ongoing programme development and continuous improvement. A key element in achieving this has been the introduction of service user events (beginning with the first in 2013). The sixth of these annual events was held on 26 April 2018, bringing together over seventy participants. This included men who have benefitted from screening, their wives and members of the programme team at the Belfast HSCT, the service provider.

The PHA, along with Belfast HSCT colleagues, presented updates regarding recent service developments, previously suggested by service users; this included viewing a new video (to help men better understand what screening involves). Discussion during the event generated ideas to guide future service development. Potential candidates for the role of Patient Representative were also identified, with three individuals subsequently appointed to the programme's commissioning group (reflecting the programme's ongoing efforts to support Personal and Public Involvement (PPI) and co-production).

Abdominal Aortic Aneurysm Screening

In March 2019, to help validate the quality of the screening programme, colleagues from Public Health England and the English NHS AAA Screening Programme undertook an 'External Quality Assurance' assessment. The team identified that the programme is generally performing well: recommendations to guide the future operation of the service were identified – these will be pro-actively taken forward by the programme over the coming year.

Promoting uptake of cancer screening

People from areas of higher socio-economic deprivation, and also specific population sub-

groups, are generally less likely to attend for screening. To help address this, the PHA have been working with the Women's Resource and Development Agency (WRDA) to raise awareness and promote informed choice in uptake of the cancer screening programmes. In 2018/19, peer facilitators continued to deliver educational awareness sessions to participants from disadvantaged, diverse and sometimes remote or rural backgrounds.

The PHA also worked with a range of voluntary and community group representatives to develop and run a social media campaign to promote cervical screening to younger women. The successful campaign focused on overcoming the key barriers and concerns that women may have that prevents them from attending screening for the first time.

Women's
RESOURCE & DEVELOPMENT AGENCY
Supporting Women's Groups and Networks Across Northern Ireland

MAHI - STM - 120 - 2551

Theme four

Raising the standards

4.1 Introduction

The HSCB and PHA have established a framework of clear evidence-based standards and best practice guidance which is used in the planning, commissioning and delivery of services in Northern Ireland. The HSCB and PHA are continuously striving for excellence and raising the standards of care and the quality of services delivered.

4.2 Establishment of new networks

Northern Ireland Frailty Network

Frailty is noticed when the body loses its ability to recover, from a fall for example. It affects more than a quarter of our population aged 85 and over and can be prevented and even, in some cases, reversed.

During 2018/19 the PHA identified frailty as a key priority area of focus in line with its corporate outcome 'all older adults are enabled to live healthier and more fulfilling lives'. In response to this priority, the Northern Ireland Frailty Network was launched in March 2018. The Network, which is led by the PHA linking closely with the HSCB was established using transformation funding secured through the DoH and has brought together a wide range of people and organisations all with a part to play in caring for our population living with frailty, as well as having a strong focus on prevention. The frailty programme adopts a co-production approach, with Age NI's consultative forum central to the development of our frailty structure.

The ambition of the Network for Northern Ireland is that frailty will be seen as everyone's business and we all should know what to do when presented with a person living with frailty. Last year the network commissioned a literature review which considered current local, national and international evidence and best practice around frailty. This information will be used to inform the key messages, specifically focusing on prevention and early intervention techniques such as diet, exercise, keeping mobile, and remaining socially active.

WWW For further information or to join the NI Frailty Network, email frailtynetwork@hscni.net

Regional Trauma Network: enhancing mental health services in Northern Ireland

The Regional Trauma Network (RTN) involves the design, co-production, and implementation of an integrated service model to respond to the needs of adults and children with trauma-related psychological and psychosocial difficulties in Northern Ireland.

As part of the Stormont House Agreement (2014), the Northern Ireland Executive made a commitment to establish a "world class trauma service" to respond to the psychological impact of the troubles/conflict. Consequently, during 2018/19 the Regional Trauma Network was established. In partnership with the Victims and Survivors Service the HSCB lead the implementation of the network which aims to

deliver a comprehensive regional trauma service, drawing and building on existing resources and expertise in the statutory and community and voluntary sector. The HSC element of the RTN, to provide specialist therapies for complex Post Traumatic Stress Disorder, has been under development over the past year, along with work to build the partnership with community, and voluntary agencies funded to provide support to people that have experienced troubles/conflict related trauma. The network has also developed a Partnership Alliance for Learning from Lived Experience (PALLE) to ensure the RTN is a highly accessible, acceptable, and effective service for those who need it.

The RTN will assist individual service-users to access the level of support that matches their clinical needs. Psychological therapies provided in RTN Local Trauma Teams have been informed by the most authoritative international evidence-based guidelines on the effective management of trauma.

The implementation of the specialist trauma service will be a phased approach . When the service is fully implemented it will offer specialist psychological therapies for any child, young person or adult in the population who is experiencing complex psychological trauma.

WWW For further information on the Regional Trauma Network email regionaltraumanetwork@hscni.net

4.3 Collaborative working

Regional Mental Health Quality Improvement Collaborative

Growing in strength year by year, the Regional Mental Health Quality Improvement Collaborative is led by HSC Safety Forum/ HSCQI hub. The main focus of work has been on communication with patients, families and carers. Last year a workshop was held with HSCT staff, service users and carers to identify key areas of focus. Key themes emerged such as support and information for carers and carers' assessments.

Each of the five HSCTs identified areas to progress and, through quality improvement methodologies and working with carers and service users, are working on a variety of key areas:

- development of a conversation and listening meeting with carers;
- obtaining carers' feedback to improve services;
- increasing involvement of family, carers, and friends in a patient's treatment;
- availability of improved information carers;
- training for carers;
- development of wellness groups for carers.

Through the collaborative, HSCTs have the opportunity to share and learn from each other.

Dysphagia Project

The regional dysphagia project is led by the PHA working closely with HSCB, HSCT and community and voluntary organisations to take forward a core area of work relating to improving the quality of services for people living with dysphagia. Last year these included:

Collaborative working through the Q community

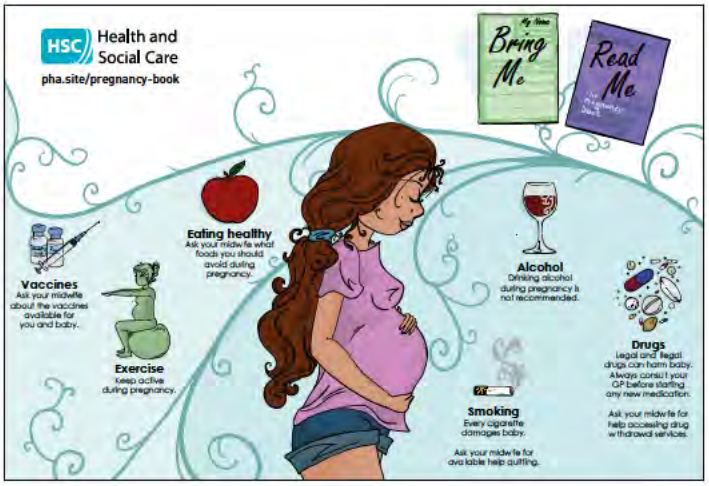
Q is an initiative connecting people who have health and care improvement expertise across the UK. In Northern Ireland the Q community is made of up a diverse range of people including those at the front line of health and social care, patient leaders, managers, commissioners, researchers, policymakers, and others. The HSC Safety Forum/HSCQI hub are the lead partner for Q in Northern Ireland. Through a range of recruitment drives there are currently around 180 members who have had access to the online resources provided by the core Q team. Members have the opportunity to participate in a range of activities coordinated locally by HSC Safety Forum/HSCQI hub including data masterclasses, national and local Q events, training on coaching and a cross-border collaboration on liberating structures. In 2018, Q members were also successful in attaining a Q exchange award to explore the impact of advanced quality improvement training on practice. It is anticipated that the local and national network will continue to expand and be supported during 2019/20.

WWW For further information on how to get involved with Q Community https://q.health.org.uk/join-q/

4.4 Maternity and children's services

Maternity safety wallet

As part of the redesign of the maternity handheld record, the HSC Safety Forum/HSCQI



hub worked in partnership with a design student from the Ulster University, the regional maternity quality improvement collaborative and service users to develop a protective safety wallet. In addition to the maternity notes the wallet will hold the *Pregnancy Book* and *Birth to Five*, plus any other information sheets.

The messages on the outside of the wallet, using evidence-based guidelines, are focused on public health, maternal mental health, bonding with baby and actions to take if the mum has reduced fetal movement.

The weigh to a healthy pregnancy

Maternal obesity is an ongoing concern for maternity services as it is associated with significant risks to both mother and baby. Such risks include miscarriage and stillbirth, gestational diabetes, hypertension and premature birth. In Northern Ireland, over 22% of mothers giving birth during 2017/18 were obese at the booking appointment and this proportion has increased year on year since 2011/12.

In response to this need, a programme of support was developed known as the Weigh to

a healthy pregnancy programme (WTHP). The programme is in place across all five HSCTs and funded by the PHA.

The programme initially targeted pregnant women with a body mass index (BMI) ≥ 40kg/m^2, and after evaluation was expanded to reach women with a (BMI) ≥ 38kg/m^2. WTHP aims to help women make healthy lifestyle changes and limit their gestational weight gain. In 2018/19 a total of 1,082 pregnant women in Northern Ireland had a (BMI) ≥ 38kg/m^2 at booking and eligible women were offered extra support from a WTHP dietitian, midwife and physiotherapist. Support is available throughout pregnancy and up to 10 weeks after the birth. A key component of the programme is weight recording and participants are encouraged to self-monitor their weight, alongside weight recording by the WTHP teams at various times throughout the pregnancy.

WWW For further information in relation to this programme https://www.publichealth.hscni.net/publications/weigh-healthy-pregnancy-0

New parenting resources

Each year, there are 23,500 births in Northern Ireland.

Last year a new version of the maternity hand-held record was tested which aims to enhance safe, high quality maternity care for all mothers and babies. Both mothers and health professionals were involved in the development of the record. There is a new section for mothers or fathers to record any concerns or issues that they would like to discuss with the midwife or doctor at the next appointment.

Two other health books are given to all mothers in Northern Ireland .The Pregnancy Book is given at the booking clinic at the first appointment and the Birth to Five Book is given to the new parents following delivery. Each April, the PHA updates these books with the latest maternal, child health and parenting information, research and evidence. In 2019, the PHA rebranded and refreshed the books to take account of the latest evidence, modernise the layout and update photographs.

The Pregnancy Book is the complete guide to:

- a health pregnancy;
- labour and childbirth;
- the first few weeks with a new baby.

The *Birth to Five* Book provides information on:

- becoming a parent;
- taking care of mother and child;
- finding practical help and support.

The Personal Child Health Record (the 'red book') has also been updated this year and will be available to all new parents. It is a record of the child's health, growth and development. Parents bring the book with them to all health and medical appointments.

As part of the 3+ review, parents are given a booklet containing useful health and parenting tips to help prepare their child for going to school. The booklet 3+ review: additional information contains information on the child's social and emotional development, as well as information on safety, physical activity, nutrition and dental health.

WWW For further information relating or to access these resources see https://www.publichealth.hscni.net/publications

Paediatric audiology

The HSCB working with the PHA, Department of Health, HSCTs, the National Deaf Children's Society (NDCS) and user representatives from the Regional Audiology Forum developed an agreed set of quality standards for paediatric audiology services in Northern Ireland. Newborn Hearing Screening services were excluded from this exercise.

A paediatric audiology quality standards scoring tool was developed to test the quality of paediatric audiology quality services across Northern Ireland and to ensure the standards were fit for purpose. The assessment covered such areas as accessing the service, assessment and hearing aid management, selection, verification and evaluation of outcomes.

The results of this exercise, which was carried out between November 2018 and March 2019, showed that HSCTs achieved an average level of 78% performance across all the standards. HSCTs have also taken learning from this exercise to identify areas of improvement in the paediatric services pathway and waiting times.

The results of this baseline exercise were then used by the Regional Audiology Forum to further develop and finalise the draft quality standards which are currently being equality impact assessed.

4.5 Raising the standards with primary care

Practice-based pharmacists' evaluation

Each GP Practice in Northern Ireland now has its own Practice Based Pharmacist (PBP) who works in the practice, alongside GPs, nurses and other practice based staff as part of a multidisciplinary team. Five waves of recruitment for PBPs have been completed, with wave six recruitment expected to take place next year. This will see all GP practices in Northern Ireland at their full allocated PBP capacity.

The investment in PBPs has been made to support GP practices and federations to improve patient care, to promote safer, more rational and cost-effective prescribing and to deliver better health and wellbeing outcomes for patients. Strategic drivers for this initiative include a need to focus on chronic disease management in general practice, and the requirement for increased capacity and capability in primary care, with the initiative helping to increase the workforce in primary care against a background of a shortage of GPs.

One of the key objectives of the initiative was to release GP time spent on prescribing activities to increase overall GP capacity and improve patient outcomes. Evaluation of this aspect of PBP work after the first two waves of recruitment (across 229 practices) demonstrated that PBPs saved an average of approximately 12 hours per week per practice of other staff's time, with an associated total cost saving of around £516,955. The majority of this was GP time, meaning that GPs could focus on other activities which required their specific expertise.

PBPs have been given a key role in reviewing the prescribing systems that operate in general practice and they carry out an annual audit of these in each practice, making recommendations each year that will continue to improve the quality of practice systems, and ultimately improve patient care. They also have an important role in reviewing the medicines that are prescribed for patients in the practices that they work in. They work alongside GPs to ensure that regular medication reviews are undertaken for patients in the practice who are most vulnerable, for example elderly patients, patients on multiple and/or high risk medicines, those residing in care homes and patients who have recently been discharged from hospital. Many PBPs are qualified to prescribe for patients and will run disease-specific clinics for particular patient groups such as diabetic or asthmatic patients.

There has been widespread acceptance of the PBP service and feedback from practices has been extremely positive.

4.6 Campaigns

Delivering improvements in the quality of care for service users requires a holistic approach which places the service user and their needs at the centre of the design process. A key part of this involves giving due consideration to the communication needs of current or potential service users ranging from general awareness to tailored communications. The communication solutions can take many forms depending on the target audience, the messaging to be delivered and the communication channels available. Below is just one example of communication programmes that were developed jointly by the HSCB and the PHA during the year to help bring about improvements in the care offered by services.

Stay Well This Winter

Stay Well This Winter is a multi-channel campaign aimed at easing seasonal pressure on urgent care and emergency services by highlighting different ways people can keep themselves healthy and signposting to alternative health services. The joint campaign by the HSCB and the PHA was to help ensure people, who are most at risk of preventable emergency admission to hospital, were aware of, and motivated to take, key actions to help them stay well.

We used a digital first approach for this campaign, supplemented by traditional (unpaid) PR efforts.

To complement the digital reach, we created graphics to accompany press releases for each local newspaper area, detailing localised, useful health service numbers as well as opening times over the holiday period. We also facilitated a number of broadcast interviews with spokespersons from HSC and partner organisations.

We produced five versions of an information leaflet (tailored for each Trust). A total of 116,000 copies were distributed through councils, HSCTs, pharmacies, libraries, GPs and Age NI as well as having the leaflet available as a PDF on nidirect and the PHA website.

We worked with stakeholders including HSCTs, AgeNI, BMA, Surestart and ParentingNI to amplify the messages on social media using #StayWellNI. To create a unifying theme for the campaign across the health service, all Trusts and partner organisations used the same online web and social media banners.

Key facts and figures

Stay Well Facebook organic posts performance:

- 4% – 14% average engagement on Facebook posts (median engagement rate across all industries 2018 is 0.16% - source: www.rivaliq.com/blog/2018-social-media-industry-benchmark-report)
- Organic Facebook posts reach between 11K to 38K (HSCB Facebook followers – 8400)

Stay Well Twitter (#StayWellNI)

- 642 tweets using the hashtag between 1 Nov 2018 to 18 Jan 2019
- 2.6 million impressions (how many times tweets with the hashtag were potentially seen)

Facebook Ads performance (Paid to reach an audience of non-followers)

- 162,272 people reached
- 652,155 impressions (number of times the ad was seen)
- Ad spend over 2 months - £983.77
- Cost per result £0.03 to £0.07

Traditional (unpaid PR)

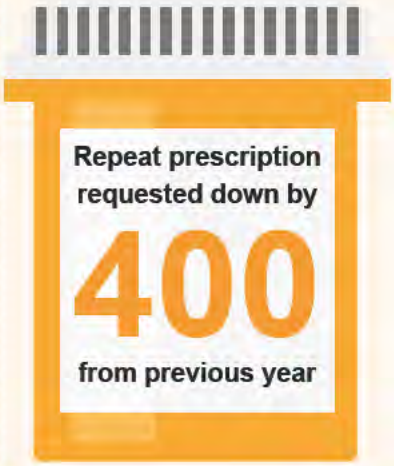
- 96 press articles and radio interviews

WWW For further information relating to Stay Well this Winter campaign https://www.publichealth.hscni.net/publications/stay-well-winter

Following the stay well this winter campaign:

Calls to GP OOH providers were down

from previous year



70%

uptake of flu vaccine among those 65 years and older

MAHI - STM - 120 - 2561

Theme five

Integrating the care

5.1 Introduction

The HSCB and PHA are committed to supporting an integrated HSC system in Northern Ireland which will enable the seamless movement across all professional boundaries and sectors of care. A number of key improvements were led by the HSCB and PHA last year which contributed to raising the quality of care and outcomes experienced by patients, clients and their families.

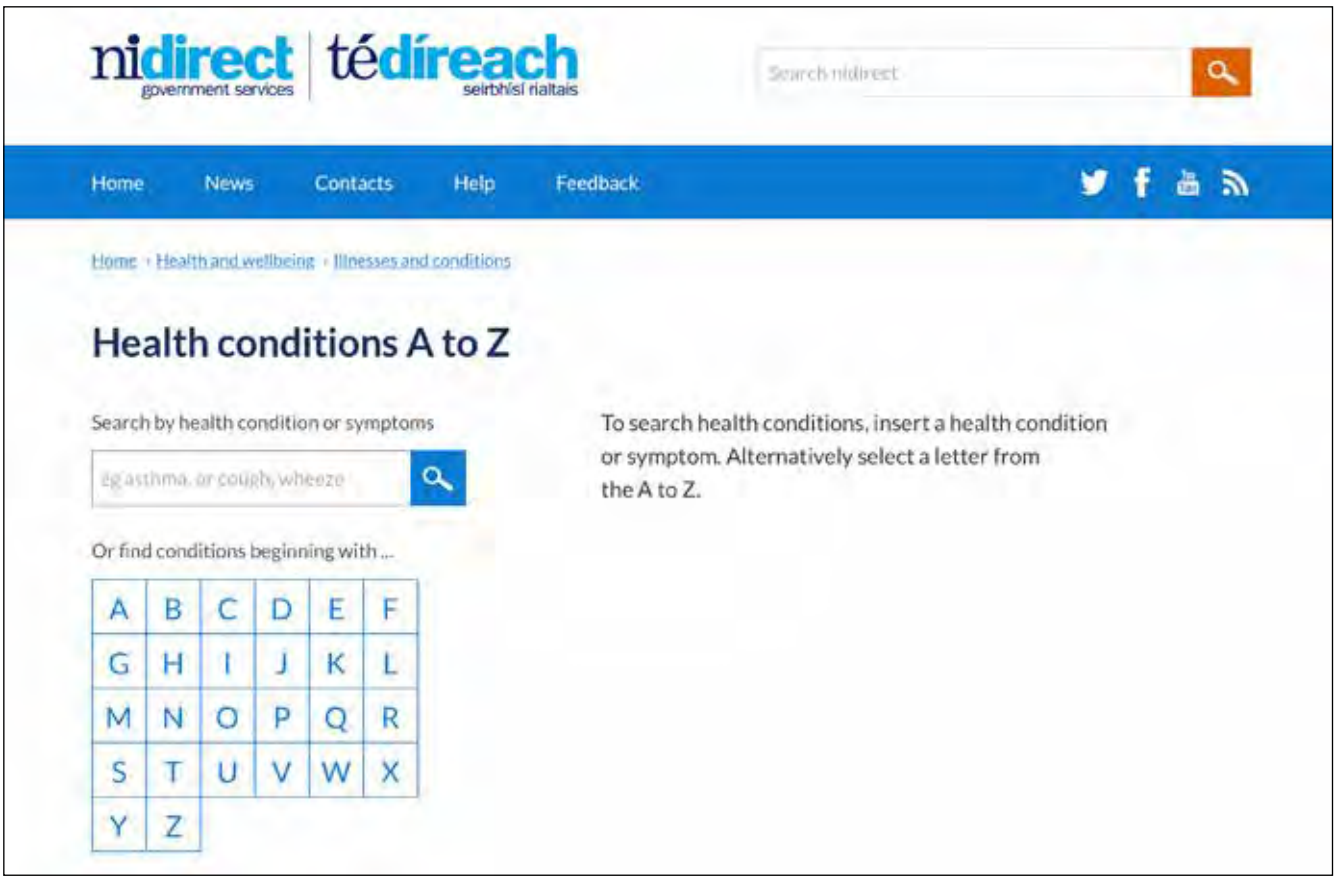
5.2 Centre for Connected Health and Social Care

The Centre for Connected Health and Social Care (CCHSC), located within the PHA, promotes the use of technology and innovation in the HSC system in Northern Ireland in partnership with HSCB. The primary purpose of CCHSC is to improve patient/client experience and to provide better quality and more effective care through the use of enabling digital technologies.

During the year the CCHSC continued to contribute to improving health and wellbeing through a number of partnership activities including:

HSC online

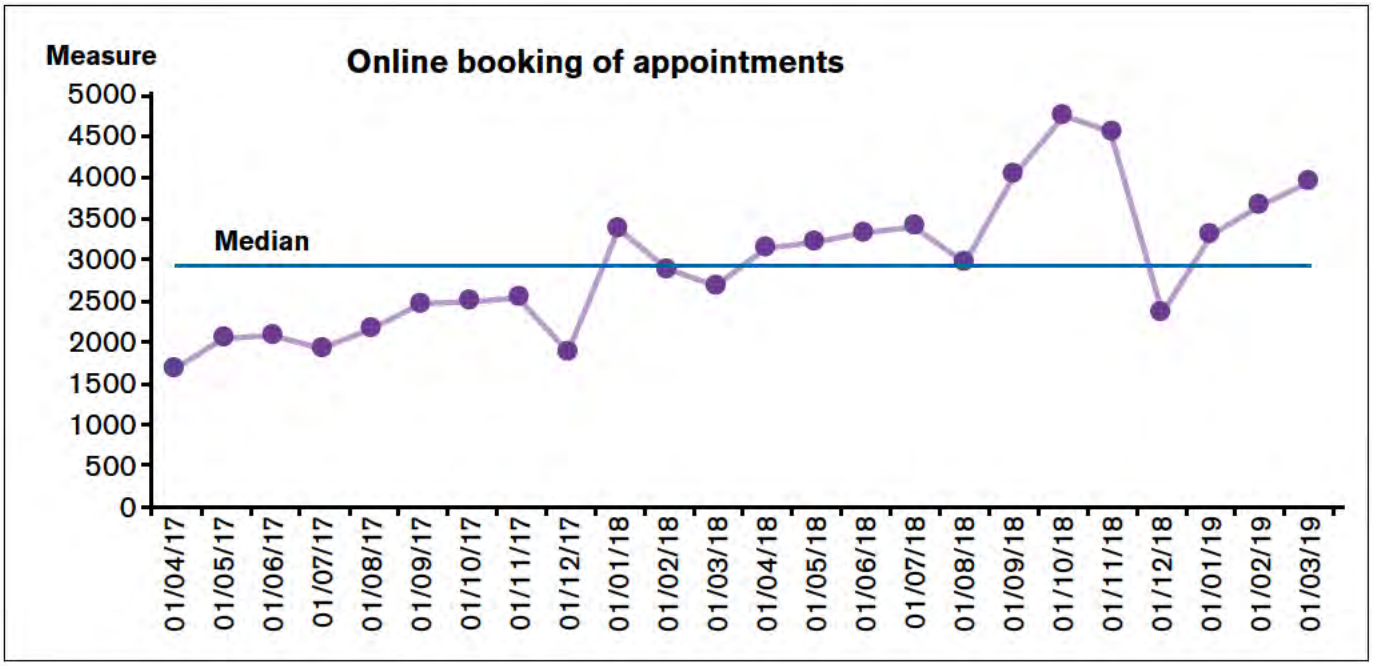
The A-Z platform of health conditions now provides a comprehensive suite of health information, supporting people to make decisions in relation to their personal illness and chronic conditions. Hosted by nidirect, the HSCB eHealth initiative developed in conjunction with the PHA will promote self-management where appropriate, and help people decide whether their condition has

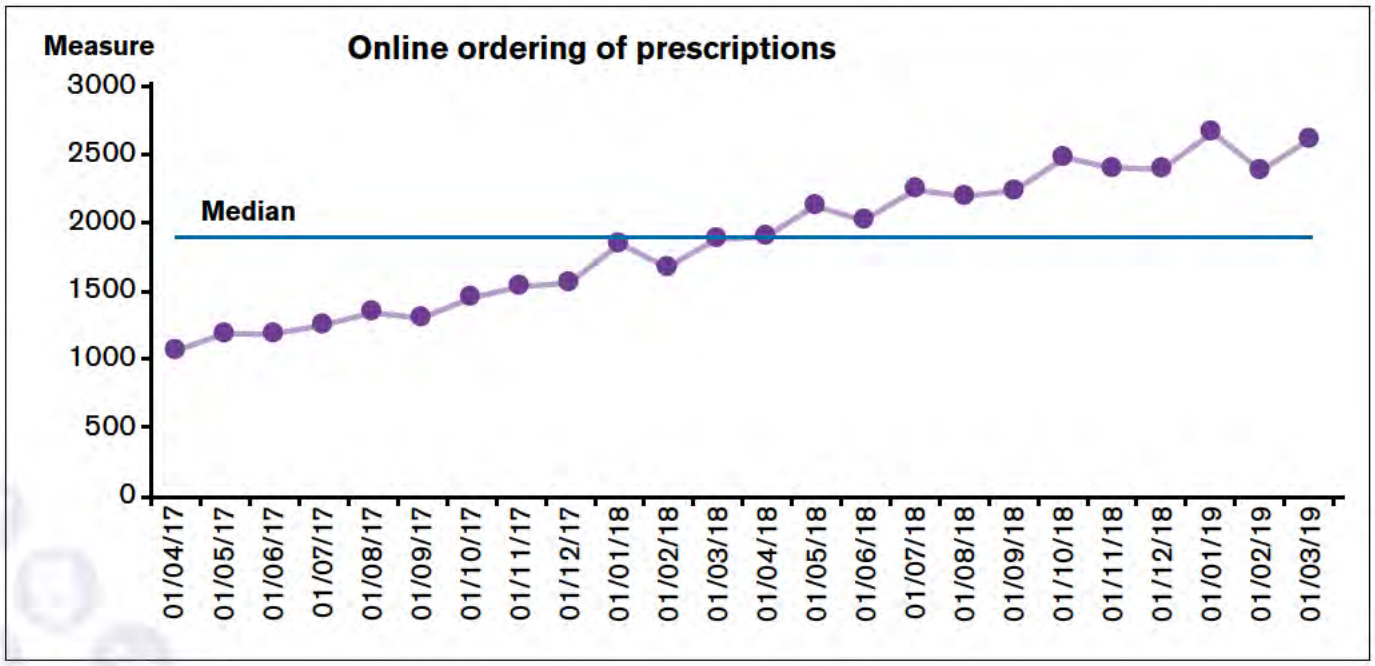


reached the threshold where advice or clinical assessment is required. It will link to signposting of appropriate services, assisting people in accessing services they require.

WWW For further information on HSC online tools www.nidirect.gov.uk/health-conditions

Links also provide access to GP practices to book appointments online and order prescriptions, where these services have been made available by practices.





eHealth and Data Analytics Dementia Pathfinder Programme

Through the eHealth and Data Analytics Dementia Pathfinder programme a number of key components have been designed and implemented which provide a platform for integration of health and social care services particularly relating to dementia services.

- **A patient portal** has been designed in partnership with people living with dementia and their carers. Linked to the Northern Ireland Electronic Care Record (NIECR), those living with dementia can log in and access their hospital appointments as well as all their hospital letters and educational material. Phase 2 and 3 of the project are now being designed. CCHSC are also working with other service groups such as diabetes, neurology and mental health to scope the use of "My Care Record" for these groups of service users.

- **Key Information Summary (KIS)** in the NIECR are now operational for a number of dementia patients. This means that the patients will be recognised and flagged as having dementia across the electronic system.

- **12 Dementia Analytics and Research Projects** were awarded £100K each to use data to inform better services and support for people with dementia in order to assist in service development and design.

WWW For more information see: **http://www.hscboard.hscni.net/our-work/ehealth-and-external-collaboration/darug-round-01/**

- **The apps4dementia library is a** new digital service offering support for people living with dementia and their carers that has been launched by the HSCB. It provides a place for users to find safe, trusted apps to provide information and guidance on the condition, support self-care of symptoms and enable users to carry on with their day-to-day activities for as long as possible. The library has been developed alongside people living with dementia and their carers who have provided feedback on design and content. To help with the ongoing development of the library, a number of roadshows will be held across NI during the summer to showcase the apps library for people living with dementia, carers and healthcare professionals.

WWW For further information relating to the library see **https://apps4dementia.orcha.co.uk**

5.3 Encompass

The transition from the current situation of multiple, aging digital systems and a large reliance on the paper record to 'encompass' will improve outcomes for our patients and service users by making it easier for our HSC professionals to deliver sustainable, high quality care, improved efficiencies and greater collaboration across all care settings. The Transformation Implementation Group oversee initiatives such as elective care centres, reform of services and regional roll outs of new social work models; all of which can be better supported when underpinned by encompass's single integrated digital care record. This will allow the record to follow the patient, enabling HSC-wide scheduling, multi-disciplinary, multi-location team working, rapid scaling of revised assessments and using everyday smartphone technology to let patients and service users do more for themselves, such as booking their own appointments and more easily communicating with the people looking after them in the HSC.

encompass

HSC care and non-care professional staff and a number of patients, service users and carers have been engaged throughout, from pre-procurement activity such as the Discovery Days held in early 2017, development of demonstration scenarios and preparation of the Output Based Specification, through to evaluation of the bids during 2018/19.

The involvement of patients, service users and carers in the selection of the supplier for encompass was particularly novel, and this involvement will continue to be developed and embedded in governance structures throughout the implementation phases of encompass.

5.4 New ways of working

Virtual Fracture Clinic

Western Trust Fracture clinics are carried out across 4 sites in the Western HSCT and Northern HSCT by the Trauma and orthopedics (T&O) service. In order to improve 'did not attend' (DNA) rates, staffing and increase flow through the service, the HSCB and PHA agreed to support the development of new virtual fracture triage clinics in the Western Trust. The HSCB provided £100,000 recurrent investment to ensure that the necessary clinical staff were available to deliver this new service. These clinics provide a mechanism whereby all fracture referrals from the 4 EDs are triaged and discharged where appropriate. The use of virtual clinics has meant that patients do not attend fracture clinics unnecessarily and this helps free up capacity for other patients. Figures to date have shown that 33% of patients referred do not require a consultant outpatient appointment, with the patient either discharged by a nurse over telephone or transferred to an alternative pathway (eg physio).

This equates approximately to 1,300 new appointments each year not being required. Further pathways are being developed which will result in less demand for fracture outpatient new appointments. All clinics now have consultant or trust grade presence, DNA rates are reducing

and a small number of fracture clinics have been remodelled to cover urgent new Elective Orthopaedic cases instead.

Scoliosis Mega Clinic

In order to improve the time for new outpatient assessments relating to scoliosis, the HSCB worked with Belfast HSCT to establish dedicated scoliosis mega clinics. The clinics followed the same model as the spinal mega clinics which have been operational for the last 18 months. These clinics utilise the capacity and clinical expertise of specialist staff, who run multiple clinics simultaneously to maximise the throughput of patients.

To ensure that the scoliosis mega clinics delivered maximum throughput, it was agreed that additional evening x-ray slots would be run which would ensure that the patient's essential preparation was complete in advance of the assessment. Consultants were therefore able to agree a definitive treatment plan on the day of clinic ie place on a review list or list for surgery.

The use of non-recurrent funding to clear the backlog, coupled with the appointment of two new spinal consultants will ensure that this waiting list reduction is sustainable, with patients now seen as soon as they are referred. The backlog clearance of the new outpatient backlog has meant that there are now no new scoliosis patients waiting longer than nine weeks for an outpatients assessment.

Primary Care Infrastructure Project

The HSCB continues to support the roll out of the Primary Care Infrastructure Development Programme, aimed at delivering a hub and spoke approach to the delivery of primary and community care services. Primary and community care is considered to be the appropriate setting to meet the majority of the health and social care needs of the population. The services and resources available within this setting have the potential to prevent the development of conditions which might later require hospitalisation as well as facilitating earlier discharge from hospital. The hub facilities will essentially encompass those services which do not require a hospital bed but which are too complex or specialised to be provided in a local GP surgery (a spoke).

Last year, a milestone was reached with the handover of the site at Lagan Valley Hospital to the successful contractor for the development of a new Primary and Community Care Hub. The new Hub is due to be completed in 2021. It will facilitate the co-location of primary and community care and complementary secondary care services, grouped within a single facility for the purposes of delivering integrated care services and patient care.

Significant investment in spoke premises has allowed for increased capacity within primary

and community care making services more accessible to patients as well as facilitating the roll out of multi-disciplinary working within GP premises and an increase in the number of practices who can provide GP training.

Last year the HSCB invested £2.2m in transforming GP premises to support new ways of working and providing more services closer to people's homes

5.5 Inter-agency working

Joint PHA and PSNI Custody Pathfinder

The PHA in conjunction with DoH, DoJ and PSNI and the Belfast HSCT has lead work to develop a Trust-led model for healthcare in custody. Since 1 December 2018, the 24 hour nurse-led custody pathfinder has been operated in Musgrave PSNI custody suite. This transformative service has showed evidence that the service is becoming embedded with custody nurse practitioners assessing approximately 90% of detained persons. This pathfinder has been extended to the end of September 2019.

A bid has been submitted to DoJ and DoH to secure funding for the roll out of the service across eight further PSNI custody suites. The pathfinder has reduced the number of detained persons requiring assessment and treatment within HSC Trust Hospitals and thereby reducing pressure on the service and reducing the amount of police time required to escort detained persons out of custody. The pathfinder has also reduced considerably the Forensic health medical officer budget as one rota now exists for the Belfast area as opposed to two rotas. PSNI have accrued savings of £766K from December 2018 to 31 March 2019. Part of these monies has been reinvested in extending the pathfinder.

Social Prescribing

Social Prescribing is a means of enabling GPs and other frontline healthcare professionals to refer patients to a link worker. This provides them with a face-to-face conversation during which they can learn about opportunities to improve their health and wellbeing. People with social, emotional or practical needs are empowered to find and design their own personal solutions, such as, co-produce their 'social prescription', often using services provided by the voluntary and community sector.

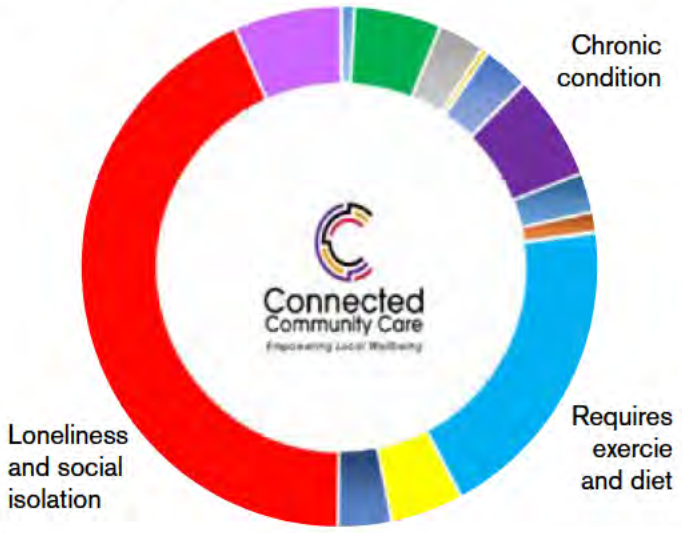
IMPACTAgewell

Mid & East Antrim agewell Partnership

A number of social prescribing projects have been established over the last number of years due to the hard work of a range of partners primarily the community and voluntary sector supported by HSCB, PHA, Integrated Care Partnerships(ICPs) and local commissioning groups.

The potential for social prescribing to provide more integrated and person centred care and support has been recognised. In January 2019 a workshop was hosted by ICPs to explore the range of social prescribing work underway locally, learn from the UK Social Prescribing Network and to identify the steps that need to be taken to support the social prescribing agenda in Northern Ireland.

Reason for referral



Key messages emerged from the workshop including;

- the importance of having a common approach to evaluating the work;
- the need for mechanisms for shared learning across the projects to support quality improvement;
- the importance of establishing a more co-ordinated and strategic approach to the growth of social prescribing;
- sustainable investment into the voluntary and community sector.

Work is underway to address these key messages to help ensure that quality improvement is central to the development of social prescribing and that its potential as a tool for health improvement is optimised.

CASE 1

An 89-year-old lady, who had lived since her husband passed away 3 years ago, was referred to the IMPACTAgewell® Project due to Diabetes and Hypertension by her GP.

During the home visits, the lady talked a lot about loneliness, dying and not having her husband around to talk about these concerns. The IMPACTAgewell® project officer devoted time to build a trusting relationship so that they could talk about 'What if' and these converstions led to supporting the lady to create a funeral plan and help appoint an executor to her will.

These conversations may be difficult for a family to have with loved ones, but the older lady was able to express her worries in a safe place and receive the relevant support with assistance from the community advice services.

Belfast Safer Homes

Belfast Safer Homes is a multi-agency partnership (PHA, BHSCT, Belfast City Council & Bryson Energy) providing services to older people who have had a fall, are at risk of falling, or have a fear of falling: These services include a free home hazard assessment, free accident prevention equipment and subsidised handyman service to fit equipment and undertake repairs that will remove slip, trip or fall hazards.

Since its establishment the service has continued to evolve to meet the needs of older people. Last year this included:

- Supporting older people to stay warm and well during winter. The service has been able to avail of additional resources to support older people to operate their home heating controls effectively and fit simple equipment to stay warm (for example draught excluders, radiator foils).
- Engaging with health professionals to better target the service. The service is now part of the Belfast HSCT Falls Care Pathway. Thus, patients presenting to any part of the health service because of a fall (for example ED, ambulance service, GP clinic) will be referred to this service as part of a multi-factorial intervention, in line with NICE guidance.
- Engaging with Belfast Policing & Community Safety Partnership to add value by providing a new function which enables older people who are victims of crime; and have been provided with crime prevention equipment by a PSNI Crime Prevention Officer; to get the Belfast Safer Home service to fit the equipment for free.

"Very good service which will enable me to remain safe within my home. The jobs I couldn't do were making me feel down so thanks for doing these"

"It's a brilliant service that helps identify hazards that I wouldn't have guessed could be potentially dangerous to my father.".

To find out more or to arrange a visit call 0800 1422 865 (calls are free from a BT landline).

Children and Families Programme

The HSCB concluded on the Review of Regional Services for Children and Young people in March 2018. The report's findings and recommendations, endorsed by DoH and DoJ, established a transformation programme of improvement for childrens services. A primary recommendation was the introduction of an Integrated Care and Justice Campus comprising the current standalone Secure Care and Juvenile Justice Centres.

In collaboration with the respective Departments and key partner agencies the HSCB has embarked on building foundations to support the implementation of the primary recommendations.

Building blocks being progressed include:

- funding proposals secured to assist with creating more conducive conditions that will enable change for example the delivery of an accredited coaching programme for frontline managers across residential childcare to strengthen capacity and leadership;
- appointment of an Independent Chair to lead on the establishment of a Regional Multi-Agency Decision Making Panel for applications, in the first instance, to Secure Care;
- testing a bespoke peripatetic residential support model for residential childcare which seeks to enhance and strengthen mainstream childrens homes. This will introduce a skills mix service comprising of youth workers, sensory support specialisms and psychology. It will provide young people with high level diversionary strengths based interventions which are intended to better support their integration into local communities, build resilience and enable stable and enduring care placements;
- introduction and testing of new housing and support solutions for vulnerable young people in a Trust area intended to better meet the complex needs of young people transitioning from care to the community. Underpinned by a partnership with other statutory and voluntary sector partners the investment proposal is transformational in that it is integrated within a newly innovative housing led service; it eliminates silo working and duplication of effort; provides a rapid person centred support service; and will afford the opportunity to explore the feasibility of redesign of existing homeless provision and resources to better respond to need.

For further information
please contact

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Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Regional HSC Workforce Planning Framework

March 2015

Skills for Health

better skills better jobs better health

Contents

Section 1

Introduction

- Effective workforce planning is complex and challenging but is essential in order to contribute to ensuring services across Northern Ireland are both sustainable and delivered to the appropriate standard. The range of challenges faced by the health and social care system has reinforced the need to ensure that the workforce is balanced correctly in terms of numbers and skills.

- There are many **drivers** for workforce planning, such as:

    a. The recognition of the changing nature of health and social care needs and the link to demographic changes in local populations; (greater emphasis on preventative approach and supporting people)

    b. The need for revised service delivery models to meet the needs of patients and clients and health and social care staff and in meeting the career needs of the health and social care workforce in the wide ranging geography of Northern Ireland;
    c. Patient safety and quality of care;
    d. Affordability of services given the challenging financial context for all organisations; and
    e. The need to connect workforce issues with the overall strategic direction as set out in documents e.g. Programme for Government Transforming Your Care, , Making Life Better, HSC Quality Strategy 2020 and the annual Commissioning Plan Direction.

- This Framework aims to support the following **outcomes** for the workforce planning process:

    a. An adaptive Health and Social Care workforce of the right size with the right skills deployed in the right way.

b. Developing a shared understanding of the core elements of effective workforce planning;
c. Providing greater clarity of roles and responsibilities, process, structures and governance;
d. Providing an understanding of how organisations and individuals can contribute effectively in a mixed economy; and
e. Encouraging partnership working both within and between organisations;
f. Better informed education commissioning decisions.

Section 2

Workforce Planning: A Working Definition

- At its simplest, effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, delivering services to provide the best possible care for patients and clients within available resources

- The approach to workforce planning as set out in this Framework Document is designed to:
    a. *Be centred around the needs of patients and clients;*
    b. *Embrace complexity;*
    c. *Recognise uncertainty;*
    d. *Be open and transparent;*
    e. *Be flexible and responsive to change;*
    f. *Whole system approach to workforce planning taking into account impact on changes to one part of the system on another (taking a Programme of Care approach where possible);*
    g. *Recognise that workforce planning is not just about the numbers but also the competence and deployment of the workforce;*
    h. *Enable the HSC to anticipate where possible, and respond to, Departmental and Ministerial directions and policies;*
    i. *Set out the NHS Six Step Model and its underlying principles as the primary model for workforce planning (Annex A), which can be complemented by other regionally agreed methodologies where appropriate;*
    j. *Make a clear linkage between workforce data, intelligence and projections with decisions on the commissioning of education and training;*
    k. *Engage with key stakeholders including employers and staff;*
    l. *Ensure timely, robust and accurate workforce information and analysis is available.*

Section 3

Organisational Roles and Responsibilities

- Effective workforce planning demands a collaborative, consistent, integrated and proactive approach across multiple stakeholders. No individual, group or organisation can undertake the process unilaterally and as a result, there is a range of responsibilities that lie within and between organisations that contribute to effective workforce planning.

- This section sets out the core roles and responsibilities involved in the HSC workforce planning process. Not every organisation with a role in workforce planning is included in this overview however key stakeholders will be included in the process as appropriate.

- The Framework focuses on the core elements deemed necessary to support effective workforce planning.

Department of Health, Social Services and Public Safety (DHSSPS)

- The DHSSPS has a range of statutory responsibilities regarding the effective functioning of health and social care service provision across Northern Ireland. As part of these responsibilities, the DHSSPS should ensure that key core responsibilities regarding workforce planning are delivered both in terms of leadership and ensuring effective functioning of the process. It is responsible for:

    a. setting the strategic vision;
    b. securing commitment to a high level workforce strategy which will underpin the Department's wider policy objectives;
    c. providing regional workforce information and trends;
    d. ensuring a regional approach is taken to workforce planning;
    e. facilitating of capacity building within the HSC Trusts; and

f. making decisions on the commissioning of pre- and post-registration education and training across the HSC.

Health and Social Care Board/Public Health Agency

- The commissioning of health and social care services is a crucial function within the wider health and social care economy. The Health and Social Care Board, through Local Commissioning Groups, and the Public Health Agency have a duty to ensure, through the commissioning process, that they are able to:
    - meet the current and future health and social care needs of the population of Northern Ireland;
    - secure value for money and ensure the appropriate quality of service provision; and
    - utilise appropriate processes to develop and reform services.

- In relation to workforce, the commissioners' role is to:

a. agree the models of service delivery;
b. be assured that HSC Trusts and independent practitioners have considered and identified the workforce needed for service delivery, through for example demand/capacity analysis;
c. exercise a challenge function where appropriate;
d. identify to the Department areas where intervention is required; and
e. lead or contribute to workforce reviews as required.

The Public Health Agency has an additional specific role in providing professional advice across the HSC and to the Department

Health and Social Care Trusts

- HSC Trusts are responsible for:

    a. ensuring that they have an appropriate and skilled workforce to deliver the services commissioned from them;
    b. utilising both qualitative and quantitative information to inform operational Workforce Plans (to include information projection and risk) which are reviewed annually;
    c. regularly liaise with other stakeholders (including local commissioners) to determine priorities and overcome challenges; and
    d. agree courses of action and implementation of workforce change.

Regional Workforce Planning Group

- The Regional Workforce Planning Group, chaired by the Director of Human Resources, DHSSPS, will:

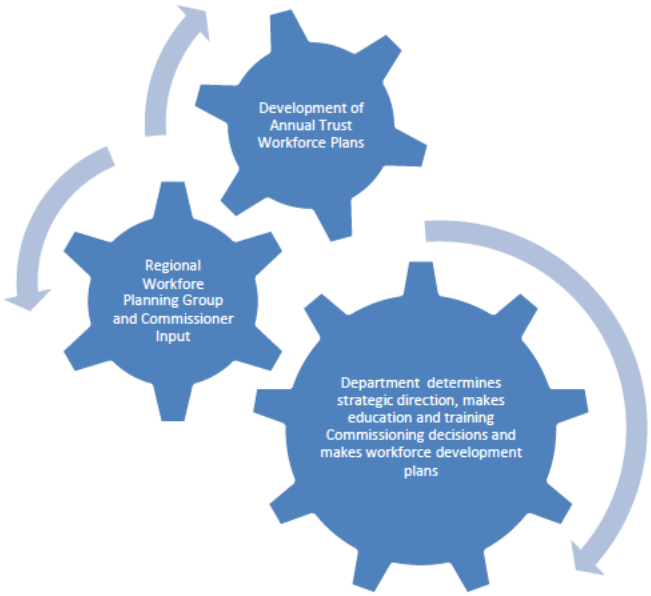
    a. act as the hub for all workforce planning activity within Health and Social Care;
    b. provide expert advice to the Department regarding workforce planning matters;
    c. inform the overall strategic direction for workforce planning;
    d. agree a programme of workforce reviews; and
    e. receive, comment on and endorse commissioned Workforce Reviews.

- The Table below describes the key roles and responsibilities in relation to regional workforce planning:

DHSSPS	HSCB/ PHA	Trusts	Regional Workforce Planning Group
Set the strategic vision	Agree models of service delivery	Ensure Trusts have an appropriate and skilled workforce to deliver the services commissioned from them	Act as hub for HSC workforce planning activity
Secure commitment to a high level workforce strategy which will underpin the Department's wider policy objectives	Be assured that HSC Trusts have considered and identified the workforce needed for service delivery, through demand/capacity analysis	Utilise both qualitative and quantitative information to inform operational Workforce Plans, which are reviewed annually	Inform overall strategic direction
Ensure a regional approach is taken to workforce planning	Exercise a challenge function where appropriate	Regularly liaise with other stakeholders to determine priorities and overcome challenges	Agree a programme of workforce reviews
Facilitate capacity-building within HSC Trusts	Identify to the Department areas where intervention is required	Agree courses of action and implementation of workforce change	Receive comment on and endorse commissioned workforce reviews

Take decisions on the commissioning of pre- and post-registration education and training across the HSC	Lead and contribute to workforce reviews as required

Diagram to Illustrate Workforce Planning process



Governance Arrangements

- This Framework Document has been developed under the aegis of the Regional Workforce Planning Group (RWPG). This Group will be re-purposed to oversee the next phase of workforce planning within Health and Social Care. It will have a revised Terms of Reference (including membership), which will be formally submitted by the Chair of the RWPG for approval by DHSSPS.

- Membership of the RWPG will include core representation from the DHSSPS, HSCB, PHA and HSC Trusts, at Senior Executive level as well as other key stakeholders. A list of the members is attached at the Annex B.

- Additional members will be co-opted on an agenda-specific basis or as the work programme dictates.

- Processes will be put in place to ensure that wider stakeholder engagement is facilitated.

Section 5

Next Steps

- This version of the Framework articulates the regional roles and responsibilities envisaged for HSC workforce planning; however it is recognised that this is an evolving process. In view of this, the Framework will be subject to ongoing review and refinement as appropriate.

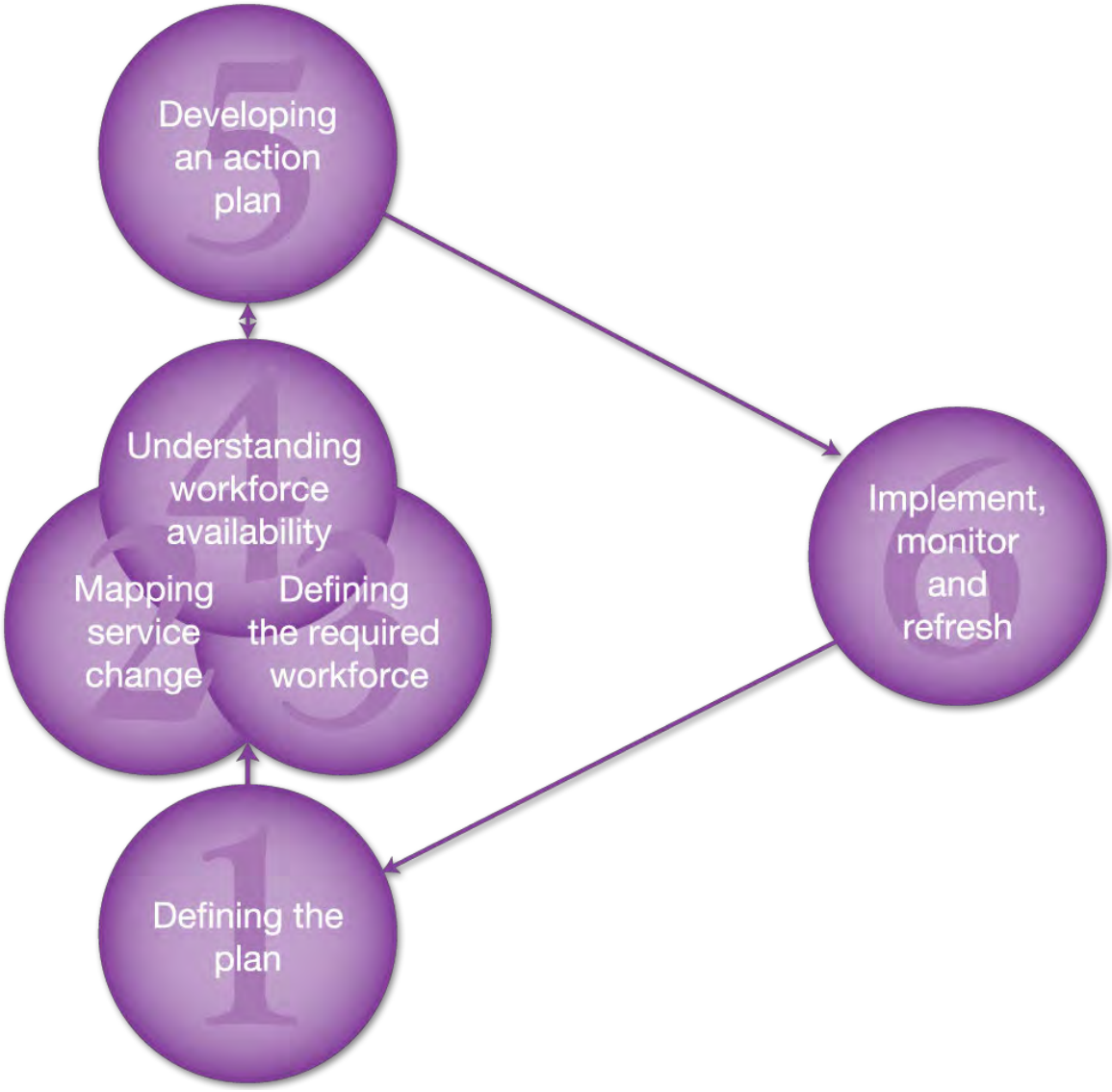
- Implementation of the framework will be led by the DHSSPS, and primarily taken forward through the RWPG. The primary implementation steps shall be:

    a. Development of revised Terms of Reference for the RWPG for approval by DHSSPS;
    b. Reconstitution of the membership of RWPG to fulfill the Terms of Reference;
    c. To pilot a service area review within a Programme of Care (POC) approach;
    d. Further development of workforce planning capability and capacity across the region.

For further information regarding this Framework please contact wpu@dhsspsni.gov.uk.

Annex A

Adapted from the Six Step Model to Integrated Workforce Planning



Step 1 – Defining the Plan

Identify why a workforce plan is needed and for whom it is intended:

- Purpose;
- Scope;
- Ownership.

This is the critical first step in the planning process. It is important to be clear why a workforce plan is required and what it will be used for. The scope of the plan should be determined, for example, whether it will cover a single service area, a particular patient pathway or a whole health economy; responsibility for ensuring the plan is delivered and other parties who will need to be involved in the planning process should be clearly stated.

Step 2 – Mapping Service Change

Identify the purpose and shape of any proposed service change that will impact upon future workforce requirements:

- Goals / benefits of change;
- Current baseline;
- Drivers/constraints;
- Option appraisal;
- Working models.

This is the first of three interrelated steps. It is the process of service redesign in response to service user choice, changes in modes of delivery, advances in care or financial constraints. It is important to be very clear about current costs and outcomes and to identify the intended benefits from service change. Those factors that support the change or may hamper it, should be identified. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

Step 3 - Defining the Required Workforce

Identify the skills required and the type / number of staff to deliver the new service model (workforce demand):

- Activity analysis;
- Types / numbers;
- Productivity / New ways of working.

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff could best carry out particular activities in order to reduce costs and improve the service user experience even where this leads to new roles and new ways of working.

Step 4 - Understanding Workforce Availability

Identify current and future staff availability based on current profile and deployment (workforce supply):

- Understanding the current workforce;
- Workforce forecasting;
- Demographics;
- Supply options.

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any particularly challenging areas arising from its age profile or turnover. It may be the case that the availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.

Step 5 - Developing an Action Plan

Plan to deliver the required workforce (new skills in new locations) and manage the change:

- Gap analysis;
- Priority planning;
- Action planning;
- Managing change.

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. An assessment of any anticipated challenges and how the momentum for change will be created, including staff engagement should be included in the plan.

Step 6 - Implement, Monitor and Refresh

Implement the plan, monitor progress and refresh the plan as required.

- Implementation;
- Measuring progress;
- Revisiting Six Steps.

As the plan is being implemented, it should undergo periodic review and adjustment as appropriate. This should be done by monitoring the agreed indicators of success and by identifying any unintended consequences of the changes.