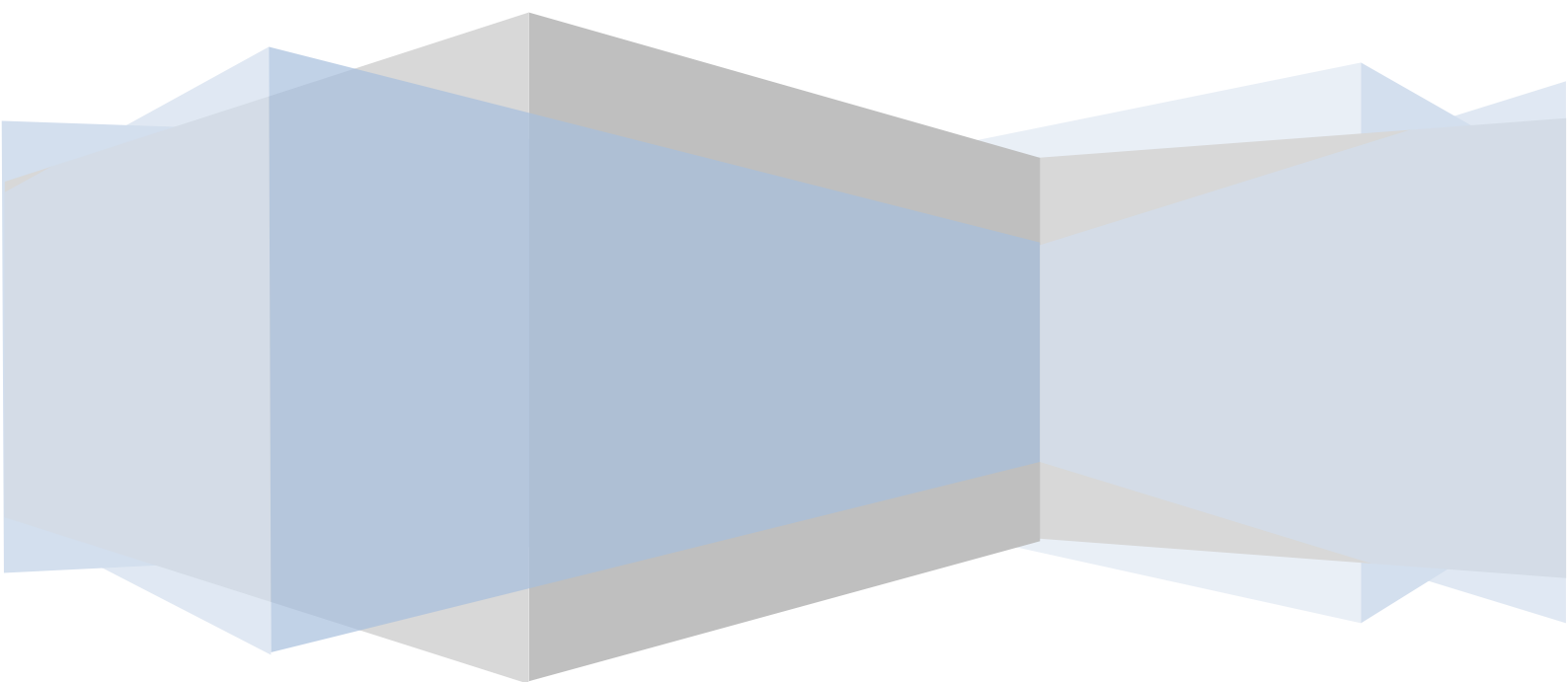


Commissioning Plan

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 to 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.



Dr Ian Clements
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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

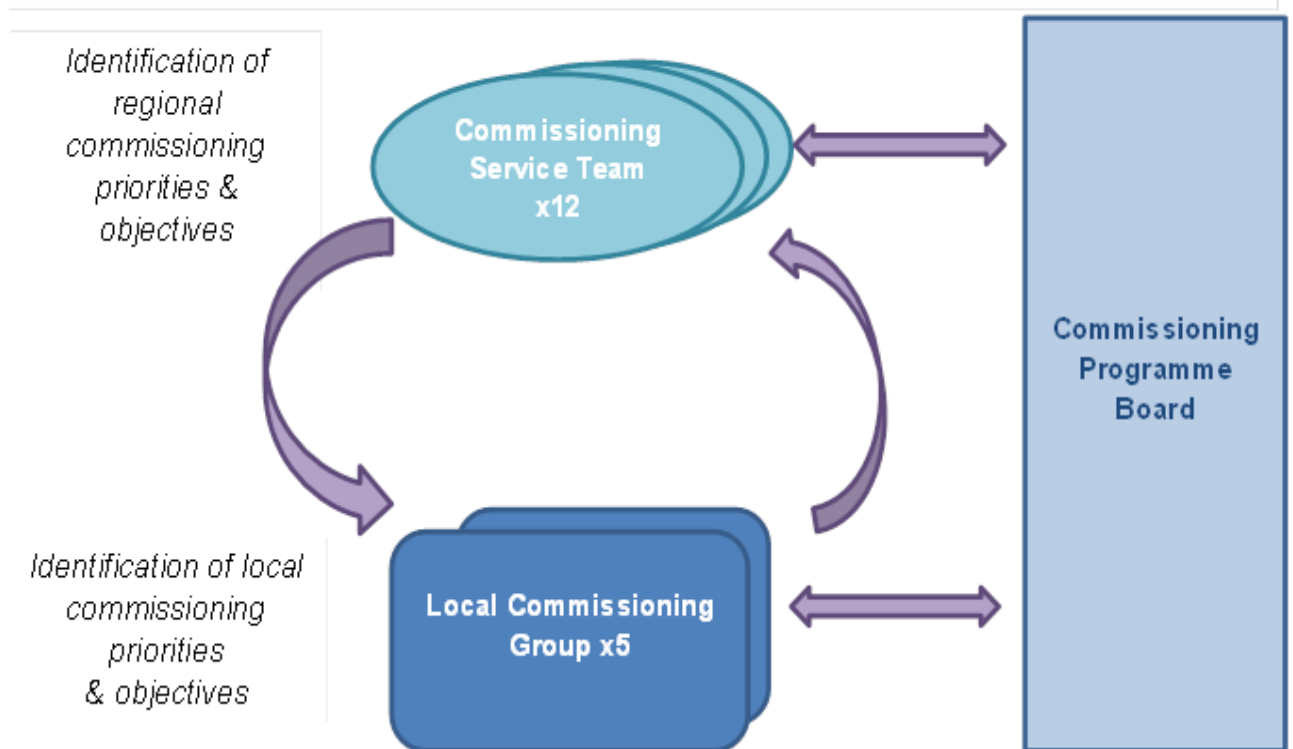
Commissioning objectives are determined at both a regional and local level. The process for identifying commissioning priorities is two-way, with local commissioning informing regional priorities and regional priorities providing a frame of reference for local commissioners to work from (see Figure 1). 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 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	<ul style="list-style-type: none"> ▪ 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? 	<ul style="list-style-type: none"> ▪ Needs assessment & health inequalities data ▪ Demand and capacity information ▪ Evidence of unmet/poorly met need through PPI
	Outcomes	<ul style="list-style-type: none"> ▪ Where are outcomes significantly below or above targets/benchmarks? 	<ul style="list-style-type: none"> ▪ Health inequalities data ▪ Comparative peer benchmarking
	Service Quality, Safety & Performance	<ul style="list-style-type: none"> ▪ 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? 	<ul style="list-style-type: none"> ▪ 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 SAls ▪ Deanery reports, Trust QI Plns, RQIA Reports ▪ NICE, Service Framework documents
	Health inequalities & Service	<ul style="list-style-type: none"> ▪ Where do we have significant health inequalities and variation in service performance, by 	<ul style="list-style-type: none"> ▪ Health inequalities data ▪ LCG needs assessment, performance data and PPI initiatives

	variation	locality or client group?	<ul style="list-style-type: none"> Managed Clinical Networks
	Policies, strategies & guidelines	<ul style="list-style-type: none"> What policies, strategies and guidelines do we need to consider? 	<ul style="list-style-type: none"> Ministerial Priorities and Programme for Government, Quality 2020, Fit and Well Changing Lives, <i>Transforming Your Care</i> 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	<ul style="list-style-type: none"> 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? 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> How will our population and need/demand change over the coming years? What policy drivers will we have to meet (e.g. NICE, Service 	<ul style="list-style-type: none"> Population projections Emerging strategies, policies and guidelines

		<p>Frameworks etc.)?</p> <ul style="list-style-type: none"> ▪ 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? 	
	<p>Technology & Innovation</p>	<ul style="list-style-type: none"> ▪ 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? 	<ul style="list-style-type: none"> ▪ 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.

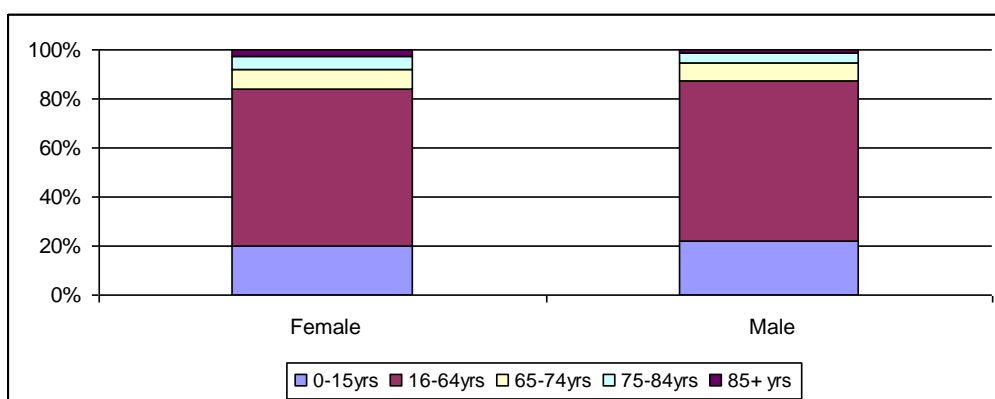
2.1 Demographic Changes & Health Inequalities

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 known 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.

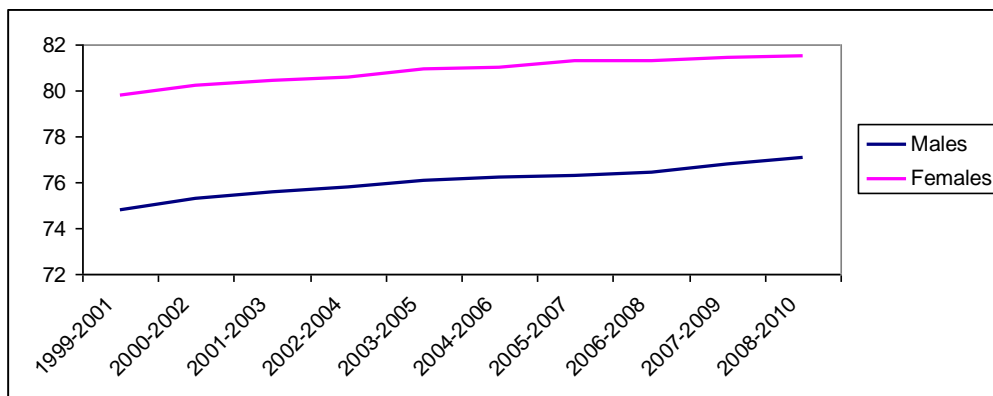
Life Expectancy

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 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 (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.

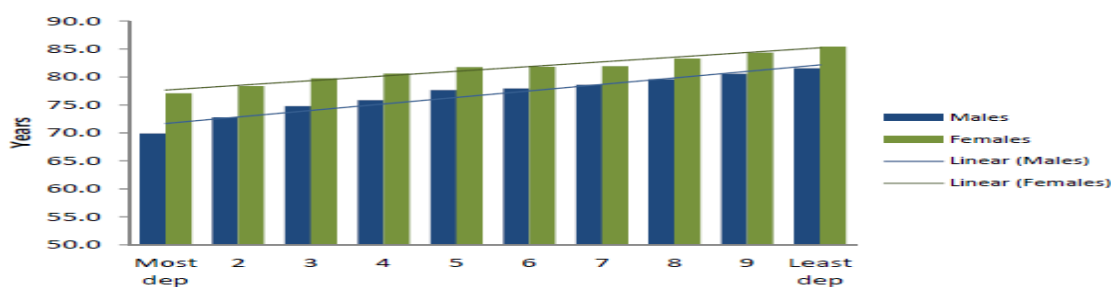
Figure 3. Life expectancy by Gender in Northern Ireland, 1999-2001 to 2008-2010.



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

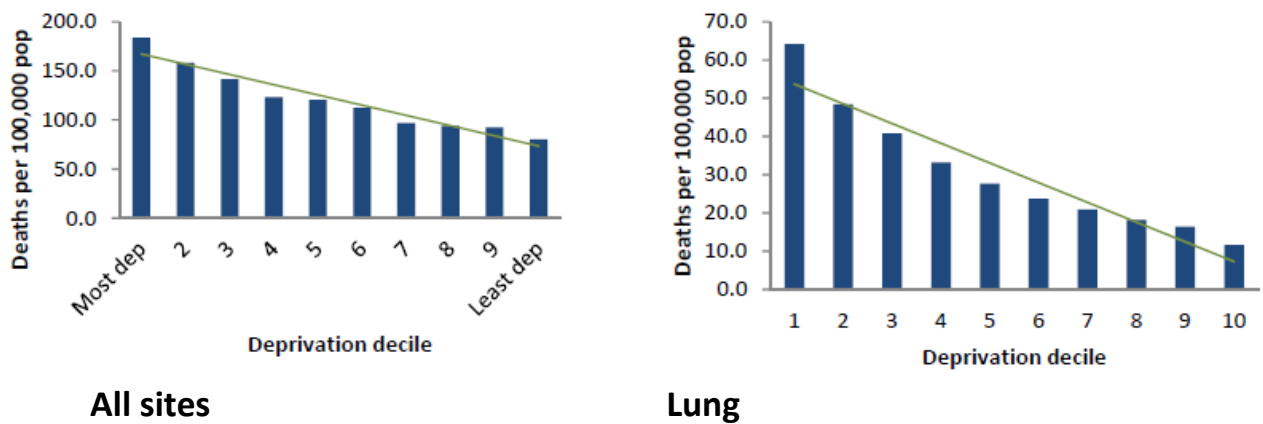
Source: Hospital Inpatient System, DHSSPS

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



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 profile 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

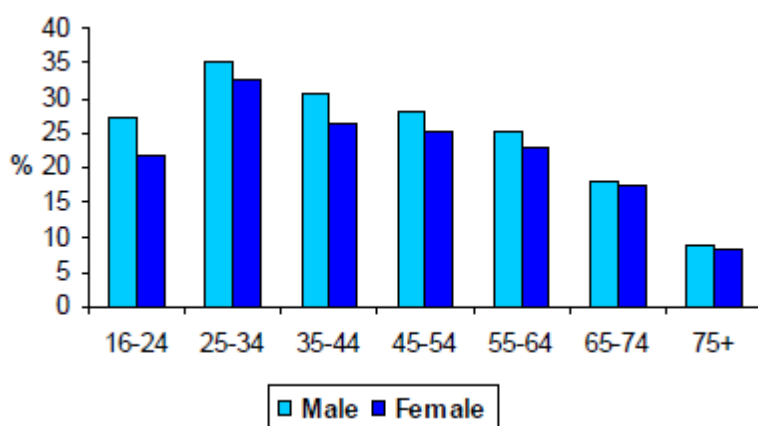
Smoking

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.

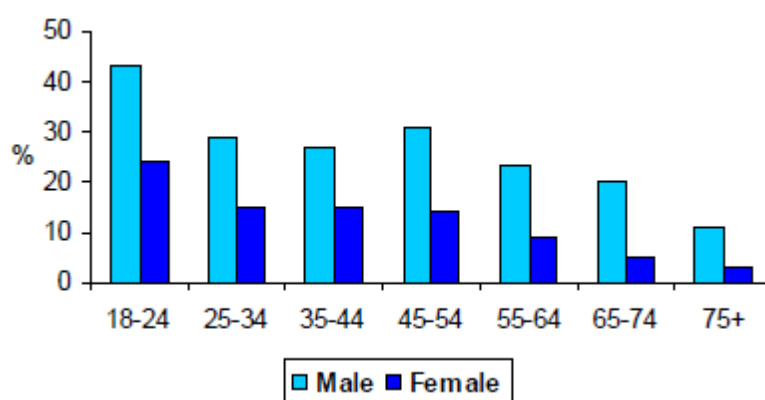
Alcohol

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.

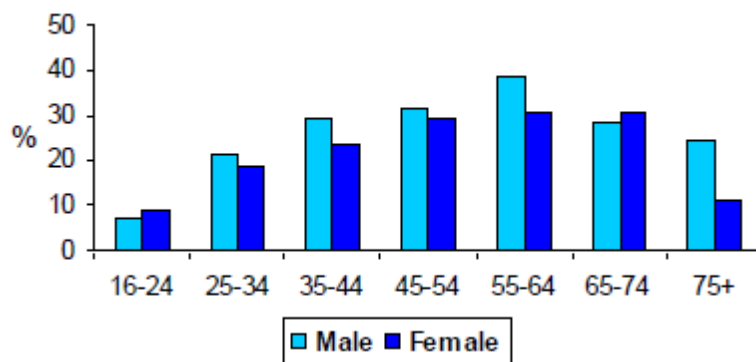
It is well known that health outcomes are generally worse in the most deprived areas, with alcohol related mortality in the 10% most deprived areas of Northern Ireland being almost 9 times that in the least deprived areas (PHA, 2012).

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 disproportionately concentrated amongst particular deprived groups (Source: PHA, 2012), as are the social determinants 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. Give every child the best start

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.

3.2.1 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 these 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	<u>Pressure Area</u>	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	12/13 - 14/15	13/14	14/15
	Net £m	Gross £m	Gross £m	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

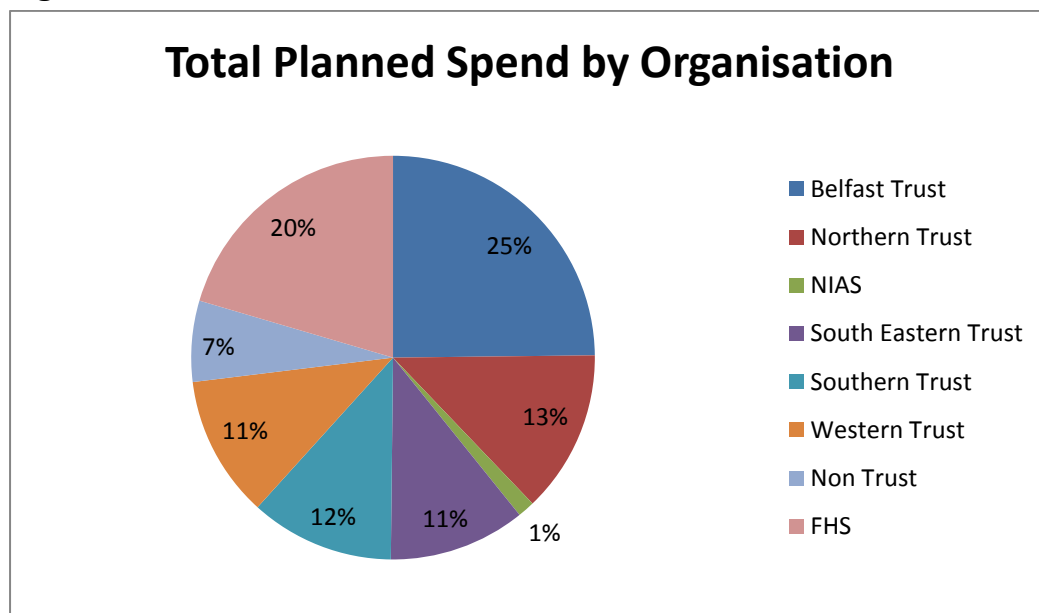


Table 16 sets out how the total resources are planned to be allocated across the Programmes of Care and Family Health Services. The planned expenditure set out in the table reflects the transitional costs for TYC. However, it is anticipated that the TYC programme will also result in a shift of resources 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%
<i>Sub Total</i>	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

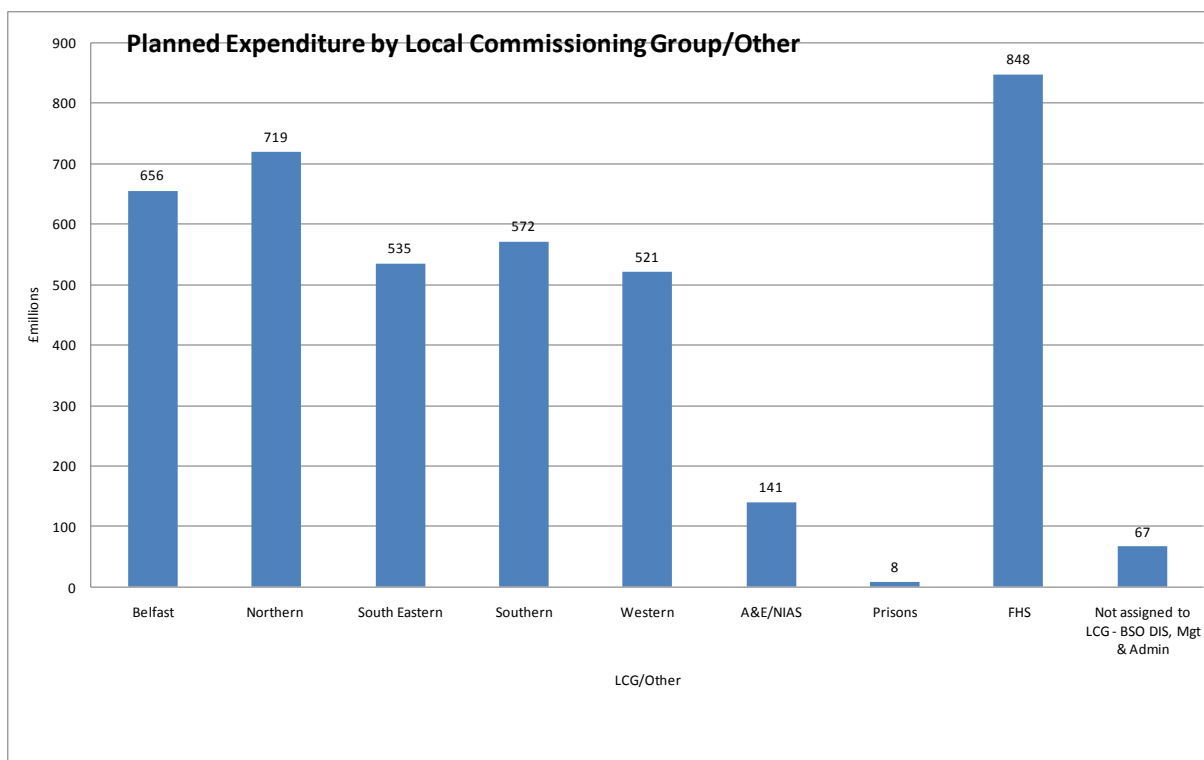


Table 17 demonstrates how each Local Commissioning Group plans to allocate its resources to providers of Health and Social Care.

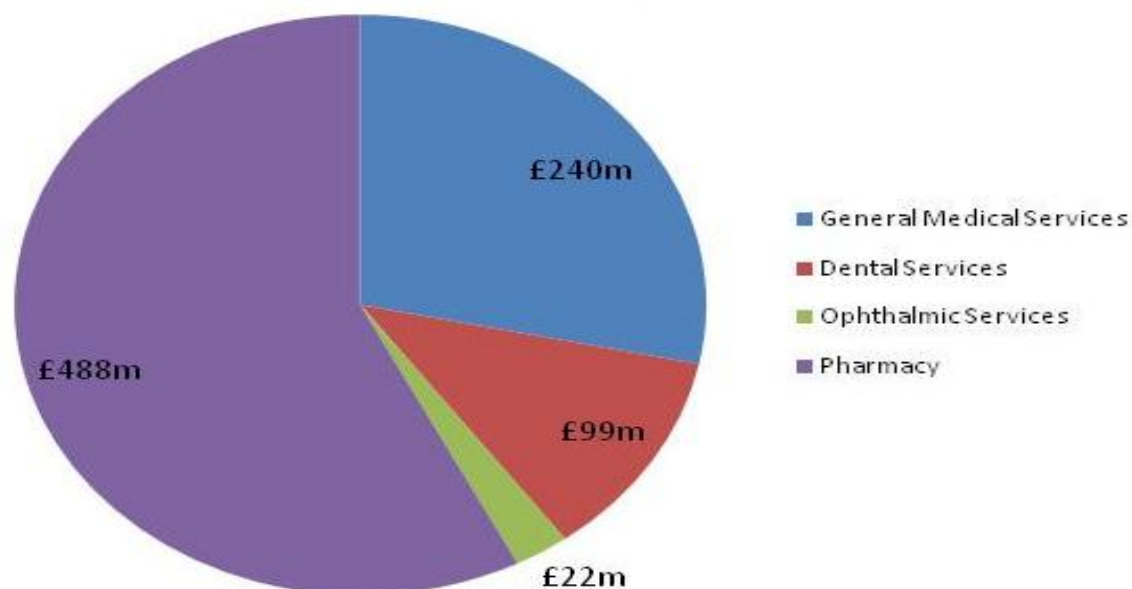
Table 17. Resources by LCG

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

Planned Spend for Family Health Services



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.

²The 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
	Diagnostics	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
		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 & Social Work	Face to face	2,163,000
		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

<p>Activity commissioned 2012/13</p> <p><u>Elective</u></p> <ul style="list-style-type: none"> • Inpatient (finished consultant episodes) – 69,000 • New Outpatient Appointments - 1,375,000 • Review Outpatient appointments – 889,000 • Day Case Procedures -164,355 <p><u>Unscheduled</u></p> <ul style="list-style-type: none"> • 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 <p><u>Diagnostics</u></p>
--

MRI – 50,000	Plain film x-ray – 960,000
CT – 111,000	Echos – 50,000
Ultrasound – 156,000	Endoscopy – 49,000
Total investment 2012/13	£1,350m
<i>Additional investment 2013/14</i>	<i>£69m³</i>
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
<i>Additional investment in year</i>	<i>£4.0m</i>
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
<i>Additional investment in year</i>	<i>£4.0m</i>
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

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

Social Work (Active Caseload) – 9,000	
Total investment 2012/13	£226m
<i>Additional investment in year</i>	<i>£11m</i>
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
<i>Additional investment in year</i>	<i>£10.5m</i>
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
<i>Additional investment in year</i>	<i>£23m</i>
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
<i>Additional investment in year</i>	<i>£4.0m</i>
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, Ophthalmology, 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
- Ophthalmology : 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	2013/14	2014/15	Total
	£m	£m	£m	£m
	FYE	FYE	FYE	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

Key Deliverables	Timescale for achievement			Strategic Driver/Needs Assessment		
	2013/14	2014/15	2015/16	Ministerial target	TYC	Other
<p>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</p> <p>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.</p>	<ul style="list-style-type: none"> ● 			<ul style="list-style-type: none"> ✓ Targets 14		

<p>Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery.</p> <ul style="list-style-type: none"> • 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
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⁴National Cancer Improving Outcomes; 1- Survival, 2 – Patient Experience, 3 – Safety & Quality, 4 – Productivity, 5 – Quality of Life

<p>of follow up across all other cancer groupings, which will clear and prevent review backlog</p> <ul style="list-style-type: none"> Findings of external evaluation to be incorporated into Trust Transforming Follow Up action plans 		●				
<p>All Trusts should work with HSCB to implement the recommendations of the 2010 NI Chemotherapy Service Review. This should include:</p> <ul style="list-style-type: none"> 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	<p>Chemotherapy Service Review</p> <p>Improving Outcomes 1,2,3,4&5</p>

<p>to the HSCB on a monthly basis via the performance management information returns</p> <ul style="list-style-type: none"> • 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 	<p>•</p>	<p>•</p>	<p>•</p>		<p>Rec 79 & 95</p>	
<p>Effective Multidisciplinary Teams All Trusts should ensure that cancer MDTs undertake the NICA Peer Review process and develop action improvement plans which will be shared with HSCB.</p> <ul style="list-style-type: none"> • All Trusts should participate in 						<p>Cancer Services Framework Standard 20</p> <p>Improving Outcomes</p>

<p>peer review of, Lung, Gynae, Colorectal, Urology and Haematology</p> <ul style="list-style-type: none"> • 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 	<p>●</p>	<p>●</p>	<p>●</p>	<p>●</p>	<p>●</p>	<p>1,2,3,4&5</p>
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<p>for Amending the Status of a Red Flag Referral including the implementation of the NICE Guidance for Suspected Cancer</p>	<p>●</p>					
<p>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.</p> <ul style="list-style-type: none"> • 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 	<p>●</p>	<p>●</p>			<p>Rec 27</p>	<p>Cancer Service Framework Standard 32 Improving Outcomes 1,2,3,4&5</p>

<p>Haematology Services</p> <ul style="list-style-type: none"> • 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 	<p>●</p> <p>●</p> <p>●</p>	<p>●</p> <p>●</p>				<p>Cancer Service Framework Standard 39 &40</p> <p>Improving Outcomes 1,2,3,4&5</p>
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<ul style="list-style-type: none"> 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 		●				
<p>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.</p>	●					<p>Improving Outcomes 1,2,3,4&5</p> <p>NICE Quality Standard for Ovarian Cancer</p> <p>Cancer Service Framework</p>

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

Commissioning Objectives	Timescale for achievement			Strategic Driver/Needs Assessment		
	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.

<p>intervention required.</p> <p>The HSCB / PHA will progress Family Support and Parenting Programmes to address TYC recommendation 46.</p> <p>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.</p>	●	●	●			
<p>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.</p>	●	●	●		Rec 50	Learning Disability Service Framework
<p>All Trusts to engage in the Review of AHP support for Children with Special Needs within Special Schools and Mainstream Education</p>	●	●				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
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⁶This 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

⁷This 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

<i>Timescale for achievement</i>				<i>Strategic Driver/Needs Assessment</i>		
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:- <ul style="list-style-type: none"> • To improve provision of advice information and signposting 	●				Rec 14	Service Framework for Older People

<p>on all aspects of health and wellbeing improvement</p> <ul style="list-style-type: none"> • 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 						
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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

Commissioning Objectives	Timescale for achievement			Strategic Driver/Needs Assessment		
	2013/14	2014/15	2015/16	Ministerial target	TYC	Other
<p>All Trusts should ensure that RQIA radiology recommendations are fully implemented during 2013/14.⁸</p> <p>As a minimum this requires all Trusts to:</p> <ul style="list-style-type: none"> 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

<p>All Trusts should have implemented a direct access pathway for ECHO for patients considered for left ventricular failure (LVF) <i>as defined by NICE Guidance CG for chronic heart failure</i>, by September 2013 with the aim to have reduced referrals to cardiology outpatients by 10 % by March 2014.</p>	<ul style="list-style-type: none"> ● 	<ul style="list-style-type: none"> ● 				<p>NICE CG 108</p>
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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

Commissioning Objectives	Timescale for achievement			Strategic Driver/Needs Assessment		
	2013/14	2014/15	2015/16	Ministerial target	TYC	Other
<p>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:</p> <ul style="list-style-type: none"> All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more than 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	

<p>rates at April 2012)</p> <ul style="list-style-type: none"> • 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. 		<p>●</p> <p>●</p> <p>●</p>	<p>●</p> <p>●</p>		<p>Rec 77</p> <p>Rec 77</p> <p>Rec 77</p>	
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<ul style="list-style-type: none"> 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). <p>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</p>		●				
<p>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</p>		●	●	✓ 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; proctectomy; 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. <ul style="list-style-type: none"> 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

<p>a primary care setting.</p> <ul style="list-style-type: none"> • 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. 	<p>●</p>	<p>●</p>			<p>Rec 77</p>	<p>NICE Guidance</p>
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<p>All Trust will support improved outcomes measurements to support service improvement and evidence based commissioning</p> <ul style="list-style-type: none"> • 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 		<ul style="list-style-type: none"> • • • • 				
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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 to 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

<i>Timescale for achievement</i>				<i>Strategic Driver/Needs Assessment</i>		
Commissioning Objectives	2013/14	2014/15	2015/16	Ministerial target	TYC	Other
<p>All Trusts are expected to deliver on the implementation of 'Fitter Futures for All' framework including:</p> <ul style="list-style-type: none"> • 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

<p>intervention programmes including:</p> <ul style="list-style-type: none"> • Roots of Empathy • Family Nurse Partnership • Infant Mental Health Training • Parenting support. 	●					<p>CYP Strategy, HSCB Hidden Harm, DHSSPS</p>
<p>All Trusts will ensure that they support the implementation of key public health strategies including:</p> <ul style="list-style-type: none"> • 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	<p>'Fit and Well', DHSSPS Ten Year Tobacco Control Strategy, DHSSPS New Strategic Direction on Alcohol and Drugs, DHSSPS Protect Life, DHSSPS Bamford Review, DHSSPS</p>

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: <ul style="list-style-type: none"> • Looked After Children; • Homeless people • LGBT 	●					'Fit and Well', DHSSPS All Ireland Traveller Health Study, DHSSPS

<ul style="list-style-type: none"> • Travellers • Migrant groups 						<p>European Convention on Human Rights, EU</p> <p>CYPS, HSCB</p> <p>'Including the Homelessness', DSD</p>
<p>All Trusts should support social economy businesses and community skills development through public procurement, expanding capacity incrementally over the following 3 years.</p>	●	●	●		Rec 5	<p>'Fit and Well', DHSSPS</p>

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

<i>Timescale for achievement</i>				<i>Strategic Driver/Needs Assessment</i>		
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 Infections and 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

Commissioning Objectives	Timescale for achievement			Strategic Driver/Needs Assessment		
	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.	<p style="text-align: center;">●</p> <p>BHSCT (25)</p> <p>NHSCT (12)</p> <p>SEHSCT (5)</p> <p>SHSCT (33)</p> <p>WHSCT (0)</p>	<p style="text-align: center;">●</p> <p>BHSCT (24)</p> <p>NHSCT (12)</p> <p>SEHSCT (13)</p> <p>SHSCT (0)</p> <p>WHSCT (1)</p>		<p>✓</p> <p>Target 23</p>	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

Commissioning Objectives	Timescale for achievement			Strategic Driver/Needs Assessment		
	2013/14	2014/15	2015/16	Ministerial target	TYC	Other
<p>By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions through:</p> <ul style="list-style-type: none"> 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						
<p>Respiratory</p> <ul style="list-style-type: none"> 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. 	<p>●</p> <p>Service in place</p> <p>●</p>	<p>●</p> <p>Service in place</p>			<p>Rec 77</p> <p>Rec 77</p> <p>Rec 22</p>	<p>Regional TB Action Plan</p> <p>NICE Guidance</p> <p>Respiratory Service Framework Standards</p> <p>NICE COPD Quality Standards</p>

<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> ● ● 					
<p>Stroke</p> <ul style="list-style-type: none"> • Thrombolysis <ul style="list-style-type: none"> ➤ 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 (ABCD²>4) must be available on a 7 day basis • All Trusts should support early supported discharge (ESD) following 	<ul style="list-style-type: none"> ● 70% 10% ● Service in place 	<ul style="list-style-type: none"> ● 80% 11% 	<ul style="list-style-type: none"> ● 90% 12% 	<ul style="list-style-type: none"> ✓ Target 13 	<ul style="list-style-type: none"> Rec 77 	<ul style="list-style-type: none"> NICE Guidance & NICE Quality Standards for Stroke

<p>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.</p>	<p>● Progress report</p>				<p>Rec 22</p>	
<p>Diabetes</p> <ul style="list-style-type: none"> All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes Subject to satisfactory pilot evaluation, all Trusts should 	<p>●</p> <p>Adults 141 Paeds 76</p>	<p>Adults 162 Paeds 104</p>	<p>Adults 138 Paeds 86</p>		<p>Rec 22</p> <p>Rec 21</p>	<p>NICE Diabetes in Adults Quality Standard</p>

<p>mainstream the CAWT pre pregnancy care and structured patient education program (CHOICE) for children from January 2014 onwards.¹⁰</p> <ul style="list-style-type: none"> All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14. 		●				
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¹⁰ Requires further discussion between the Commissioner and provider(s) and /or DHSS&PS with regard to funding.

<p>Cardiac</p> <ul style="list-style-type: none"> • 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 	<p>●</p> <p>●</p>	<p>●</p>			<p>Rec 77</p>	<p>Cardiovascular Service Framework</p>
<p>Prevention</p> <ul style="list-style-type: none"> • All Trusts should ensure that smoking cessation services are available in all locations where patients with LTCs are seen including hospitals, primary 	<p>●</p>					

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)

<p>care and community pharmacy</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> ● ● ● ● <p>Progress Report</p>			<p>✓ Target 18</p> <p>✓ Targets 16 & 19</p>	<p>Rec 21</p> <p>Rec 27</p>	<p>PfG commitment 44</p> <p>Connected Health</p>
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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

Commissioning Objectives	<i>Timescale for achievement</i>			<i>Strategic Driver/Needs Assessment</i>		
	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: <ul style="list-style-type: none"> Keeping first pregnancy and birth normal 	●				Rec 37	DHSSPS Maternity Strategy

<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Direct access for women to their community midwife 	●					DHSSPS Maternity Strategy

<ul style="list-style-type: none"> • 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. 						
<p>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</p>	●				Rec 36, 37 & 38	DHSSPS Maternity Strategy
<p>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</p>	●					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
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Child Health:

Commissioning Objectives	<i>Timescale for achievement</i>			<i>Strategic Driver/Needs Assessment</i>		
	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

<p>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.</p>	<ul style="list-style-type: none"> ● 					
<p>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</p>	<ul style="list-style-type: none"> ● 					<p>RQIA Independent Review of Pseudomonas in neonatal units; NICE CG 149</p>

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

Commissioning Objectives	Timescale for achievement			Strategic Driver		
	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

Key Deliverables	Timescale for achievement			Strategic Driver/Needs Assessment		
	2013/14	2014/15	2015/16	Ministerial target	TYC	Other
<p>All Trusts are required to fully implement the refreshed “Protect Life” strategy.</p> <p>This should include:</p> <ul style="list-style-type: none"> • 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 complete 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: <ul style="list-style-type: none"> ● Autism Spectrum Disorder (ASD) services for Adult Services ● access to dedicated eating 	●	●		✓ Targets 22 & 27		Autism Act Action Plan 2013 Identified need

<p>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))</p> <ul style="list-style-type: none"> • 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). • 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 	<p>●</p> <p>●</p> <p>●</p>	<p>●</p>				<p>to reduce the number of people who have to leave NI to access Eating Disorder Services</p> <p>Personality Disorder Strategy 2010</p> <p>New Strategic Direction for Drugs and Alcohol DHSSPS</p>
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<ul style="list-style-type: none"> 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

Commissioning Objectives	Timescale for achievement			Strategic Driver/ Needs Assessment		
	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)

<p>life.</p> <p>This should include:</p> <ul style="list-style-type: none"> • 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 						
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<p>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:</p> <ul style="list-style-type: none"> • 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)
<p>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 <i>general palliative care</i> services in the community, supporting patients within their own home and</p>	●	●	●			Regional Palliative & End of Life Strategy, Living Matters, Dying Matters (2010-15)

<p>nursing homes where that is their choice.</p> <p>This should include:</p> <ul style="list-style-type: none"> • 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 						
<p>Trusts and ICPs should provide evidence of how they are working with the voluntary sector to ensure that there is an increased provision of <i>specialist palliative care</i> services in the community, supporting patients dying within their own home and nursing homes where that is their choice. This should include:</p> <ul style="list-style-type: none"> • Support to generalist palliative care services • Education and training 	●	●	●		Rec 81	Regional Palliative & End of Life Strategy, Living Matters, Dying Matters (2010-15)

<ul style="list-style-type: none"> • 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 						
<p>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)</p>	●	●	●			<p>Regional Palliative & End of Life Strategy, Living Matters, Dying Matters (2010-15)</p>

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

<i>Timescale for achievement</i>				<i>Strategic Driver/Needs Assessment</i>		
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.	●					

<p>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.</p>	<ul style="list-style-type: none"> ● 				<p>Rec 33</p>	<p>Dementia Strategy</p> <p>Physical Disability and Sensory Impairment Strategy</p>
<p>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.</p>	<ul style="list-style-type: none"> ● 				<p>Rec 31 & 33</p>	<p>Dementia Strategy</p> <p>Physical Disability and Sensory Impairment Strategy</p>

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

Commissioning Objectives	Timescale for achievement			Strategic Driver/Needs Assessment		
	2013/14	2014/15	2015/16	Ministerial target	TYC	Other
SET to develop staff profiles for each of the main staffing groups including: <ul style="list-style-type: none"> • 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

<p>SET should continue to progress the development of medical services and chronic disease management in line with the principle of equivalence. This should include:</p> <ul style="list-style-type: none"> • Production of an annual profile of prisoners by chronic disease category as per Quality and Outcomes Framework (QOF). • Development of registers for individuals with: <ul style="list-style-type: none"> ➤ Cancer ➤ Obesity ➤ Smoking addiction ➤ Neuroses 	●	●	●			<p>Prison Ombudsman Reports</p> <p>Owers Review</p>
<p>SET should develop care pathways in and out of prison, for prisoners with complex needs including:</p> <ul style="list-style-type: none"> • Improved information at committal relating to: <ul style="list-style-type: none"> ➤ Medication needs ➤ Substance abuse ➤ Mental Health 	●	●	●			<p>Prison Ombudsman Reports</p> <p>Owers Review</p>

<ul style="list-style-type: none"> Discharge plans are in place prior to prisoner release. 						
<p>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:</p> <ul style="list-style-type: none"> Tobacco Healthy eating and nutrition Health lifestyles including sexual health Active living Drug and other substance misuse 	●	●	●			<p>Prison Ombudsman Reports</p> <p>Owers Review</p>
<p>SET should ensure the recruitment of CAMHS and Psychological Therapies posts following additional investment from HSCB in line with IPTs</p>	●					<p>Prison Ombudsman Reports</p> <p>Owers Review</p>
<p>SET should develop Mental Health services for the prison population in accordance with delivering the Bamford</p>	●					

<p>Vision for People with Mental Health and Learning Disability. This should include the introduction of a recovery approach for mental health service provision.</p>						
<p>SET should ensure that prescribing and medicine administration processes comply with national and Local standards to include :</p> <ul style="list-style-type: none"> ● 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. 	<ul style="list-style-type: none"> ● ● 					<p>Medicines Formulary</p> <p>Medicines safety</p>
<p>SET should ensure that people with a Learning Disability are identified and their care managed in accordance with</p>	<ul style="list-style-type: none"> ● 					

<p>“Equal Lives” to include:</p> <ul style="list-style-type: none">• Introduction of Learning Disability Screening tool baseline audit.• Development of an appropriate care pathway.						
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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.

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 BHSCCT 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 rationale 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, ankylosing 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

<i>Timescale for achievement</i>			<i>Strategic Driver/Needs Assessment</i>			
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: <ul style="list-style-type: none"> 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

Commissioning Objectives	<i>Timescale for achievement</i>			<i>Strategic Driver/Needs Assessment</i>		
	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	

<p>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 Network¹⁴.</p>	<p>●</p>				<p>Rec 72 & 74</p>	
<p>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:</p> <ul style="list-style-type: none"> • Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage; 	<p>●</p>			<p>✓ Target 5</p>	<p>Rec 74 & 93</p>	

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

<ul style="list-style-type: none"> • 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. 						
<p>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.</p>	<ul style="list-style-type: none"> ● 					

<p>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.</p>	<ul style="list-style-type: none"> ● 					
<p>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) .</p>	<ul style="list-style-type: none"> ● 					

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.

Increasing our capacity to engage with patients and the public

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 of 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 cytology, 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 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.

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 been 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 <i>Transforming Your Care</i>

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.ofmdfmi.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
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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>
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<http://www.nisra.gov.uk/demography/default.asp130.htm>
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- Risk Behaviour and GP consultation rates – primarily NISRA Continuous Household Survey
<http://www.csu.nisra.gov.uk/survey.asp29.htm>
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<http://www.ofmdfmi.gov.uk/transgenderequality22may07.pdf>
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http://www.ofmdfmi.gov.uk/gender_equality_strategy_a_baseline_picture-4.pdf
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Religion

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- Fair Society, Healthy Lives: (Strategic review of health inequalities in England) The Marmot Review, 2010
- Half a million voices: Improving support for BAME carers (CARERS UK 2011)
- Achieving Equality in Health and Social Care. A framework for action (The Afiya Trust 2010)

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http://www.dohc.ie/publications/aiths2010/ExecutiveSummary/AITHS2010_SUMMARY_LR_All.pdf?direct=1

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http://www.niccy.org/uploaded_docs/EC%20-%20Travellers%20report%20complete%20pdf.pdf

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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	<i>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?</i>
Gender	<p>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</p> <p>Female 51% Male 49%</p> <p>Birth proportions – NISRA http://www.nisra.gov.uk/demography/default.asp8.htm</p> <p>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%).</p>
Age	<p>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</p> <p>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 12-15yrs Northern Ireland is projected to have the highest</p>

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 16-74 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\(F\)I.doc](http://www.equalityni.org/archive/tempdocs/LiteratureRev(F)I.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

	<p>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).</p>
Ethnicity	<p>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.</p> <p>English is not the main language for 3.1% (54,500) of the population at the 2011 census.</p> <p>The Traveller population in N Ireland is estimated at 3905.</p> <p>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).</p> <p>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</p>
Sexual Orientation	<p>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.</p>

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 and 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 2010 All 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
Orientatio
n

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 IDENTITIES

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 not 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 than 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 in 1999 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.

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	<i>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?</i>
Gender	<p><i>Elective Care</i></p> <p>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.</p> <p>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</p>

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 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

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

	<p>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.</p> <p><i>Long Term Conditions</i></p> <p>Stroke and diabetes are more common in men but women have higher levels of morbidity and premature mortality.</p>
Age	<p><i>Specialist Services</i></p> <p>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.</p> <p>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.</p> <p><i>Cancer</i></p> <p>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.</p> <p>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</p>

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

	<p>Long term conditions are more common in older age groups. Children with diabetes have a lower life expectancy than children without diabetes.</p>
Religion	<p>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.</p>
Political Opinion	<p>Political opinion is not a determining factor for access to health care.</p>
Marital Status	<p><i>Cancer</i></p> <p>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.</p> <p><i>Children and Families</i></p> <p>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.</p>
Dependent Status	<p><i>Unscheduled Care</i></p> <p>There is recognition that persons with dependents can find it more difficult to access in-hours unscheduled care.</p> <p><i>Elective care</i></p> <p>Those with dependents may have difficulties regarding the flexibility of appointment times.</p>

	<p><i>Cancer</i></p> <p>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.</p> <p><i>Disability</i></p> <p>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.</p> <p>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.</p> <p>Parents with a disability are least likely to have information made available to them in a way that meets their needs.</p> <p><i>Long Term Conditions</i></p> <p>Gestational diabetes and Type 2 diabetes is more common in overweight and obese women which are more commonly seen in disadvantaged areas.</p>
Disability	<p><i>Specialist Services</i></p> <p>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.</p>

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

	<p>population and higher amongst people with Down's syndrome (Based on UK figures).</p> <p>Stroke survivors may develop disability and require prolonged periods of rehabilitation following a stroke.</p> <p>High quality diabetes care and early detection of complications in Diabetes can reduce the frequency of disability.</p>
Ethnicity	<p><i>Unscheduled Care</i></p> <p>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.</p> <p><i>Health and Social Wellbeing Improvement</i></p> <p>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.</p> <p>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.</p>

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 funds

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;

	<p>42% of Travellers are under 15 years of age compared with 13% nationally.</p> <p>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.</p> <p><i>Mental Health</i></p> <p>There is evidence of high rates of mental ill health for Traveller women. Traveller men often deny that they have depression.</p> <p>Women from ethnic minorities are particularly vulnerable to mental illness with women of Asian descent having higher suicide and self harm rates.</p> <p>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.</p> <p>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.</p> <p><i>Long Term Conditions</i></p> <p>Diabetes is more common in BME groups and hypertension is more common in Asians.</p>
Sexual Orientation	<i>Specialist Services</i>

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

	<p>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.</p> <p><i>Prison Services</i> 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.</p> <p><i>Health & Social Wellbeing Improvement</i> 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.</p>
Multiple Issues	<p><i>Specialist Care</i> 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.</p> <p><i>Elective Care</i> Health Inequalities monitoring data showed that people from the</p>

	<p>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.</p>
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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-

The 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 2012/13 will 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. voluntary/user representatives as a feature of Commissioning Team functioning.

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

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.

<i>Group</i>	<i>Impact</i>	<i>Suggestions</i>
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	<input type="checkbox"/>
Minor impact	<input type="checkbox"/>
No further impact	<input type="checkbox"/>

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	<input type="checkbox"/>
No	<input checked="" type="checkbox"/>

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?

<i>How does the policy or decision currently encourage disabled people to participate in public life?</i>	<i>What else could you do to encourage disabled people to participate in public life?</i>
<p>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:</p> <ul style="list-style-type: none"> • 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 	<p>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.</p> <p>For example, the Community Care Team will ensure effective implementation arrangements are established with PPI Steering Group.</p>

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?

<i>How does the policy or decision currently promote positive attitudes towards disabled people?</i>	<i>What else could you do to promote positive attitudes towards disabled people?</i>
<p>Meet with groups advocating on behalf of specific groups needs.</p> <p>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</p>	<p>Seek to examine impact of communication materials and make resources available in various formats.</p>

(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 Plan 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
<p>Ongoing monitoring and screening of health and social wellbeing plans in accordance with Section 75, equality legislation and human rights legislation.</p> <p>Monitoring of complaints</p>	<p>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.</p>	<p>Monitoring of complaints & Serious Adverse Incidents</p>

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 as 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.