Public Health Agency

Health and Social Care Board

Commissioning Plan 2014/15

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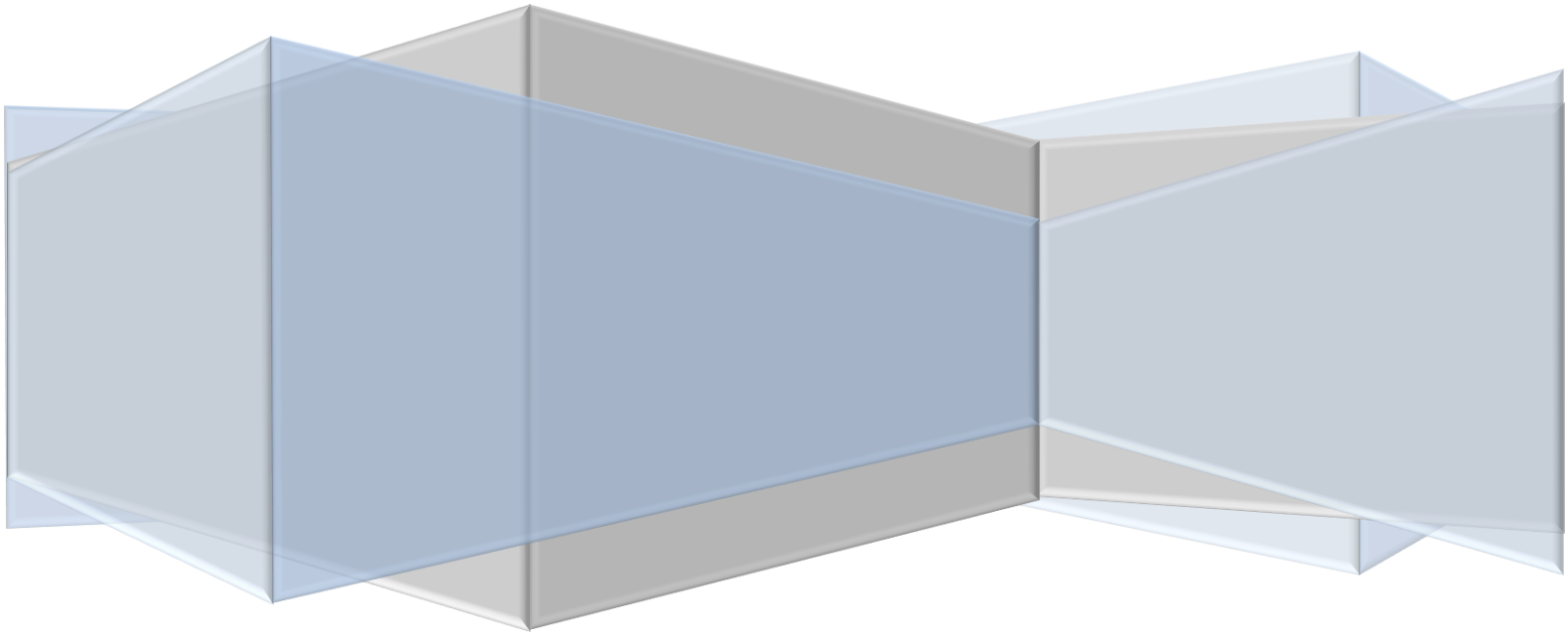

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FOREWORD

The HSC Board, working in partnership with the Public Health Agency (PHA), is committed to securing high quality health and social care services within available resources which meet the needs of the Northern Ireland population. Over the last number of years, continuing to meet these needs within the budget available has become increasingly challenging. A number of factors, including a growing and ageing population, the rising prevalence of long-term conditions, and advances in medical technology, have resulted in growing demand for increasingly costly services. In this context, a draft Commissioning Plan for 2014/15 was submitted to the DHSSPS in March 2014, which identified a funding shortfall of £160m required to meet the priorities, standards and targets set out in the Commissioning Plan Direction 2014. In the months following submission of the initial draft Plan the HSCB and PHA have been working closely with the DHSSPS and the various health and social care providers to resolve this funding gap and develop a financial plan which will deliver financial balance across the HSC system.

In addition, increased pressures identified by Trusts which emerged following the development of the original plan have been addressed through in year contingency measures within each Trust.

Revised Financial Plan 2014/15

The draft Commissioning Plan 2014/15 submitted to the DHSSPS in March 2014 identified the funding sources available to the HSCB and PHA, including additional funding from the DHSSPS and savings opportunities from baseline commissioning investments. These funding sources were then compared to costs associated with the delivery of the service priorities set out in the Commissioning Plan Direction and maintain existing services. The result was the estimated funding shortfall of £160m referred to above.

The HSCB, in conjunction with DHSSPS has now agreed a balanced financial plan for 2014/15. This has been achieved primarily through:

- securing additional non recurrent resources from Monitoring Rounds in June, £20m, and October, £53.5m
- curtailing a number of pressures through a delay or rephasing in implementation of some developments whilst protecting essential and

unavoidable service investments

- taking the decision not to proceed at this time with a number of planned service developments.

Table 17 in Chapter 3 of the Plan provides a summary of the revised financial plan to provide financial balance across the HSC after taking account of slippage, productivity and the agreed reprioritisation of planned investments. The main changes to the draft Commissioning Plan submitted to the DHSSPS in March 2014 are as follows:

(a) Pay Pressures

The original pay pressure of £22m has been reduced to £8m following further refinement of the assumptions in the HSC pay model.

(b) Revenue Consequences of Capital Expenditure

The revised plan incorporates a £3.5m reduction in expenditure requirements as a result of re-phasing of a range of planned schemes.

(c) Learning Disability Resettlements

The revised plan reflects a £2.5m reduction in expenditure requirements on resettlements. This was achieved through re-phasing of the original plan.

(d) Transforming Your Care (TYC)

The revised plan reflects a £6m reduction in expenditure requirements in relation to TYC. Notwithstanding this reduction, significant investment is being put in place including £4.5m for local and regional reform projects; £3.5m in Integrated Care Partnerships; £2.1m for implementation support staff; £1.5m to support release of frontline staff to deliver local Trust reforms; £1.1m for specialist foster carers and £0.7m for enhanced stroke care services.

(e) Family Health Services

The revised plan reflects an £18m reduction in pharmacy expenditure in both acute and primary care sectors.

(f) Baseline Funding

In addition to the reprioritisation or rephasing of investments and the monitoring funds secured by the DHSSPS the HSCB has reduced funds from baseline allocations totalling £21m in the areas of Elective, blood transfusion, DIS and Revenue Consequences of Capital Investment.

(g) Service developments

The original draft plan proposed service developments amounting to £51m; this figure has been reduced down to £38m through the curtailment of various planned service developments. The HSCB and PHA prioritised planned service developments taking account of a range of factors including:

- Whether the service development was already fully or substantially on the ground, or contractually committed.
- Whether the service development was essential to the safety and /or sustainability of services
- Whether the service development was essential to discharge statutory requirements

The table below details the £38m service developments approved to proceed during 2014/15.

Service developments to be funded 2014/15

Service pressure	In year (£m)
Elective care	18.50
Implementation of elements of the Cancer Care Framework	0.029
Hospice funding	0.200
Emergency Department capacity building	2.500
Haematology training posts	0.036
Radiology diagnostics	1.000
24/7 blood sciences	1.650
GMC recognition and approval of trainers	0.250
24/7 acute and community working	0.470
Dementia strategy	0.180
CHOICE (Education programme for children and young people with diabetes)	0.090
Lakewood secure provision	0.420
Availability of personal advisers as required under the Leaving Care Act	0.225
Extended fostercare scheme	0.300
Supported accommodation (Young Homeless and Care Leavers)	0.285
Safeguarding child exploitation	0.600
Assessment & approval support kinship foster carers	0.125
Health visiting	0.750

Expansion of Family Nurse Partnership programme	0.100
NHSCT Looked After Children Specialist Nurse	0.024
Primary care infrastructure	0.250
Out of Hours General Medical Services	0.600
Alcohol/substance liaison services	0.100
Revalidation – Medical and General Medical Services	0.106
10,000 Voices	0.256
Review of AHP services in special needs schools	0.083
Normative nursing	9.000
TOTAL	**38.127**

Service developments that were not able to proceed in 2014/15 included plans to extend existing IVF services, to expand GUM services, addiction services, sleep apnoea services, additional nursing support for looked after children and a range of health improvement initiatives.

In addition to the planned service developments which were not taken forward, it has been necessary to pause the assessment and treatment of patients within the Independent Sector, which had been planned to supplement shortfalls in capacity in the Health and Social Care service. It is regrettable that this will result in significantly increased waiting times for elective care by March 2015. The HSCB continue to have performance management processes in place to ensure that Trusts keep waiting times as short as possible through the delivery of core volumes and effective waiting list management approaches.

The values and volume of services commissioned as a result of the revised finance plan are set out in the values and volumes tables contained within the main plan. These are detailed at both regional and local level.

(h) Trust Contingency Plans

At the outset of 2014/15 the planned pressures within Trusts amounted to £87m. Trust Financial Monitoring during the early months of the financial year showed a deteriorating position with the reports for the four months to the end of July projecting a deficit for the year of £134m.

Trusts were asked to propose a range of contingency measures aimed at addressing this difficult financial position, minimising as far as possible, any potential adverse impact on patient and client care, and at all times putting the

safety of patients and clients as a first priority. The funding made available through the June and October Monitoring Rounds has enabled HSCB to significantly reduce the scale and range of contingency measures required to ensure the HSC system achieves balance in 2014/15.

The HSCB and PHA liaised closely with the Trusts, and critically reviewed, assessed and revised the proposals as appropriate with a view to safeguarding as far as to possible the quality of services, and maintaining the safety and integrity of services. The HSCB and PHA then provided their assessment to the DHSSPS and Minister, who, after consideration of and challenge to the plans, in conjunction with the HSCB, PHA and Trusts, approved the implementation of the contingency proposals.

Trust contingency proposals included:

- A range of workforce control measures to reduce expenditure on overtime and agency/temporary staff, whilst endeavouring to ensure that the integrity of the service is maintained.
- A reduction in planned elective activity with the focus being on ensuring that urgent patients are seen and treated in a timely way.
- A reduction in domiciliary care spend.
- Restrictions to bring aids and equipment expenditure in line with budget while ensuring urgent clinical need continues to be met.
- Restrictions on Travel Expenditure by minimising Non-Clinical travel where practical.
- Temporary closure of some Minor Injuries Units.
- Temporary closure of wards / beds.

The HSCB, PHA and Trusts will continue to take all proactive steps to protect critical and urgent frontline services and to monitor and review temporary arrangements that are put in place to ensure the impact on services is minimised, through the challenging winter period.

1.0 Introduction

1.1 The Purpose of the Plan

This Commissioning Plan is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Service and Public Safety for 2014/15. It includes the underpinning financial plan and outlines how commissioning will serve to deliver the planned transformation of services consistent with Transforming Your Care. Consequently, a key area of focus within the plan is the shift left of services from hospital into primary and community. While the plan focuses predominantly on 2014/15, it also signals a direction of travel for 2015/16.

The Plan identifies the key strategic priorities, including NI Executive, Ministerial and Departmental priorities, that will influence the commissioning of health and social care services over the next two years and provides direction for the development of those services for the population of Northern Ireland. In line with established commissioning arrangements, the plan provides an overview of regional commissioning priorities and decisions for 2014/15 and 2015/16 (Section 4) together with information on the priorities and decisions being taken forward at local level by the five Local Commissioning Groups (LCGs; Sections 6-10).

The Plan makes explicit those areas of service development and delivery that providers will be expected to respond to in their development plans for 2014/15 and against which they will be monitored. The document does not attempt to encompass all of the many strands of work that HSCB and PHA will continue to progress with providers during 2014/15. Rather it provides focus on a discrete number of key strategic and service priorities which we feel will have the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level, and those which represent a step change in how we deliver our services.

The commissioning priorities and decisions outlined within the Commissioning Plan have been identified through regional and local needs assessment and with reference to evidence-based or agreed best practice. In particular, they aim to

respond to the seven strategic priorities and statutory obligations identified by the Minister in the Commissioning Plan Direction:

- To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion anticipation and early intervention.
- To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting.
- To improve the management of longterm conditions in the community with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more longterm conditions.
- To promote social inclusion, choice, control, support and independence for people living in the community, especially older people, and those individuals and their families living with disabilities.
- To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the community, voluntary and independent sector.
- To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities.
- To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services.

In responding to these priorities the document seeks to outline how commissioning will support the implementation of a range of Government and Departmental strategies and standards including:

- Achievement of Ministerial standards / targets 2014/15 (see Chapter 6)
- *The Executive's Programme for Government, Economic strategy and Investment Strategy*
- *Transforming Your Care* (TYC)
- *Quality 2020*
- *Public Health Strategic Framework: Making Life Better 2013-23*
- *Other Departmental guidance and guidelines such as (e.g. Service Framework documents, NICE, Maternity Strategy).*

Within the plan, both regional and local commissioning priorities are presented largely by Programme of Care (PoC). PoCs are divisions of health care, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. In total, there are nine PoCs. Definitions of each PoC are provided in Appendix 1. Regional commissioning priorities in relation to the nine PoCs are presented in Section 4; local priorities for each PoC are outlined in Sections 6-10.

For each PoC, at regional and local level, the plan details the commissioned values volumes of activity during 2013/14 together with the indicative additionality for 2014/15. The activity figures cover various contract currencies depending on the PoC. A contract currency is a term used to briefly describe or define the activity. Examples include inpatient episodes, births, domiciliary care hours and face-to-face contacts. The activity data presented does not attempt to account for all of the spend or commissioned activity for a given PoC, rather it selects anywhere between two and six "activities" or "currencies" which account for the large majority of the total spend for that PoC.[1]

The plan also outlines how we will meet our Equality duties under the Northern Ireland Act 1998(b) and how we have sought to embed Personal and Public Involvement (PPI) in our commissioning processes. The equality screening template that accompanies this document can be found on the HSCB website (www.hscboard.hscni.net/publications/Commissioning%20Plans).

Commissioning priorities and decisions also seek to take account of opportunities for and the benefits of partnership working with other Departments and agencies whose policy; strategy and service provision impinges on health and social care.

1.2 Placing communities at the centre of commissioning

The HSCB and PHA are committed to ensuring that commissioning priorities are focused upon need, are locally responsive and reflect the aspirations of local communities and their representatives. There are five Local Commissioning

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

Groups (LCGs) and each is a committee of the HSCB: Belfast; Northern; South Eastern; Southern; and Western. LCGs are responsible for assessing local health and social care needs; planning health and social care to meet current and emerging needs; and supporting the HSCB to secure the delivery of health and social care to meet assessed needs.

In line with established commissioning arrangements, the plan provides an overview of regional commissioning themes and objectives for 2014/15 together with information on the priorities and decisions being taken forward by the five Local Commissioning Groups (LCGs; see Sections 6-10).

1.3 Monitoring Performance

The priorities and targets detailed in the *Commissioning Plan Direction* are complemented by a number of indicators of performance indicated in a separate *Indicators of Performance Direction* for 2014/15, which can be found on the HSCB website (www.hscboard.hscni.net/publications/Commissioning%20Plans).

The *Indicators of Performance Direction* has been produced to ensure that the Health and Social Care sector has a core set of indicators in place, on common definitions across the sector, which enable us to track trends and performance. The HSCB, PHA and Trusts monitor the trends in indicators, taking early and appropriate action to address any variations / deterioration in unit costs or performance or in order to ensure achievement of the Ministerial targets.

2.0 Strategic context & drivers

This section outlines the key strategic drivers that have shaped our commissioning priorities for 2014/15 and 2015/16. These include:

- The assessed needs of the population
- Transforming Your Care
- Programme for Government
- Quality 2020
- Public Health Strategic Framework – 'Making Life Better'.

2.1 Assessing the health and social care needs of the population

This section provides an overview of the assessed needs of population of N Ireland. This assessment is based on demographic changes and information we have relating to health inequalities. These needs inform the commissioning of services at regional and local level.

2.1.1 Demographic Changes

(i) Introduction

N Ireland has the fastest growing population in the UK. Some of the key demographic changes are noted below:

- Recently published Census figures for 2012 indicate that there are approximately 1.824m people living in N Ireland (NI).
- There are a total of 273,000 older people (65+ yrs) in N Ireland.
- Current population projections anticipate the population will rise to 1.918m by 2022.
- This increase is characterized by a marked rise in the proportion of older people – up to 2022, number of people aged 65+ is estimated to increase by 26% (71,000) to 344,000. This is 18% of the total population compared with 15% currently.
- Revised population projections are not available until Spring 2014 however, 2008 based projections suggest, at sub-regional levels, the areas with the highest projected growth overall is the Southern LCG (+14%), for the aged 65+ and 75+ cohorts of the population is in the West is the Western LCG at +40%, and for aged 85+ years is in the Southern LCG (+74%).
- Births in N Ireland have remained stable over the last 5 years; there were some 25,300 live births registered during 2012.

- 14,756 deaths were registered in N Ireland during 2012 which is an increase of 552 or 3.9% since 2011.
- The main cause of death was cancer accounting for 28% of deaths in N Ireland (4134).
- Life expectancy across the region has improved by 8 years for females and 6 years for males since 1980/82. In 2008/10 males can expect to live to the age of 77.1 years and females to the age of 81.5 years
- The prevalence of long term conditions such as COPD, diabetes, stroke and hypertension is increasing. In conjunction the number of people coping with co-morbidities is increasing.
- Deprivation has an impact on health and wellbeing in many ways resulting in the lack of social support, low self-esteem unhealthy life style choices, risk taking behaviour and poor access to health information and quality services.

(ii) Demographic changes

Mid-year estimates for 2012 estimated the N Ireland population to be 1.824 million. This is an increase of an estimated 9,300 (0.5%) people since 2011. The highest increase can be found in the population aged 85 and over, which increased by 3.0% (from 31,800 to 32,700) between mid-2011 and mid-2012 (NISRA, 2013).

Northern LCG has the highest share of the N Ireland population, with 466,000 residents or 26% of the N Ireland total (Table 1). The resident population of the Southern LCG is the second largest at 363,000 (20% of NI total). Belfast and South Eastern LCGs have similar resident total populations and contribute 19% each to the N Ireland total population (348,000 and 350,000 respectively). The Western LCG has the smallest population of the five LCGs at 297,000 or 16 % of the N Ireland population.

N Ireland Resident Populations by Local Commissioning Group:

Table 1

Age Band (Years)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	66,000	96,000	72,000	83,000	65,000	382,000
16-39	124,000	144,000	105,000	119,000	96,000	589,000
40-64	105,000	152,000	117,000	112,000	95,000	580,000
65+	53,000	73,000	57,000	49,000	40,000	273,000
Overall	**348,000**	**466,000**	**350,000**	**363,000**	**297,000**	**1,824,000**

Source: NISRA, 2012

The age structure of the LCG resident populations varies. Belfast LCG has the lowest proportion of younger people aged 0-15 yrs, in comparison to other LCGs (19% or 66,000) and the Southern LCG has the highest percentage at (23% or 83,000). The Northern LCG however has the highest number of younger people within its population at 96,000 or 21% of its population. Persons of working age account for the highest proportions across all LCGs, ranging from 66% of the population in Belfast to 64% in the South Eastern LCG.

As people grow old the likelihood of illness increases and therefore also does the reliance on health and social care services. Over all in N Ireland there are 273,000 older people (those aged 65 and over) which equates to 15% of the total population. In terms of geographical distribution of this age category, 19% of these or 53,000 persons aged 65+ are in Belfast LCG, 27% or 73,000 are in Northern LCG; 21% or 57,000 reside in South Eastern; 18% or 49,000 are in Southern LCG and the remaining 15% or 40,000 live in Western LCG.

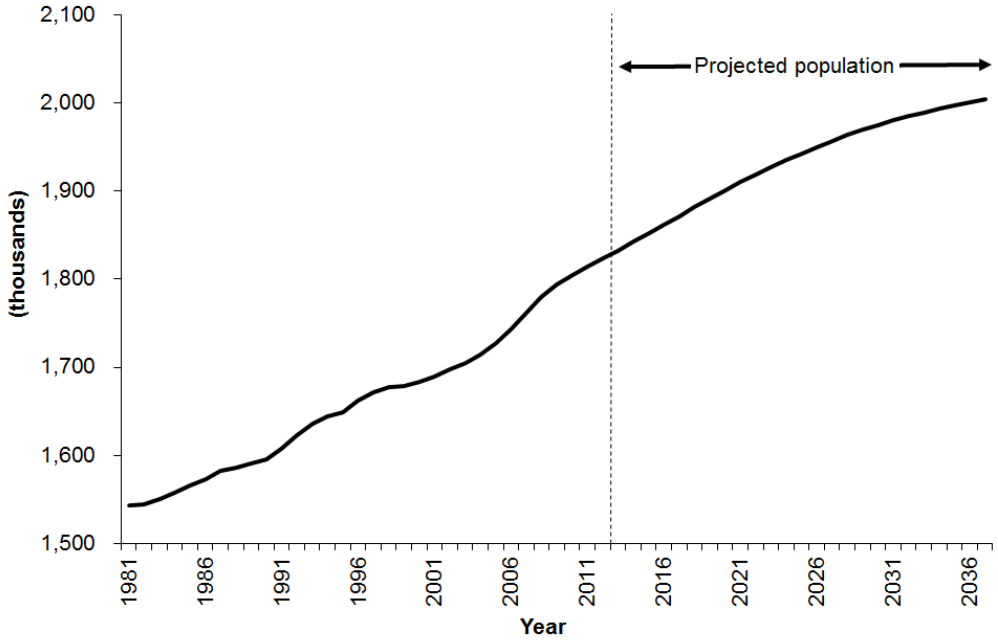
Population Projections

The N Ireland population is projected the population is projected to increase to 1.918 million in 2022 from 1.824 million in 2012, an average annual rate of growth of 0.5%.

- Natural growth is the driver of the projected population increase: between 2012 and 2022 there will be 99,000 more births than deaths.
- While the population aged under 65 is projected to increase by 1.5% (24,000 people) from 2012 to 2022, the population aged 65 or more will increase by 26% (71,000 people);
- Longer-term projections show the real impact of the marked increase in the size of the population at older ages. The number of people aged 65 and over is projected to increase by 44% in the next fifteen years (2012-2027).

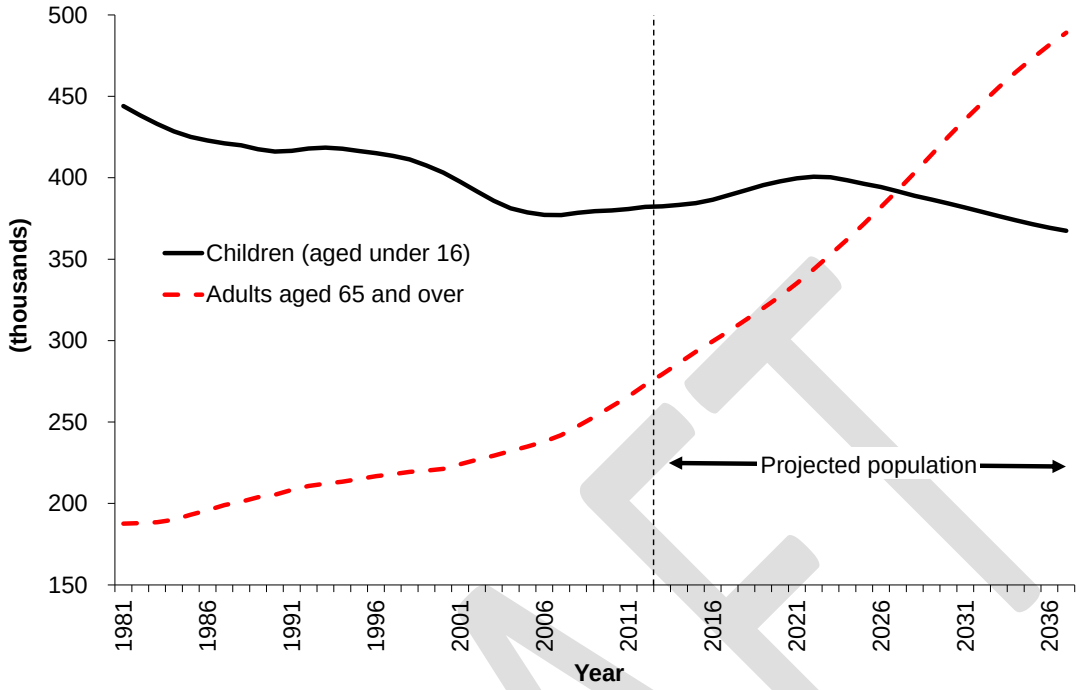
Population of N Ireland, actual and projected, 1981-2037 (non-zero y-axis)

Figure 1



Children aged under 16 and adults aged 65 and over, actual and projected, 1981-2037 (non-zero y-axis)

Figure 2



Source: NISRA

Projected age distribution of population, 2012-2037 (percentages)

Table 2

	2012	2017	2022	2027	2032	2037
Children (Under 16)	*21*	*21*	*21*	*20*	*19*	*18*
Adult Population (16-64)	*64*	*63*	*61*	*60*	*58*	*57*
Older population (65+)	*15*	*16*	*18*	*20*	*22*	*24*
Working age population[2]	*62*	*62*	*62*	*61*	*60*	*60*
Pensionable population[2]	*17*	*17*	*17*	*19*	*21*	*22*

Source: NISRA

Births

In 2012 there were 25,269 live births registered in N Ireland, which is a small change from the 25,273 births registered in 2011. The number of births in N Ireland has remained relatively stable since 2008 following an increasing trend from a record low in 2002 when there were 21,385 births. In 2012, there were

1,100 births to teenage mothers, which according to NISRA is the lowest on record.

Deaths

In 2012, there were 14,756 deaths registered in N Ireland, an increase of 552 deaths (3.9%) compared to 2011. The average age at death has increased over the last 30 years from 70.1 years in 1982 to 76.4 years in 2012 (NISRA, 2013).

The main causes of death in 2012 were cancer 4,134 deaths (28% of all deaths) – the largest number of cancer deaths on record, diseases of the circulatory system 4,001 deaths (27% of all deaths) and diseases of the respiratory system 2,023 deaths (14% of all deaths).

Of the 14,756 deaths registered in 2012, just under half (49%) of deaths occurred in hospital. A further 27% died in their own home, followed by 18% in a nursing home. The remaining 6% of deaths occurred elsewhere (NISRA, 2013).

Typically more deaths occur in the winter months, however last year we witnessed higher numbers of deaths occurring in spring, with the exception of January in which over 1,400 deaths were registered. On average there were around 6% more deaths in the spring months of March to May (around 1,300 each month) than the monthly average for the year (1,230). In contrast there is virtually no variation on the day of the week that people die (NISRA, 2013).

Standardised morality ratios (SMRs) for 2012 are presented in the table below. Belfast and Western LCG areas exhibited higher than average standardised mortality rates (SMRs) for all causes of death in 2012 (112.3 and 101.4 respectively). SMRs for Northern and South Eastern LCG areas were lower than average (94.4 and 94.0 respectively).

Standardised Mortality Ratios 2012 by Local Commissioning Group for the main causes of death (All causes, Cancer (including trachea bronchus or lung), Circulatory diseases (including Ischemic heart disease and Cerebro-vascular disease), and Respiratory disease (including Pneumonia).

Table 3

Area	All deaths	Malignant neoplasms			Circulatory diseases			Respiratory diseases	
		All sites (C00-C97)	Trachea, bronchus & lung (C33-C34)	Breast[1] (C50)	All circulatory diseases (I00-I99)	Ischaemic heart disease (I20-I25)	Cerebro-vascular disease (I60-I69)	All respiratory diseases (J00-J99)	Pneumonia (J12-J18)
NORTHERN IRELAND	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***	***100.0***
Belfast	***112.3***	***114.9***	*129.8*	*107.6*	***107.5***	*104.5*	*115.6*	***123.7***	*109.4*
Northern	***94.4***	***96.4***	*88.4*	*93.0*	***97.0***	*92.4*	*100.0*	***91.2***	*94.2*
South Eastern	***94.0***	***90.7***	*84.6*	*100.6*	***97.0***	*91.9*	*92.1*	***83.7***	*96.8*
Southern	***100.1***	***98.4***	*99.3*	*108.4*	***100.1***	*114.1*	*86.2*	***96.6***	*80.8*
Western	***101.4***	***101.7***	*104.9*	*90.9*	***98.6***	*101.8*	*106.5*	***110.3***	*124.9*

Female deaths only

Note: Rates relate to the 2012 mid-year population estimate for 2012

Source: NISRA.

Health Status

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

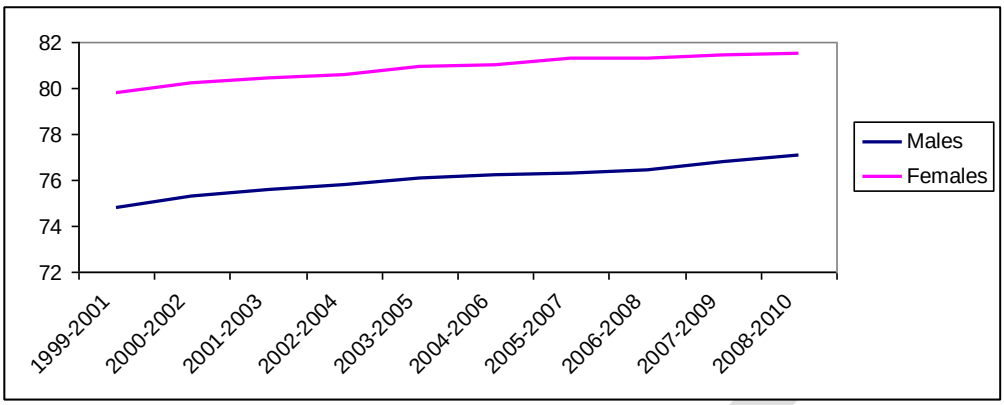
Life Expectancy

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

In Northern, life expectancy has increased between 1999-2001 and 2008-2010 from 74.8 years to 77.1 years for men, and from 79.8 years to 81.5 years for women.

Life Expectancy by Gender in N Ireland, 1999-2000 to 2008-2010.

Figure 3



Source: NISRA, 2012

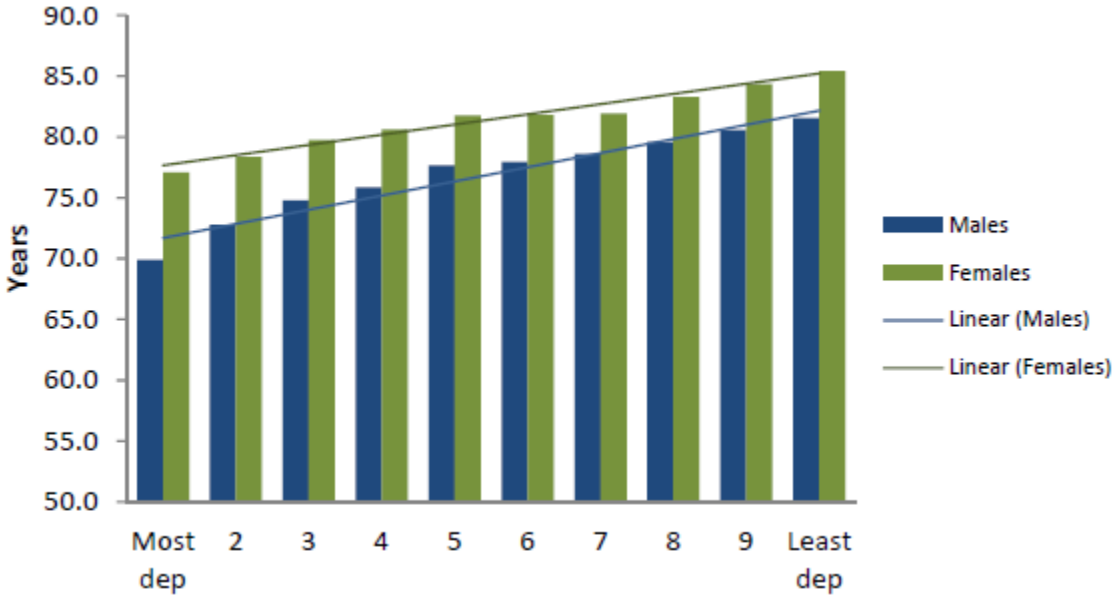
While there are some signs of general improvement in life expectancy, not everyone has been able to avail fully of the benefits of this progress. Social inequality has endured to the extent that health outcomes for some groups remain poorer than for others, and smoking, obesity, misuse of drugs and alcohol, teenage conception rates, poor mental health are disproportionally concentrated amongst particular deprived groups (Source: PHA, 2012).

The influence of social conditions and lifestyle behaviour is evident when we compare life expectancy and other health outcomes across geographical areas and population groups.

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

Life expectancy by Deprivation decile 2008/10

Figure 4



Source: PHA, 2012.

Recently published findings of a study of health inequalities reveal that health outcomes are generally worse in the most deprived areas within an LCG area than when compared to the LCG as a whole.

Chronic Illness / Long term conditions

Self-assessed health and long term limiting illness (Census, 2011)

The 2011 Northern Ireland Census asked respondents how they perceived their health, whether they had a long term limiting illness and if they provided unpaid care. Approximately one fifth of the N Ireland population stated that they had a long term limiting illness and almost 80% felt they were in good health.

Percentage of population with a long term limiting illness, with good or very good general health, Census 2011

Table 4

	Long term limiting Illness	General health: Good or Very Good
Belfast	23.04	76.71
Northern	19.65	80.43
South Eastern	19.82	80.84
Southern	19.64	80.60
Western	21.85	78.46
Northern Ireland	20.69	79.51

Source: Census 2011

When asked about the type of long term condition suffered 6.6% of the N Ireland population stated they had a chronic illness and 10% suffered long term pain or discomfort Table 5).

Type of Long Term Condition as assessed by the Northern Ireland Census 2011

Table 5

LCG	Deafness or partial hearing loss (%)	Blindness or partial sight loss (%)	Communication difficulty (%)	A mobility or dexterity difficulty (%)	A learning, intellectual, social or behavioural difficulty (%)	An emotional, psychological or mental health condition (%)	Long-term pain or discomfort (%)	Shortness of breath or difficulty breathing (%)	Frequent periods of confusion or memory loss (%)	A chronic illness (%)	Other condition (%)	No condition (%)
Belfast	5.6	2.0	1.9	13.1	2.6	7.4	11.4	10.3	2.5	7.2	5.6	66.0
Northern	5.2	1.6	1.5	10.7	2.0	5.1	9.7	8.4	1.7	6.6	5.1	69.2
South Eastern	5.6	1.7	1.6	11.1	2.2	5.1	9.9	8.5	1.9	6.7	5.3	68.4
Southern	4.5	1.6	1.6	10.8	2.0	5.3	9.5	7.8	1.8	5.9	4.9	70.8
Western	4.8	1.7	1.8	11.9	2.4	6.6	10.2	8.8	2.0	6.4	5.3	68.2
Northern Ireland	5.1	1.7	1.7	11.4	2.2	5.8	10.1	8.7	2.0	6.6	5.2	68.6

Source: Census 2011

QOF Disease Registers

The Prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions

there is a link between prevalence and deprivation (PHA, 2011). Across N Ireland the most prevalent LTCs are hypertension (127.38 per 1000 patients), asthma (59.81 per 1000 patients) and diabetes (39.95 per 1000 patients).

Emergency Admissions to hospital for LTC

During 2011/12 long term conditions such as asthma, COPD, diabetes, heart failure and stroke accounted for a total of 11, 620 emergency admissions to hospital (where relevant ICD-10 codes were coded as a primary diagnosis or main condition treated on the admission episode). COPD accounted for just over 40% of this total, at a rate of 342 admissions per 100,000 population (aged 18+).

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

Table 6

	Asthma	COPD	Diabetes	Heart Failure	Stroke
Number of Emergency Admissions	835	4,717	1,008	2,363	2,697
Rate per 100,000 popn.	61	342	73	171	195

Source: PAS, HSCB PMSI 2013.

Cancer

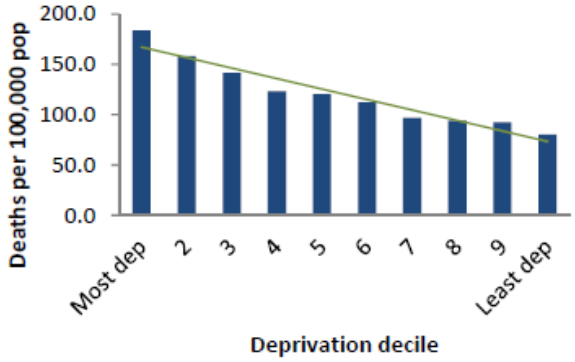
According to NIISRA, cancer now accounts for the largest number of deaths attributable to a single cause. The proportion of deaths due to cancer in N Ireland has increased from 18% in 1981 to 29% of all deaths in 2011. By way of contrast, deaths in 2011 due to ischemic heart disease decreased by 60% since 1981 from 4,909 to 1,966.

In 2011, the most common cancer sites for males and females was the trachea, bronchus or lung which accounted for 26% of deaths in males and 19% of female deaths. Breast cancer accounted for 18% of female deaths in 2011, and prostate cancer for 11% in males. The graphs in Figure 5 illustrate the social gradient in relation to the death rate under 75 due to (i) cancer (all sites) and (ii) lung cancer.

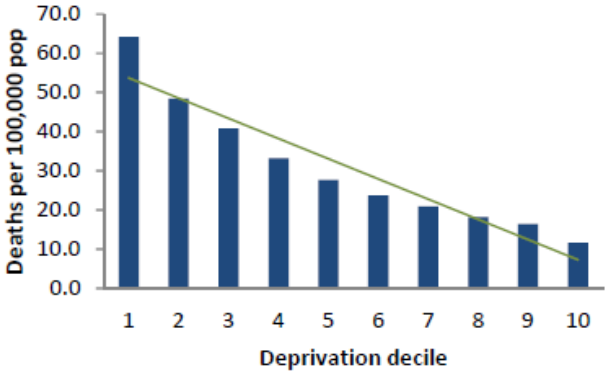
Standardised death rate (SDR) for cancer (all sites) and lung cancer for the aged under 75yrs, by deprivation decile, 2005-2009

Figure 5

i. SDR due to cancer (U75) - all causes, 2005-09



ii. SDR due to lung cancer (U75) - 2005-09



Source : PHA, 2012.

Cancer related mortality in the most deprived decile was more than twice that in the least deprived and one and a half times that in N Ireland as a whole. Lung cancer related mortality in the most deprived decile was five and a half times that in the least deprived.

Lifestyle and behaviour

Smoking

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

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in N Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 48 individuals every week (PHA, 2012).

Generally smoking related deaths have decreased by around 9% over the last number of years (Table 7). This trend has been observed at sub regional level for all LCGS with the exception of Belfast which has remained relatively stable. In

general, Belfast LCG residents experience significantly higher death rates due to smoking related causes (figure 6). South Eastern residents experience the lowest mortality rates due to smoking related causes.

Standardised death rates by LCG of Residence for smoking related causes

Table 7

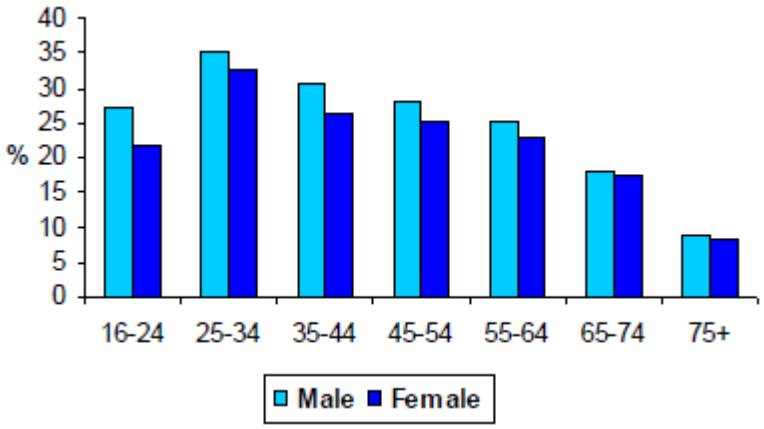
LCG/ Trust Area of Residence	00/01-02/03	08/09-10/11	% Change
Belfast	161	164	2%
Northern	129	119	-8%
S-Eastern	122	115	-6%
Southern	134	127	-5%
Western	148	141	-5%
N. Ireland	134	122	**-9%**

Source: NI Health and Social Care Monitoring System, 2012.

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

Smoking prevalence by age and gender 2011/12

Figure 6



Source: Health Survey Northern Ireland DHSSPSNI, 2012.

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

Alcohol

Alcohol and drugs misuse have been a significant issue in N Ireland for many years. The number of alcohol related deaths has been increasing over the past decade. Since 2001, there has been a total of 2,785 alcohol related deaths, 68% of which have been deaths to males. Of this total, 854 or 31% were registered to Belfast LCG area of residence.

Alcohol related admission rates have also been on the increase in N Ireland over the past decade. In general admission rates have increased for all LCGs with the exception of Northern which has fallen by 11%.

Standardised alcohol related admission rates by LCG of Residence

Table 8

LCG/ Trust Area of Residence	00/01-02/03	08/09-10/11	% Change
Belfast	805	943	17%
Northern	470	419	-11%
S-Eastern	418	551	32%
Southern	479	602	26%
Western	476	670	41%
N. Ireland	**528**	**641**	**21%**

Source: NI Health and Social Care Monitoring System, 2012.

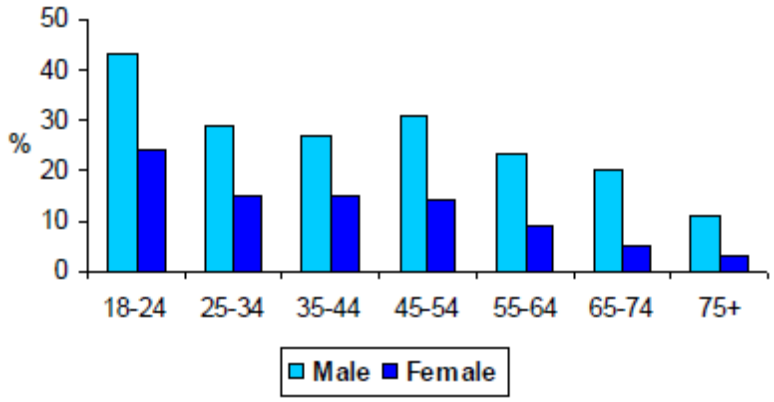
Alcohol related standardised admission rates and death rates for Belfast LCG residents are significantly higher than all other LCGs.

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

of all respondents aged 18 and over reported drinking in excess of the weekly drinking limits.

It is well known that health outcomes are generally worse in the most deprived areas, with alcohol related mortality in the 10% most deprived areas of N Ireland being almost 9 times that in the least deprived areas (PHA, 2012). The same is true within an LCG area than when compared to the LCG / trust as a whole. For example, within Belfast LCG alcohol related hospital admission rate was 120% higher in the most deprived areas than in the LCG area as a whole (DHSSPSNI, 2012).

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



Source: Health Survey Northern Ireland DHSSPSNI, 2012.

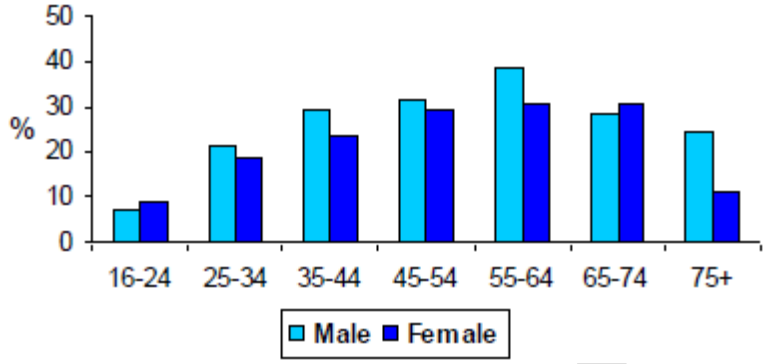
Obesity

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

Recently published findings of the Health Survey Northern Ireland shown in Figure 8 indicate that 10% of 2-5 year olds were assessed as being obese. Overall, 61%

of adults measured were either overweight (37%) or obese (23%), with a higher prevalence in males (25%) than females (34%).

Obesity levels by age and gender
Figure 8



Source: Health Survey Northern Ireland DHSSPSNI, 2012.

Rurality

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

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

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

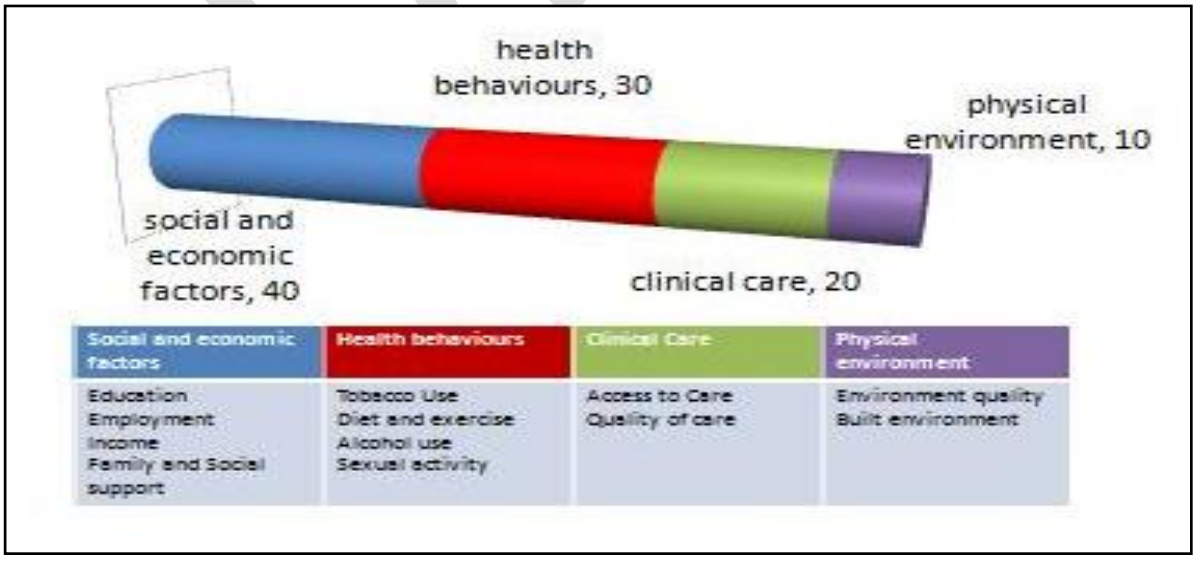
The *New Policy Institute* found, for example, that disadvantage was more prevalent in western districts of N Ireland. Broader research carried out across rural areas in the UK indicates that most rural areas are affluent, with rural poverty scattered and hidden amongst general affluence. People in rural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

2.1.2 Health Inequalities

In N Ireland between 2001 and 2011 37,500 people died prematurely of conditions which were potentially preventable. An additional 8,765 people died prematurely of conditions which, if diagnosed and treated early enough, might have been avoidable[2]. Figure 9 illustrates the potentially preventable causes of death which contribute most to this situation. Not all these conditions are directly related to healthcare and many reflect lifestyle and underlying social and environmental influences or what are referred to as the 'social determinants' of health. Work by the University of Wisconsin Population Health Institute has estimated the relative weight of various factors on health outcomes (see Figure 10).

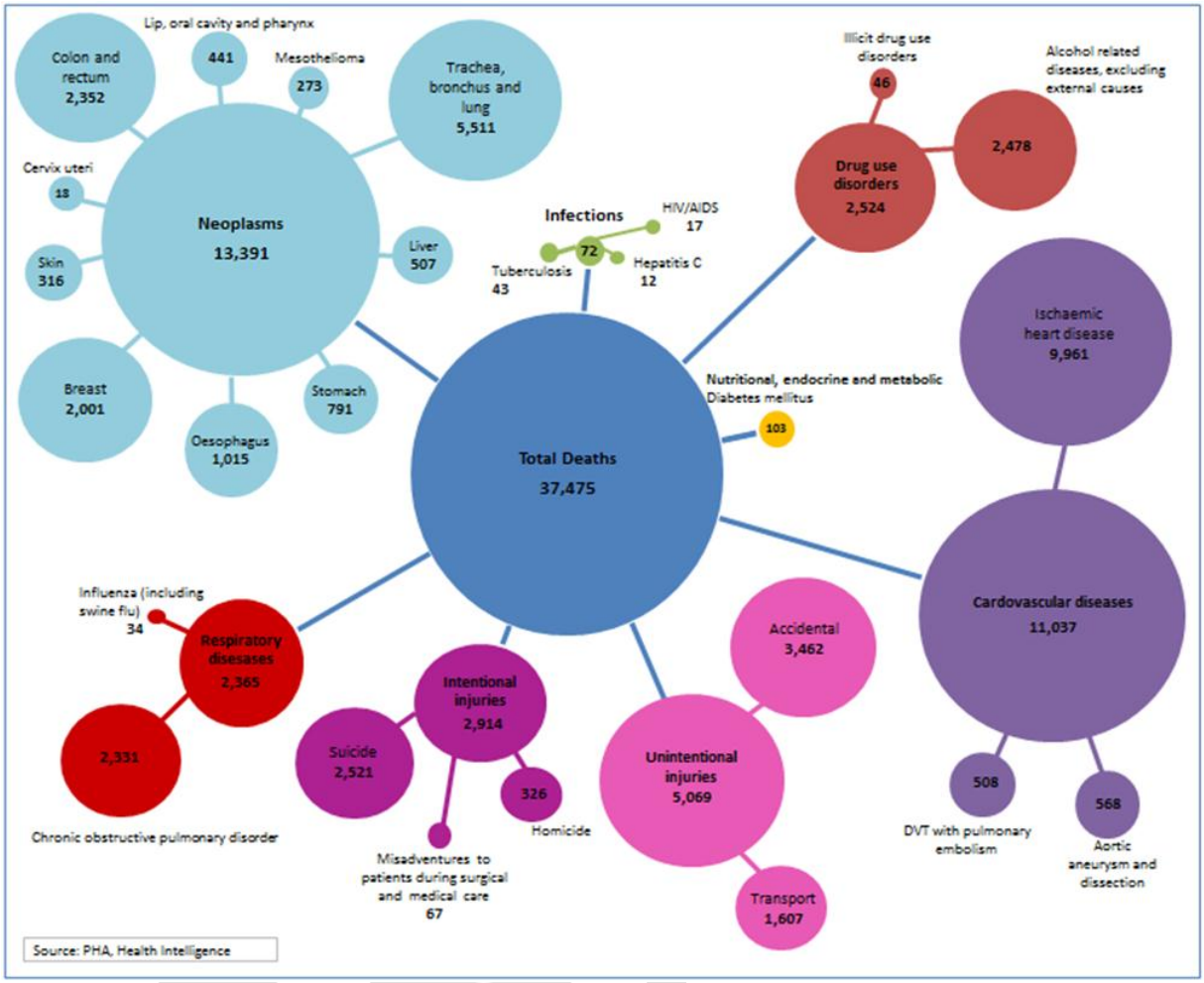
Percentage contribution to health outcomes

Figure 9



[2] PHA Health Intelligence briefing on avoidable deaths.

Relative Weighting of Factors on Health Outcomes
Figure 10



While N Ireland has seen reductions in inequalities (for example in relation to infant mortality, cancer incidence rates, teenage births) gaps still exist and the improvements have not been seen in all groups at the same rate. The position of inequality has been persistent over time. Those most likely to die prematurely include men (63%), reflecting the four and a half year gap in life expectancy between men and women, and those living in our most deprived areas. Residents of most deprived areas are twice as likely to die prematurely of preventable causes as those in least deprived areas. This increases to a factor of six for drug related deaths, four times for alcohol and respiratory problems and three times for suicide, diabetes and lung cancer.

The DHSSPS disaggregation of life expectancy differentials in N Ireland[3] highlighted the reducing impact of circulatory disease on premature mortality with the increased contribution of cancers and accidental injuries and suicide amongst the younger age groups, particularly in more deprived areas.
While life expectancy in N Ireland is broadly similar to that in the rest of the UK, 'healthy life expectancy' is significantly below that of England, Scotland and Wales[4].

The 2011 census reported that over 80,000 (6%) aged 16-74 years in N Ireland described themselves as in bad or very bad health. [5] There was a marked socio-economic gradient ranging from 2% of those in higher managerial and professional occupations to 12% of those in routine occupations and nineteen per cent of those who had never worked. This increased to 13% overall of those aged sixty- to sixty-four years with 21% of those in routine occupations in this age group describing their health as bad or very bad. These people were likely to identify long term health problems and disabilities that limited their day to day activities and this pattern has a strong age gradient.

In terms of preventable illness, GP QOF data for N Ireland (March 2013) identified some 245,000 registered adult patients with hypertension, 169,000 with obesity, 79,000 with diabetes, and 33,000 with cancer.

The World Health Organisation in 2010 [6] identified major contributors to the 'Global Burden of Disease' and ranked the ten most influential risk factors for Western Europe as shown in Table 9.

[3] http://www.dhsspsni.gov.uk/hscims_life_expectancy_decomposition_2013.pdf
[4] http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-and-age-65-in-the-united-kingdom/2008-10/index.html
[5] http://www.nisra.gov.uk/Census/2011_results_detailed_characteristics.html
[6] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61766-8/abstract

Ranking of Risk Factors Contributing to Quality Adjusted Years of Life Lost in Western Europe

Table 9

1. Tobacco use	2. High blood pressure
3. Overweight/obesity	4. Low physical activity
5. High blood glucose	6. Alcohol use
7. Diet low in fruits	8. High cholesterol
9. Diet low in nuts and seeds	10. Sodium levels in diet

Table 10 illustrates the substantial variations in the prevalence of risk behaviour within different groups across N Ireland. Other communities, for example Lesbian, Gay, Bisexual and Transgender (LGB&T) have higher levels of reported risk from tobacco, excess alcohol and drugs[7].

Many of these risk factors cluster in individuals. While 58% of people did not meet physical activity guidelines in 2010/11 and 68% did not eat the recommended five a day, 41% of people did not do either.[8] Of the five main healthy lifestyle behaviour choices [9] 20% of people in more deprived areas meet only one or none (NI value 12%)[6].

[7] http://www.publichealth.hscni.net/publications/all-partied-out

[8] Bulletin 6 Lifestyle choices 2010/11 Health survey http://www.dhsspsni.gov.uk/index/stats_research/stats-public-health.htm

[9] Ensuring alcohol intake is within weekly guidelines. Not being overweight or obese by maintaining Body Mass Index (BMI) of less than 25 kg/m2. Eating at least 5 portions of fruit and vegetables a day. Meeting the recommended weekly level of physical activity (i.e. exercising for at least 30 minutes five days a week). Not smoking cigarettes.

Individual risk factors from the Northern Ireland Health survey 2011/12

Table 10

	N.I.	Gender		Age Group			Trust/LCG					Deprivation	
		M	F	16-24	45-64	75+	Belfast	Northern	South Eastern	Southern	Western	Most deprived	Least Deprived
General health - 'not good' (%)	14	13	14	4	16	22	16	13	14	13	13	18	12
Eating ' five a day' (%)	32	26	37	26	33	28	30	30	33	36	33	27	34
Obese or overweight (%)	61	67	56	28	70	63	58	63	60	58	64	63	55
Smoking (%)	25	27	23	24	26	8	28	24	22	23	23	39	15
Drinking > weekly limit (%)	25	28	13	M 43 F 24	M 31 F14	M 11 F 3	32	20	26	18	26	M 44 F 22	M 32 F18
Meeting Physical activity levels (%)	35	40	31	35	38	13	30	37	31	41	34	34	30
Mental health – potential psychiatric disorder (GHQ12) (%)	19	17	20	18	23	15	23	16	22	17	15	27	16

Widowed, divorced or cohabiting were more likely than respondents that were separated, married and single to not meet the Health recommendations. Females were more likely than males to meet three or more of the lifestyle recommendations (61% and 50%, respectively). [6]

Known inequalities in health have been identified across a range of groups. Some specific examples of these include:

- For male Travellers life expectancy at birth is 61.7 years – 15years less than that of the general population and now at the level of the ROI overall population on the later part of 1940s. For female Travellers life expectancy at birth is 70.1 years – 11 years less than the general population and equivalent to that of women in the early 1960s.
- Traveller men had a 6.6 times higher suicide risk compared to settled men (AITHS Team, 2010b – based on ROI data [10]).
- Carers UK 2013 survey of over 3000 carers in the Uk said that 84% of carers said that caring had a negative impact on health.[11]
- Almost a third (31%) of those caring for 35 hours or more per week received no practical support for caring. [9]
- At the 2011 census 6,065 people aged 65+ who described themselves as being limited 'a lot' in their daily activities due to a long term condition were themselves providing twenty or more hours of unpaid care to family or friend. Of these 4,743 were providing fifty or more hours a week.[12]
- An estimated 2/3 of prisoners have mental health problems.
- Thirty-six per cent of unskilled manual workers smoke – four times more than the level amongst professional groups [13] (2010/11 Health survey).
- A survey of 967 homeless people in Salvation Army centres within the UK and Ireland revealed a high level of reported traumatic childhood experiences including sexual abuse (3%), physical abuse (25%) and

[10] AITHS Team (2010b). *All Island Traveller Health Study. Our Geels. Technical Report 1: Health survey findings*. Dublin: UCD. http://www.dohc.ie/publications/aiths2010/TR1/AITHS2010_TechnicalReport1_LR_All.pdf?direct=1

[11] The State of Caring 2013 CarersUk http://www.carersuk.org/professionals/resources/research-library/item/3090-the-state-of-caring-2013

[12] http://www.nisra.gov.uk/Census/2011_results_detailed_characteristics.html

[13] 2010/11 Health Survey http://www.dhsspsni.gov.uk/health_survey_2010-11_socio-economic_group.pdf

emotional abuse (30%)[14].

- High levels of mental health problems, self- harm, suicide and alcohol and drug abuse are reported in the homeless population[15].
- A survey of homeless people revealed a smoking prevalence of 77% with only half (55%) having been offered smoking cessation advice (UK data)[16].
- Analysis of the mortality of homeless people in England between 2001 and 2009 revealed that the average age of death is substantially lower than the general population (47 years compared with 77 years) and that they were 9 times more likely to die by suicide than the general population[17].
- In a NI survey of young same-sex attracted men, over one quarter (27.1%) of the respondents had attempted suicide and over two thirds (71.3%) of respondents had thought about taking their own life.[18]
- LGB&T people are nearly three times more likely to have taken an illegal drug in their lifetime compared with the N Ireland population as a whole (62% compared with 22%).
- LGB&T people are more likely to drink alcohol (91%) compared with 74% of the N Ireland population and of those who drink, LGB&T people are twice as likely to drink 'daily' or 'most days' compared with the N Ireland average (13% as opposed to 6%).
- 44% of LGB&T people smoke cigarettes compared with 24% of the N Ireland population.[19]
- NI rates of fuel poverty in 2011 (42%) were noticeably higher than England (15%) or Scotland (25%). [20]
- In NI in 2011 52% of those aged 60-74 and 66.3% of those over seventy-five were in fuel poverty (under 60 =34%).[21]

[14] The seeds of exclusion report (2009) http://www.doorwayproject.org.uk/Documents/SA%20Seeds%20of%20Exclusion%202009.pdf

[15] See PHA Health Intelligence briefing on Homelessness for more information.

[16] The health and wellbeing of people who are homeless: Evidence from a national audit. Homeless Link (2010). http://homeless.org.uk/sites/default/files/Health%20Audit%20Findings_National%20evidence.pdf

[17] Homelessness Kills: An analysis of homeless mortality in early twenty-first century England. www.crisis.org.uk/data/files/publications/Homelessness%20kills%20-%20full%20report.pdf

[18] http://www.rainbow-project.org/assets/publications/out_on_your_own.pdf

[19] http://www.rainbow-project.org/assets/publications/All%20Partied%20Out.pdf

[20] http://www.ofmdfmni.gov.uk/tackling-fuel-poverty-in-ni-liddell-lagdon.pdf

[21] http://www.nihe.gov.uk/news-energy-efficiency-has-impact-on-fuel-poverty

- In NI in 2011/12 sixteen per cent of mothers were smoking at the time of first booking. This increased to twenty-nine per cent of mothers from the twenty per cent most deprived areas.[22]

The cost of some health behaviours is significant. For example, the misuse of alcohol is estimated at some £900million each year with an impact of approximately £250million costs to health and social care[23].

The WHO office in Europe in 2012 reviewed the evidence at that point and concluded that - 'Real health benefits can be attained at an affordable cost by investing in health promotion and disease prevention'.[24]

[22] PHA internal profile of Child Health 2013.

[23] Social Costs of Alcohol Misuse in Northern Ireland for 2002/0. Research commissioned by Public Health Information and Research Branch, DHSSPS.

[24] http://www.euro.who.int/__data/assets/pdf_file/0020/170093/RC62wd08-Eng.pdf page 26

2.2 Transformation

Transforming Your Care (TYC) proposes a different model for health and social care, designed with the person at the centre and with health and social care services built around the individual, supporting them to make good health decisions and achieve the best health outcomes.

One of the key drivers for transformation is the demographic change described in Section 2.1 above. With an increasing ageing population comes an increased burden in terms of longterm conditions and the resulting demands on our services. Population projections indicate that we need to act now in order to preserve and sustain our services in the face of these increasing demands and to meet the care needs of the population. In particular, we need a greater focus on prevention so that people live healthier and independent lives for longer and we need to introduce measures to reduce the reliance on secondary care and begin to shift more provision into community and primary care.

The main aims of the "shift left" approach outlined in TYC are to prevent ill health in the first place, provide care closer to home, personalise care through empowering patients and service users and reduce unnecessary hospital admissions. Within this, there should be more control (including financial control) for patients, users and carers, more choice about the services we access and those services should be better joined up across the health and social care sector and beyond.

This vision and these aims, received widespread support and implementation has commenced. As this Commissioning Plan demonstrates transformation and service improvement is embedded across all those services that we deliver, and the implementation of TYC is critical to ensuring that the services we commission meet the population's needs and expectations.

The TYC aims have been translated into five strategic outcomes which all TYC related projects map back to, and will be tracked to ensure progress towards achievement. These are:

- The individual at the centre
- Improving health and well being

- Providing safe, sustainable and resilient services
- Living independently
- Home as the hub of care

The HSCB, supported from the beginning of 2014 by external expertise, will work alongside Trusts to develop shift plans for 14/15 and 15/16 which will translate the shift left from secondary care into primary and community care. Integrated Care Partnerships (ICPs) will play a critical role in improving the management of longterm conditions through greater integration across primary, secondary and community care and will be central to the delivery of shift left.

Transformation is the key focus of commissioning across all PoCs in 2014/15. Consequently, a consistent theme is the need to reduce our reliance on hospital and institutional care while focusing investment on the development of more responsive and individualised care closer to home and the promotion of early intervention, prevention and greater choice and independence. This means that the way in which we deliver care will change; patients will be able to access new services in different places. How we are commissioning these different services are set out throughout this plan within each PoC.

The transformation agenda is throughout this plan, and this is augmented by the information below which outlines how some of the key overarching 'shift left' commissioning priorities in 2014/15 will change how we deliver care through investment in community based alternatives. Often these will impact on a range of PoCs; these include:

1. Expansion of 7 day working
2. Review of domiciliary care
3. Short Break services for carers
4. Re-ablement
5. Self-Directed Support
6. Day Opportunities
7. Social Care Procurement

In addition, one of the major changes to the way we are commissioning services will be through the development of Integrated Care Partnerships (ICPs). ICPs are providers of services and bring together a range of primary, secondary, community, voluntary and independent sector providers who work together to identify opportunities to provide more seamless care, closer to home, reducing reliance on hospital-based care.

As noted in Section 2.1, demographic information indicates that the prevalence of long term conditions such as COPD, diabetes, stroke and hypertension is increasing in conjunction with an increase in the number of people living with co-morbidities. Hence, in addition to a focus on the frail elderly, ICPs will prioritise the following clinical areas across people of all ages: respiratory conditions, diabetes and stroke. Their work will include palliative and end of life care in respect of these agreed condition groups. The work of the ICPs will therefore impact across all PoCs.

ICPs will aim to improve the integration of care for these patient groups by identifying how the blockages and barriers to the integration of services might be overcome and creating opportunities to integrate and streamline care, through delivery of the RICE agenda, namely:

(1) Risk stratification of service users with specific longterm conditions to allow the provision of more appropriately targeted care.
(2) Information sharing across partners to ensure a coordinated and prioritised approach to the development and delivery of integrated care pathways.
(3) Care pathways – local application of fully integrated, Commissioner approved care pathways.
(4) Evaluation – reviewing how well the new pathways are working with a view to supporting continuous improvements in care.

During 2013/14, LCGs asked ICPs to bring forward service investment proposals which support the shift left agenda. It is anticipated that a number of these services will be formally commissioned during 2014/15. Further information on these is included in LCG plans.

7 day working

A significant commissioning priority for 2014/15 is the development of 7 day working within secondary care together with the development of primary care aligned 7 day Community Nursing Services, including District Nursing to deliver acute and complex care at home and palliative and end of life care at home or in the most appropriate community facility. These developments will enable patients to receive diagnostics, treatment and care on a "same or next day" basis, delivering better patient outcomes. Within secondary care, this will improve patient flow, enable earlier discharge and easing pressures on Emergency Departments. It will also mean that a GP who has a patient with worsening symptoms will be able to speak to a secondary care clinician to get advice about their management. This will enable GPs to provide more of care in the community; perhaps with support from rapid response teams/acute care at home were necessary.

Domiciliary care

As we know more people want to stay in their own home, and to be as independent as possible, we are increasing our investing in a range of services to support them to do so. Within this, we recognise the importance that domiciliary care plays in allowing people to remain in their own home. It is against this backdrop that the HSCB will undertake a review of domiciliary care in 2014/15. The purpose of the review is to ensure that we have in place a 'fit for purpose' model of domiciliary care that can respond to the needs of clients and service transformation.

Carers' Support

Carers also play a key role in supporting people to remain at home/near home for as long as possible. The Transforming Your Care Review and subsequent public consultation acknowledged the important role that carers play and the HSCB are continuing to progress the implementation of the Carers Strategy. In working to address the needs of carers in 2013/14 a range of short break/respite pilots were established in each of the five LCG areas. Short breaks are designed to minimise the risk of breakdown of carer support, help the carer to deal with crisis situations that might prevent them continuing in their caring role, prevent

a sense of isolation for the carer and provide positive benefits for both carer and service user.

During 2014/15 the HSCB will work with the LCGs to evaluate the short break pilots undertaken to take and ensure that the lessons learned are embedded in future short break schemes. Work will also be undertaken to increase the uptake of carer's assessments, and enhance how carer's access information about our services.

Reablement

Many people being discharged from hospital or otherwise entering the care system as a result of crisis, are often referred to a single profession / service or have a number of separate referrals for different care professionals / services (e.g. social work, AHP, domiciliary care). It may take a number of weeks for a service to respond to a referral. Reablement is a short-term programme (typically 6-12 weeks) of intensive support and therapy provided in a person's own home. It is for people of any age who have suffered from a health or social care crisis, and those who are recovering from an illness or injury and have become frail as a result. Support usually involves practical support with input from occupational therapists, physiotherapists, nurses, case managers and trained support workers, who work with a person to help them relearn the skills of daily living and build their confidence to live independently.

During 2014/15 the HSCB aim to roll it out more fully so that by the end of 2015, it will be available to everyone who needs it. This means that rather than have to stay in hospital or be admitted to a nursing home until they regain their independence, the person, can be referred to a reablement service and receive care at home. In order to further drive improvements associated with reablement the key actions in 2014/15 are:

- An assessment of the current baseline of reablement service provision and uptake, including benefits delivered
- Refinement of the reablement pathway to ensure inclusion of core components to deliver successful outcomes for clients

Self-Directed Support

During 2014/15 the HSCB will continue to progress the implementation of Self Directed Support (SDS). Self Directed Support allows people to develop tailored support plans to meet their assessed needs. The provision of a personalised budget results in people having greater choice, independence and control over how their support needs are met.

Key activities associated with Self Directed Supported in 2014/15 will include:

- A stocktake to establish the current uptake and benefits associated with SDS
- Progression of a regional target for uptake with designated client groups
- Progress the development of a resource allocation model which promotes the sustainability of SDS.
- Support Trusts in the development of HSC staff capability to facilitate a the cultural change associated with progression of SDS.
- Work with HSC Trusts and the Community and Voluntary sector to raise awareness of SDS.
- Engagement with the community and voluntary sector regarding the administration of SDS.

Regional Day Opportunities

In 2013/14 the HSCB undertook a consultation on regional day opportunities. The recommendations arising as a result of the consultation will commence implementation in 2014/15. It is likely that this will mean that young adults with a learning disability can access a more diverse and innovative range of day opportunities outside of the traditional day centre model. Working with the individual and their family, community learning disability services will provide community support which is tailored to their needs and interests so that they might choose to attend college two days a week, attend a supported employment placement one day a week and have one evening a week where they are supported to attend their local leisure centre.

Social Care Procurement

The transformational changes associated with social care will mean that the HSC as a system will need to have the ability to procure services differently. For

example, the model for procurement will need to acknowledge an increasing role for the voluntary, community and independent sector within the context for a mixed economy of care advocated in TYC. In addition, 2014 will see the implementation of new EU Directives which aim to modernise procurement processes. It's against this context that during 2014/15 the HSCB will be working towards the development and implementation of a new social care procurement model and strategy.

This plan sets out what services we will be commissioning in future, and how they differ to those which are currently commissioned. In each Programme of Care, the recommendations and activities associated with Transforming Your Care are integrated and embedded to demonstrate how health and social care services will develop and invest in primary and community based alternatives, promote choice and diversity, and enhance earlier intervention and prevention. Taken together, these will represent a further step in the journey towards the model of care set out in Transforming Your Care, and the 'shift left' of activity contained therein.

2.3 Programme for Government 2014/15

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

PFG identifies a number of key priorities to be delivered over a three year planning cycle across all Government departments. Health and social care have committed to the achievement of a number of related targets across the three year plan to support the delivery of the Executive's priorities. Table 11 outlines the targets for 2014/15 and references the section of the plan which provides detail regarding implementation.

In line with the PFG commitment 22, an additional £10m (from the 2011/12 baseline) is expected to be invested in public health during 2014/15. PHA has responsibility for investing this funding in a range of programmes that will help to reduce health inequalities and improve health and well-being outcomes. In 2013/14, the first tranche of the funding was invested in a number of new areas including:

- The provision of additional services to help support people affected by suicide and mental health issues;
- Establishment of a regional Self Harm Registry
- new initiatives to support vulnerable young children and their families, including the establishment of 2 additional Family Nurse Partnerships;
- development of new programmes to help older people to continue to live independently;
- additional investment to support research focused on improving health and well-being and addressing health.

PfG Targets 2014/15

Table 11

Commitment	2014/15 target	Referenced
Commitment 22: Allocate an increasing percentage of the overall health budget to public health	During 2014/15, invest an additional £10m in public health (increase based on 2011/12 baseline)	Section 4.9 - POC8 Health Promotion & Disease Prevention
Commitment 44: Enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic condition management programme	During 2014/15, people with a longterm condition will be offered access to appropriate education, information and support programmes relevant to their needs, including innovative application of connected health.	Section 4.1 - POC1 Non-specialist Acute; LCG plans
Commitment 45: Invest £7.2 million in programmes to tackle obesity	During 2014/15, invest £2.8m in tackling obesity through support of obesity prevention framework.	Section 4.9 - POC8 Health Promotion & Disease Prevention
Commitment 61: Introduce a package of measures aimed at improving safeguarding outcomes for children and vulnerable adults across N Ireland	During 2014/15, develop an updated Inter-Departmental Child Safeguarding Policy Framework.	Section 4.5 - POC4 Elderly Care

PfG Commitment	2014/15 target	Referenced
Commitment 79: Improve Patient and Client outcomes and access to new treatments and services	During 2014/15, expand cardiac catheterisation capacity to improve access to diagnostics intervention and treatment and further develop the primary percutaneous coronary intervention (pPCI) service to reduce mortality and morbidity arising from myocardial infarction.	Section 4.2 - POC 1 Acute Specialist Services
Commitment 80: Reconfigure, Reform and modernise the delivery of Health and Social care services to improve the quality of patient care.	During 2014/15, secure a shift from hospital-based services to community-based services together with an appropriate shift in share of funding in line with the recommendations from *Transforming Your Care*.	Section 4.1 - POC1 Non-specialist Section 4.5 - POC4 Elderly care Section 4.6 - POC5 Mental Health Section 4.7 - POC6 Learning Disability Local Commissioning Plans (Sections 6-10)

2.4 Improving Quality, Outcomes and Patient Experience - Quality 2020

The HSCB / PHA place the quality of patient care in N Ireland, especially patient safety, above all other aims, and works continually to improve services. Whilst healthcare is complex and pressurised, the HSCB / PHA are focused on ensuring that patients, carers and users experience remains a priority and appropriately influences commissioning. The Francis report highlights that statistics, benchmarks and action plans are not ends in themselves and should not come before patients and their experiences. This is reflected in the strategic direction and the comprehensive programme of work undertaken by the HSCB, PHA in conjunction with HSC Trusts in the Patient Client Experience Standards.

The DHSSPS Quality 2020 is the strategic framework that ensures patients and their experiences remain at the heart of service design and delivery by defining Quality under three headings:

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

Quality 2020's vision for the HSC is "to be recognised internationally, but especially by the people of N Ireland, as a leader for excellence in health and social care". It highlights five strategic goals to realise this vision:

1. Transforming the culture
2. Strengthening the workforce
3. Measuring the improvement
4. Raising the standards
5. Integrating the care

During 2014/15 the DHSSPS Quality 2020 Steering Group will provide strategic direction to the implementation team and ensure that the work of the task

groups will continue to align with the strategic goals of the Quality 2020 strategy. In 2014/15 the task groups will continue to:

- *Develop HSC Trust Annual Quality Reports*
  HSC Trusts will produce an annual quality report by January 2015 to include core quality indicators. Phase 2 will focus on community care, social care, and mental health-related indicators, as well as other developmental areas e.g. patient-reported measures, and research. The membership of the Task Group has been amended to reflect this.

- *Implement the DHSSPS Patient Client Standards*
  During 2014/15 the Patient and Client Experience Steering Group will provide strategic direction for the implementation of the DHSSPS Patient and Client Experience Standards and agree the annual work plan.

- *Review the policy framework for safety and quality*
  A report from Phase 1 will be made available to the Quality 2020 Implementation Team in January 2014. The task group will continue to review the current policy framework and develop a catalogue of standards.

- *Develop professional leadership*
  A Leadership competency framework is to be developed and mapped to existing leadership development programmes.

- *Develop an E-Learning system to support and track training*
  Minimum mandatory training content has been agreed for medical staff and is now being developed for social care and nursing staff. A preferred option to host an E-learning programme has been identified and will roll out in 2014/15

- *Ward level review of the quality of clinical & social care*
  In early 2014 the task leads, CMO, CNO and implementation team co-chairs will review the learning from the ward-level review pilot of patient and client care.

- *Review the literature on changing organisational culture*

Task Leads will identify key priorities from the Literature review on Organisational Culture which was published in 2013/14 and along with feedback from the Stakeholder event will be used to develop proposals to drive improvements.

In 2014 the DHSSPS, Patient Client Council and RQIA will plan a Stakeholder Forum and engagement workshop which will include key stakeholder involvement from patients, clients and professionals from Health and Social Care. The aim is to share progress from Phase 1, seek stakeholder views on the priorities for Phase 2 and develop proposals for 2014/15 tasks for Steering Group approval.

A Quality 2020 Project Manager has been appointed and will lead the communication plan with support from Communications staff in HSC organisations. A key aim will be to raise awareness of the Quality 2020 strategic direction amongst staff, patients/clients and carers in N Ireland. The HSCB and PHA will, through the Commissioning Plan and more generally, seek to support the taking forward of Quality 2020.

The PHA and HSCB have established an overarching Quality Safety and Experience Group to enhance current arrangements and provide an overview of all sources of information in relation to the Safety Quality and Patient Experience of services. This group will consider issues and learning identified from SAI's, Complaints, Patient Experience, patterns/themes and Medicines Safety; to determine the most appropriate way to put learning into practice, monitor progress and seek assurance on implementation.

Quality and Safety Assurance Programme

The PHA and HSCB will continue to work to develop a comprehensive Quality and Safety Assurance programme linked to the DHSSPS Quality 2020 strategy (see Appendix 2). This programme includes:

- Monitoring and analysis of the HSC Trust Quality Improvement Plans
- Implementation and monitoring of the DHSSPS Patient and Client Experience Standards

- Working in partnership with the DHSSPS in reviewing the most appropriate methodology for a Regional Learning System.
- Measure and monitor the Key Performance Indicators for Nursing and Midwifery Care and develop further indictors to improve quality of care.
- Provide support in relation to patient safety across a range of initiatives from emergency medicine to falls prevention.
- Workforce Planning within Nursing and Midwifery Services

Evidence from recent reports such as the Francis Report, the Keogh Review and the Berwick Review highlight the importance of placing the quality and safety of patient care and safety above all other considerations. The commissioning of safe, high quality Health and Social Care Services is a top priority and core responsibility of the HSCB and PHA, and the monitoring of feedback from the Patient Experience Standards and Patient stories, as well as the learning identified from complaints and Serious Adverse Incidents provide an opportunity to continually strive to improve the safety and quality of services. The HSCB and PHA will continue to ensure that the lessons from the above reports, along with any recommendations from the imminent O'Hara report into the Inquiry into Hyponatraemia Related Deaths, are fully embedded and prioritised in the services we commission.

It is anticipated that HSC Trusts will use this funding to continue to develop a Gateway or single point of entry approach for adult safeguarding. In particular, Trusts should use this funding to support the recruitment of 1.0 (WTE) appropriately trained and experienced Nurse in each Trust to act as professional lead on adult safeguarding for nursing within all adult Programmes of Care (including Acute) as required across the HSC Trust.

Implementation of Service Frameworks

Service Frameworks for Cardiovascular Disease, Respiratory Conditions, Cancer, Mental Health, Learning Disability and Older Peoples will continue to be implemented through engagement with clinicians and other practitioners, charities and voluntary groups, people with these conditions and service managers. A framework for children is being developed.

- The cardiovascular framework has been revised and consulted on and is due to be reissued. Significant work was undertaken during 2013 to commence primary PCI in Belfast in September 2013. Further work and investment in 2014/15 will be required to complete the roll-out of this service to cover the whole of N Ireland and provide the necessary technical infrastructure to support interventional cardiology requirements for N Ireland residents.
- The respiratory framework is also undergoing revision. Specific priorities include expansion of end of life care at home, patient education programmes, timely GP access to diagnostics and increased provision of insulin pumps for children.
- The Service Frameworks for Mental health, Learning Disability and Older People have specific priorities which include; promoting health and well-being, social inclusion, person centred care and setting standards for people over 65 whilst taking into account the needs of those over 50 in relation to preventative measures. Arrangements are in place to ensure progress is made with each framework.
- Work continues to progress to ensure that standards within the Cancer Services Framework (CSF) are achieved and sustained. Audits undertaken during 2013/14 have confirmed baseline positions which had not previously been available for a small number of standards. Full implementation of the CSF has been costed and further progress on achievement of standards is anticipated.
- Palliative Care Standards are contained with Cancer, Learning Disability, Older People, Respiratory Service Frameworks

NICE Clinical Guidelines

NICE regularly produces guidance on current best practice in health and social care, including public health, health technologies and clinical practice. The HSCB is responsible for commissioning and monitoring the implementation of all NICE guidance endorsed by the DHSSPS in N Ireland and has in place robust arrangements to ensure the dissemination and implementation of all guidelines within Departmental timelines.

Strategies and Reviews

The Public Health Agency continues to work to progress a number of strategies launched by the DHSSPS such as:

- A Strategy for Maternity Care in Northern Ireland
- A Strategy for the Allied Health Professions in Northern Ireland
- Quality 2020
- Breastfeeding - A Great Start
- Transforming Your Care - Vision to Action
- Nursing and Midwifery Strategy
- Healthy Child Healthy Future

2.5 Reducing Health Inequalities - Public Health Strategic Framework

As outlined in Section 2.1.2, there are a number of known health inequalities within N Ireland. Improving health and wellbeing and reducing health inequalities is a central goal of the PHA and HSCB and we are committed to addressing these inequalities where they exist. A new Public Health Strategic Framework, 'Making Life Better' is expected by the Government, will provide direction for policies and actions to improve health and wellbeing and reduce inequalities over the coming year period. The new Framework will make clear the need for cross departmental action to address the wider socio-economic determinants of health through shared priorities, coordinated action and use of resources.

The Framework is reflected in the PHA and HSCB approach to reducing inequalities and improving health and wellbeing. Action is centred on four key building blocks:

1. <u>Give every child the best start</u>

   Evidence suggests that effective intervention in early child development will bring significant benefits long into adult life in terms of educational attainment and economic status. The PHA and HSCB will advance investment in and extend evidence based initiatives such as the Family Nurse Partnerships, parenting support and infant mental health programmes as well as advancing with the HSCB the Early Intervention Transformation Programme. HSCB is also investing in Family Support Hubs.

2. Ensure a decent standard of living

   The current economic climate presents a challenge, both in terms of available government resource and as a direct influence on health and wellbeing. For example, there is clear evidence of the link between unemployment and poor health with every 1% increase in unemployment met with 0.8% increase in suicide. Approximately one fifth of the NI population are in relative poverty[25]. The PHA and HSCB will work with government and across sectors to ensure a decent standard of living, in particular working to address poverty.

3. Build sustainable communities

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

4. Make healthy choices easier

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

In line with TYC, the PHA will address active ageing as a key priority, working with HSCB and other partners, including local communities, to promote the inclusion and full engagement of older people in improving their health and wellbeing. It will also work closely with OFMDFM, Councils, Age sector partners and others to support the realisation of Age Friendly and Dementia Friendly Communities across the province. These themes and related priorities are expanded on in Section 4.9, POC 8 Health Promotion and Disease Prevention.

[25] Broke- not Broken, Princes Trust 2012

3.0 Ensuring Financial Stability & Effective Use of Resources

3.1 Introduction

Ensuring financial stability across the HSC is one of the core objectives of the Health and Social Care Board. The current Spending Review period 2011/12 to 2014/15 has been characterised by significant financial constraints within the Public Sector and this pattern is likely to continue into the next Spending Review period. Therefore, the HSC has and will continue to experience unprecedented challenges in delivering this objective whilst ensuring quality standards are maintained and performance targets are met. Central to the achievement of financial stability in 2014/15 is the early development of comprehensive financial plans across the HSC. This involves projecting initial funding requirements and funding shortfalls, identifying realistic savings targets across the HSC to contribute towards anticipated funding shortfalls and early identification of other options to enable overall financial breakeven.

3.1.1 Approach to the Financial Plan

In each year of the Spending Review period projected increases in financial pressures have significantly outstripped additional income sources available. The financial strategy to break even has been to address this funding shortfall through challenging cash and productivity savings from within the HSC. Where possible these have been delivered recurrently however, in order to break even in year, these have also been supplemented by one off income sources and savings measures. This has meant the system has been able to break even in year but carries forward opening deficits into the following financial year.

In 2014/15 the HSCB and PHA expect to receive allocations totalling £4.2bn, this includes £84m additional resources from DHSSPS (£124m 2013/14). The first part of this section sets out the position regarding opening deficits carried forward from 2013/14 into next year and additional expenditure requirements 2014/15. These are then compared to the available income to identify the shortfall in funding which requires to be addressed if the key target of financial break-even is to be met. It also shows how total resources are planned to be deployed across local populations, providers and Programmes of Care.

A key aim of commissioning is that the HSC uses its resources to ensure local populations receive maximum benefit from health and social care services. Central to this is a performance framework which seeks to maximise productivity without impacting on services and to oversee and monitor the delivery of the cash and productivity targets set to allow the system to break even. As Trusts have not been able to fully deliver the savings targets set by the HSCB over the Spending Review period a more strategic approach to performance management of these targets will be taken during 2014/15. This will involve the HSCB reviewing and concluding on the totality of the potential savings available within the current HSC system within the relevant timeframe. Focused and detailed performance monitoring will be aimed at ensuring these are then fully delivered. Section 3.3 sets out in more detail the proposed approach.

Whilst Transforming Your Care is not driven by the financial and productivity agenda there will be opportunities to improve efficiencies in the longer term through the shift left approach. Much of the improved financial efficiency that is required to return the system to financial stability will require investment in community and non-hospital services in order to develop new service models. This will be consistent with the shift left approach. However, in the interim there are bridging costs to facilitate the delivery of Transforming Your Care and these are set out in section 3.4.

3.2 Producing the Financial Plan 2014/15/2015/16

This section sets out an overview of the HSCB/PHA financial plan for 2014/15 with indicative spending commitments for 2015/16 covering:

- An assessment of opening deficit positions across the HSC 2014/15;
- An overview of the additional inescapable pressures of Health and Social Care Board and Public Health Agency in 2014/15 and indicative 2015/16;
- A summary of income sources available to HSC;
- Potential options to address funding shortfalls;
- An analysis of total planned investments by POC, LCG and Provider; and
- An equity analysis across Local Commissioning Group area.

3.2.1 Assessment of opening financial positions across the HSC 2014/15

The Commissioning Plan 2013/14 identified £275m pressures (£303m including TYC). At the time of the Commissioning Plan funding solutions to these pressures were identified as per Table 12.

2013/14 Funding Solutions

Table 12

2013/14	**£m**
Total Pressures	(275)
TYC Pressures	(28)
Less DHSSPS & DSD funding	154
Projected deficit	**(149)**
Sources:	
In year easements	31
Trust Cash and Productivity Targets	93
FHS Targets	25
Total resource requirement	**149**

The in year easements in the table above, which allowed 2013/14 expenditure to be deferred until 2014/15 will manifest as an opening deficit of £29m, as they are one off in nature and not automatically repeatable.

Following detailed engagement between the HSCB and Trusts it has become evident that Trusts will also carry forward significant deficits into the opening 2014/15 Financial Year. During 2013/14 Trust reported positions have experienced significant volatility and deterioration. This is a result of a combination of

- recurrent under-delivery of cash savings targets £51.3m and
- unavoidable additional pressures £35.9m carried forward into 2014/15.

Table 13 sets out closing recurrent deficits in 2013/14 carried forward into 2014/15 of £116.2m.

Total closing deficit by organisation 2013/14

Table 13

Organisation	Cash Savings Deficit £m	Pressures Deficit £m	TOTAL £m
Trusts Total	51.3	35.9	87.2
HSCB	-	29	29
TOTAL	51.3	64.9	116.2

3.2.2 Planned additional investment 2014/15 (indicative commitments 2015/16)

This section provides an overview of additional pressures identified in 2014/15 – 2015/16. Total pressures across the two years are detailed in Table 14. In arriving at these forecasts the approach has sought to identify only those which are likely to be viewed as inescapable in the context of delivering the requirements of the Executive, Minister and Department as set out in the Commissioning Direction and elsewhere.

Narrative on each of the pressure areas is also provided in Appendix 3.

Total new pressures 2014/15

Table 14

Summary	2014/15 £m	2015/16 £m
Pressures:		
Pay & Non Pay	52	112
Demography	35	35
Specialist Hospital Services	7	2
NICE Drugs	19	16
Revenue Consequences of Capital Expenditure (RCCE)	7	3
Mental Health resettlements	4	3
Learning Disablity resettlements	13	3
Service Pressures/Service Developments(including Elective Care £15m& Normative Nursing)	77	28
Family Health Services	37	37
Public Health Agency	4	10
Transforming Your Care (net)	21	44
Total pressures	**277**	**292**

3.2.3 A summary of income sources and options to address identified funding gap

This section sets out the assumed additional income for 2014/15 (Table 15).

Income 2014/15

Table 15

	2014-15 £m
HSCB opening allocation	4,035
PHA opening allocation	86
DHSSPS additional HSCB	80
DHSSPS additional PHA	4
DSD additional	6
Sub total Additional Income	90
TOTAL	**4,211**

Table 16 below shows additional income sources which will contribute towards the additional funding pressures identified for 2014/15. These comprise cash and productivity targets for Trusts, the HSCB and PHA totalling £99m.

Other income sources 2014/15

Table 16

	2014/15 £m
Trust Original Cash Target	50
Trust Original Productivity Target	22
FHS	25
PHA	2
TOTAL	**99**

In addition to these, as in prior years there will be in-year easements.

3.2.4 Options to Ensure Financial Stability

The plan suggests that maintaining existing levels of service and meeting predicted levels of growth will be linked to the financial budget settlement. In the event that the HSC system does not have a break even plan, urgent

consideration of other options available to ensure that financial stability is maintained through 2014/15 will be necessary. These might include:

- Choices to be made between Maintaining Existing Services and the implementation of service developments/pressures including avoidance of all 'non critical' service developments;
- Workforce expenditure controls;
- Changing access to elective and drug therapy services, with resultant impact on waiting time performance; and
- Other options to increase income and / or reduce expenditure.

In addition there may be further opportunities in the context of support for major service redesign/ consolidation. However such major service redesign would not be deliverable within the required timeframe.

If the HSC is to deliver the challenging targets set out in the 2014/15 Commissioning Plan Direction and establish recurrent financial balance across the system, a realistic financial plan needs to be finalised as a matter of urgency.

Table 17

Revised Financial Plan 2014-15

Summary	Original Plan less Slippage & Productivity £m	Curtailed Plan Less Slippage & Productivity £m
Opening Gap	**(30)**	**(30)**
Pressures:		
Pay Pressures	(22)	(8)
Non Pay inflation	(30)	(30)
Demography	(12)	(11)
Specialist Hospital Services	(6)	(6)
NICE Drugs	(11)	(10)
Revenue Consequences of Capital Expenditure	(6)	(2)
Mental Health resettlements	(3)	(3)
Learning Disability resettlements	(10)	(7)
Service Pressures/Service Developments**(including Elective Care £15m& Normative Nursing)**	(51)	(38)
Family Health Services	(12)	6
Public Health Agency (PHA)	(2)	(0)
Add Costs of Transforming Your Care (TYC) Reforms	**(29)**	**(23)**
Less reduction to Demography & elective care pressures above which will be used to part fund TYC Reforms	8	8
Total pressures incl TYC	**(213)**	**(154)**
Assumed income from DHSSPS net of savings	84	84
Trust Savings	50	50
Baseline Funding		21
DSD	6	6
June Monitoring		20
Oct Monitoring		54
Add DHSSPS Sources	0	0
Total Pressures net of income	**(73)**	**80**
To Trusts		(80)
HSCB/PHA Projected (Deficit)/Surplus	**(73)**	**0**
Trust Gap	**(87)**	**(134)**
Already included in HSCB Pressures		**16**
Trust and Board Contingency Plans		23
Additional Low Impact Measures from Trusts		15
Contribution from HSCB/PHA- Above		80
Trust Gap/Surplus	**(87)**	**(0)**
Total HSC Gap/Surplus	**(160)**	**0**

3.2.5 Analysis of total planned investments by POC, LCG and Provider

The Health and Social Care Board and Public Health Agency will receive some £4.2bn for commissioning health and social care on behalf of Northern Ireland 1.8m resident population for 2014/15.

Of the total received, over £3bn is spent in the six provider Trusts and other providers of care such as Family Health Services and voluntary organisations. Figure 11 illustrates this for both the HSCB and PHA.

Figure 11

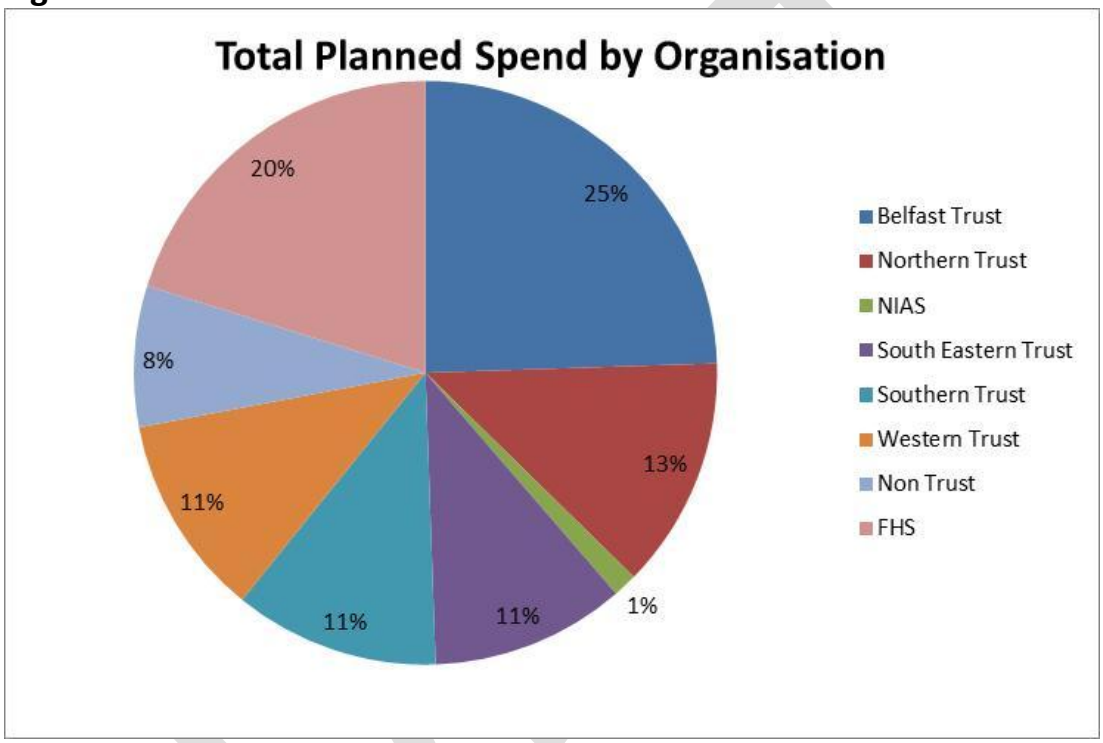


Table 18 sets out how the total resources are planned to be spent across the Programmes of Care and Family Health Services.

Planned Expenditure by Programme of Care

Table 18

Programme of Care	PHA		HSCB		TOTAL	
	£m	%	£m	%	£m	%
Acute Services	5	6.90%	1,454	44.52%	1,459	43.73%
Maternal & Child Health	0	0.06%	139	4.25%	139	4.16%
Family & Child care	-	0.00%	212	6.48%	212	6.34%
Older People	0	0.05%	662	20.28%	662	19.85%
Mental Health	14	19.34%	241	7.39%	255	7.64%
Learning Disability	-	0.00%	245	7.50%	245	7.34%
Physical & Sensory Disability	-	0.00%	103	3.14%	103	3.08%
Health Promotion	51	73.30%	49	1.50%	101	3.01%
Primary Health & Adult Community	0	0.35%	161	4.93%	161	4.84%
Sub Total	*70*		*3,265*		*3,336*	
FHS			861		861	
Not allocated to PoC*	19		69		88	
Total	**89**		**4,195**		**4,284**	
* BSO, DIS, Management &Admin						

Ensuring resources are fairly distributed across local populations is a core objective in the Commissioning process. The HSCB commissions by LCG population. Table 19 shows how the HSCB resources are planned to be spent across localities. This reflects the different population sizes and need profiles within each locality (e.g. the Northern LCG crude resident population is the largest with 25.56% and the Western LCG the smallest with 16.31%). Family Health Services (FHS) are not assigned to LCG as these are managed on a different population base. A&E, prisons and other regional services have not been assigned to LCG.

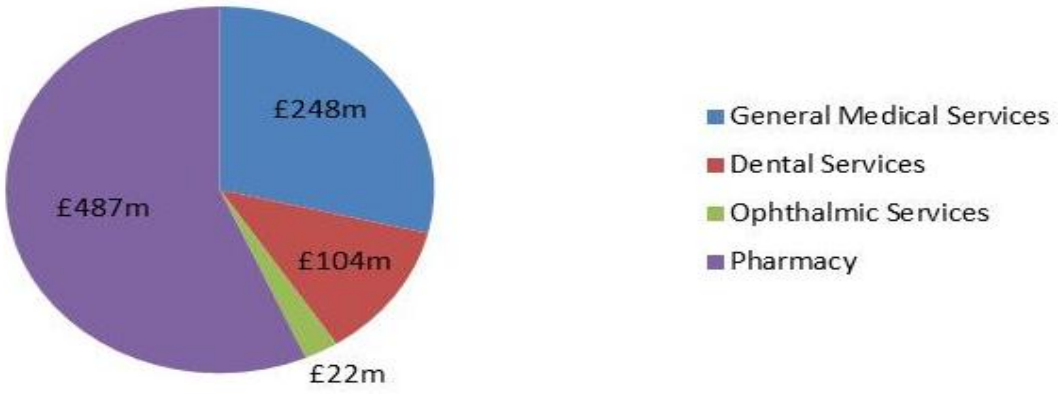
Resources by LCG

Table 19

TOTAL	Local Commissioning Group									
Trust	A&E £m	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Prisons £m	FHS £m	Regional £m	Total £m
BHSCT	22	541	135	125	53	29	-		152	1,056
NHSCT	16	2	517	1	1	2	-		13	551
NIAS	56	0	0	0	0	0	-			57
SEHSCT	18	40	6	355	9	2	8		26	463
SHSCT	15	1	6	8	447	3	-		9	488
WHSCT	12	1	8	1	4	437	-		17	481
Non Trust - Vols, Extra Contractual Referrals etc	9	49	55	41	44	39	-	861	3	1,100
Sub Total	**147**	**634**	**726**	**531**	**559**	**512**	**8**	**861**	**219**	**4,197**
Not Assigned to LCG*										88
TOTAL										**4,284**
* BSO, DIS, Management &Admin										

The Board commissions services from a range of Family Health Services. Figure 12 below shows the breakdown of planned spend across these services.

Planned Spend for Family Health Services
Figure 12



3.2.6 Equity

Achieving equity in commissioning health and social care for its local population is a key objective of the Health and Social Care Board. At its November 2012 Board meeting the Health and Social Care Board commissioned an equity review to be led by the Capitation Formula Review Group (CFRG) across its five Local Commissioning Group (LCG) areas covering four main strands of work:

- The provision of Capitation Formula fair shares to reflect the latest available population data and models together with an assessment of any associated statistical risks and confidence intervals;
- The development of a robust expenditure analysis against which the Capitation Formula fair share resources can be measured to identify potential equity gaps in funding;
- An assessment of significant differences in access to services and performance across LCG populations including waiting lists and times; and

- An assessment of significant differences in health outcomes and quality of service in health and social care services provided to LCG populations.

The findings are set out below and will inform the longer term equity strategy of the HSCB and future annual Commissioning Plans.

Capitation Formula

The Capitation Formula has been developed over the past two decades to measure the relative health and social care needs of local populations and to provide resource allocation fair shares for local populations. It takes account of factors which differentiate one population's need from another including age, socio economic factors and the cost of rural versus urban living. For this exercise updated Capitation Formula shares have been calculated to reflect the Census 2011 population.

Expenditure

The expenditure analysis identifies investment on local populations across all Programmes of Care (excluding regional services and A&E). The 2013/14 figures show the most material variance is £21.1m (3.8%) relative underspend in the Southern LCG with the greatest relative overspend in the Belfast LCG £7.2m. These variances do not only capture expenditure differences in access to services but also differences in efficiency levels within the Trusts accessed by local populations. In order to extract the efficiency component, which should be subject to a separate strategy, reference cost indices have been applied to restate variances. When applied these show that the variance in the Southern LCG is primarily the result of higher levels of efficiencies within the Southern Trust compared to the NI average. Southern LCG reduces to £3m relative underspend bringing the variance in the Southern LCG to less than 1%.

The financial plan for the HSCB has in recent years been skewing additional resources and efficiency targets with the specific aim of reduction capitation variances within a manageable process. More material adjustments would potentially destabilise services, however, it is recognised that the best strategy

would therefore be to ensure increased access to local populations within the existing infrastructure.

Access and Performance

The access and performance element of the review focuses largely on the distribution of activity across LCGs and the impact that this activity has had on access to services (primarily in terms of waiting times). Within the acute programme of care there are some geographical variations in the distribution of care and treatment. There is no evidence of any significant impact in waiting times for services (and hence on the presence of unmet need) in both the acute and community programmes of care.

Quality and Outcomes

Many of the general health outcome measures used by the PHA and HSCB reflect the additional needs patterns identified in the Capitation Formula. However, over time the relative under investment identified in the Southern LCG does not appear to have a clear correlation with differential investment levels. Over the past decade, for example, Standard Mortality Rates (SMRs) in the Southern Locality have improved relative to the Northern Ireland average. The quality analysis shows no significant variations across local Trusts.

One of the recommendations in the Equity review was that the HSCB should continue actively skewing additional commissioning resources in its annual Commissioning Plan to address expenditure equity variances at Local Commissioning Group level. The following table illustrates how the additional resources and efficiencies targets are planned across LCG areas for 2014/15.

The Equity Review was approved by the HSC Board in May 2013, and submitted to the DHSSPS in that month. A Departmental view on the strategy is required to inform future strategy for this area.

Impact of 2014/15 Plan Compared to Capitation Share

Table 170

LCG	Belfast £m	North £m	South E £m	South £m	West £m
Additional Funding above/(below) Capitation share	-2.7	0.9	0.9	-0.1	1.0
Cash Savings requirement below/(above) capitation share	-2.1	-0.1	-0.2	2.1	0.3
Impact on Equity	**-4.8**	**0.8**	**0.7**	**2.0**	**1.4**

The cash savings differential reflects the HSCB policy to address the differential efficiency levels within local Trusts. Belfast LCG has a relatively lower level of demography increase and this is reflected in the differential share of additional funding.

3.3 Improving Productivity

The financial projections for 2014/15 set out an unprecedented challenge if we are to ensure the HSC breaks even financially. Over the Spending Review period challenging annual cash and productivity efficiency targets have been set for all organisations to support the objective of breakeven and maximise productivity. These are set out for 2014/15 and previous years below in Table 21.

Savings Targets

Table 21

	12/13	13/14	Cum
	£m	£m	£m
Trust Cash target	78	69	147
Trust Achieved recurrently/Planned	44	52	96
Trust Carry forward Cash deficits	34	17	51
Trust Productivity Target	29	24	52
FHS Productivity Target	42	25	67
TOTAL Achieved	115	100	215

To date productivity savings targets have generally been met however Trusts have increasingly struggled to recurrently deliver the cash elements of their savings targets.

In recognition of these difficulties and the significant funding shortfall set out in Section 3.2, the HSCB, in conjunction with key staff from the DHSSPS, has undertaken a comprehensive review of all potential cash and efficiencies savings opportunities across the HSC. This has drawn on benchmarking activity and performance levels with a range of peers both within Northern Ireland and GB.

The conclusion of this review is that cash (£50m) and productivity (£22m) targets, should be achievable during 2014/15. However, there is limited capacity to address shortfalls from previous years.

The following table summarises by Trust the Cash and Productivity targets.

Savings Targets by Trust

Table 22

	Belfast £k	Northern £k	South Eastern £k	Southern £k	Western £k	NIAS £k	Total
Cash Target 2014/15	19,300	8,900	7,100	6,400	7,500	800	50,000
Productivity Target 14/15	4,442	4,795	3,813	5,135	3,535	400	22,120

Performance Monitoring Arrangements

A set of productivity and efficiency indicators have been developed to support the development and subsequent delivery of the cash and productivity targets. These are:

- Excess bed days
- Length of stay
- New/Review ratio
- DNA rate new
- DNA rate review
- Day case rates based on the British Association of Day Surgery trolley of procedures
- Cancelled operations
- Cancelled appointments
- Theatre utilisation

- Sickness levels
- Staffing number

Further work is being undertaken on the development of robust community indicators.

Working with the Local Commissioning Groups a process for the on-going performance management and review of the key productivity and efficiency indicators is currently being developed. This will form part of the Board's routine performance management arrangement with Trusts and will be discussed at routine performance meetings, with escalation as necessary. The aim is to demonstrate improved performance against the indicators at pace and to enhance accountability arrangements for the delivery of the necessary reform required to realise the cash and productivity targets.

3.4 Shifting Financial Resources Through Transforming Your Care (Based on Gross Costs)

A key financial objective with the TYC reforms is to ensure that financial resources appropriately reflect the proposed new service models across all areas of care. This was described in TYC as a *Shift Left.* The TYC report highlights the intention to shift approximately 5% (£83m) of recurrent funding in real terms out of the projected cost of hospital based care and into a primary/community based setting within 3 years of a fully funded transformation programme commencing. As a consequence, spend is anticipated to increase in Personal and Social Services, Family Health Services, Primary Care Services and Community Services.

3.4.1 Effecting the shift

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

(1) *Integrated Care Partnerships (ICPs)* - It is anticipated that the initial focus of ICPs will be on the Minister's priorities of frail elderly and aspects of long term conditions for all ages, namely diabetes, stroke care and respiratory

conditions. This should include Palliative & End of Life Care in respect of these agreed condition groups. Care will also move to community and primary care settings through reform of commissioner -approved care pathways and more active anonymised casework, information sharing and improvement in control and prevention of inappropriate hospital admission, it is expected that these collaborative networks will shift £1.5m during 2014/15 which is equivalent to 30 beds and 3,000 Emergency Department attendances.

(2) *Acute care* - It is envisaged that a number of reform initiatives will be undertaken specifically within acute care, which ultimately will shift care out of hospital settings. Examples of potential initiatives where shift left from acute care could be delivered in 2014/15 and beyond are listed below. These will be confirmed via the Trusts response to this Commissioning Plan.

- Patients being admitted to an acute stroke unit as the ward of first admission
- Increased hyper acute care post thrombolysis treatment
- Increased Stroke Community Infrastructure to support Early Supported Discharges from hospital
- Establishment/further roll out of Community Wards
- Increased use of Rapid Response Nursing Teams
- Increased use of Community Mental Health Teams
- Primary Percutaneous Coronary Intervention services
- Sepsis Screening, Early Detection and Intervention
- Virtual respiratory clinics
- Implementation of Day of Surgery Units
- New Ambulance Response Models
- Ambulatory Wards
- Increased Access to Renal Home Therapies
- Increased review by Hospital Pharmacists of Prescribed Medicines
- Introduction of Home Based Diabetes Management Systems
- Reforms in relation to Palliative Care pathways.

(3) *Learning disability & mental health resettlement programmes* - Resettlement programmes will see a significant amount of resource shift from acute care

provision to the community in order to strengthen community services and prevent people from being readmitted to hospital.

For the Learning Disability programme, an estimated 179 people will move from a hospital to a community setting over the 3 year period 2012/13 to 2014/15, with 50 PTL patients planned to be resettled in 2014/15.

For the Mental Health programme, an estimated 220 people will move from a hospital to a community setting over the 3 year 2012/13 to 2014/15, with 39 PTL patients planned to be resettled in 2014/15.

Following an initial assessment, it is anticipated that £41m (at 2014/15 prices) of health and social care will be shifted by the end of 2014/15 from hospital services budgets to community/primary care budgets as a result of the service changes outlined in the table below.

This represents a shift left of approximately 2.75% from hospital based care before the range of further possible measures as outlined in para 3.42 are taken into consideration. The Board will continuously review, through the TYC programme, the potential to shift more care out of the hospital services budget than is currently projected.

Table 23
Overview of financial resources to be shifted into primary/community setting

	2012/13	2013/14	2014/15	Total
	£m	£m	£m	£m
	Actual	Projected	Estimated	Cum
ICPs	0	0	2	2
Acute Care	0	0	4	4
MH Resettlement	4	7	5	16
LD Resettlement	7	7	5	19
	11	14	16	41

Note: The HSCB also plans to shift circa an additional £4m of resources through implementation of re-ablement by March 2015.

As confirmed in the table above, £11m of care previously delivered in a hospital setting has been transferred to a community/social care setting as at March 2013.

Table 23 reflects the full year effect of service transfers from the hospital services budget that is expected to be made by March 2015.

- The 2013/14 Commissioning Plan identified that £19m of financial resources would have shifted left through the introduction of ICPs by 2014/15. The updated 2014/15 figure above, of £2m, recognises the delays encountered in the establishment and development of ICPs in 2013/14 and the likely impact on the timing of the delivery of Shift Left benefits.
- The 2013/14 Commissioning Plan identified that £7m of financial resources would have shifted left through the development of Acute Care proposals (largely represented Stroke Service Changes). The updated 2014/15 figure, above of £4m, recognises the challenges encountered during 2013/14 when seeking to design and develop Stroke Service change initiatives and the consequent impact on the timing of Shift Left benefits.
- In regard to Mental Health Resettlement the updated 2014/15 figure, of £5m, is only slightly lower than the £6m figure included within the 2013/14 Commissioning Plan. This lower value is in recognition of the reduced Shift Left benefits, from £18m to £16m, over the 3 year period 2012/13 to 2014/15.
- In regard to Learning Disability Resettlement the updated 2014/15 figure, of £5m, is only lower than the £6m figure included within the 2013/14 Commissioning Plan. This lower value is in recognition of the reduced shift left benefits from, £20m to 19m, over the 3 year period 2012/13 to 2014/15.

Through the existing governance arrangements, HSCB will monitor both the CYE and FYE of each transformation proposal across all programmes of care.

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

3.4.2 Further shift left considerations

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

Therefore, in addition to the hospital based initiatives noted above, the HSCB plans to shift some £4m of financial resources at 2014/15 prices by implementing re-ablement models by March 2015.

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

3.4.3 Monitoring the Delivery of Financial Shift Left

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

4.0 Regional Commissioning Priorities 2014/15 by Programme of Care

This section provides an overview of commissioning priorities for each of the nine Programmes of Care (POC) and for a number of other regionally led service areas. Each POC section details priorities to be taken forward at regional and local level. Strategic drivers are outlined in brackets after each of the regional priorities as appropriate. Specific local commissioning requirements to be taken forward by the five LCGs are outlined in the local plans (Sections 6-10).

4.1 POC 1: Acute Services (Non-specialist)

(i) Introduction

Acute non-specialist services are those which provide emergency and planned patient care, from investigation and treatment through to rehabilitation and palliative and end of life care. They therefore include radiology, endoscopy and other diagnostic services, planned day case procedures or inpatient surgery, and care of patients with acute illness that requires hospital admission. They cover many disease conditions with the most common being cardiovascular and respiratory disease, cancer, diabetes and neurological conditions.

As outlined in the Commissioning Direction and Transforming Your Care, the strategic direction in 2014/15 and beyond, is to provide patients with the assessment, investigation and treatment they need, when they need it, thereby enabling earlier diagnosis, simpler treatment, and better outcomes. Services which respond on a 'same or next day' basis, are safer and higher quality, provide a much better patient experience, and are substantially more efficient than services where patients have long waits. The importance patients place on being treated promptly was highlighted in the Patient Client Council Report in July 2013 "Care When I Need It: A Report on Urgent Care".

Key issues for acute non-specialist services are therefore firstly to reduce waits at all stages of a patient's journey from their GP to, and through, secondary care; secondly, to enable GPs to complete more of a patient's management through timely support from secondary care; and thirdly, to free resources from

intermediate care and acute beds by reducing the total number of beds and/or sites, to enable investment in early intervention and intensive acute care. Addressing these issues will require a move towards 7 day working and a transformation in the way in which secondary care supports GPs. Haematology services in the Western Trust, Nephrology in the Southern Trust, Genitourinary Medicine services in the South Eastern Trust, direct admission to hospital in the Belfast and Northern Trusts, are examples of new ways of working whereby GPs can easily get advice from secondary care colleagues on the management of patients or admission, without the need for the patient to go to an Emergency Department or traditional Outpatients.

In addition to transformation of local acute services, a number of developments will be progressed in services which are provided on a networked basis for the region, for example, vascular services, chemotherapy and radiotherapy, interventional cardiology, paediatrics, neonatal services, trauma and orthopaedics.

(ii) Regional commissioning priorities for 2014/15 and 2015/16

Key commissioning priorities to be taken forward at regional level during 2014/15 are:

- Establish a regional Trauma Network and develop protocols for patient management (*Ministerial targets 7&8 and TYC Recommendation 72)*
- Develop and implement "see and treat" protocols for NI Ambulance Service paramedics on (*Ministerial target 7 and TYC Recommendation 74)*
- Undertake work with Trusts to reduce cancelled sessions, increase day case rates, increase the number of patients per session, and reduce new:review ratios where appropriate (*Ministerial targets 6,10,12 & 30)*
- Implement the recommendations from the Review of Vascular Services and establish networked services across NI
- Assess chemotherapy services' capacity, service model and skill mix and revise the current arrangements, as appropriate
- Enable earlier diagnosis and treatment of ovarian cancer and therefore better 5-year survival rates by auditing adherence to the 2013 Ovarian

Cancer Pathway *(NICE Quality Standard for Ovarian Cancer, Cancer Service Framework, & Improving Outcomes 1,2,3,4 & 5)*

- Commission an Acute Oncology Service for all Trusts and introduce a Haematology Advice Service *(Chemotherapy service review & Improving Outcomes 1,2,3,4 & 5)*
- Take forward priority recommendations in the DHSSPS Paediatric review, once published and arrangements for a networked approach to providing general paediatric surgery
- Work with Trusts to establish a sustainable, robust paediatric radiology service for NI to enable emergency diagnostic and interventional work 24/7 (*Ministerial targets 6, 11 & 12)*
- Engage with clinicians to review the management of conditions of lower clinical priority and as necessary, revise the Effective Use of Resources Policy
- Commission a service to provide self-management education programmes for patients with long term conditions and their carers (*Ministerial targets 9 & 21, TYC Recommendation 21 and PFG Commitment 44)*
- Commission a service to train members of the public in emergency life support to improve survival rates following cardiac arrest *(Resuscitation Strategy for Northern Ireland)*
- Expand substance misuse liaison services to achieve the Commissioning Direction target for a 7-day service in all appropriate HSC acute settings (*Ministerial target 3)*
- Commission sufficient capacity to meet demand for planned care *(Ministerial targets 6,10,11 and 12)*
- Undertake a scoping exercise to identify opportunities to provide more effective care for patients living with chronic pain (*Patient & Client Council Report – The Painful Truth)*
- Enhance end of life care, particularly in the community and Nursing Home sector *(Living Matters, Dying Matters, DHSSPS)*
- Undertake a scoping exercise to identify opportunities to raise awareness in patients and in primary care of endometriosis as a condition, and to further integrate and streamline the care pathway for women living with severe (stage 4) endometriosis. *(Patient & Client Council – Peoples Priority)*

Key commissioning priorities to be taken forward by the five LCGs in 2014/15 are as follows:

- Enabling GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to reduce/flatten demand for outpatients, and Emergency Department attendances.
- Reducing waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions at the large hospital sites.
- Enabling district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present.
- Review and take forward opportunities to consolidate the number of intermediate care beds and acute beds and the sites on which they are provided.

Specific local commissioning requirements in relation to these priorities are included in each of the LCG plans.

4.2 POC 1: Acute Services (Specialist)

(i) Introduction

Specialist services for acute care include specialist tertiary services delivered through a single provider in Northern Ireland or in Great Britain. They are often high cost, low volume and provided by small clinical teams. There are some 30-40 sub-specialist or small specialist areas within this area.

Services which fall within this branch of commissioning include rare diseases, renal services, genetics, specialist services for children, specialist ophthalmology services; specialist neurology services and cardiac surgery.

As some of these services evolve they will move to multicentre provision, for example renal dialysis and biologic therapies.

Due to our small population the most specialist services are becoming increasingly difficult to sustain. Opportunities to link our clinical teams to larger centres outside Northern Ireland in a network arrangement are essential to supporting the long term sustainability.

(ii) Commissioning Priorities for 2014/15 and 2015/16

The commissioning priorities to be taken forward at regional level during 2014/15 and 2015/16 include:

1. ***Catheterisation Laboratory Expansion and pimary Percutaneous Coronary Intervention (pPCI)*** (PfG Commitment 79)
   - Securing the provision of primary PCI services for STEMI heart attacks in the West of the Province. This will ensure the service is available across N Ireland.
   - Further expansion in capacity with a particular emphasis on electrophysiology and ablation cases.

2. **Expand Radiotherapy Capacity**
   - To commission additional radiotherapy services in Belfast by September 2014 and a new radiotherapy unit at Altnagelvin Hospital in late 2016

3. ***Growth in the use of existing specialist drug therapies / introduction of new drugs and other specialist therapies*** *(Ministerial target 15)*
   - Maintenance of waiting times and achievement of targets for specialist drug therapies – rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, psoriasis, inflammatory bowel disease, multiple sclerosis and wet age related macular degeneration.
   - Introduction of newly approved drugs to include services for retinal vein occlusion and diabetic macular oedema.
   - Explore opportunities to support the delivery of services associated with the provision of specialist drug therapies in more local settings e.g. increase the number of sites providing specialist therapies for multiple sclerosis and increase the number of locations able to provide imaging services for specialist ophthalmology conditions.

- Ensure access to HIV drugs to support increase in numbers presenting with the condition.
- Ensuring timely access to new specialist drugs and other therapies in line with Departmental circular HSC(SQSD) 04/11 - NICE Technical Appraisals and Clinical Guidelines.
- Ensuring timely access to new specialist treatment regimes.

4. Specialist paediatrics

To ensure safe, sustainable and resilient, high quality clinical care in specialist paediatric services by:

- Further development of clinical network arrangements within and outwith N Ireland;
- Redesign and delivery of the acute care clinical pathway for children with cancer;
- Redesign and modernisation of paediatric cardiology services to support service provision across N Ireland and linkages to other tertiary providers as appropriate;
- Equity of waiting times, irrespective of where a child lives;
- Transition to adult services;
- Implementation of the recommendations relating to specialist care in the Review of Paediatrics. This will involve working closely in partnership with commissioners of general acute paediatric services in agreeing pathways for paediatric surgical and paediatric medical services; and,
- Putting in place arrangements to ensure the timely diagnosis of hip dysplasia.

5. Renal services *(Ministerial target 14)*

The HSCB and PHA will continue to work closely with the service towards optimising the potential for organ donation to include:

- Continuing to provide at least 50 live donor transplants per annum;
- Increasing the number of kidneys retrieved and transplanted in Northern Ireland that are kidneys donated after circulatory death (DCD);
- Increasing consent rates for deceased organ donation; and,

- Increasing the use of peritoneal dialysis / home haemodialysis during 2014/15 and beyond.

6. Rare Diseases *(NI Rare Disease Implementation Plan)*

In response to the development of a four nations UK Strategy for Rare Disease, N Ireland is expected to launch its Rare Disease Implementation Plan in early 2014. The Board will establish a process to:

- Progress the agreed priorities contained with the Northern Ireland Rare Disease Implementation Plan;
- Work with the Northern Ireland Rare Disease Partnership in the planning and delivery of services for people with rare diseases;
- Co-ordinate services for people living with neuromuscular conditions;
- Ensure the provision of timely information and support; and,
- Ensure transition arrangements are in place for young people.

7. Clinical Partnerships With Other Health Economies

There is a need to ensure the resilience of a range of specialist services that are currently delivered in N Ireland by one or one or two person clinical teams. This will allow services to be delivered in line with agreed access times and will secure resilience in the provision of services for the local population.

Much progress has been made within specialist paediatrics in developing clinical partnerships with other tertiary and quaternary providers outside NI but some adult services are also highly vulnerable. To achieve this, the Board will work with and support Belfast Trust in identifying tertiary and quaternary partners outside N Ireland and thereafter developing appropriate pathways to support these as formal clinical partnerships.

8. Paediatric Congenital Cardiac Surgery (PCCS)

Pending a Ministerial decision on the longterm provision of PCCS, the HSCB and PHA will work with Belfast Trust and other providers in the RoI and Great Britain to ensure that NI children continue to have access to timely, safe care.

9. Closure of Belfast Blood Cord Bank for Unrelated Donations

The DHSSPSNI has requested that the HSCB takes forward the implementation of the closure of the Belfast Cord Blood Bank for unrelated donations and to put in place arrangements for the continuation of collection, processing and storage of directed cord donations.

Consistent with the Board's equality obligations, a public consultation exercise on this change will be undertaken during 2014/15 to ensure that people in Northern Ireland can be fully informed about the changes and have the opportunity to comment and seek clarification on how the new system would operate.

Specific objectives for Trusts to take forward in relation to these priorities are outlined below.

Trust requirements in relation to Specialist Services 2014/15

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Key Deliverables***	***2014/15***	***2015/16***
Western Trust (networking with NIAS) should establish 24/7 primary Percutaneous Coronary Intervention (pPCI) services at Altnagelvin Hospital.	●			Rec 89	Programme for Government Clinical Engagement Activity predicted in the NI stocktake National estimates used by DOH Demand as seen from Belfast pilot, uplifting activity in BHSCT residents for NI
By March 2015, Belfast Trust should ensure the delivery of a minimum of 80	●		√		Clinical engagement

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Key Deliverables***	***2014/15***	***2015/16***
kidney transplants in total, to include live, DCD and DBD donors.			Target 14		2008 DHSSPS Update of renal review DHSSPS 2011 Current Activity and Future Prediction of Need for Renal Replacement Therapy in NI
Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access specialist ophthalmology regimes, such as Wet AMD	●				NICE Clinical engagement Equity of access
Belfast Trust should progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast	●			Rec 45 & 89	Demand capacity analysis DHSSPS Review of

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Key Deliverables***	***2014/15***	***2015/16***
Hospital for Sick Children Network Plan					Paediatric Health Care Services Provided in Hospitals and in the Community 2013
Belfast Trust will supply a plan to expand ICU capacity to funded levels in 2014/15	●				Service Continuity

Values and Volumes

These commissioned values and volumes include figures for Specialist Services

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**[26]	53,248	1,216	54,464
	Daycases[27]	146,508	1,878	148,386
	New Outpatients	532,244	14,173	546,417
	Review Outpatients	741,209	22,652	763,861
Unscheduled	**Non Elective admissions - all**	187,811	3,714	191,525
	ED attendances	710,965	1,473	712,438
	NIAS Journeys	180,070	3,328	184,998
	VALUE OF COMMISSIONED ACTIVITY[28]	£1,376m	£81m	£1,457m

[26] Four scopes excluded (OGD,ERCP,Flexi Sigm,Colonoscopy)

[27] Four scopes excluded (OGD,ERCP,Flexi Sigm,Colonoscopy)

[28] This includes activity in addition to that set out above.

4.3 POC 2: Maternity and Child Health Services

(i) Introduction

This PoC encompasses the following services: maternity; neonatal; non-specialist acute and community paediatrics / child health; and subfertility services.

Maternity services

The total number of births in hospital in N Ireland has decreased by 2.9% from 25,994 births in 2008/09 to 25,234 births in 2012/13. Between 2011/12 and 2012/13, hospital births decreased by 469 (1.8%) overall, although there is variation between different LCG areas.

The number of births in NI hospitals to women who are not resident in NI has fallen from around 500 such births each year to 343 in 2012/13. There continue to be very few home births (26 planned home births in 2012/13). During 2012 there was a continuing trend towards later child bearing, with more than 50% of births to mothers aged 30 years and over. The number of births to teenage mothers was the lowest on record during 2012 at 1,100. In 2012/13 58% of all births in N Ireland were normal deliveries, and 29% of deliveries were by caesarean section. NI has the highest rate of caesarean sections in the UK.

A Strategy for Maternity Care in N Ireland 2012 / 2018 has provided a strategic framework for maternity care and work is underway to implement its 22 objectives. During 2013/14 a number of NICE clinical guidelines relevant to maternity care were issued to the service for implementation, including NICE guidance on multiple pregnancy (CG 129); ectopic pregnancy and miscarriage (CG 154); caesarean section (CG 132); and pregnancy and complex social factors (CG 110). As the NICE guideline on multiple pregnancy recommends a networked approach, work is underway to develop a regional networked service model and agreed care pathways in N Ireland.

Neonatal services

Neonatal services have developed rapidly in the past 30 years. Demand in more recent years is also associated with increased numbers of complex pregnancies and assisted conception. The widespread use of antenatal steroids, use of replacement surfactant and advances in technology has also led to an increase in survival of very preterm, vulnerable babies and for infants with complex congenital and perinatal problems.

Around 8% of all babies born in Northern Ireland require admission to a neonatal unit. Of those needing neonatal care, around two-thirds receive either intensive or high dependency care. Neonatal is a high cost, low throughput service in which clinical expertise is a key determinant of the outcomes for babies born pre-term or who become ill in the early new born period.

A Neonatal Network for Northern Ireland was formally launched in 2013 with the central aim of 'ensuring that babies who require neonatal services get the right standard of care in the right environment by the right staff. Work has commenced across a number of key areas to further improve and streamline services across the neonatal pathway from antenatal care to discharge including the implementation of relevant clinical standards and guidelines, infection prevention and control, service specification and further development of data systems to support monitoring of key outcomes. A series of quality focused initiatives are also planned for 2014/15 in the areas of breast feeding and parent and user engagement.

A review of neonatal capacity is also planned for 2014 in line with the network's quality improvement approach.

Paediatric / child health

There are 430,763 children and young people under the age of 18 in N Ireland. Most enjoy good health and can expect to live longer, healthier lives than ever before. There are significant numbers of children with long term conditions, for example, asthma, epilepsy or diabetes. In addition, technological and clinical advances mean that an increasing number of children with serious and complex

conditions survive infancy and require expert input from health services to ensure they lead as long and full a live as possible.

Most children who need to access health services are treated in the community. However, around 80,000 children and young people attend an emergency department each year and around 60,000 are admitted to hospital each year. Admission to hospital is particularly common in the first year of life, information from hospital systems suggests that around one quarter of children in N Ireland are admitted to hospital in their first year of life. Admission to hospital, while sometimes unavoidable and in the child's best interest, can be traumatic for children and their families. The HSCB/PHA is working with all Trusts to develop short stay paediatric assessment and observation units across NI. These units are designed so acutely unwell children can be assessed and treated rapidly by specialist paediatric doctors and nurses and avoid the need for many hospital admissions.

The needs of children who are admitted to hospital are different to adults. The 2014/15 commissioning plan sets out the HSCB/PHA commitment to ensure that children and young people who are admitted to hospital are looked after in age appropriate settings by staff who have expertise in looking after children and young people.

A consultation document on "Enhancing Healthcare Services for Children and Young People in Northern Ireland" (from birth to 18) has recently been issued by DHSSPSNI and draft recommendations from the review have been considered in this commissioning plan. The HSCB/ PHA await the final published review which will shape commissioning direction in 2015/16 and beyond.

(ii) Commissioning priorities for 2014/15 and 2015/16:

Key commissioning priorities to be taken forward at regional level in 2014/15 include:

Maternity *(Inequalities information)*

- To ensure implementation of the strategic recommendations of the "Strategy for Maternity Care" to ensure safe, resilient maternity service models across Northern Ireland, the objectives of the maternity strategy including the strategic shift towards the provision of more maternity care in the community and more midwife-led care *(Strategy for Maternity Care)*;
- To ensure the provision of safe, sustainable maternity, neonatal and child health hospital and community services;
- To facilitate the regional implementation of NICE Guideline 129 on Multiple Pregnancy which requires a regional cooperative approach to agree care pathways (*NICE)*
- To develop a regional resource (a specialist midwife post) to develop expertise and promote awareness among health care professionals of the special maternity needs of BME and migrant pregnant women (subject to funding).

Neonatal

- To undertake a review of neonatal nursing workforce
- In collaboration with Neonatal Network, to undertake a review of numbers and geographical location of neonatal cots across all levels of care within N Ireland
- To develop of escalation and contingency plans for neonatal services for capacity and extraordinary events
- To develop processes to improve user engagement to inform improvements in the neonatal pathway from antenatal care to discharge.

Paediatric / Child Health *(Paediatric Review)*

- Establish on a phased basis an operational paediatric network which will include paediatric medicine, paediatric surgery and specialist paediatric services

- Work with Trusts to establish sustainable services that meet the standards in the Review
- Work with Belfast and other Trusts with a view to informing the configuration and profile of the planned new Children's Hospital
- Work with Trusts to ensure services meet Commissioning requirements to standardise the minimum upper age limit for children in Paediatric wards (15 years in 14/15)
- Commence a review of transition arrangements across specialties

Sub-fertility *(NICE Guidance)*

- The HSCB will consider NICE Clinical Guideline 156: Fertility: assessment and treatment for people with fertility problems (update) which has significant implications for the available budget for subfertility services

Key commissioning priorities to be taken forward by the five LCGs in 2014/15 include:

- Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy (*TYC Recommendations 34 & 37)* including:
  - Written and oral communication for women to enable an informed choice about place of birth
  - Services in consultant-led obstetric and midwife-led units available dependent on need
  - Promotion of normalisation of birth, leading to reduction of unnecessary interventions
- Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129
- Trusts to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife led antenatal care in the community for women with straightforward pregnancies
- Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained variation in intervention rates throughout Northern Ireland.

- Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.

Local commissioning requirements associated with these priorities are outlined in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	Births	25,714	48	25,762
	Comm Midwives	Contacts	362,757	581	363,338
	Health Visiting	Contacts	302,692	0	302,692
	Speech and Language Therapy	Contacts	137,420	0	137,420
		VALUE OF COMMISSIONED ACTIVITY[29]	£137m	£6m	£143m

[29] This includes activity in addition to that set out above.

4.4 POC 3: Family & Child Care

(i) Introduction

Children in need, including children with a disability, children on the Child Protection Register, and those in care are among the most disadvantaged in society and have significantly reduced life chances. These children and young people encounter significant obstacles to having a stable family life and to progressing in education to enjoying learning and achieving and reaching their potential.

In line with Transforming Your Care (TYC), there has been, and will continue to be, a significant focus on early intervention and this agenda is being pursued on a uni-disciplinary, single agency and multiagency basis. There is a strong commitment to partnership working to progress this agenda through vehicles such as the Children and Young People's Strategic Partnership, Childcare Partnerships and Child Development Board. The strategic direction for the statutory social work component is taken forward through the Children's Services Improvement Board with the involvement of senior HSCB and Trust staff. The Partnership arrangements allow for service user involvement and the participation of representative umbrella organisations to convey and ensure that the views of children, young people and families are taken into account.

Improving the experience of young people with disabilities as they transition to adulthood is a key priority for the HSCB during 2014/15. This work is being taken forward by the Children and Young People's Strategic Partnership and will be underpinned by the participation of young people with disabilities throughout. The Partnership will explore a range of measures aimed at improving the experience of transition to adult services for the young person and their families focussing on key areas such as Integrated Plans and the development of individual Passports.

As referenced, relevant actions, as detailed in TYC, are being progressed on the early intervention front and further into the system where services are provided for looked after children. The DHSSPS has also commenced a review of all

existing strategy and guidance for looked after children, with a view to developing a strategic statement which will encompass services from the edge of care through to leaving and aftercare. Neither early intervention nor adoption will be included but it is envisaged that new legislation, Adoption and Children Bill, will be progressed and the HSCB is engaged with the DHSSPS and other stakeholders in consideration of content and the implications of same.

The Safeguarding Board for N Ireland is now fully operational with the HSCB and Trusts included as members. The HSCB will continue to monitor performance in the area of safeguarding as this is a key delegated statutory function and both agencies continue to ensure communication and sharing of information.

There continues to be significant demand across Children's Services. The HSCB/PHA recognise the role of Health Visiting in providing support and interventions at the earliest possible stage in a child's life. We are committed to addressing the shortage of Health Visiting staff across the Health and Social Care Trusts, consistent with the Healthy Child/Healthy Futures Strategy.

The numbers of referrals into Children's Social Services has also continued to increase with the consequent impact across the system. There has been a slight decline in the overall number of children on the Child Protection Register (-8% currently 1,961) at the end of year. However, when examining these figures as rates per 1000 child population, an upward trend is evident across all Trust areas.

In line with the national trend, there has been a steady and significant growth in the number of children coming into the looked after system - there are currently around 2,800 looked after children within N Ireland; an increase of 13.9% between 2009 and 2013. This increase reads through into leaving and aftercare and has placed considerable demands on acquiring appropriate placements with a rise in the percentage of children placed within kinship placements. This is consistent with policy and legislative direction, although there remains a need to ensure that placements can meet the assessed needs of children. The DHSSPS has issued Kinship Standards which recognise the requirement for quality

placements with robust assessment and safeguarding practices in place. The growth of kinship placements, aligned with the introduction of the standards, has been highlighted by Trusts as a capacity issue.

The numbers of unallocated cases and waiting lists for CAMHS and Autism Services have fluctuated across Trusts and continue to be subject to review and service improvement. Further work is progressing to review demand and capacity within these service areas.

The underinvestment in Children's Services has been recognised previously and reinforced within a number of independent reports. The Trusts report, however, that further financial efficiencies requiring to be made within Children's Services have compounded this pressure. In this regard, the HSCB continues to seek assurance that care delegated services are being delivered to a required standard. The growing concern being articulated is that this focus could result in circumstances being referred when they are even more entrenched. Whilst not possible at this stage to provide a strong evidence base, it has been postulated that there is a correlation between the economic downturn and the rise in demand.

(ii) Regional commissioning priorities for 2014/15 and 2015/16

Key commissioning priorities to be taken forward at regional level in 2014/15 include:

- To ensure that a child only becomes looked after where their long term outcomes will be improved or there is a need for the child to be removed as a safety measure *(Commissioning Specification)*
- To ensure an adequate range of placements to meet assessed needs of LAC and care leavers *(TYC Recommendation 48, Children (NI) Order and Children Leaving Care Act and a Commissioning Specification)*
- Work with CYPSP and outcomes groups to progress the establishment and consolidation of family support hubs by 1st September 2014.
- PHA/HSCB to strengthen early year's provision and family support through parenting programmes.

- Ensure a robust needs assessment and localised service for children with complex needs including those with learning disabilities or challenging behaviour *(Commissioning Specification).*
- Engagement in review of AHP support for children with statements of special educational needs attending both special schools and mainstream education.
- Full implementation of RQIA recommendations of CAMHS review and Departmental CAMHS "step care" model *(TYC Recommendation 51).*
- Implementation of the RQIA Fostering Review recommendations
- Engage with the regional review of fostering and development of a commissioning specification for fostering/permanence *(TYC Recommendations 49 & 50).*
- Full implementation of the RQIA Review of Community Services for Children with a Disability.
- The Forensic Adolescent Consultation and Treatment Service will become operational *(Consistent with proposed developments in Residential Child Care Review and CAMHS developments).*
- The PHA, in collaboration with NIPEC, will carry out a normative staffing exercise for Health Visiting with a view to enhancing the HV workforce to provide the full Core Universal Service as set out in Healthy Child Health Future (Ministerial target 28ii).
- Work with the CYPSP and cross-departmental Early Intervention Transformation Programme to deliver integrated services through pooled budgetary arrangements *(TYC Recommendation 47).*
- Family Nurse Partnership programmes will be expanded to include access within all five Trusts *(Ministerial target 2).*

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Family and Childcare	**Social Work**	Caseload	21,000	0	21,000
	Residential Homes	Occupied bed days	61,000	0	61,000
		VALUE OF COMMISSIONED ACTIVITY[30]	£205m	£8m	£213m

While there has been an increase in investment within this POC, as reflected in the values above, the uplifts in activity during 2014/15 relate to currencies other than those presented above, for example, increased investment in foster care provision, safeguarding and transition planning for young people with a learning disability.

[30] This includes activity in addition to that set out above.

4.5 POC 4: Older People's Care

(i) Introduction

As outlined in Section 2.1, N Ireland has a growing ageing population and with that come a number of service challenges, including an increase in the number of people living with longterm conditions and comorbidities and an increasing reliance on secondary care. Older people's services need to be reconfigured if we are going to continue to meet increasing needs now and into the future. Transforming Your Care focuses on home as the hub of care. Shift left will aim to deliver more services closer to home with a focus on promoting healthy ageing, providing support for those who wish to remain at home, developing diversionary services to maintain independence and more targeted specialist support for highly dependent individuals.

This approach has been underpinned by the recent launch of the Service Framework for Older People which thematically focuses on: person-centred care; promoting health and well-being; support for carers; safeguarding individuals at risk of neglect, abuse or exploitation; medicines management; care of conditions more common in older people; significant points of transition within older people's services and palliative and end of life care. It will significantly shape the agenda for change within this programme.

Alongside on-going attempts at service reform through the development of reablement and efforts to reform statutory residential care, during 2014/15 we will also need to respond to significant pressures on domiciliary care services and to develop a more consistent approach to the provision of intermediate care. There are also significant service pressures resulting from increased awareness of adult protection and the need for an adequate safeguarding response to protect individuals at risk of neglect, abuse or exploitation. Funding will be made available to support the continued development a Gateway or single point of entry approach for adult safeguarding

Underpinning all of these strands is the need for effective assessment of individual need through the implementation of eNISAT.

ICPs will be focusing on the integration of care for the frail elderly. It is anticipated that LCGs will work with ICPs to develop and commission new services which will better meet the needs of this group of people, to include the development of a focused case management approach which will improve the coordination and delivery of care to "high risk" individuals thereby avoiding unnecessary hospital admissions and facilitating early supported discharge and a return to independence.

(ii) Commissioning Priorities for 2014/15 and 2015/16

Key commissioning themes to be taken forward at regional level during 2014/15 are:

- Complete consultation processes regarding statutory residential care and agreed Trust proposals for service reform *(TYC Recommendations 9 & 10).*
- Undertake review of domiciliary care services and revised contractual arrangements *(TYC Recommendation 9).*
- Development of enhanced safeguarding arrangements *(TYC Recommendation 17, PfG 61 and Service Framework for Older People).*
- Agreed service developments in dementia services with associated performance targets *(Dementia Strategy).*
- Regional implementation of e-NISAT including the functionality to share information within and across Trusts *(TYC Recommendation 16).*

Commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive. *(Ministerial target 22; TYC Recommendation 19).*
- Access to more options for carers in the provision or arrangement of their respite/short breaks. *(TYC Recommendation 13& 19)*
- Increased uptake of direct payments *(Ministerial target 23; TYC Recommendation 18).*
- Working with ICPs to improve the care of the frail elderly *(TYC)*.

- Enhancement of dementia services *(Dementia Strategy).*
- Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements (TYC Recommendation 13).
- Continued roll-out of targeted PHA preventative health and well-being improvement programmes *(TYC Recommendation 14).*
- Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact *(TYC Recommendation 11)*.

Specific local commissioning requirements in relation to these priorities are included in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied bed days	247,770	-3,822	243,948
	Day Care	Attendances	309,899	0	309,899
	Domiciliary Care	Hours	10,721,105	252,151	10,973,256
	Residential and Nursing	Occupied bed days	3,736,807	29,930	3,766,737
	Community Nursing	Face to face	1,956,389	9,302	1,965,591
	Social Work	Caseload	40,661	0	40,661
		VALUE OF COMMISSIONED ACTIVITY[31]	£644m	£27m	£671m

[31] This includes activity in addition to that set out above.

4.6 POC 5: Mental Health

(i) Introduction

Mental health has a significant effect on life expectancy and is a key cause of health inequalities. People who live in the most deprived areas experience the highest levels of poor mental health. Indeed many mental health problems start in early life and are associated with multiple deprivation. N Ireland has a 25% higher overall prevalence of mental health problems compared to England. N Ireland has a unique range of problems as a result of 'the troubles'. It also experiences high levels of socio-economic deprivation which is more pronounced in some geographical areas by the prolonged effect of 'the troubles'.

This year's Commissioning Plan reflects the commitment to tackle a number of serious and ongoing issues. The continued high level of suicides in N.I will be addressed by the further implementation of the Protect Life Strategy. The recent National Inquiry into Suicides and Homicides, August 2013, University of Manchester, highlights the disturbing role of substance misuse, primarily alcohol, in suicides in N.I. at a higher rate than Great Britain. Consequently, efforts to tackle harmful drinking at all of the four tiers of the Drugs and Alcohol Commissioning Framework must be strengthened.

The stigma still associated with seeking help for mental health issues needs to be reduced by increasing access to appropriate talking therapies in primary care and by improving the patient experience in secondary mental health care by implementing more recovery focused approaches working in partnership with mental health service users and carers.

In line with the reduction in hospital beds as resettlement ends, there is a need to continue to improve the quantity and quality of Crisis Resolution and Home Treatment services alongside other specialist community services for assessment, treatment and care.

The Board will also work to improve the quality, safety and service user experience of all commissioned services in line with feedback from service users, carers and lessons learned from analysis of SAI's and RQIA reports.

The crucial role which carers play in supporting people who use mental health services to live in the community needs to be further recognised and supported by practical measures, such as short breaks/ respite, as well as increased information on and better access to services. These services should increasingly be delivered in line with the Regional Care Pathway in order to meet the Mental Health Service Framework standards and N.I.C.E guidance.

(ii) Regional Commissioning Priorities for 2014/15 and 2015/16

The key commissioning priorities to be taken forward at a regional level during 2014/15 and 2015/16 are:

- All Trusts should ensure the resettlement of the remaining long stay population *(Ministerial targets 27 & 32, TYC Recommendation 62 and Bamford Action Plan 2012-15 DHSSPS).*
- All Trusts should deliver Recovery Approaches and the Regional Mental Health Care Pathway *(TYC Recommendations 56 & 57 and Bamford Action plan 2012-15).*
- A range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual referrals based on the 01/04/12 baseline - *Personality Disorder Strategy 2010 & New Strategic Direction for drugs and Alcohol DHSSPS).*
- The implementation of the regional Tier 4 Substance Misuse Model including the development of agreed Tier 3 supporting community services *(Ministerial Target 3)*
- The implementation of services to identify, assess and treat first episode psychosis (age 16+) including CAMH's *(Ministerial Target 33 and TYC Recommendation 59.)*
- Ensure delivery of Bamford Action Plan for Mental Health 2012-2015 (46 Targets) *(Ministerial Target 31, TYC Recommendations 39 and 55 and Bamford Action plan 2012-15)*

- Implementation of Mental Health and Wellbeing Service Framework *(Safety and quality requirement)*
- Implementing the Commissioner Guidance for Advocacy

Key commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive. *(Ministerial target 22; TYC Recommendation 19).*
- Access to more options for carers in the provision or arrangement of their respite/short breaks. *(TYC Recommendation 13& 19)*
- Increased uptake of direct payments *(Ministerial target 23; TYC Recommendation 61).*
- Implementation of the Protect Life Strategy *(TYC Recommendation 53)*.
- Establishment of integrated care arrangements for the care and treatment of patients with common mental health needs *(Ministerial target 33; TYC Recommendation 60)*.
- Implementation of the Crisis Resolution Home Treatment services for CAMHs *(TYC Recommendation 58)*.
- Further development of specialist community services *(TYC Recommendation 59)*.
- Improved psychiatric liaison services *(TYC Recommendation 57)*.
- Consolidation of mental health inpatient beds - Mental health inpatient beds have been consolidated to a single site within Southern Trust. The development of a single site for Belfast is underway. The development of a new site is also underway within the Western Trust. Acute in-patient facilities are also planned for the Northern and South Eastern Trust areas, with a second site planned for the Western Trust. The timescale for delivery of these sites will be subject to their prioritisation within the capital investment programme.

Specific local commissioning requirements in relation to the above are included in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied bed days	287,124	0	287,124
	CPN	Contacts	239,242	1,000	240,242
	Res & Nur homes & supported housing	Places	204,379	0	204,379
	Day Care	Attendances	206,963	0	206,963
	Domiciliary Care	Hours	348,743	602	349,345
		VALUE OF COMMISSIONED ACTIVITY[32]	£246m	£7m	£253m

[32] This includes activity in addition to that set out above.

4.7 POC 6: Learning Disability

(i) Introduction

There are a number of key demographic factors and strategic priorities which underpin this year's commissioning plan for Learning Disability. The population of people with a learning disability is continuing to rise in line with the very welcome increase in the average lifespan. Consequently, there are greater numbers of people with a learning disability reaching adulthood and requiring day opportunities and appropriate community support. As adults continue to reach old age in greater numbers, planning is required for their future long term care and housing and support for carers, in particular older carers, is more necessary than ever.

Evidence such as "Health Inequalities and People with Learning Disability in the UK" (E. Emerson & S. Baines, 2010) showed that people with a learning disability on average had a higher rate of poor ill health and of mortality than their non-learning disabled peers. The HSCB/PHA evaluation of the learning disability D.E.S highlighted progress on providing annual physical and mental health checks for adults with a learning disability in primary care. The evaluation's recommendation for improving health promotion activities for people with a learning disability within the overall health promotion strategy is being implemented as a further measure to tackle this health inequality.

This year will see the completion of the resettlement of the long-stay population from learning disability hospitals and the opening of the last of the 3 new in-patient assessment and treatment hospitals for learning disabilities on the Craigavon Area Hospital Site. Alongside the continued reduction of hospital beds for learning disability community services there will be an increase in those specialist support services which were previously mostly provided in hospital settings.

2014/15 will also see a continued focus on the promotion of self-directed support and on improving the support we provide to carers.

(ii) Commissioning Priorities for 2014/15 and 2015/16

Commissioning priorities to be taken forward at a regional level during 2014/15 and 2015/16 include:

- All Trusts should resettle the remaining long stay population *(Ministerial Targets 27 & 32, TYC Recommendation 71 and Bamford Action plan 2012-15).*
- All Trusts should work with primary care to further develop the Directed Enhanced service (DES) for learning disability in line with the findings of the current evaluation *(TYC Recommendation 64 and Implementation of Directed Enhanced Service Evaluation Recommendations).*
- Bamford Action plan for learning disability 2012-15, 24 targets to be implemented by all Trusts *(Ministerial Target 32, TYC Recommendation 66 and Bamford Action plan 2012-15).*
- Development and implementation of Learning Disability specific Health Promotion initiatives within overall Health Promotion Strategy.
- Develop a Learning Disability Information Portal for inclusion on NI Direct-HSCB *(TYC Recommendation 69 and Bamford Action plan 2012-15).*
- Learning Disability Service Framework Year 2-targets to be implemented by all Trusts *(Safety and Quality).*
- Implementing the Commissioner Guidance for Advocacy *(TYC Recommendation 70).*
- During 2014/15 the HSCB, in partnership with Trusts, will extend its scoping of the numbers of adults with a learning disability who require future plans to be made for their care from 50 years and above to 35 years and above.

Commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive. *(Ministerial target 22; TYC Recommendation 19).*

- Access to more options for carers in the provision or arrangement of their respite/short breaks. *(TYC Recommendation 13& 19)*
- Delivery of day services in line with the Regional Day Opportunities Model *(TYC Recommendation 67)*.
- Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.
- Increased uptake of direct payments *(Ministerial target 23; TYC Recommendation 68).*
- Development and implementation of health promotion initiatives for people with a learning disability.

Specific local commissioning requirements in relation to the above are included in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied bed days	113,602	-27,372	86,230
	Day Care	Attendances	663,981	12,115	675,996
	Domiciliary Care	Hours	829,569	5,271	834,840
	Residential & Nursing	Occupied bed days	539,226	6,234	545,460
	Community Nursing and AHPs	Face to face contacts	144,478	0	144,478
	Social Work	Active Caseload	8,716	0	8,716
		VALUE OF COMMISSIONED ACTIVITY[33]	£232m	£17m	£249m

[33] This includes activity in addition to that set out above.

4.8 POC 7: Physical Disability & Sensory Impairment

(i) Introduction

According to results from the Northern Ireland Survey of Activity Limitation and Disability conducted by NISRA in 2006/07, 18% of all people living in private households in N Ireland have some degree of disability.

Developments in services for people with Physical and Sensory Disabilities have received a renewed impetus with the recent publication of Departmental and OFMDFM strategies. Implementation has benefitted from the involvement of voluntary sector partners and emphasis on the participation of service users. There has been a strong emphasis on the importance of inter-agency working in the fields of housing, transport and employment. There is also a need to review and reform traditional models of service delivery through an increased emphasis on giving people more control over their support needs through the promotion of personalised budgets, support for carers and advocacy.

In terms of specific initiatives there is a need to remain focussed on improving and sustaining performance in the provision of wheelchairs and equipment, reviewing and piloting initiatives to progress the reform of existing day care provision, establishing appropriate links with reablement, building on the recent service enhancements in sensory services and promoting community based accommodation options for people with brain injury.

(ii) Regional Commissioning Priorities 2014/15 and 2015/16

Commissioning priorities to be taken forward at regional level during 2014/15 and 2015/16 include:

- Improve performance in the provision of wheelchairs and prosthetics. This will involve greater regional coordination of referral and eligibility processes and alignment of equipment and maintenance/repair budgets.
- Progress further roll out of eNISAT/NISAT in this programme to promote further integrated working and improved assessment processes.

- Complete regional reviews of the Communication Support Services and the needs of Deaf Blind individuals to assess potential for enhanced service provision in these areas.
- Promote and pilot the potential for telecare to maintain individual independence and security in the community.

Commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive. *(Ministerial target 22; TYC Recommendation 19).*
- Access to more options for carers in the provision or arrangement of their respite/short breaks. *(TYC Recommendation 13& 19)*
- Increased uptake of direct payments *(Ministerial target 23; TYC Recommendations 28 & 32).*
- To review Trust progress in relation to the review and reform of day service opportunities to ensure alignment with personalisation strategies *(TYC Recommendation 28).*

Specific local commissioning requirements in relation to these priorities are outlined in each of the LCG plans.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability and Sensory Impairment	**Hospital services**	Occupied beddays	58,199	0	58,199
	Day care	Attendances	127,129	0	127,129
	Domiciliary care	Hours	1,627,123	19,000	1,646,123
	Resid & Nursing Home	Occupied beddays	143,634	0	143,634
	Community nursing & AHPs	Contacts	121,947	1,167	123,114
	Social work	Active caseload	10,895	0	10,895
		VALUE OF COMMISSIONED ACTIVITY[34]	£101m	£4m	£105m

[34] This includes activity in addition to that set out above.

4.9 POC 8: Health Promotion & Disease Prevention

This POC comprises three key areas:

- Health and wellbeing improvement
- Health screening
- Health protection

Each of these areas is addressed separately below.

4.9.1 Health & Wellbeing Improvement

(i) Introduction

Improving the health of the N Ireland population is an imperative, both because of the impact on quality of life and life expectancy, and also because the costs of not doing so leave a financial challenge to the entire health and social care system. The 'shift lift' toward prevention is essential, with clear evidence of its cost-effectiveness. Yet it is also recognised that the patterns of inequality are persistent over time and mirror wider inequalities in society. Action is required across government departments in order to influence the socio-economic determinants of health. The new Public Health Strategic Framework 'Making Life Better' will provide such direction over the coming ten year period. The focus will support a broad population approach, whilst also highlighting the need to provide specific support to those experiencing particular disadvantage and inequalities.

The need to engage all sectors, including communities, has led to important partnerships across N Ireland which will provide essential infrastructure to assist with implementation of the new Framework. Current engagement with community and voluntary sector partners in particular has been essential in shaping service design and delivery, for example, standards for mental and emotional wellbeing services, the implementation of the new Strategic Direction for alcohol and drug services and the rural community networks in the delivery of programmes designed to promote wellbeing and reduce rural poverty and isolation.

(ii) Regional Commissioning Priorities 2014/15

The commissioning priorities for 2014/15 and 20151/16 to be taken forward at regional level are to focus on consolidating action based around the four building blocks identified within the Public Health Strategic Framework:

1. *Give every child and young person the best start in life* - through the Implementation of Healthy Child, Healthy Futures and expansion of the Early Intervention programmes including: Roots of Empathy; Family Nurse Partnership; Infant Mental Health Training and Parenting support.

2. *Work with others to ensure a decent standard of living* - Development of social economy businesses and community skills development through public procurement.

3. *Build Sustainable Communities* – During 2014/15 we will continue to implement the HSCB / PHA Community Development strategy and work to ensure that existing service provision is tailored to meet the needs of vulnerable groups including the delivery of programmes to promote the health and wellbeing of older people.

4. *Make Healthier Choices Easier* - through the implementation of key public health strategies (e.g. 'Fitter Futures for All' framework, tobacco cessation; treatment and support for substance misuse and associated mental health; emotional wellbeing and suicide prevention).

Key priorities to be taken forward by the five LCGs during 2014/15 include:

- Expansion of the early years intervention programme.
- Incremental expansion of social economy businesses and community skills development.
- Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.
- Implementation of the "Fitter Futures for All Framework".
- Implementation of key public health strategies.

- Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland".

Specific local commissioning requirements in relation the above are included in each of the LCG plans.

4.9.2 Screening

(i) Introduction

Screening is an important public health function that involves inviting members of the public, who have no symptoms of a particular disease, to be tested to see if they might have the disease, or are at risk of getting it.

Population screening allows certain diseases and conditions to be identified at an early stage when they are more amenable to treatment. The PHA is the lead organisation for commissioning and for quality assuring population screening programmes.

(ii) Commissioning Priorities for 2014/15 and 2015/16

Commissioning priorities to be taken forward at a regional level during 2014/15 and 2015/16 include:

- Complete the roll out of digital mammography for the breast screening programme.
- Extend the capacity of the bowel cancer screening programme to include the population aged 60-74.
- Implement the new UK blood spot standards to support the newborn blood spot programme.
- Within the diabetic retinopathy screening programme complete the implementation of the electronic system to support the direct referral and information flow to GPS and ophthalmologists.

Specific objectives for Trusts to take forward in relation to these priorities are outlined below.

Trust requirements in relation to Screening 2014/15

POC 8 Screening 2014/15 & 2015/16	***Timescale for achievement***		***Strategic Driver/Needs Assessment***		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
1. From April 2014, all Trusts should work with PHA and HSCB to increase screening colonoscopy capacity across the region by 25% to facilitate age extension of the bowel screening programme to age 74	●		Target 1		PFG commitment
2. Increase the number of JAG accredited units by one in 2015/16	●	●	Target 1		Bowel Cancer Screening programme Board.
3. All Trusts should deliver a bowel cancer screening service from April 2014 to the eligible population aged 60 -74	●		Target 1		PFG commitment 22

POC 8 Screening 2014/15 & 2015/16	***Timescale for achievement***		***Strategic Driver/Needs Assessment***		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
4. Achieve the target uptake for the bowel cancer screening programme of 55%	●	●	Target 1		
5. All Trusts should report on the implementation of their action plan to enhance informed choice for the eligible populations for bowel, breast and cervical cancer. These should be aligned with the PHA's Action Plan on Promoting Informed Choice in Cancer Screening.	●	●	Target 1		PHA corporate plan
6. PHA, HSCB, Primary care and BHSCT should work together to ensure robust processes are in place to maintain the screening interval and grading for diabetic retinopathy.	●				PHA corporate plan

POC 8 Screening 2014/15 & 2015/16	***Timescale for achievement***		***Strategic Driver/Needs Assessment***		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
7. BHSCT, NHSCT, SHSCT and WHSCT should implement their local action plans to complete the roll out of digital mammography across N Ireland by October 2013.	●				PHA corporate plan
8. BHSCT, NHSCT, SHSCT and WHSCT should ensure that they have a quality management system (QMS) in place which supports the safe and effective provision of breast screening.	●				PHA breast screening quality assurance visit reports
9. From April 2014 all hospital Trusts to have robust referral mechanisms into the screening surveillance programme for newly identified women at higher risk (X8) of breast cancer.	●				Target from CMO PHA corporate plan

4.9.3 Health Protection

(i) Introduction

The Health Protection Service was established in April 2009 within the Public Health Directorate in the Public Health Agency. The Service is a multi-disciplinary service comprising Consultants in health protection, nurses in health protection, epidemiology and surveillance staff, and emergency planning staff. The health protection service is responsible for the prevention control of communicable disease and environmental hazards and provides the acute response function to major issues, such as outbreaks of infection. The PHA Health Protection Duty room, located in Linenhall Street at PHA headquarters, is the first point of call for all acute issues in relation to infectious disease incidents and for notifications of infectious diseases. The Health Protection Service has a number of work programmes in key areas with regional consultant leads for each area. These include areas such as healthcare associated infections, immunisation, emergency preparedness, gastrointestinal infections, sexually transmitted infections, influenza, and tuberculosis.

The Health Protection Service has led a major programme of work in partnership with colleagues in Trusts, Primary Care, RQIA, and the independent sector in relation to reducing healthcare associated infections. The immunisation programme in N Ireland is one of the most successful public health programmes in terms of preventing disease and protecting health, both in children and in adults. Immunisation uptake rates N Ireland are the highest in the UK for a range of the childhood immunisation programmes, due to efforts of colleagues across the HSC system. The Health Protection Service has led the public health response to a number of major public health issues in recent years, including Pandemic 2009, the Pseudomonas outbreaks of 2012, and the E coli outbreak of 2012.

Communicable diseases disproportionally affect certain groups in the population including those at social disadvantage, living in poor housing conditions, migrants from countries that have higher prevalence of infectious diseases, and

those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities.

(ii) Commissioning Priorities for 2014/15

Commissioning priorities to be taken forward at regional level during 2014/15 and 2015/16 include:

- Extend the seasonal flu immunisation programme to include all pre-school children aged two and over and achieve an uptake of 60%, and all primary school children, and achieve 75% uptake for these school-aged children *(DHSSPS Immunisation Policy)*
- Achieve high uptake (50%) of seasonal flu immunisation among all front line healthcare workers to support prevention of spread of flu in the population and to alleviate winter pressures for Trusts *(DHSSPS Policy)*
- During 2015, test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards, and disruptive events *(Departmental Objective)*
- During 2014/15, test and review business continuity management plans to ensure arrangements to maintain services to a predefined level through business disruption *(Departmental Objective)*
- Through the Microbiology Forum of the Regional Pathology Network, investigate and confirm full standardisation of laboratory antimicrobial testing practice across Trusts*(Awaiting confirmation from CMO)*
- Trust microbiologists to work with health protection consultants in PHA to scope up a core set of priority organisms for a routine antimicrobial resistance surveillance *(Awaiting confirmation from CMO)*
- Belfast Trust to ensure Regional Virology Service Preparedness for surge in respiratory infections such as Flu during winter *(Required to Implement DHSSPS requirements for Seasonal Flu Planning)*
- To maintain the current capability and capacity of existing Hazardous Area Response Team within NIAS *(DHSSPS Policy in Parenthesis).*

4.10 POC 9: Primary Health and Adult Community

This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability. There are therefore five key areas:

1. General Medical Practitioners Services
2. General Dental Services
3. General Opthamology Services
4. Community pharmacy provision
5. Community nursing and AHP provision

Primary care and adult community services play a critical role in terms of supporting people to stay well, for as long as possible in the community and avoiding unnecessary hospital attendance and admissions. The development of these services in line with the transformation agenda is therefore key to reducing pressure on scarce resource within secondary care.

In conjunction with the ICPs the Transforming Your Palliative and End of Life Care Programme will redesign service across sectors to improve the quality of life for those in the last year of life. Marie Curie have been commissioned to deliver this programme, as they have demonstrated success in 19 other programmes across the UK.

4.10.1 General Medical Practitioners Services

(i) Introduction

General Medical Services are delivered across the Health and Social Care Board (HSCB) by 351 general medical practices, through a contract between the HSCB and each individual practice (Contractor).

The GMS contract covers three main areas:

- The Global Sum – funds Essential and Additional Services

- The Quality and Outcomes Framework (QOF) – including primary and secondary prevention indicators. Practices can choose whether to deliver these standards.
- Enhanced Services – covering services which practices can choose to provide. They can be commissioned regionally or locally to meet the populations healthcare needs. There are four categories of enhanced services:
  - Directed Enhanced Services (DES)
  - Northern Ireland Local Enhanced Services (NI LES)
  - National Enhanced Services (NES)
  - Local Enhanced Services (LES) which are commissioned through the Local Commissioning Groups.

General Medical Practices can opt out of providing Out of Hours Care. The HSCB remains responsible for 24 hour high quality care is available to all patients. The Out of Hours service is commissioned from three Trusts and two 'mutual' organisations to provide urgent care for people when their normal GP surgery is closed.

The Strategic Framework for GP Out of Hours aims to simplify access, improve operational efficiency and improve alignment with other healthcare services and will be the vehicle to deliver a single telephone number to access GP Out of Hours services. Out of Hours services do not function in isolation, but need to integrate in each locality with other community based unscheduled care services as identified in the Strategic Framework. Investment in Out of Hours to meet increasing demand needs to be matched by additional funding for community unscheduled care services, in particular nursing, to ensure coordinated capacity building. In this regard, LCGs will play an essential role in commissioning interface unscheduled care services, integrated with GP Out of Hours services. Engagement has already commenced with LCGs to coordinate such service development through implementation of the GP Out of Hours Strategic Framework (approved by HSCB Board, January 2013 and still awaiting final DHSSPS approval) and relevant Transforming Your Care policies.

A financial review for GP Out of Hours was completed in 2013 and passed by HSCB Board. It identified the need to harmonise budgets between the five providers by redeploying resources based on demand. Currently, over bank holidays demand outstrips capacity and requires additional resources. Commissioning an increase of clinical professional skill mix will help reduce reliance on GPs within Out of Hours, alleviating inflationary pressures within the service due to reduced GP availability. Implementation of all the recommended actions in the Financial Review will deliver greater equity in the funding allocation, and, based on efficiency measures agreed between providers and HSCB officers, without any diminution in the quality of service experienced by the public accessing it. Continued progress is dependent upon the allocation of £1.95m recurrent that has been requested from the Department. This will provide a sound platform to enable future re-investment of resource in order to support continuous improvement in the quality of service delivery; through education, patient focus and through supporting improved access to and integration of the service, as envisaged in the regional Out of Hours Strategic Framework.

(ii) Commissioning priorities 2014/15 and 2015/16

Commissioning priorities to be taken forward at a regional level during 2014/15 include:

- Continue to commission a range of Enhanced Services which align to strategic commissioning priorities including NI LES Advance Care planning for Residential & Nursing Homes, DES Adults with Learning Disability and NI LES Chronic Respiratory Conditions.
- Implementation of the GP Out of Hours Strategic Framework.
- Continue to work with LCGs to produce LES which support the transformation and integration of care for example, development of Enhanced Services for the Care of Older, Frail Patients in their Own Home.

Commissioning priorities to be taken forward by the five LCGs during 2014/15 include:

- Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.

Local commissioning requirements in relation to this priority are included in the LCG plans.

4.10.2 General Dental Services (GDS)

(i) Introduction

There are currently 1049 independent contractor dentists working in N Ireland and the General Dental Services (GDS) expenditure in 2012/13 was £117m. The Department has described the overall outline of the new GDS contract and has asked the HSCB to pilot and test aspects of this. The Board is responsible for piloting this contract and has established a Pilot Working Group and a Project Board to ensure that appropriate pilots are set-up and evaluated within the agreed timescales. It is anticipated that the new GDS contract will focus on prevention, maintain access for N Ireland's population, help dentists to focus on care quality, allow HSCB to locate practices in areas of greatest need and make management of the GDS budget easier.

The new contract will be piloted in 3 waves over the 2014-2016 period with the roll-out of the contract to all practices scheduled for 2016-17. The first wave of the pilot is due to begin by June 2014 and will involve 5 dental practices. It is anticipated that this pilot wave will run for 9 months when a further 15 practices will be added in wave 2. This again will run for 9 months before being evaluated with wave 3 commencing at the end of this period. Each successive wave of pilots will refine the contract with the intention that on completion of the final evaluation in June 2016, a thoroughly tested and N Ireland appropriate contract will be ready for implementation across the region.

The Oral Surgery pilot ended in September 2013 and it is hoped that the full evaluation will be completed by early 2014. However, while the pilot focussed on Oral Surgery provided by primary care specialists, the appointment of three new Consultant Oral Surgeons in the School of Dentistry has led to a significant increase in secondary care Oral Surgery capacity.

The challenge now for HSCB is to take account of the evaluation of the Oral Surgery pilot and the potential for increasing the proportion of patients who

receive their specialist Oral Surgery care in the primary care setting while at the same time working with the Commissioning Directorate to maximise the utility of the new School of Dentistry staff. The goal is to ensure that patients requiring outpatient Oral Surgery care are seen within 15 weeks by 1 April 2014 and that in-patients and day-cases are seen within 26 weeks. The Board will need to agree mechanisms with Trusts to move Oral Surgery patients from areas where demand exceeds capacity to areas where the reverse is true. At the same time, through the dissemination and implementation of Oral Surgery referral guidelines, HSCB will seek to ensure that only those patients who actually need to be seen in the secondary care environment are seen by Trust Oral Surgery services.

(ii) Commissioning Priorities 2014/15 and 2015/16

Key commissioning priorities to be taken forward at regional level during 2014/15 include:

- Implement pilots to test proposed new General Dental Services contract
- Complete final evaluation of Oral Surgery pilot and use findings to help address excessive waiting times for Trust Oral Surgery Services

4.10.3 General Ophthalmic Services (GOS)

(i) Introduction

GOS is going through a period of change in line with the principles of Transforming Your Care. In addition to provision of core GOS, contractors will be more fully involved in the delivery of extended services in primary care, and more fully integrated care pathways for long term ophthalmic conditions, largely for the frail elderly population.

This commissioning direction is set against a backdrop of a review of the current GOS contract in line with objectives contained within "Developing Eyecare Partnerships (DEP); improving the commissioning and delivery of eyecare in Northern Ireland".

DHSSPS Policy document DEP (Developing Eyecare Partnerships) contains 12 objectives, set within a 5 year planning cycle, and DHSSPS have asked HSCB and

PHA to jointly lead on the delivery of these objectives. In terms of commissioning, DEP will deliver care pathways on the following long-term conditions:

- Glaucoma
- Cataract
- Age-related Macular Degeneration (AMD) /Maculopathies
- Diabetic Retinopathy

(ii) Commissioning Priorities 2014/15 and 2015/16

Key priorities to be taken forward at regional level during 2014/15 include:

- AMD/Maculopathies – Work with all stakeholders, including providers and users, to develop pathway approach (with increased resilience) to maculopathy treatments. This will include better access to diagnostics, and better use of the available skills mix.
- Work with ICPs to develop fully integrated care pathways for long term ophthalmic conditions, largely for the frail elderly population and develop associated enhanced services as required.
- Diabetic Retinopathy (DR)
  - Use the resource resilience identified within AMD pathways to assess and treat diabetic macular oedema.
  - Work with GP's and Trusts to add resilience to DR screening, and apply safe and robust hospital discharge policies back into screening programme.
- Deliver essential and enhanced services in line with DHSSPS clinical priorities.
- Deliver Electronic Claims and Payment System and secure email communications and referral system.
- Glaucoma - Reduce demand by referral refinement and commencement of consultant-led multi-skill clinics

Key priorities to be taken forward at LCG level during 2014/15 include:

- Roll-out and evaluation of pilot on primary care facing advice and treatment of non-sight-threatening Minor Eye Conditions in Southern LCG Area.

Specific commissioning requirements in relation to these objectives are included in the LCG plans.

4.10.4 Community Pharmacy Services

(i) Introduction

Pharmaceutical services are delivered across the HSC by a range of providers, the biggest group of which is community pharmacy with over 530 pharmacies across N Ireland. The vision for community pharmacy services is to further integrate and apply clinically focussed activity which utilises the skills of community pharmacists to improve outcomes for patients.

It has been proposed in successive strategic reviews (and most recently TYC) that the Health Service should commission health improvement and medicines management activity through pharmacies. Patients and clients repeatedly score community pharmacy exceptionally well with respect to the services that they provide. Community pharmacy has potential to contribute to the transformation agenda in a number of ways:

(1) *Extended roles in supporting chronic disease management* - In 2013/14, medicines use review services were introduced in community pharmacies and are initially targeted at improving understanding and adherence to medicines for respiratory patients who are taking multiple medicines. In the first six months, over 3500 patients have had a review through the services. Further commissioning is being considered to support strategies for managing other chronic diseases such diabetes and to support medicines adherence following introduction of new medicines or changes to medication at hospital discharge.

(2) *Supporting self-care and providing advice and treatment for minor ailments thereby reducing demand for GP services both in hours and out of hours* - A

review of the current minor ailment service has been started to inform the future commissioning arrangements for this service.

(3) *Supporting health improvement strategies through provision of brief advice and interventions, specialist smoking cessation services and community development initiatives* - Health + Pharmacy is a new initiative which has been developed enhance the public health role of participating community pharmacies. In 2013/14, training was delivered for the first cohort of pharmacies leading to a process of accreditation as a Health + Pharmacy. The focus for this accreditation is to drive up the quality and improve outcomes for patients. There will also be co-ordination of health improvement activities through the introduction of a Health Promoting Pharmacy service.

It should be noted that these innovations have taken place within the context of the current contract model which is over fifteen years old and provides limited opportunities to clarify commissioning specifications for the existing funding or for the development of further enhanced and additional services.

(ii) Commissioning Priorities 2014/15 and 2015/16

Commissioning priorities to be taken forward during 2014/15 include:

- Clarify/update commissioning specifications for current pharmacy service
- Develop further activity through community pharmacy which will promote better patient understanding of medicines to improve adherence and reduce waste
- Develop enhanced level of health improvement activity through community pharmacy
- Complete review of current minor ailment service in order to inform future commissioning of the service.

4.10.5 Community Nursing and AHP Provision

(i) Introduction

District nurses play a crucial role in the primary health care team. They visit people in their own homes or in residential care homes, providing care for patients and supporting family members, to include the provision of palliative and end of life care.

As well as providing direct patient care, district nurses also have a teaching role, working with patients to enable them to care for themselves or with family members teaching them how to give care to their relatives and therefore play a critical role in terms of the effective management of longterm conditions.

District nurses play a vital role in keeping hospital admissions and readmissions to a minimum through supporting the provision of intermediate care and through the provision of acute and complex care at home. They also facilitate early supported discharge, ensuring that patients can return to their own homes as soon as possible.

AHPs will also play a fundamental role in the transformation of care through the use of preventative upstream approaches which enable people to live well and for as long as possible in their own homes and communities:

- undertaking roles in health promotion, health improvement, diagnosis, early detection and early intervention;
- supporting service users to avoid illnesses and complications through enhanced rehabilitation and re-ablement to maximise independence; and
- supporting people of all ages to manage long term conditions.

Investment in community nursing and AHP provision will be fundamental to the successful delivery of the integrated care pathways and the new models of care (e.g. community wards, rapid response teams) that will be developed and implemented by ICPs across the clinical priority areas during 2014/15.

(ii) Commissioning Priorities 2014/15 and 2015/16

Commissioning priorities to be taken forward at regional level during 2014/15 include:

- To develop a Regional Commissioning Framework for Community Nursing.
- To complete a review of current AHP workforce and activity to include Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics to ensure the DHSSPS targets are fully achieved and that these services respond appropriately to patients presenting within Emergency Care settings during the 24 hour period.
- To introduce electronic referrals for the AHP professions (Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics).
- SE Trust to work with the commissioner to pilot and evaluate self-referral physiotherapy for people experiencing musculoskeletal pain with a view to roll out to all Trusts.
- To commence the implementation of Independent Prescribing in Physiotherapy and OT services.

The main priority to be taken forward by the five LCGs during 2014/15 is:

- Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility.

Specific local requirements in relation to this priority are outlined within the LCG Plans.

4.11 Prisoner Health

(i) Introduction

Within N Ireland there are just over 5,000 committals annually and approximately 1,800 – 1,900 prisoners throughout the prison estate at any time. Prisoner Health Services are delivered within three prison establishments and are managed by the South Eastern Health and Social Care Trust. These are;

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

Prisoners receive a full range of healthcare services. The majority of services provided within the prison are primary care services, complemented by dedicated services for a number of mental health and addiction needs. Access to secondary care services are usually provided in acute hospitals through normal referral processes.

The Board takes as an underlying principle of prisoner healthcare delivery that people in prison should be entitled to the same level of healthcare as those in the community, although it is accepted that security considerations may modify exactly how healthcare is structured and delivered. There are in addition a number of factors arising from the prison environment and the nature of prison populations which need to be taken into account in taking forward service development and change agendas:

- Prison populations are rising, placing increasing pressure on health care resources.
- There is a particular need to address the healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities.
- Rates of mental ill health for those in prison are higher than the general population, with the prison population having a much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses.

- There is a continuing need to consider how prison healthcare systems can develop greater integration with community and secondary care services on committal and discharge.
- There is a need to ensure that, following the identification of prisoners' healthcare needs at committal, these are followed up with appropriate action.
- There are issues associated with the misuse of prescribed medicines and the supply of illicit drugs.
- There is a need for improved cooperation between the criminal justice system and Health and Social Care.

A Prison Review Team (PRT) was established in 2010 by the Department of Justice under the chairmanship of Dame Anne Owers "to conduct a rolling review…encompassing the conditions of detention, management and oversight of all prisons" in N Ireland. While the main thrust of the review and the majority of its recommendations addressed the issue of improved prison management, a small number of the recommendations related to the delivery of healthcare.

In response to the recommendations contained within the Owers Review, the Department of Justice and the Department of Health are now working together to develop a joint Healthcare and Criminal Justice Strategy. A Steering Group has been established incorporating key stakeholders and work-stream leads have been appointed to take forward the development of strategy in the following areas:

- Prevention and diversion
- Offenders in the community
- Offenders in custody
- Re-integration

(i) Commissioning Priorities 2014/15 and 2015/16

The basic approach adopted by the Prisoner Health Commissioning Team is an incremental one which seeks to:

- Agree annual targets for the improvement of information systems and data gathering mechanisms.

- Use these improved information systems to produce more accurate and timely needs assessments of those in prison.
- Where additional prison – specific funds have been identified, work with the South Eastern Health and Social Care Trust to identify appropriate service developments in line with assessed need.
- Ensure that prisoner health needs are also considered where additional funds are identified for broader health service developments.
- Work with the South Eastern Trust and the Northern Ireland Prison Service to ensure that the prisoner health systems are gradually re-engineered to bring them into line with best practice in the broader HSC system.

In addition to the general commissioning approach described above, the Board considers it important to take forward in 2014/15 the recommendations of the Owers Review relating to healthcare delivery in cooperation with the Department of Justice, the Department of Health and the South Eastern Trust.

Specific objectives for Trusts to take forward in relation to these priorities are outlined below.

Commissioning Objectives Prisoner Health 2014/15 and 2015/16

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
1. SET should continue to progress the development of healthcare services and chronic disease management in line with the principle of equivalence	●	●			*HSCB/PHA Strategic Intent*
2. Mental Health services for the prison population should be further developed in accordance with delivering the Bamford Action Plan 2012 – 2015 for people with Mental Health and Learning Disability	●	●	Bamford Action Plan		
3. SET should produce a 2014/15 implementation plan directed toward the implementation of the Health & Social Well-being Strategy for Prisoners.	●				*HSCB/PHA Strategic Intent*

	Timescale for achievement		*Strategic Driver/Needs Assessment*		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
4. Trusts should continue to work together to develop care pathways, into and out of prison, for prisoners with complex needs.	●	●			*HSCB/PHA Strategic Intent.* *PRT Recommendation*
5. Trust based information systems should be further developed to help facilitate a whole systems approach to prisoner healthcare.	●	●			*HSCB/PHA Strategic Intent*
6. SET should produce a 2014/15 Health Needs Assessment.	●				*HSCB/PHA Strategic Intent.* *PRT Recommendation*
7. SET will produce proposals for improvements in Medicines Management, with a particular emphasis on the safe use of prescription medications.	●				*HSCB/PHA Strategic Intent*
8. The Board and the PHA will revise its processes for the production of the annual Commissioning Plan to	●				PRT Recommnedation

Key Deliverables	Timescale for achievement		Strategic Driver/Needs Assessment		
	2014/15	2015/16	Ministerial target	TYC	Other
incorporate feedback from the Northern Ireland Prison Service.					
9. The Board and the PHA will work with the Dept of Justice, the Dept of Health and the South Eastern Trust in taking forward PRT recommendations relating to healthcare delivery and improved working with key stakeholders.	●	●			PRT Recommendation
10. The Board and the PHA will work with other key stakeholders in the development of the Joint Healthcare and Criminal Justice Strategy	●	●			PRT Recommendation
11. SET will progress service developments in psychological therapies in line with HSCB guidance.	●		Bamford Action Plan		

	Timescale for achievement		Strategic Driver/Needs Assessment		
Key Deliverables	***2014/15***	***2015/16***	***Ministerial target***	***TYC***	***Other***
12. SET, in co-operation with commissioners and other relevant Trusts, will actively explore the potential for tele-health alternatives for specialist and/or emergency assessments and reviews.	●				*HSCB/PHA Strategic Intent*

4.12 Medicines Management

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

- A need to ensure a high and consistent level of quality in the prescribing, dispensing and administration of over 35 million prescriptions
- An investment of over £500m per year on medicines across primary and secondary care
- An ongoing need, as with other modern healthcare systems to focus on improving medicines safety.

Policy has highlighted the need to optimise how medicines are managed through the selection of the most appropriate medicine through to how medicines are ordered, supplied and administered such that the desired therapeutic benefits are achieved, adverse events and waste are minimised.

(iii) Commissioning priorities for 2014/15 and 2015/16

Commissioning priorities to be taken forward at regional level during 2014/15 include:

- Development and implementation of NI formulary
- Refinement of the mechanism to manage entry (and exit) of medicines into routine use on the HSC
- Delivery of more cost effective prescribing
- Improved use of medicines such that there is less risk and waste

Specific objectives for Trusts and ICPs to take forward in relation to these priorities are outlined in the Table 24 below.

Trust and ICP requirements in relation to Medicines Management 2014/15

Table 24

	Timescale for achievement		*Strategic Driver*		
Commissioning Objectives	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
All Trusts and ICPs to ensure the formulary is embedded within prescribing practice through active dissemination within electronic prescribing platforms	●	●	Target 18	Rec 91	
All Trusts and ICPs will work with the Health & Social Care Board in 2013/2014 to establish the baseline position with ICPs ensuring 70% compliance by end 13/14 and Trusts attaining target delivery in 2014/2015.	●	●	Target 18	Rec 86	
All Trusts and ICPs should put in place arrangements to manage regional monthly managed entry	●	●			DHSSPS requirement for managed entry arrangements

	Timescale for achievement		*Strategic Driver*		
Commissioning Objectives	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
recommendations including monitoring, reporting and disinvestment arrangements					
All Trusts and ICPs to ensure 100% compliance with local delivery against the Regional Pharmaceutical Clinical Effectiveness Programmes such that all targets are met	●	●			Efficiency programme
All Trusts and ICPs should support development of e-prescribing in hospitals through identification of clinical champions and leads and co-ordination of local Trust implementation teams	●	●		Rec 91	Medicines Safety
All Trusts and ICPs should ensure that all patients with highest risks (complexity; high risk medicines) have their medicines	●			Rec 77	Medicines Safety; NICE Guidance

	Timescale for achievement		*Strategic Driver*		
Commissioning Objectives	**2014/15**	**2015/16**	**Ministerial target**	**TYC**	**Other**
reconciled on admission and at discharge in line with NICE guidance (http://guidance.nice.org.uk/PSG001) – baseline in 13/14; delivery 14/15					

5.0 Achievement of Ministerial Targets 2014/15

Overview of Ministerial Targets

This section provides a brief overview of performance against the Ministerial targets set out for 2013/14. It also outlines the proposed approach to the delivery of the Ministerial targets set out in the Minister's Commissioning Plan Direction 2014. It does not address every target; rather it seeks to outline how we intend to:

(1) support the achievement of a number of new targets introduced for 2014/15
(2) support the achievement of targets where the performance standard has been extended for 2014/15
(3) address underperformance against existing targets through the commissioning of additional capacity or other actions during 2014/15.

A copy of the Commissioning Plan Direction and Indicators of Performance can be found on the HSCB website (www.hscboard.hscni.net/publications/Commissioning%20Plans).

Areas of progress 2013/14

During 2013/14, the HSCB continued to closely monitor Trusts' progress against the standards and targets set out in the Minister's Commissioning Plan Direction 2013 and take action as necessary.

Particular progress was made in 2013/14 in a range of areas including:

- there has been a significant reduction in the number of patients attending A&E Departments who waited more than 12 hours to be admitted or discharged home compared to 2012/13
- The number of patients waiting longer than nine weeks for access to a diagnostic test has reduced significantly
- The target associated with Child and Adolescent Mental Services access within nine weeks has been substantially achieved

There have also been a number of performance challenges on which the HSCB will continue to work with Trusts during 2014/15 to secure further improvements, including:

- A&E (4 hour)
- Cancer (62 day)
- Elective Care waiting times
- Access to AHP services

The HSCB and PHA will work with Trusts during 2014/15 to maximise performance against all of the standards and targets set out in the Department's Commissioning Direction.

Bowel screening: The HSC will extend the bowel cancer screening programme from April 2014 to invite, by March 2015, 50% of all eligible men and women aged 60-74, with an uptake of at least 55% of those invited.

The Bowel Cancer Screening Programme (BCSP) was extended to include all eligible men and women aged 60-71 from April 2012. A further age extension, up to 74 years, will be introduced from April 2014. Capacity within all elements of the programme will be expanded in 2014/15 to facilitate the increased demand which will result from age extension. This includes the call/recall process, the screening laboratory and the screening colonoscopy service.

The programme operates on a 2-year screening round: this means that approximately 50% of the total eligible population is invited to participate in any one year. The service will aim to invite 50% of the eligible population aged 60-74 in 2014/15 with the remaining balance invited during 2015/16.

The PHA intends to continue to raise awareness of the screening programme so that the eligible population can make an informed choice as to whether they wish to complete the screening test. Uptake rates continue to improve, and further work will be taken forward in 2014/15 to promote informed choice both to the general population and to those population groups who are less likely to participate in screening.

Family Nurse Partnership: By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust.

Around 2,600 children are born each year to first-time mothers in more vulnerable circumstances. Family Nurse Partnership (FNP) is a voluntary preventive programme for teenage mothers, which offers intensive and structured home visiting, delivered by specially trained 'family nurses', from early pregnancy until the child is two years of age. The aim of FNP is to improve the health and wellbeing of our most disadvantaged families and children, and to prevent social exclusion.

FNP is now in place in three Trusts in N Ireland, the Western, Southern and Belfast Trust. During 2014/15 the programme will be expanded to the Northern and South Eastern Trusts.

Substance misuse: By March 2015, Services should be commissioned and in place that provide seven day integrated and co-ordinated substance misuse liaison services within all appropriate HSC acute hospital settings undertaking regionally agreed Structured Brief Adviser Intervention Programmes.

During 2014/15 the HSCB and PHA will work with Trusts to establish effective substance misuse liaison services within appropriate acute hospital settings. This will include:

- Undertaking alcohol-related case-finding and delivery of brief advice and structured brief interventions within the E.Dept and general hospital setting
- Contributing to the management of patients identified with alcohol-related problems and/or arrange input from other medical services
- Liaison with community based alcohol and other specialist services and also work with other relevant services/teams, in particular those undertaking self-harm, child/family care and crisis related work also the community/voluntary sector.

- Improving the capacity of Trust staff: Training the wider range of medical/nursing staff, particularly those undertaking assessment functions, to better identify patients with latent alcohol-related problems is therefore a vital component of the liaison practitioner's role. This training will enable hospital staff to provide brief advice and undertake appropriate referral where necessary. This can be achieved through training which focuses upon identification (screening tools) and provision of brief advice and motivational skills training in the hospital setting.

Tackling Obesity: By March 2015, ensure all pregnant women, aged 18 years or over, with a BMI of 40kg/ m^2 or more at booking, are offered the Weight to a Healthy Pregnancy Programme, with an uptake of at least 65% of those involved. (New target)

Obesity during pregnancy carries significant risk of complications. Children born to women who are obese are also at increased risk of childhood obesity. Data from the Child Health System indicate that approximately 2% of all maternities in NI are to women with a BMI≥40; approximately 500 women per year.

The Weigh to a Healthy Pregnancy programme is a regional pilot to develop and test an approach to providing extra information and support to pregnant women with a BMI≥ 40 at booking, with the aim of limiting gestational weight gain to recommended levels. During 2014/15, on a pilot bases across the five Trusts, support will be delivered within maternity services by designated midwives, dieticians and physiotherapists through face to face contacts, group sessions and telephone or text support during pregnancy and up to 6 weeks post-natal. Information and support will involve encouraging healthy eating habits, promoting appropriate levels of physical activity and promoting breastfeeding. The longer term aims of the programme are to enable women to sustain pregnancy lifestyle changes, and to support a longer term reduction of weight during the post-natal period.

Cancer Care Services: From April 2014, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should

receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.
During 2013/14 good progress has been made by the HSC to reduce the longest waits experienced by cancer patients. Further efforts will be required in 2014/15 to improve the percentage of patients with a diagnosis of cancer who commence definitive treatment within 62 days of urgent referral.

To support the delivery of the cancer targets, the HSCB will continue, during 2014/15, to seek to commission adequate capacity across all relevant specialties as required to ensure all patients have timely access to assessment, diagnosis and treatment. During early 2014/15 the HSCB will also complete its current review of urgent 'red flag' referrals for suspected cancer which have increased very significantly in the last two years without any apparent increase in the incidence of cancer.

The HSCB will work with primary and secondary care professionals to ensure the effective application of regional referral guidance from the NI Cancer Network. The Board will also explore the potential to use the electronic referral system to support effective practice in this regard.

Unscheduled Care: From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.
During 2013/14 good progress has been made to reduce the number of 12-hour breaches. However further progress is required to eliminate such breaches and to improve significantly the percentage of patients attending A&E who are treated and discharged, or admitted within four hours of arrival.

During 2014/15 the HSCB will, as far as possible within available resources, move to a position where at the large hospital sites key services (diagnostics, AHPs, social care, etc.) are delivered on a seven-day basis, thereby improving

patient flow at weekends. The HSCB will also continue to work with Trusts to ensure that available resources for unscheduled care are used as effectively as possible to include full implementation of agreed best practice actions.

Finally, the HSCB working with Trusts directly, and with Trusts and primary care through Integrated Care Partnerships, will seek to reduce the need for patients to attend A&E and/or be admitted to hospitals. Measures in this regard will include the establishment of more effective arrangements to provide GPs with specialist advice, and the greater provision of ambulatory care services for patients.

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

The HSCB will continue to ensure this area is prioritised in 2014/15, seeking as far as possible within available resources to maintain the current momentum and secure further reductions in maximum waiting times for patient assessment and treatment.

Further improvements in performance will be secured through a combination of ensuring Trusts deliver agreed levels of core capacity for 2014/15, together with investment in additional in-house or Independent Sector activity where this is required, and through the recurrent investment that was applied during 2013/14 being realised as activity as quickly as possible.

In relation to diagnostics reporting, the HSCB/PHA will continue to work with Trusts to ensure timely reporting of urgent tests. The HSCB will work with Trusts to ensure the effective planning and implementation of those RQIA review recommendations for which the HSCB is in the lead.

Specialist drugs: From April 2014, no patient should wait longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis, ankylosing sponylitis or psoriasis.

During 2014/15 the HSCB will ensure that sufficient services are commissioned to ensure continued timely access for these NICE-approved specialist therapies, with all new patients commencing treatment within three months.

Medicines Formulary: From April 2014, ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area.
As a result of work taken forward by the HSCB to date; from April 2014 almost 90% of prescribing choices will be covered by the formulary.

With the development of each formulary chapter, monitoring arrangements have been developed and in 2013/14 a compliance rate of 70% is expected to be achieved. The launch of the public facing NI formulary website is planned for March 2014.

Work will be taken forward in 2014/15 to identify and research outlying prescribing practice with the aim of aligning this to the regional average. 2014/15 will also see incorporation of the formulary within electronic prescribing systems.

AHPs: From April 2014, no patient waits longer than nine weeks from referral to commencement of AHP treatment.
The number of people waiting longer than 9 weeks for commencement of AHP treatment has increased significantly since March 2013. 140 clients were waiting beyond nine weeks at the end of March 2013 and at the end of September 2013 it was 4337.

A number of Trusts have reported an increase in demand as a contributing factor to the increased waiting times. The HSCB and PHA are working with Trusts to undertake a rapid demand and capacity exercise, with an initial focus on occupational therapy (OT) and physiotherapy. Trusts have also been allocated funding in-year to undertake additional activity to improve the waiting time position, and will continue to receive support as appropriate in 2014/15.

- Complete the review of current AHP workforce and activity to include Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics.
- Evaluate current demand in Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics.
- Introduce regionally consistent monitoring of AHP services specific to individual sub-specialty for each profession (Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics.)
- Define the percentage of each profession (Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics) which are delivered as scheduled and unscheduled.
- Introduce the monitoring of individual AHP MDTs and special schools activity in the ministerial 9 week target.
- Introduce electronic referrals for the AHP professions (Dietetics, Podiatry, Physiotherapy, Occupational Therapy, Speech and Language Therapy and Orthoptics).
- Put a mechanism in place to ensure patient identities are available to the PHA/HSCB for individual breachers.

Telehealth: By March 2015, deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.

This target remains the same as the 2013/14 target. 440,000 patient days were delivered during 2014/15. During 2014/15, the HSCB and PHA will be working with Trusts and the NI Telemonitoring service provider to further increase the number of telehealth monitored patient days to the target level. Specific actions include:

- The development of an implementation plan for the integration of Telemonitoring data into the Electronic Care Record (ECR)
- The development of services for hypertension, palliative care needs, and for multi-user settings such as residential/nursing facilities and prisons

- Amendments to the Telemonitoring NI service to increase flexibility to step-up and step-down care and to facilitate easier referrals for new conditions in the future.
- Work to explore the role of telemonitoring in supporting the clinical care provided by GPs and under the development of ICPs.

Unplanned admissions: By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions
Integrated Care Partnerships will play a key role in the delivery of reductions in unplanned admissions for people with longterm conditions, ensuring integration among primary and secondary care providers to meet patient needs with clear arrangements for dealing with patients with long term conditions, multi-morbidity and complex medication regimes, and access to specialist medical or nursing advice. In addition, the HSCB and PHA will ensure the provision of one-to-one and group education programmes to support self-management that have agreed content and arrangements for patients to receive regular updates.

Moreover, the introduction of risk-stratification, provision of integrated community teams and enhancements to remote telemonitoring during 2014/15 will all contribute to a reduction in ED attendances, emergency admissions, and length of stay and/or bed days.

Telecare: By March 2015, deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.
This target represents an increase of 80,000 monitored patient days over and above the 2013/14 target. During 2014/15, the HSCB and PHA will be progressing work with Trusts to establish the appropriate utilisation and deployment of telecare across a range of client groups, including older people, dementia, learning disability, physical and sensory disablement.

In addition the following will be progressed:

- Refining the service specification including electronic referrals;
- Migrate existing Telecare clients from old service to new service
- Specify and commission an evaluation to the service

This will be supported with a range of appropriate communication and engagement activities.

ICPs: By March 2015, 95% of patients within the four ICP priority areas (frail elderly, diabetes, stroke, respiratory) will have been identified and will be actively managed on the agreed Care Pathway. (New target)
During 2014/15 this issue will be progressed as part of the on-going process for the implementation of ICPs. The achievement of the target will require risk stratification at primary care level of patients at medium of high level of likelihood to require admission to hospital, and ensuring these patients are care-managed in line with agreed care pathways.

Delivering Transformation: By March 2015, transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. (New target)
Transforming Your Care requires a shift in healthcare with the potential for more acute care to be delivered in the home and community and that the resources from hospitals and institutions will be transferred to primary, community and social care settings to allow a more diverse provision of services, delivered closer to home. The HSCB will ensure effective arrangements are in place to plan and deliver the required transformation of services and associated resource transfer.

Normative Staffing: The Regional Agency should continue to lead and monitor the programme of work to develop and implement Normative Nurse Staffing which should be used to commission and deliver services as follows:
From April 2014, the Normative Nurse Staffing Tool should be applied to all inpatient general and specialist adult hospital medical and surgical care settings and by March 2015 normative staffing ranges will be developed and

introduced for Health Visiting within a range which secures the delivery of the service model detailed within the Departmental Strategy 'Healthy Futures'. (New target)

The PHA will continue to lead on the implementation, monitoring and development of The Normative Nurse Staffing framework "Delivering care" for N. Ireland. Specifically during 2014/15 the PHA will take forward the following:

- The development of regionally agreed workforce tools including health visiting to support the delivery of safety, quality and patient/client experience outcomes in community and primary care settings.
- The Normative Nurse Staffing Tool will be applied to all inpatient general and specialist adult hospital medical and surgical care settings. A range of key performance indicators will be developed to monitor the implementation process. In addition E- rostering will be in place across all HSCT settings.
- During 2014/15, work will continue on the implementation of Specialist Nurse Job planning. This work is aimed at delivering on Safety Quality and Patient Experience outcomes within hospital services. Work will commence on the development of similar plans for Specialist Community Nursing Services.
- The development of normative staffing ranges for Health Visiting.

Unnecessary Hospital Stays: By March 2015, reduce the number of excess bed days for the acute programme of care by 10%

Transforming Your Care requires a shift in healthcare with the potential for more acute care to be delivered in the home and community. Extended community nursing services, including acute care at home and ambulatory care within primary care centres, will support early discharge.

The development of Integrated Care Partnerships will lead to greater collaboration in the delivery of care with prevention and early intervention in the management of long-term conditions. Moreover, *Transforming Your Care* means GPs will have improved access to diagnostics and rapid outpatient

assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion between GP and senior hospital doctor and agreed decision on steps to take in patient management.

Cancelled Clinics: By March 2015, reduce the number of hospital cancelled consultant-led outpatient appointments by 17%. (New target)
Building on improvements made in 2013/14 through the creation of a Short Life Working Group to more accurately code and record the reasons for clinics being cancelled and to assess the impact on patients, this target is designed to monitor a reduction in the numbers now that they can be accurately and consistently measured. Although not formally a target to date, cancellations have been reducing year on year since 201/11 at a rate of around 5% per year.

Learning Disability & Mental Health: By March 2015, resettle the remaining long-stay patients in learning disability and psychiatric hospitals to appropriate places in the community.
At September 2013 Trusts had plans in place to ensure that both these Standards for the 2013/14 year would be met and to ensure the resettlement of all the mental health and learning disability long stay patients by 2015, in line with the Minister's overall target.

Children in Care: From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%
Children in Care: By March 2015, ensure a three year time frame for 90% of children who are to be adopted from care
Children in Care: From April 2014, ensure that all school-age children who have been in care for 12 months or longer have a Personal Educational Plan (PEP)
These priorities continue to reflect the need for stability and permanency for children in the looked after system. The HSCB will work with Trusts to ensure that a range of looked after placements which meet the assessed needs of the children are available to deliver on this target.

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

The adoption standard continues to confirm the need to expedite permanency via adoption where this is the preferred care plan for the children in question.

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

6.0 Belfast Local Commissioning Plan

6.1 LCG Population

This section provides an overview of the assessed needs of the population of the Belfast LCG. This assessment is based on demographic changes and information we have relating to health inequalities and will inform the commissioning of services at a local level.

Demography

The total resident population of the LCG area is just over 348,000 (NINIS) accounting for 19.23% of the Northern Ireland (NI) total. However, the population using local health and social services in Belfast, which the LCG must commission on behalf of the HSCB, extends to parts of Northern and South Eastern LCG areas. Belfast Trust also delivers a range of regional acute, rehabilitative and social care services to the whole of the NI population.

Characteristics of the LCG population include:

- The population of Belfast LCG is projected to be stable over the next decade (NINIS 2008)
- Belfast LCG area has the smallest proportion of population aged under 16 of any LCG (NISRA 2012)
- The number of people in Belfast LCG area aged over 65 is projected to increase by 11% over the next decade, however the number aged over 85 will increase by 27% (NINIS 2008)
- 3.5% of the population are from an ethnic minority group(NINIS 2013).
- In 2012 there were almost 5000 births to Belfast mothers (NISRA 2013). While the number of births has increased over the past decade, there are signs that this may now be stabilising or declining.

Deprivation

Deprivation has an impact on health and wellbeing in many ways, resulting in the lack of social support, low self-esteem unhealthy life style choices, risk taking behaviour and poor access to health information and quality services. The extent of deprivation in Belfast Council area is greater than in any other Local Government District in Northern Ireland with 46% of the population estimated to be living in multiple deprivation (NINIS 2010). The risk of ill health is known to be greater where there is multiple deprivation as key risk factors for poor health outcomes are more prevalent, including obesity, smoking, drug and alcohol abuse, common mental health conditions, suicide and self-harm and births to teenage mothers.

Premature mortality

Life expectancy for people living in the most deprived areas within the Trust was 6.7 and 3.9 years lower than in the LCG as a whole for males and females respectively. (DHSSPS 2012). Between 2001 to 2011, those living in the most deprived areas were twice as likely to die prematurely from potentially avoidable deaths as those in the least. These were driven primarily by ischaemic heart disease (IHD), lung cancer, chronic obstructive pulmonary disorder (COPD) and suicide.

Standardised Mortality Ratios (SMRs) for the main causes of death are higher than in any other LCG and 12% higher than the NI average. The highest proportion of avoidable premature deaths by main cause was from cardiovascular diseases. The death rate in Belfast LCG area was 89.03 per 100,000 (3,082 people) whereas the NI average was 74.72. While the numbers have declined in the last ten years, ischaemic heart disease remains the leading cause of avoidable deaths for both genders. The rate in Belfast is highest at 63.84 per 100,000 population (2,210 people) compared to the NI average of 55.43 per 100,000. The death rates from neoplasms were the most common main cause of preventable deaths, of which the trachea, bronchus and lung was the most common cancer site. Death rate from neoplasms per 100,000 people was 95.56 (3,308 people in total), NI average 74.51.

Chronic illness/Long Term Conditions

In Belfast 23% of people are living with a long term illness (Census 2011), which is a significantly higher proportion than in other LCG areas. The prevalence of long term conditions such as COPD, stroke, diabetes and hypertension is increasing in Belfast and for many of these conditions there is a link between prevalence and deprivation (PHA 2011). Belfast consistently shows higher prevalence of patients on registers per 1000 of all the key QOF measures eg heart failure, heart disease and COPD than the NI average.

Risk Factors

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in Northern Ireland. It is known to be an important factor in a wide range of diseases including respiratory disease, heart disease, stroke and cancer. Between 2001-05 and 2006-10, the standardised death rate (SDR) due to smoking related causes decreased within NI but increased by 2% in the Belfast LCG. The inequality gap between the most deprived areas and the LCG as a whole remained fairly constant at around 50% throughout the period.

Alcohol related standardised admission rates and death rates for Belfast LCG residents increased by 17% from 2000-01/2001-2 to 2008-9/2009-10 and are significantly higher than all other LCGs. Within Belfast LCG, alcohol related hospital admission rate was 120% higher in the most deprived areas than in the LCG area as a whole (DHSSPSNI, 2012).

Obesity is one of the most important public health challenges in Northern Ireland and the prevalence of obesity has been rising over the past number of decades. The average number of obese children in the Belfast LCG and its most deprived areas in 2009-11 was higher in NI as a whole. The LCG inequality gap was 47%, with the most deprived areas being higher than across the whole LCG. In 2013 the raw prevalence of patients aged 16 plus (per 1000 patients) on the obesity register was 102.3 for the Belfast HSCT.

Issues raised during Public and Personal Involvement

The LCG has a continuous programme of engagement with patient and carer advocates, local community partnerships and older peoples' forums. Monthly LCG Public Meetings are well-attended enabling issues to be raised through discussion with members. BHSC Trust also has a range of engagement forums where issues are raised and these are shared with the LCG.

The LCG is a partner in the Belfast Strategic Partnership (BSP) which has a range of stakeholder engagement methods which raise issues which the LCG takes into account. BSP workshops on drugs and alcohol issues and poverty have been particularly informative.

The BSP Thematic Group for Mental Health of which the LCG is a member has had over 3000 responses to its engagement on its draft Emotional Health and Well Being Strategy. The LCG will take the response to this consultation into account in planning mental health services for common conditions within local communities.

The Healthy Ageing Strategic Partnership, chaired by the LCG, is carrying out a baseline survey and developing an Action Plan for submission to the World Health Organisation as part of the development of an Age Friendly City.

Engagement with the Greater Belfast Seniors' Forum and the many groups it represents has been a core component of the baseline survey. The issues raised will provide guidance to the LCG in planning for older people's services.

Formal public consultation around Transforming Your Care enabled engagement across the broad range of health and social care. Local engagement on TYC and the LCG Population Plan has included the local Councils and political parties as well as the local Health and Well Being Forums.

The LCG has closely involved a range of voluntary organisations, community groups, minority ethnic groups and the older people's forums in the

development of new care pathways and the design of new services. Carers groups have been and will continue to be fully involved in decisions about the deployment for funding ring-fenced to meet the needs of carers.

The LCG pays close attention to the health and well-being priorities highlighted within the strategic programmes and action plans of Belfast Area Partnerships and Neighbourhood Renewal Partnerships and engages with these partnerships in developing joint approaches. A key aspect of the LCG's approach to the development of the Primary Care Infrastructure Programme in Belfast has been engagement with local community and voluntary organisations through workshops facilitated by the Area Partnerships.

Some broad themes have emerged from engagement:

- The importance of health improvement, early intervention and supported self-care and in particular targeting people at risk of poor health outcomes
- The impact of the misuse and abuse of alcohol and drugs in local communities
- The important role that emotional well-being plays in underpinning physical health
- Psycho-social and practical support for people living with long term conditions
- The need for joined up planning across agencies and with the community and voluntary sectors
- The importance of sustainable community and voluntary provision to provide alternatives to more specialist Trust services
- Links between GPs, Pharmacists and community and voluntary support at local level and the uncertainty among people about the availability and use of local services
- Problems in accessing GPs

6.2 Key Challenges

This section provides an overview of the key challenges which will be faced by the LCG within 2014/15 and 2015/16. These inform and underpin Belfast LCG commissioning objectives for 2014/15 and 2015/16.

Challenge 1: Contribute effectively to reducing life inequalities and improving health outcomes.

The extent and scale of deprivation presents the most significant risk to poor health outcomes in Belfast. The LCG, in conjunction with the Public Health Agency and Belfast Trust, is engaging with local communities and other agencies, particularly through the Belfast Strategic Partnership, to address the multiple social determinants of health outcomes. The LCG views the work of the Partnership as a significant opportunity to address these wider risk factors to health and social well-being. It sets the strategic direction for health and wellbeing improvement in Belfast, through the development of agreed priorities for Belfastand the alignment of corporate plans and resources of the key service providers.

The Partnership aims to reduce life inequalities through:

- Improving outcomes for children and young people
- Promoting physical activity, active travel
- A strategic approach to healthy ageing
- Developing emotional resilience and coping with stress
- Reducing poverty
- Tackling drug and alcohol abuse

Challenge 2: Commission integrated service provision for people living with long term conditions and the frail elderly through ICPs and plan future infrastructure to support integrated working.

The greater prevalence of a range of long term conditions and disability in Belfast, and higher rates of emergency admission, especially in areas of deprivation, makes integrated working a priority for the LCG.
However, a major opportunity for the LCG lies in the previous work it took forward with Primary Care Partnerships over the past three years which

demonstrated the commitment from the Trust, GPs and particularly community and voluntary providers to work together for a common purpose on integrated care pathways.

The Belfast LCG will commission from four Integrated Care Partnerships, whole pathways of care, including end of life care, for the frail elderly and people living with respiratory disease and diabetes, and those who have survived a stroke. The Integrated Care Partnerships will aim to implement the 5 strategic outcomes identified in Transforming Your Care:

- The individual at the centre
- Improving Health and Wellbeing
- Provide safe, sustainable and resilient services
- Living independently
- Home as the Hub of Care

This will require primary and community care, specialist secondary care and community and voluntary organisations working closely together for the promotion of self-care and healthy lifestyles which address inequalities, the identification of patients who are at risk of requiring an unplanned hospital admission and the integrated planning of support for them to remain at home and to lead lives as independently as possible, including support for their carers.

The LCG will produce a strategic framework for commissioning primary and community care 'Hub and Spoke' infrastructural configurations to support this integrated working and which targets health improvement and inequalities of access to services.

The LCG will continue to direct investment towards community services to reduce unnecessary use of hospitals. However, comparisons with other HSC Trusts indicate that there is also room for improvement in the productivity of community resources in Belfast Trust. This will be facilitated through innovation, integrated working with primary care and greater use of information and communications technology.

Challenge 3: Commission timely, appropriate and equitable access to safe, sustainable and efficient hospital services, ensuring people can return home as soon as they are able to.

Waiting times for planned appointments and treatments and for emergency care are longer in Belfast Trust for a wide range of services than for other Trusts. Standardised admission rates are higher, partly due to higher levels of need particularly in areas of deprivation. Increasing standards and difficulties in recruiting and retaining key staff presents a challenge in ensuring that Emergency Departments and hospital wards continue to be staffed to a level which provides sufficient senior medical nursing cover.

Benchmarking with average performance in other parts of the UK has demonstrated considerable opportunities for greater efficiency in the way acute hospital services in Belfast are used. In particular, patients tend to stay in hospital longer than elsewhere for the same conditions. Performing at the average of comparative hospitals elsewhere would reduce the need for a substantial number of hospital beds and enable the re-deployment of investment into ambulatory care and community support.

The LCG will expect the Belfast Trust to make more productive use of its assets including 7 day working and extended hours of access. It will continue to work with the Trust to re-configure its infrastructure to meet developing service needs.

The LCG has agreed core performance baselines with the Belfast Trust for planned episodes of care, which are kept under review as circumstances change. Year on year improvements in productivity by the Trust will be expected so that more patients can be treated within the same capacity.

A challenge for the LCG is to commission sufficient outpatient, theatre and diagnostic capacity to meet the current demand for planned care.

Challenge 4: Commission alternatives to hospital attendance and admission which can better meet the needs of patients.

Studies by the Belfast LCG have shown that the majority of people who use Emergency Departments are not admitted to hospital and many could have had their needs addressed in primary care. A challenge for the LCG is to ensure people are aware of and can readily access appropriate alternatives to Emergency Departments, including primary care services or community support, when clinically, required on a 24/7 basis.

GPs now have direct access to advice and assessment from a senior hospital doctor in considering admission. For those patients whom the GP and hospital doctor consider should be admitted, this should be available directly to an assessment and admission unit rather than through an Emergency Department. Opportunities for new ways of working are presented by the reconfiguration of emergency care within Belfast Trust and the potential of a strategic approach to out of hours care.

Admission rates in the Belfast Trust remained higher than in the wider region. Admissions in the most deprived areas within the LCG remained 30% higher than then overall LCG area in 2010/11 (PHA 2011). Integrated Care Partnerships are an opportunity to develop alternatives to admission by providing care for patients in their own home.

The LCG will continue to seek integrated approaches by primary and secondary care to develop innovative ways of providing planned care in community settings rather than on acute hospital sites. The development of primary care infrastructure in particular presents the opportunity for new one-stop clinics which bring together assessment, diagnosis and treatment such as the LCG has commissioned in eye services.

Challenge 5: Commission a Stepped Care Model of recovery for common mental health conditions.

Poor mental health and stress underlie many of the physical health problems which affect the LCG population, especially in areas of deprivation where there is low income, employment and educational attainment. A challenge for the Belfast LCG is presented by the relatively higher use of mood disorder medicines. The LCG has been working to make use of the opportunity presented by the wide range of emotional health support provided by the many community and voluntary providers in Belfast.

The LCG will also continue to contribute to the strategic approach to emotional resilience being taken forward by the Belfast Strategic Partnership PHA investment in Protect Life services. This will complement LCG investment in Step 2 of the Stepped Care Model to expand where the provision of talking therapies by community and voluntary organisations to avoid the need for referral to Trust services and provide patient-centred care.

Challenge 6: Contribute to cost-effective Medicines Management, reducing the over-use, misuse and abuse of medicines.

Prescribing rates in Belfast LCG are lower than in other LCGs but Northern Ireland as a whole has higher prescribing costs than the rest of the UK. The LCG will work to address this by reducing the over-use and misuse of medicines, investing in targeted physical activity interventions, re-investing prescribing savings in talking therapies as an alternative or complement to medicines, piloting a pain management programme to support self-care, promoting adherence to the new evidence-based NI Medicines Formulary, promoting good nutrition for older people.

Challenge 7: Ensure best value for commissioned investments.

Given the increasing needs of its population in the context of a restricted financial outlook, the LCG must ensure that the services it commissions are delivering best value in terms of:

- the evidence-base for benefits to patients, clients and the public
- effective delivery of what has been commissioned
- the coverage of the service
- equity of access and
- productivity in the utilisation of assets

This requires systematic monitoring of service delivery, the intense scrutiny of investment proposals and evaluation of benefits. The LCG will review its Service and Budget Agreement with the Belfast Trust to ensure it reflects best value, deliverable expectations and clarity of accountability. New forms of agreement with multiple provider networks will be explored to facilitate commissioning from Integrated Care Partnerships for whole care pathways.

6.3 Ensuring Financial Stability & Effective Use of Resources

Use of Resources

The Belfast LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £603m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Baseline investment by Service Area in 2014/15

Table 25

Programme of Care	£m	%
Acute Services	209.5	34.8
Maternity & Child Health	24.0	4.0
Family & Child Care	44.6	7.4
Older People	144.2	23.9
Mental Health	64.4	10.7
Learning Disability	49.5	8.1
Physical and Sensory Disability	22.1	3.6
Health Promotion	26.9	4.5
Primary Health & Adult Community	18.0	3.0
POC Total	**603.2**	**100.0**

This investment will be made through a range of service providers as follows:

Proposed investment by Service Provider in 2014/15

Table 26

Provider	£m	%
BHSCT	523.57	86.8
NHSCT	1.85	0.3
SEHSCT	38.84	6.4
SHSCT	0.69	0.1
WHSCT	0.98	0.2
Non-Trust	37.29	6.2
Provider Total	**603.2**	**100.0**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2014/15 in respect of Emergency Care by the Belfast Trust is in the region of £26m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2014/15 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Belfast area and additional investment in the therapeutic growth of services.

Financial Pressures in 2014/15

Table 27

Pressures	**£m**
Demography	2.22
Learning Disability	2.99
Mental Health	1.49
Pay	4.41
Non Pay (Goods & Services)	5.57
RCCE	2.58
PHA Pressures	0.70
Service Pressures	16.34
NICE Drugs & Therapies	4.00
Learning Disability Resettlement (Bridging)	4.25
Total	**44.55**

6.4 Commissioning Priorities and Requirements by POC

This section provides an overview of the LCG's commissioning priorities for 2014/15 and 2015/16 by Programme of Care

6.4.1 POC1: Acute

Introduction

The LCG will continue to invest in outpatient, day case and elective outpatient capacity to meet the demand for planned care within health and social care services.

The LCG will also enhance the ability of primary care to manage demand outside hospital through referral guidelines, peer education and enhanced practitioners. Lessons learned from the ENT Pathfinder for Demand Management of elective care in East Belfast were similar to research into demand management approaches in GB (King's Fund 2010). A greater focus needs to be applied to peer education, feedback from specialists and the dissemination of best practice guidelines within primary care. The LCG has worked closely with the Trust, Optometry NI, NIGPC and RNIB to transform Eye Care pathways. It has put in place cataract referral guidelines and a Glaucoma Referral Refinement scheme to reduce demand for secondary care. The LCG has also invested in an Integrated Eye Care Pathway which will reduce referrals for general Ophthalmology. This approach will be extended to other specialties in 2014/15.

Comparison with other parts of the UK shows that the use of hospitals in Belfast could be significantly reduced with appropriate access to diagnostics, day procedures and primary and community services. The LCG will produce an Unscheduled Care Improvement Plan which will ensure that key components of health and social care are available when they are needed. Investment in Integrated Care Partnerships will be aimed at avoiding unnecessary admissions and expediting discharge.

In 2013/14 the HSCB led the consultation process on the future of the Belfast City Hospital Emergency Department enabling local people to have a say in the future of ED service. A decision by the minister on the future of Emergency Departments in Belfast is awaited.

Overview of Local Needs and Demands

Demand for planned care exceeds the capacity which the LCG commissions from the Belfast Trust. Up to 19000 new outpatient assessments and nearly 5000 treatments are required to meet current demand, of which Orthopaedics comprises 10000 new appointments and 4000 inpatients and day cases. In addition there are also shortfalls in capacity for key diagnostic tests such as MRI and CT. There are almost 40,000 patients requiring a follow up review appointment who wait longer than clinically indicated. Between March and November 2013 the outpatient list grew by 9000 and the inpatient/day case list by 1000.

Admission rates for emergency care are higher in Belfast than elsewhere, partly as a consequence of a higher level of deprivation. Although the number of attendances at Emergency Departments reduced by 12,500 (7%) from 2011/12 to 2012/13, the number of those patients who were then admitted to hospital increased over the same period. Many of these patients are discharged on the same or next day suggesting that with better coordination of and access to community support their admission could have been avoided.

Ministerial Targets

The LCG will commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. Delivery of waiting time targets for elective and emergency care present a major challenge for the LCG and will require significant additional investment as well as delivery by the Belfast Trust of the activity which has been commissioned. However, in orthopaedics, a shortage of Consultants will make it very difficult to reduce waiting times to an acceptable level.

Delivery of new pathways of care by Integrated Care Partnerships will be fundamental to reducing unplanned admissions through the transformation of primary and community care.

Commissioned Services:
The LCG will commission additional outpatient, inpatient, day case and diagnostic capacity in Elective Care to meet assessed need in the following specialties:

- Orthopaedics
- Rheumatology
- Pain Management
- General Surgery
- Gynaecology
- ENT
- Dermatology
- Oral Medicine

The LCG will also contribute to the regional development of Urology services.

The LCG will review the hospital capacity it requires to commission to meet the needs of its population for emergency and urgent care based on reasonable expectations of performance by the Belfast Trust in ensuring that patients are only admitted where necessary and are discharged as soon as they can safely return home. This will reduce the hospital capacity required and increase the capacity in primary and community care commissioned by the LCG.

The LCG will commission additional capacity in community and primary care services, including the community and voluntary sectors, to further reduce the hospital capacity required to meet the needs of the frail elderly and those with diabetes or those who have had a stroke or who have a respiratory condition, including patients who are at the end of life.

The LCG will commission an integrated approach to minor illness which provides an alternative to attendance at Emergency Departments. This will build on the Choose Well Campaign and research undertaken by the PHA, Trust and West Belfast Partnership on the motivations of people living in communities who use the Royal Hospitals most often. This will reduce attendance at Emergency departments but may increase the number who access Community Pharmacy, community nursing and community and voluntary providers.

The LCG will commission the further transformation of Eye Care and Musculo-skeletal pathways which ensure that patients receive the right advice, support or care at the right place at the right time. This will increase the proportion of patients seen in community settings by suitably qualified healthcare professionals but may increase the capacity commissioned from the community and voluntary providers and primary care.

The LCG will also work with ICPs to commission a risk-stratified approach to follow up appointments, promoting and supporting self-care, commissioning appropriate reviews from primary care and ensuring that Consultants only see patients requiring specialist review. This will reduce the number of new appointments seen by specialists and may increase the number seen by primary care.

Commissioning Priorities and Requirements

POC 1: Acute	
Regional Commissioning Objective	**Associated Local Requirement**
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians.	Belfast Trust is expected to work with GPs through ICPs to provide timely advice, assessment and diagnostic support. including providing GPs with direct access to a range of options for urgent care including: a mobile phone carried 24/7 by a designated senior decision-making doctor in hospital to provide immediate telephone support, assessment beds, ambulatory services, direct access to a range of diagnostic services, urgent outpatient slots and, where appropriate, direct admission to all acute hospitals, avoiding the need for attendance at Emergency Departments.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions	Trusts are expected to put in place any arrangements necessary across the whole week and in the evenings to ensure that all patients can be discharged as soon as clinically appropriate. This will require the Expected Date of Discharge for each patient to be clearly understood as soon as possible after admission by all hospital and community staff as well as the patient and their carers and to be a focus of patient management. The Trust should ensure that the 18 key actions identified for Unscheduled Care to be fully implemented. The LCG will develop an Unscheduled Care Improvement Plan which will ensure that appropriate hospital and community services are commissioned to support this.
Enabling district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than	Belfast Trust should ensure that there is sufficient core District Nursing capacity to meet demand from primary care in a timely way. The Trust should also ensure that there is sufficient capacity to ensure there are no

at present.	delays in discharge from hospital Nurses should work with social workers and AHPs in Integrated Care Teams in 8-10 Hubs to support clusters of GP practices. Nurses and GPs should meet regularly within Hubs to agree care plans for patients at risk of admission to hospital. Integrated Care Teams should also support the health improvement activities of local community and voluntary groups.
Review and take forward opportunities to consolidate the number of intermediate care beds and acute beds and the sites on which they are provided.	The Belfast Trust has re-modelled its intermediate care bed provision and transferred rehabilitation resources into community teams to provide more support in the patient's home. The Trust should ensure that this does not result in delays in discharge of patients requiring complex packages of care from acute hospitals. The Trust should continue to seek opportunities to reduce intermediate care beds and re-deploy the resources to support patients to return home directly from hospital.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The LCG will produce an Unscheduled Care Improvement Plan which will ensure that demand for emergency and urgent care is effectively managed. ICPs are expected to bring forward plans for investment in community services to reduce admissions including rapid response from a Community Urgent Care Team.

	The Trust should ensure that discharge planning is enhanced. Day to day variation in discharges should be reduced. All patients having an agreed Expected Date of Discharge and Outcome Focused Management Plan with patients and carers fully prepared for discharge by the EDD, with timely imaging and pharmacy input and sufficient capacity in community teams to ensure 7 day timely discharge. The LCG will commission from ICPs a networked approach to management of minor illness and minor injury which reduces attendance at EDs by providing a range of easily accessible alternatives.
Ensuring that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.	The LCG has provided the Belfast Trust with an updated Indicative Opportunities Pack which benchmarks its inpatient, day case, outpatient and community services against peers. The Trust should continue to progress towards the top quartile of performance in the UK.
Local Priority	Providers within ICPs are expected to contribute to the transformation of outpatient services including a risk stratified approach to follow up care. Hospital-based review will in future be exceptional rather than routine. Protocols will be developed which identify those patients who can safely be discharged with advice on self care and when to contact their GP; those patients who can be followed up in primary care and those patients who require review by a Consultant.
Local Priority	The Trust should work with ICP partners to work towards the provision of an integrated Musculo-skeletal service

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	20,289	200	20,489
	Daycases	573,376	20	57,396
	New Outpatients	125,400	0	125,400
	Review Outpatients	266,691	0	266,691
Unscheduled	**Non Elective admissions - all**	187,811	3,714	191,525
	ED attendances	211,667	0	211,667
	NIAS Journeys	47,699	777	48,476
	VALUE OF COMMISSIONED ACTIVITY[35]	£209.5m	£18.5m	£228m

[35] This includes activity in addition to that set out above.

6.4.2 POC2: Maternity and Child Health Services

Introduction

The LCG will contribute to progressing the objectives of the maternity strategy including the strategic shift towards providing more maternity care in the community, more midwife-led care and tackling inequalities.

The paediatric review led by the DHSSPS will set a framework for the future development of inpatient services which are safe and sustainable. The LCG will continue to work closely with the Trust, GPs and West Belfast ICP in ensuring that children receive the best possible care in the most appropriate settings, only being admitted to hospital when this is the best place for them to be cared for.

Overview of Local Needs and Demands

In 2012 there were almost 5000 births to Belfast mothers (NISRA 2013). While the number of births has increased over the past decade, there are signs that this may now be stabilising.

Teenage pregnancy rates in the most deprived areas of Belfast are twice as high as the average Belfast rate (Health and Social Care Inequalities monitoring system HSCIMS, 2012). Belfast Trust also has higher prevalence of low birth weight babies than NI generally. The rate in Belfast is 64 per 1000 population, this compared with the NI rate of 59 per 1000 population (Child Health System, 2012). Obesity in pregnant women is becoming more prevalent, Between 2010/11 and 2012/13 there has been a 24% increase in pregnant women who have a BMI of over 30 recorded at time of booking in Belfast Trust. (NIMATS, 2013)

Attendances at RBHSC Emergency Department have not changed significantly over the past two years. However, local analysis of attendances has been followed up with local focus groups and showed significant potential to provide community-based alternatives for minor illness in children.

The LCG will also consider the commissioning implications of the scoping study of the maternity needs of black and minority ethnic (BME) and migrant women in Northern Ireland, highlighting the growing number of births in Northern Ireland to BME and migrant women, and that there are particular sub-groups of very vulnerable migrant pregnant women who have difficulty accessing services and have worse pregnancy outcomes.

Ministerial Targets Local Relevance

The LCG will seek to commission services in response to assessed need and ensure delivery of Ministerial Targets at a local level. The Family Nurse Partnership and Weigh to a Healthy Pregnancy programmes are particularly important in addressing local needs in Belfast. Parenting Your Teen programme will be delivered to 25 families experiencing difficulties in behaviour of teenager/pre-teenager children, and particularly to families with social complexity and/or wider disadvantage.

Commissioned Services:

Maternity services in Belfast Trust were reconfigured in 2013 to provide a stand-alone midwife-led unit in the Mater supported by a consultant led service in the Royal Maternity Hospital and the impact of this change on the choices made by women on their place of delivery will inform commissioning by the LCG in 2014/15.

The LCG is working closely with the Trust, GPs and West Belfast ICP to put in place appropriate alternatives to attendance at the RBHSC for people with a minor illness.

A significant investment in the general paediatric service in the Royal Belfast Hospital for Sick children has enabled the establishment of a dedicated short stay paediatric assessment and observation area, an increase in consultant delivered care and improved access to senior decision makers for primary care. This will ensure that necessary admissions are timely and that these are as

short as clinically appropriate and that those children who do not need to be admitted are cared for appropriately at home.

POC 2 Maternal and Child Health	
Regional Commissioning Objective	**Associated Local Requirement**
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	Belfast Trust is expected to meet the standards of the Maternity Strategy. The Trust has re-configured maternity services to establish the Mater as a free-standing midwife led unit. This change has helped increase the number of women in Belfast with mid-wife led birth. The Trust should also ensure that a Midwife-Led Unit is available in the RJMH. The number of births in Belfast is decreasing and the LCG will commission midwifery services on the basis of demand.
Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	Belfast Trust should implement an approach working alongside a regional team ,led by PHA to develop pathways for the management of multiple pregnancies in line with NICE CG 129
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife-led antenatal care in the community for women with straightforward pregnancies	Belfast Trust should contribute to progressing the objectives of the maternity strategy including the strategic shift towards providing more maternity care in the community, more midwife-led care and tackling inequalities.

Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained variation in intervention rates throughout Northern Ireland	Belfast Trust has developed an action plan to normalise births and reduce caesarean sections, and should continue to monitor the number of 'normal deliveries' and those requiring intervention.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The LCG will work with the Belfast Trust and other partners to address the implications of the scoping study of the maternity needs of black and minority ethnic (BME) and migrant women in Northern Ireland, highlighting the growing number of births in Northern Ireland to BME and migrant women, and that there are particular sub-groups of very vulnerable migrant pregnant women who have difficulty accessing services and have worse pregnancy outcomes.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	Births	6931	0	6931
	Comm Midwives	Contacts	38,293	0	38,293
	Health Visiting	Contacts	10,687	0	10,687
	Speech and Language Therapy	Contacts	31,736	0	31,736
		VALUE OF COMMISSIONED ACTIVITY[36]	£24m	£1m	£25m

[36] This includes activity in addition to that set out above.

6.4.3 POC 3 Children and Families' Services

Introduction

Commissioning of looked after services is a regional commissioning function supported by local Outcomes Groups involving LCG together with a wide range of other partners focused on family support. The Belfast Outcomes Group is working with local community and voluntary groups to establish locality plans and Family Support Hubs.

Overview of Local Needs and Demands

There has been a continuing rise demand in Belfast over the past year for Children in Need assessments, the numbers identified as in need and the number of looked after children. It is noted that the first 6 months of 2013/14 has shown a substantial rise of 35% in the total number of children in need and the number of LAC has increased by 4 % and an overall total of 14% in the past year.

Demand for Autism services has grown from a base of 380 referrals per year to current projected level of 564 referrals per year. This is proportionately much greater
than in any other LCG area and considerably exceeds the capacity available, leading to longer waiting times for assessment and services.

There are a growing number of adolescents with learning disability and challenging behaviour which creates pressures in sustaining family placements. There is an ageing foster care population and the need to replenish capacity where there is turnover is a challenge.

The extent of deprivation in Belfast and its impact on the life chances of children presents a particular challenge for the LCG in working closely with other statutory agencies and community and voluntary groups.

Ministerial Targets

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. Belfast Trust has recruited 38 clients onto the Family Nurse Partnership programme with plans to recruit up 60 clients during this initial stage. The prospect of further expansion in Belfast may be considered.

Commissioned services

The LCG will work through the Belfast Outcomes Group to commission Family Support Hubs, giving priority to enhancing support to children 5-11 years; outreach for harder to reach families and better engagement for 11-16 year olds.

The LCG will work closely with the Belfast Health Development Unit and the Trust to ensure that the particular needs of children of migrant families are met.

Commissioning Priorities and Requirements

POC 3 Children and Families' Services	
Regional Commissioning Objective	**Associated Local Requirement**
Work with CYPSP and outcomes groups to progress the establishment and consolidation of family support hubs by 1st September 2014.	Providers will be expected to contribute to the further development of family support through locality planning and family support hubs.
Local Priority	Belfast Trust is expected to bring forward plans to manage demand for Autistic Spectrum Disorder services.

6.4.4 POC4: Older People

Introduction

The LCG works closely with the older people's forums especially the Greater Belfast Seniors' Forum, in Belfast and is playing a lead role in developing Belfast as an Age Friendly City, promoting a positive image of ageing, healthy lifestyles for older people and age-friendly and dementia-friendly neighbourhoods.

Transforming Your Care stated that up to 45% of people who are assessed as requiring continuing social care could, in fact, live at home independently without this support, though they may benefit from some practical support such as help with shopping and jobs around the home as well as befriending, particularly those who live on their own. Investment in services for those with dementia is focused on improving memory services which provide earlier diagnosis and help service provider's work with patients and carers to plan for the future. The LCG continues to recognise the important role played by carers in our community and will continue to invest in carer support and place carers at the centre of its future transformation plans.

In Belfast many hospital and intermediate care beds are occupied by older people who could be cared for in their own homes with appropriate support. The LCG is commissioning this support for frail elderly people from Integrated Care Partnerships.

Overview of Local Needs and Demands

Northern Ireland (NI) is becoming an older society with the number of people aged 65+ expected to increase by 10% by 2020 for Belfast, a slower rate of growth than in other LCGs. However, the LCG population currently has the highest proportion of older people particularly those over 85 years of age and there are significant levels of deprivation affecting older people, leading to greater levels of chronic illness and lower life expectancy.

The Belfast Trust provides domiciliary care support to approximately 5650 people within their homes. Of these, a much larger proportion is for less than 5 hours per week than in other Trusts. However, the Trust does not spend significantly more on domiciliary care than other LCGs when adjusted for need. This suggests that the Trust has been successful in helping people with low or moderate needs to live at home and the potential benefits of further re-ablement may be lower. However it also suggests that there is a potential for greater involvement of the community and voluntary sectors in providing practical support as an alternative to domiciliary care for these clients.

Assuming that research elsewhere can be applied to Belfast LGD, it has been estimated that there could be 10,000 older people living alone and a proportionately similar number in Castlereagh, and therefore more likely to suffer social isolation with consequent impacts on their mental and physical health.

Over 5% of the Belfast LCG population provide 20 hours or more per week of unpaid care and the LCG has prioritised support for carers within its plans..

It is estimated that at present in NI there are 19,000 people living with dementia, as the population ages dementia will increasingly be a major public and societal issue. The estimated number of people with dementia in Belfast Trust is 3893, of whom 2925 have an actual diagnosis. Belfast Trust had a diagnosis rate of75% in 2013 which is - the best performance in the whole of the UK.

Ministerial Targets

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. In particular, the LCG will expect ICPs to bring forward proposals for transformation of care pathways for the frail Elderly, building on evaluation of the Community Urgent Care Team pilot commissioned by the LCG and delivered by the Trust with the support of three GP practices in 2013. This provided acute care at home for

patients whom GPs considered for hospital admission and for patients in Emergency departments who were offered care at home instead of admission. The six local older people's forums and Greater Belfast Seniors' Forum were fully consulted prior to the pilot and were supportive of the approach following detailed discussions.

Commissioned services

The LCG will commission a comprehensive care pathway for the frail elderly from ICPs in 2014/15. This will focus on early intervention and intensive support for those older people at risk of hospitalisation or long term care. Local Integrated Care Teams within community hubs will support GPs in identifying older people at risk of hospitalisation and ensure appropriate support is in place. They will be able to escalate that support to specialist and secondary care teams with a single phone call which will provide acute care at home or admission to an assessment unit in hospital. This extension of acute care at home should create opportunities to consolidate the provision of hospital and intermediate care beds.

The LCG will work with the Belfast Trust, the community and voluntary sectors and ICPs to ensure that the potential for Reablement is maximised and that local implementation is consistent with the regional components. The community and voluntary sectors have formed a Reablement Stakeholder Network and have been particularly innovative in the development of a prototype for an Information Hub which will ensure that the service capacity available within local communities is easily accessible. The Network and LCG have also piloted Community Navigators to work alongside the therapists in the reablement team to source community and voluntary support as an alternative to continuing care. This will be evaluated in 2014/15 with a view to its sustainability.

Belfast LCG has invested in the establishment of a multidisciplinary model to address the substantial back log that existed within the Belfast Memory Service. Further investment has been allocated to address the increased

demand on the service and reshape the current model. Independent sector advocacy and peer support will also be available.

The LCG continues to recognise the important role played by carers in our community and will continue to invest in carer support and place carers at the centre of its future transformation plans.

Commissioning Priorities and Requirements

POC4: Older People	
Regional Commissioning Objective	**Associated Local Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	(a) Improved use of NISAT and other systems to identify carers at an early stage in the assessment process and the development of links with GP and Primary Care to assist this. (b) Information on assessment and services to be made available in a range of ways and formats (ie carer information packs, information sessions/days, posters, leaflets) and disseminated in a targeted manner to maximises exposure to carers/ potential carers. This material to be developed and disseminated in partnership with carers/ carer organisations. (c) Training and awareness sessions to be undertaken in partnership with carers/ carer organisations to ensure the assessment process is person centred and will address the range of carer needs. Carer feedback on the carer assessment process to be sought by BHSCT and formally evaluated via a representative sample of carers who have had an assessment completed.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	(a) Trust to work in partnership with the community and voluntary sector and carers to develop a range of flexible, 'non-traditional' respite and short-break options for carers (b) Cash grants and direct payments to be provided to carer

	organisations and carers to support the development of services provided via the community/voluntary sector and uptake of such services by carers.
Increase uptake of Direct Payments	Belfast Trust is expected to increase the proportion of care packages which are subject to direct payments and in particular to work with the PHA and the CLARE social enterprise in North Belfast to pilot the development of life plans as an alternative to statutory care.
Working with ICPs to improve the care of the frail elderly	ICPs are expected to bring forward proposals for the roll out acute care at home with secondary care services supporting primary and community care teams, access to social care and community and voluntary provision of practical support. ICPs are expected to bring forward proposals for transforming services for the Frail Elderly which provide a more coordinated approach to intermediate care, including arrangements for hospital discharge, direct access to specialist assessment at home or, if necessary, at a hospital or other healthcare setting.
Enhancement of dementia services	The Belfast Trust is expected to respond to commissioner specifications for the further development of memory services.
Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge	The Belfast Trust has re-modelled its intermediate care bed provision and transferred rehabilitation resources into community teams to

arrangements.	provide more support in the patient's home. The Trust should ensure that this does not result in delays in discharge of patients requiring complex packages of care from acute hospitals. The Trust should continue to seek opportunities to reduce intermediate care beds and re-deploy the resources to support patients to return home directly from hospital.
Continued roll-out of targeted preventative health and well-being improvement programmes and promote active ageing.	ICPs are expected to bring forward proposals for improved Falls Prevention and Nutrition as part of their proposals for Frail Elderly services. Belfast Trust and Age Sector organisations are expected to contribute to the Belfast Age Friendly Action Plan to be submitted to WHO following consultation and endorsement by the Belfast Strategic Partnership.
Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The LCG will support the continued roll out of the re-ablement model from its initial pilot sites to the wider Trust area and review the model with the Trust to ensure service outcomes and financial efficiencies are achieved.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied bed days	51,739	0	51,739
	Day Care	Attendances	121,816	0	121,816
	Domiciliary Care	Hours	270,0314	0	270,0314
	Residential and Nursing	Occupied bed days	924,874	0	924,874
	Community Nursing	Face to face	347,217	0	347,217
	Social Work	Caseload	118,75	0	11,875
		VALUE OF COMMISSIONED ACTIVITY[37]	£144.2m	£5.5m	£149.7m

[37] This includes activity in addition to that set out above.

6.4.5 POC 5: Mental Health

Introduction

The LCG will continue to work closely with the Regional Bamford Commissioning Team to develop services for the severely mentally ill and for those with mild or moderate mental illness, placing an emphasis on recovery through the Stepped Care model which supports people to live as independently as possible with or without on-going mental illness.

The LCG is taking a lead role, in conjunction with the Trust, ICPs and Belfast Strategic Partnership in developing a Primary Care Talking Therapies Service enabling GPs to help patient's access appropriate community and voluntary support, or specialist support when required. This approach also aims to reduce the relatively high dependency on prescription drugs for depression, anxiety and pain within Belfast.

Overview of Local Needs and Demands

Mental illness is one of the major causes of ill health and disability in Northern Ireland. In 2013, the raw prevalence of patients (per 1000) on the Mental Health Register in Belfast was 10.2 and on the Dementia Register was 6.8. In the Belfast Trust there were 72 deaths due to suicide and undetermined intent from 1999 to 2012 accounting for 26% of the overall NI total. The rate of admissions in the most deprived areas of Belfast were 3.5times that of NI (DHSSPS 2012).

The Framework for Mental Health and Wellbeing NI (2011) highlights that 10 – 20% of older people (aged 65 years or over) suffer from serious mental health problems. The LCG is also aware of the growing numbers of children and young people with mental health problems in Belfast and in the demand for services to meet their needs.

Mood and anxiety disorder prevalence in the Belfast Trust was consistently higher than that in NI generally. The Trust inequality gap remained 50% higher

in the most deprived Trust areas throughout the period 2010. (DHSSPS 2012) In 2010 Belfast West had the highest proportion of individuals of any constituency in Northern Ireland (246 per 1000) using prescribed medication for mood and anxiety disorders, followed by Belfast North (220 per 1000) (DHSSPS). In the Belfast Trust there were 168 admissions to hospital as a result of mood or anxiety disorder in 2009/10 (NIHIS.

In 2012/13 there were approximately 13,516 referrals to Belfast Mental Health Triage. Local data collection indicates that 30-40% of referrals are returned/ redirected to community and voluntary sector for Tier 2 Psychological therapies (30% = 4054)

PHA Health Intelligence Briefing for Suicide shows that Belfast LCG area had the highest rate of suicide in 2009/2011 (most recent data at the time of writing) at 23 deaths per 100,000 followed by Western area (16.4 per 100,000). From 2006 to 2011, the male and female suicide rates in Belfast were higher than the rates in all other LCG areas and above the NI average.

Ministerial Targets (local relevance)

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. In particular, the LCG will commission increased capacity for psychological therapies through the development of a Primary Care Talking Therapies and will commission sufficient diagnostic and memory clinic services to deliver Ministerial targets for access to dementia services.

Further investment will be made in the development of community infrastructure and social care services to support the shift to 60/40 ratio in favour of community based acute services for patients with severe conditions and to provide 18 new supported housing places to support the discharge of patients from Belfast Psychiatric hospitals within 7 days of their becoming medically fit for discharge. Eleven appropriate community placements will be commissioned for the remaining Belfast long-stay patients in Belfast Trust Psychiatric Hospitals.

The LCG will continue to work closely with the PHA and the Belfast Strategic Partnership to ensure that local communities are commissioned to provide sufficient capacity for the Protect Life programme.

Commissioned Services

The LCG will commission a Primary Care Talking Therapies Service in 2014/15, building on previous work in conjunction with the West Belfast Primary Care Partnership (now ICP). A pilot Referral Hub and Coordinator facilitated weekly meetings between GPs, secondary care clinicians and community and voluntary providers to discuss and agree individual recovery plans for clients as an alternative to referral to specialist services. The pilot is being evaluated and will guide the roll out of the Talking Therapies Service.

The LCG will continue to support the re-configuration of acute mental health services in Belfast in preparation for the development of the single Acute mental health unit, ensuring that community support is available for all those for whom this is appropriate. The LCG and Bamford Commissioning Team will also commission an increase in the number of carers' assessments offered to the family carers of people with a serious mental illness living in the community in Belfast and an enhancement of the Psychiatric Liaison service to ensure a maximum 2 hour response time to Emergency Departments

Commissioning Priorities and Requirements

POC 5: Mental Health	
Regional Commissioning Objective	**Associated Local Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	(a) Improved use of NISAT and other systems to identify carers at an early stage in the assessment process and the development of links with GP and Primary Care to assist this. (b) Information on assessment and services to be made available in a range of ways and formats (ie carer information packs, information sessions/days, posters, leaflets) and disseminated in a targeted manner to maximises exposure to carers/ potential carers. This material to be developed and disseminated in partnership with carers/ carer organisations. (c) Training and awareness sessions to be undertaken in partnership with carers/ carer organisations to ensure the assessment process is person centred and will address the range of carer needs. Carer feedback on the carer assessment process to be sought by BHSCT and formally evaluated via a representative sample of carers who have had an assessment completed.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	(a) Trust to work in partnership with the community and voluntary sector and carers to develop a range of flexible, 'non-traditional' respite and short-break options for carers (b) Cash grants and direct payments to be provided to carer organisations and carers to support the development of services provided via the community/voluntary sector and uptake of such services by carers.

Increased uptake of direct payments	By March 2015 the Belfast Trust should secure a 5% increase in the number of Direct Payments to individuals with a serious mental illness living in the community in Belfast.
Implementation of the Protect Life Strategy	The Belfast Trust should continue to: • develop an improved model of support for those who self-harm. • make specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. • support the on-going delivery of the Lifeline Service and implement the regionally agreed memorandum of understanding
Establishment of integrated care arrangements for the care and treatment of patients with common mental health needs	The LCG will build on the evaluation of the pilot Mental Health Referral Hub in West Belfast to commission a Primary Care Talking Therapies Service across all 4 ICPs. The Belfast Trust will appoint Referral Coordinators based in Primary Care to ensure integrated working between secondary and primary care and community and voluntary organisations. The Belfast Trust will re-configure its primary mental health teams to support each ICP.
Implementation of the Crisis Resolution Home Treatment services for CAMHs	The Trust is expected to bring forward proposals in response to a commissioning specification for further enhancement of Crisis Resolution, Assertive Outreach and Home Treatment functions. The aim of CRHT is to enhance services which support

	the needs of children and young people with complex and severe conditions, maintain individuals in the community and reduce inappropriate admissions to inpatient services. It is recognised that the service will take time to be established and expected improvements realised incrementally.
Further development of specialist community services	The Belfast Trust should further develop community infrastructure and social care services to support the shift to 60/40 ratio for community based acute services for patients with severe conditions and to provide 18 new supported housing places to support the discharge of patients from Belfast Psychiatric hospitals within 7 days of their becoming medically fit for discharge.
Improved psychiatric liaison services	Belfast Trust should Improve Psychiatric Liaison Services to ensure a maximum 2 hours response time in Emergency Departments.
Consolidation of acute inpatient beds to a single site in each of three Trust areas (Belfast Trust, Northern, Southern and South Eastern	The Trust is expected to continue to reduce the use of hospital capacity through the effective use of community capacity in preparation for the opening of the new Acute mental Health Unit.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied bed days	90,683	0	90,683
	CPN	Contacts	48,853	450	49,303
	Res & Nur homes & supported housing	Places	57,461	0	57,461
	Day Care	Attendances	59,069	0	59,069
	Domiciliary Care	Hours	131,341	0	131,341
		VALUE OF COMMISSIONED ACTIVITY[38]	£64.4m	£0.7m	£65.1m

[38] This includes activity in addition to that set out above.

6.4.6 POC 6: Learning Disability

Introduction

The Bamford principles of promoting independence and reducing social inclusion for people with a Learning Disability continue to underpin the commissioning objectives for Belfast LCG, with a focus on supporting family carers and working with other statutory, voluntary and community partners to deliver services that enable people with a Learning Disability to maximise their potential and enjoy health, wellbeing and quality of life.

Overview of Local Needs and Demands

In 2013, the raw prevalence of patients aged 18 plus (per 1000 patients) on the Learning Disability register was 5.7 for Belfast HSCT.

Ministerial Targets (local relevance)

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level.

In particular, further community infrastructure and social care services will be commissioned to support the shift to 60/40 ratio for community based/acute services. Community services infrastructure and (in partnership with NIHE and Independent Sector providers) accommodation based services will be commissioned to support the discharge of patients from Belfast Psychiatric hospitals within 7 days of their becoming medically fit for discharge. In partnership with NIHE, 18 new supported housing tenancies will be developed for people with a Learning Disability. An additional 24 appropriate community placements will be commissioned for the remaining long-stay patients in learning disability Hospitals

Commissioned Services

The LCG has recently invested in additional carer support which will have a full year impact in 2014/15, including an increase in the level of flexible support options/ short term breaks made available to carers.

The LCG will continue to support Belfast Trust to implement its “Big Plan” to modernise day care services and further develop day opportunities, particularly for young people with complex conditions.

POC 6: Learning Disability	
Regional Commissioning Objective	**Associated Local Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	(a) Improved use of NISAT and other systems to identify carers at an early stage in the assessment process and the development of links with GP and Primary Care to assist this. (b) Information on assessment and services to be made available in a range of ways and formats (ie carer information packs, information sessions/days, posters, leaflets) and disseminated in a targeted manner to maximises exposure to carers/ potential carers. This material to be developed and disseminated in partnership with carers/ carer organisations. (c) Training and awareness sessions to be undertaken in partnership with carers/ carer organisations to ensure the assessment process is person centred and will address the range of carer needs. Carer feedback on the carer assessment process to be sought by BHSCT and formally evaluated via a representative sample of carers who have had an assessment completed.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	(a) Trust to work in partnership with the community and voluntary sector and carers to develop a range of flexible, 'non-traditional' respite and short-break options for carers

	(b) Cash grants and direct payments to be provided to carer organisations and carers to support the development of services provided via the community/voluntary sector and uptake of such services by carers.
Delivery of day services in line with the Regional Day Opportunities Model	The LCG will continue to increase its investment in Day Opportunities for young adults with complex needs. The Trust should ensure that services are delivered in line with the Regional Day Opportunities Model.
Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	Belfast Trust should ensure that specialist community services respond to the needs of people whose behaviours challenge services
Increased uptake of direct payments	Belfast Trust should ensure that by March 2015 there is a 5% increase in the number of Direct Payments to individuals with a Learning Disability living in the community in Belfast.
Development and implementation of health promotion initiatives for people with a learning disability.	GP Practices are expected to respond to the opportunity presented by the DES to offer annual physical and mental health checks to people with a learning disability.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied bed days	47,855	-8,034	39,821
	Day Care	Attendances	136,378	6,300	142,678
	Domiciliary Care	Hours	361,510	0	361,510
	Residential & Nursing	Occupied bed days	111,071	0	111,071
	Community Nursing and AHPs	Face to face contacts	22	0	22
	Social Work	Active Caseload	1,635	0	1,635
		VALUE OF COMMISSIONED ACTIVITY[39]	£49.5m	£4m	£53.5m

[39] This includes activity in addition to that set out above.

6.4.7 POC 7: Physical Disability and Sensory Impairment

Introduction

The LCG will continue to support regional approaches to increasing supported living and self-directed support. A particular focus for Belfast LCG is ensuring that patients with complex acquired disabilities are able to be discharged as soon as appropriate from specialist acute inpatient services to specialist rehabilitation or local settings where they can avail of the most appropriate care and maintain as much independence as possible.

The Belfast LCG has also taken the lead in ensuring that supporting Trusts in implementation of the NICE guidance is implemented for people suffering from ME-Chronic Fatigue Syndrome. The current regional pilot will be evaluated in with a view to roll out to all areas in 2014/15.

Overview of Local Needs and Demands

Prevalence of a range of long term conditions for the Belfast LCG includes: 5.6% for deafness or partial hearing compared to 5.1% for Northern Ireland, 2.0% for blindness or partial sight with the regional level being 1.7%. For mobility or dexterity difficulty for NI as a whole the level is 11.4% whereas the LCG area is 13.1%

Prevalence (existing cases) for CFS/ME: c.3500-7000 for NI, with incidence (new cases per year)-c.500 of which approximately 20% live in Belfast. Of these 90% of these have mild to moderate illness.

Over 5% of the Belfast LCG population provide 20 hours or more per week of unpaid care.

Ministerial Targets (local relevance)

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level.

Belfast LCG made a substantial investment in carer support in 2013/14 in conjunction with additional regional investment funding in Belfast which will increase capacity within the Trust and voluntary organisations over the next year.

Commissioned Services

The LCG is reviewing the causes of discharge delays in Neurosurgery and has committed additional funding to the Regional Rehabilitation Unit at Musgrave Park Hospital to ensure that there is sufficient medical cover for service continuity on site as well as outreach to local rehabilitation centres and support for Community Rehabilitation teams. Belfast and South Eastern LCGs are working together to ensure that Thompson House, Lisburn is able to accept new patients transferred from the specialist services.

The LCG continues to recognise the important role played by carers in our community and will continue to invest in carer support and place carers at the centre of its future transformation plans.

Following discussions with patients and carers and with commissioners in Scotland, the LCG has commissioned a regional pilot Chronic Fatigue Syndrome service which will provide additional therapeutic support for patients to manage their symptoms, in line with NICE guidance. GPs have also been offered advice as to how to support patients with mild or moderate conditions. The pilot will be evaluated in 2014/15 with a view to a regional roll-out.

POC 7: Physical Disability and Sensory Impairment	
Regional Commissioning Objective	**Associated Local Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	(a) Improved use of NISAT and other systems to identify carers at an early stage in the assessment process and the development of links with GP and Primary Care to assist this. (b) Information on assessment and services to be made available in a range of ways and formats (ie carer information packs, information sessions/days, posters, leaflets) and disseminated in a targeted manner to maximises exposure to carers/ potential carers. This material to be developed and disseminated in partnership with carers/ carer organisations. (c) Training and awareness sessions to be undertaken in partnership with carers/ carer organisations to ensure the assessment process is person centred and will address the range of carer needs. Carer feedback on the carer assessment process to be sought by BHSCT and formally evaluated via a representative sample of carers who have had an assessment completed.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	(a) Trust to work in partnership with the community and voluntary sector and carers to develop a range of flexible, 'non-traditional' respite and short-break options for carers (b) Cash grants and direct payments to be provided to carer organisations and

	carers to support the development of services provided via the community/voluntary sector and uptake of such services by carers.
Increase uptake of Direct Payments	Belfast Trust is expected to increase the proportion of care packages which are subject to direct payments and in particular to work with the CLARE social enterprise in North Belfast to encourage the development of life plans as an alternative to statutory care.
Review Trust progress in relation to the review and reform of day service opportunities to ensure alignment with personalisation strategies	BHSCT will participate in the stocktake of progress with the reform of day services locally.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability and Sensory Impairment	**Hospital services**	Occupied beddays	24,301	0	24,301
	Day care	Attendances	38,439	0	38,439
	Domiciliary care	Hours	339,886	0	339,886
	Resid & Nursing Home	Occupied beddays	39,649	0	39,649
	Community nursing & AHPs	Contacts	7,110	0	7,110
	Social work	Active caseload	3,418	0	3,418
		VALUE OF COMMISSIONED ACTIVITY[40]	£22.1m	£1m	£23.1m

[40] This includes activity in addition to that set out above.

6.4.8 POC 8: Health Promotion

Introduction

The LCG will continue to work closely with other statutory agencies and the community and voluntary sectors through the Belfast Strategic Partnership to address the multiple social determinants of ill health which are associated with the high levels of Multiple Deprivation in Belfast and with some ethnic groups and recent migrants who have a high prevalence of specific health conditions or experience difficulties in accessing health and care services.

The LCG will continue to encourage and support local community partnerships in developing community-led approaches to supporting self-care through raising awareness of the risks of ill health, identifying those who may be at risk and providing evidence-based interventions or signposting them to services which will minimise those risks, and providing support and rehabilitation services for those who are recovering after treatment.

Overview of Local Needs and Demands

The NI Heath and Social care Monitoring System 2012 encouragingly showed that in over half of the indicators used, there was a narrowing of the health inequality gaps across the Belfast LCG area – for example, noticeable improvements were recorded for infant care and cancer incidence and there was a narrowing of the Trust inequality gap in almost half of the indicators analysed.

In contrast to this, however, the most noticeable widening of gaps over time occurred for day case admissions, low birth weights, respiratory mortality, amenable death rates and suicide. The report showed that the impact of health inequalities in Belfast LCG area is still acute in areas such as and alcohol related and self-harm admissions

Communicable diseases disproportionally affect certain groups in the population including those at social disadvantage, living in poor housing

conditions, migrants from countries that have higher prevalence of infectious diseases, and those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities. The LCG is particularly concerned about the rise in the incidence of TB in the community and has invested in an enhanced nurse-led service.

Ministerial Targets
The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level.

Commissioned Services
In 2014/15 the LCG will review outcomes from the community-led Healthy Hearts West programme it funds jointly with the Public Health Agency. The programme involves integrated working between community groups, Community Pharmacists, GPs and the Trust in providing education in community and school settings and providing or sign-posting to risk reduction and rehabilitation programmes including provision of support for physical exercise, smoking cessation, dietary advice and good mental health. It has been proposed by the ICPs that the approach could be extended to other conditions with similar risk factors to underpin the pathways being developed by the ICPs for a range of chronic conditions.

The LCG hasalso extended the funding it provides to Active Belfast Partnership for the commissioning of additional physical activity interventions to which GPs refer appropriate patients. This supports theCardiac, Cancer and Pulmonary Rehabilitation programmes as well as Health Hearts West and the pre-Diabetes care pathway.

The LCG will work closely with Belfast Trust, PHA and other funders within the Belfast Strategic Partnership to align procurement processes and pool funding where this can better meet shared objectives and provide a more sustainable basis for the community and voluntary sector. The LCG and Trust will encourage community and voluntary organisations to develop networks

around the holistic needs of individuals and to share administration resources for greater efficiency. The Belfast Trust is expected to provide training support to volunteers to assist then in meeting governance standards.

Commissioning Priorities and Requirements

POC8 – Health Promotion	
Regional Commissioning Objective	**Associated Local Requirement**
Expansion of the early years intervention programme.	Belfast Trust is expected to continue to consolidate the implementation of the Roots of Empathy Programme across 35 schools in the Belfast LCG area. 60 Health and Social Care staff will receive infant mental health training to improve their assessment and intervention capacity
Incremental expansion of social economy businesses and community skills development.	The LCG will commission, through the BHSCT, additional capacity from the community and voluntary sectors in services for: • Older people •Long term conditions •Mental health •Learning disability •Physical disability Including additional support for carers. Commissioning will focus on services which can demonstrably reduce demand for more specialist services or prescribing. The LCG will work closely with BHSCT, PHA and other funders within

	the Belfast Strategic Partnership to align procurement processes and pool funding where this can better meet shared objectives and provide a more sustainable basis for the community and voluntary sector. The LCG and BHSCT will encourage community and voluntary organisations to develop networks around the holistic needs of individuals and to share administration resources for greater efficiency. The BHSCT should provide training support to volunteers to assist then in meeting governance standards
Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	Belfast Trust is expected to submit an action plan to the LCG by June 2014 showing how it will improve the accessibility and uptake of services by vulnerable groups. The Trust is expected to raise awareness amongst LAC staff of support for smoking cessation services and BHSCT smoke-free policy. All LAC staff to be offered BIT and key staff to be identified to attend specialist smoking cessation training.

Implementation of the "Fitter Futures for All Framework".	Providers within ICPs are expected to continue to support the roll-out and development of the Healthwise programme in conjunction with PHA, Belfast City Council and Sport NI. Belfast Trust is expected to continue to support the rollout of the RAFAEL programme aimed at increasing the proportion of fresh, local and sustainable food in HSC facilities.
Implementation of key public health strategies.	Belfast Trust should ensure smoking cessation services available to the following groups: •150 professional staff for brief intervention training •200 pregnant women to participate in smoking cessation services •1500 routine manual workers •20 children in LAC residential homes BHSCT to develop common guidelines and policy on smoke free facilities including LAC residential homes Providers within ICPs are expected to support the development and implementation of and Emotional Resilience Strategy and its integration with the suicide prevention strategy and Primary Care Talking Therapies Service.

	Belfast Trust is expected to support the delivery of new community-based service model for self-harm throughout the Belfast LCG area.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	Belfast Trust is expected to provide a monitoring report outlining range of specialist sexual health services available, numbers and age groups accessing services.
Roll-out and evaluation of pilot on primary care facing advice and treatment of non-sight-threatening minor eye conditions in Southern LCG area	Belfast LCG has commissioned an integrated pathway for minor eye conditions involving primary care and will evaluate the impact of this on demand for secondary care in 2014/15.

6.4.9 POC 9: Primary Health and Adult Community

Introduction

Effective primary and community services prevent unnecessary use of more expensive and limited specialist and secondary care resources. It is essential that primary and community care providers work in an integrated way and respond flexibly to the needs of local populations, supported where necessary by specialist services in a timely way.

ICPs have a critical role in developing proposals which address the LCG commissioner specifications for service transformation and integration in a comprehensive way, including health improvement and promotion of self-care as well service development and follow up, leading to maximising the return of patients to independence.

Overview of Local Needs and Demands

A higher percentage of the population has a long term limiting illness in Belfast (23%) than in other LCGs. For many chronic illnesses there is a link between prevalence and deprivation, leading to higher admission rates to hospital and other secondary care services. Belfast area has a higher proportion of the population with mobility or dexterity difficulty and frequent periods of confusion or memory loss indicating frailty.

QOF Registers indicate a higher prevalence of chronic disease in Belfast than elsewhere in Northern Ireland and significant differences between ICP areas within Belfast. A study by the HSCB of QOF indicators in 2011 showed that the prevalence of COPD is more than 60% higher in North Belfast than in NI as a whole and in East Belfast Stroke was 20% higher and Diabetes 14% higher.

Reviews of referrals from High Street Optometrists and Dentists have shown that with improved equipment, new guidelines and additional capacity, the numbers of patients referred for specialist consultations could be substantially reduced.

Research estimates indicate that up to 50% of patients who have Glaucoma, a hidden chronic disease, do not visit Optometrists and therefore have a significantly increased risk of irreversible impaired vision or even blindness. A project led by RNIB in West Belfast in 2013 was successful in working with local community and voluntary groups to raise awareness of the risks and increase uptake.

Ministerial Targets

The LCG will seek to commission services in response to assessment of need and ensure delivery of Ministerial Targets at a local level. Four ICPs have been established in Belfast and each is bringing forward respective proposals for the management of patients on care pathways for Frail Elderly, Respiratory, Diabetes and Stroke patients and end of life care as it relates to these. Commissioning enhanced primary and community services from ICPswill deliver targets related to the reduction of planned admissions to hospital, particularly for those with long term conditions.

The use of Tele-monitoring technology will be extended where evidence shows this to indicate an increased risk of hospital admission, for example for patients at risk of heart failure..

Commissioned Services

The LCG will commission proposals from the Belfast ICPs specifically aimed at providing escalated care at home as an alternative to unplanned admission to hospital for patients with long term conditions, including frail elderly patients who have fallen or who have a transient loss of consciousness, patients with an exacerbation of their respiratory condition and patients who require additional support at the end of life. The LCG will also commission Early Supported Discharge arrangements for Stroke patients to enable them to return home more quickly. The Diabetes and pre-Diabetes pathways developed by South Belfast Primary Care Partnership will be extended across Belfast.

The LCG will expect the proposals from ICPs to transform care pathways comprehensively, showing how all providers are involved in delivering health improvement and prevention, reducing risk factors, promoting and supporting self-care, developing close working relationships between GPs, Integrated Care Teams and specialists based on risk stratification to identify and plan care around those patients most likely to have an unplanned hospital, providing timely access to specialist care, rehabilitation and re-ablement.

POC 9: Primary Health and Adult Community	
Regional Commissioning Objective	**Associated Local Requirement**
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	ICPs should bring forward proposals for developments in primary care which will enhance its capacity to avoid unnecessary hospital admissions and improve health and well-being in the clinical priority areas.
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate community setting.	Belfast Trust should ensure that there is sufficient core District Nursing capacity to meet demand from primary care in a timely way. The Trust should also ensure that there is sufficient capacity to ensure there are no delays in discharge from hospital Nurses should work with social workers and AHPs in Integrated Care Teams in 8-10 Hubs to support clusters of GP practices. Nurses and GPs should meet regularly within Hubs to agree care plans for patients at risk of admission to hospital. Integrated Care Teams should also bring forward proposals for the effective management of palliative and end of life care which avoids admission to hospital wherever appropriate.

6.5 Other Commissioning Priorities 2014/15 – 2015/16

6.5.1 Primary Care Infrastructure Development

The LCG will provide input to a HSCB Strategic Implementation Plan for PCID. This will set out initial proposals for 'Hub and Spoke' configurations which will support the service models within each programme of care and particularly the transformation of care pathways for people with long term conditions and the promotion of health improvement and self-care.

The LCG will continue to consult with the Belfast Trust, primary care and community and voluntary organisations and work closely with both Castlereagh Borough and Belfast City Councils to develop proposals for combined health and well-being hubs which provide the opportunity to provide services as locally as possible, optimise integrated working and support health improvement in areas of greatest need.

6.5.2 Medicines Management

Prescribing rates in Belfast LCG are lower than in other LCGs but Northern Ireland as a whole has higher prescribing costs than the rest of the UK. The HSCB has set target reductions for the LCG and the LCG will in turn work closely with the Belfast ICP Medicines Management Group to improve quality and reduce expenditure. It will also expect Belfast Trust to ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area, in line with the Ministerial target.

Belfast LCG actions will include:

- Investment in targeted pharmacy support to GP practices
- Supporting regional campaigns to reduce the overuse of anti-biotics and waste of medicines
- A programme to address the over-use and misuse of medicines for pain relief
- Investment in a pilot Pain Management Programme to support self-care

- Re-investing prescribing savings in talking therapies as an alternative or complement to medicines,
- Investing in specialist Dietetic advice to Nursing Homes to promote good nutrition for older people.
- Investment in community-based physical activity programmes tailored to individual needs
- Requiring adherence to NICE guidance and NI Formulary as a condition for investment in services

7.0 Northern Local Commissioning Group Plan

7.1 LCG Population

The Northern Local Commissioning Group (Northern LCG) covers an area of 1,670 square miles and includes ten Local Government Districts (LGDs) with a total population of 465,529 (49% or 228,291 are male and 51% or 237,238 are female). The Northern LCG has the highest share (26%) of the Northern Ireland population.

Mid-Year population estimates by broad age bands, 2012

Table 28

	Northern HSCT	Northern Ireland
Total Population (2012)	465,529	1,823,634
Children (0-15 years)	96,199	382,141
Young Working Age (16-39 years)	144,457	588,557
Older Working Age (40-64 years)	151,622	580,117
Older (65+ years)	73,251	272,819
Population Change % (2002-2012)	8.0%	7.4%

Source: NISRA

Age profile (numbers) of Northern LCG Population by Local Government District area

Table 29

	2012										
Age Band (Years)	Antrim LGD	Ballymena LGD	Ballymoney LGD	Carrickfergus LGD	Coleraine LGD	Cookstown LGD	Larne LGD	Magherafelt LGD	Moyle LGD	Newtownabbey LGD	Northern Trust
0-15	12,090	12,891	6,668	7,535	11,335	8,321	6,038	10,530	3,440	17,351	96,199
16-39	16,946	19,348	9,886	11,404	17,637	12,928	9,064	15,270	4,914	27,060	144,457
40-64	17,313	21,284	10,201	13,626	19,720	11,158	11,350	13,751	5,778	27,441	151,622
65+	7,486	11,028	4,796	6,531	10,301	5,004	5,739	5,899	2,997	13,470	73,251
Overall	**53,835**	**64,551**	**31,551**	**39,096**	**58,993**	**37,411**	**32,191**	**45,450**	**17,129**	**85,322**	**465,529**

Source: NISRA,2012

The age structure of the LCG resident populations varies. The Northern LCG has the highest number of younger people within its population at 96,199 or 21% of its population.

As people grow old the likelihood of illness increases, as does the reliance on health and social care services. In terms of geographical distribution of the 65+ population, the Northern LCG has the highest percentage at 27% or 73,251.

Population Projections

The Northern LCG is expectedto have an overall population growth of 5.2% between 2013 and 2023. This is slightly lower than the Northern Ireland average. The number of children under 16 is expected to increase by 1.6% from 2012-23. Not surprisingly, the greatest increase is found in the number of older people (85+) which is expected to rise by 65.1% in that period hence indicating a rapidly ageing population.

It has the second fastest growing population in Northern Ireland with Cookstown, Antrim and Magherafelt projected to increase by approximately 11% from 2010-20.

Life Expectancy

Life expectancy is used internationally as a measure of population health. For the period 2008-2010, life expectancy in Northern Ireland was lower than in the rest of the UK, with the exception of Scotland (ONS Interim Life Tables).

In tandem with the overall growth in population, there is an improvement in life expectancy. When looking at the Northern LCG as a whole, for people born between 2008 and 2010, life expectancy is higher than the Northern Ireland average.

While there are some signs of general improvement in life expectancy, not everyone has been able to avail fully of the benefits of this progress. Unfortunately, social inequality has endured to the extent that health

outcomes for some groups remain poorer than for others, and smoking, obesity, misuse of drugs and alcohol, teenage conception rates, poor mental health are disproportionally concentrated amongst socially vulnerable, excluded and particularly deprived groups.

The 2011 Northern Ireland Census asked respondents how they perceived their health, whether they had a long term limiting illness and if they provided unpaid care. Approximately one fifth of the Northern Ireland population stated that they had a long term limiting illness. Almost 80% felt they were in good health, and almost 12% said that they provide unpaid care.

Chronic Illness / Long Term Conditions
Self assessed health, long term limiting illness and provision of unpaid care
Table 30

	Long term limiting Illness	General health: Good or Very Good	Providing Unpaid care
Belfast	23.04	76.71	12.33
Northern	19.65	80.43	11.55
South Eastern	19.82	80.84	12.82
Southern	19.64	80.61	11.34
Western	21.85	78.46	11.04
Northern Ireland	20.69	79.51	11.81

Source: Census 2011

When asked about the type of long term condition suffered 6.6% of the Northern area population stated they had a chronic illness and 9.7% suffered long term pain or discomfort (Table 31).

Type of Long Term Condition as assessed by the NI Census 2011

Table 31

LCG	Deafness or partial hearing loss (%)	Blindness or partial sight loss (%)	Communication difficulty (%)	A mobility or dexterity difficulty (%)	A learning, intellectual, social or behavioural difficulty (%)	An emotional, psychological or mental health condition (%)	Long-term pain or discomfort (%)	Shortness of breath or difficulty breathing (%)	Frequent periods of confusion or memory loss (%)	A chronic illness (%)	Other condition (%)	No condition (%)
Belfast	5.6	2.0	1.9	13.1	2.6	7.4	11.4	10.3	2.5	7.2	5.6	66.0
Northern	5.2	1.6	1.5	10.7	2.0	5.1	9.7	8.4	1.7	6.6	5.1	69.2
South Eastern	5.6	1.7	1.6	11.1	2.2	5.1	9.9	8.5	1.9	6.7	5.3	68.4
Southern	4.5	1.6	1.6	10.8	2.0	5.3	9.5	7.8	1.8	5.9	4.9	70.8
Western	4.8	1.7	1.8	11.9	2.4	6.6	10.2	8.8	2.0	6.4	5.3	68.2
Northern Ireland	5.1	1.7	1.7	11.4	2.2	5.8	10.1	8.7	2.0	6.6	5.2	68.6

Source: Census 2011

QOF Disease Registers

The prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation (PHA, 2011).

At sub regional level, the Northern LCG has higher than average rates of asthma, diabetes, hypertension and stroke. It also has the highest rate of emergency admissions per 1000 population for asthma, diabetes, heart failure and stroke.

Deprivation

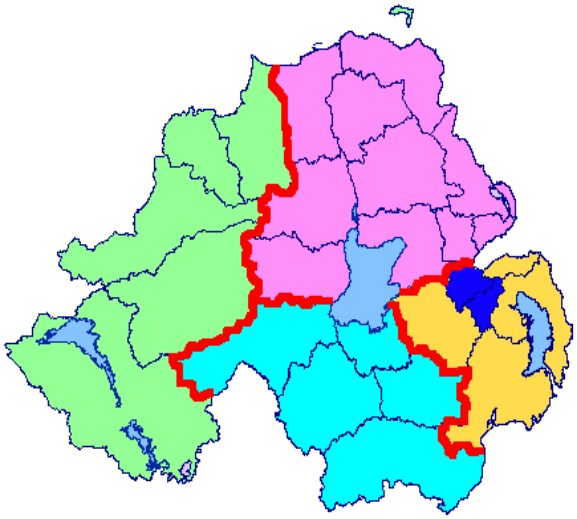
In 2010, NISRA updated the NI Multiple Deprivation Measure (NIMDM). The table below highlights the most deprived areas within each of the five Trusts. The data ranks council areas based on their level of deprivation
(1 most deprived, 26 least deprived).

District Council Deprivation Rankings

Belfast Trust	Rank of Deprivation
Belfast	1
Castlereagh	21
South Eastern Trust	**Rank of Deprivation**
Lisburn	6
Down	16
Ards	18
North Down	24
Northern Trust	**Rank of Deprivation**
Newtownabbey	8
Moyle	9
Coleraine	10
Ballymena	11
Larne	13
Carrickfergus	14
Cookstown	15
Antrim	20
Ballymoney	25
Magherafelt	26
Southern Trust	**Rank of Deprivation**
Craigavon	4
Newry and Mourne	5
Dungannon	12
Armagh	19
Banbridge	23
Western Trust	**Rank of Deprivation**
Strabane	2
Derry	3
Limavady	7
Omagh	17
Fermanagh	22

Figure 13

The Northern Trust has 3 District Council areas in the top 10 most deprived: Newtownabbey (8th), Moyle (9th) and Coleraine (10th)



Personal and Public Involvement (PPI)

The Northern LCG has established a joint working forum with representatives from the 10 district councils and the Northern Trust. This group meets quarterly and more often when appropriate to discuss matters relating to health and social care locally and in particular progress the agenda relating to TYC. The group is chaired by the Chair of the Northern LCG and the Vice Chair is a local representative. The group also shares information relating to developments in local government such as community planning which is relevant to the work of local commissioning.

The Northern LCG has also established links with Causeway Older Active Strategic Team (COAST), Mid and East Antrim Agewell Partnership (MEAAP) and Age Well Mid Ulster in order to ensure that there is on-going dialogue in respect of issues of common interest relating to older people.

Service Users and Carers are involved in specific initiatives undertaken by the Northern LCG. These include work that is on-going to develop specific pathways such as the MSK pathway and the preparatory work on pathways undertaken to inform the work of the Integrated Care Partnerships for example in dementia.

Representatives from the Northern LCG also participate in the Carers Steering Group locally and in the Northern Area Promoting Mental Health and Suicide Prevention Group.

It is recognised that the Northern LCG will need to extend opportunities for engagement and user involvement in the coming year as significant reforms will continue to be progressed as part of improving efficiency and rolling out the transformational agenda.

7.2 Key Challenges and Opportunities 2014/15

Introduction

The key challenges in the Northern area are at the core of the case for change as presented in Transforming Your Care and were presented in detail in the Northern Area Population Plan. They remain as significant challenges although reforms have been initiated to begin to address issues such as a growing and ageing population; increased prevalence of long term conditions; increased demand and over reliance on hospital beds; clinical workforce supply difficulties and the need for greater productivity and value for money.

Integrated Care Partnerships

The introduction of four Integrated Care Partnerships; Antrim/Ballymena, East Antrim, Mid- Ulster and Causeway has enabled work to commence on the design of pathways to address the clinical priorities of frail elderly, respiratory conditions, end of life care, diabetes and stroke. Multi-disciplinary groups including voluntary/community sector representatives and service users and carers have been brought together to scope existing services and initiatives and to begin to design pathways. The ICPs are designing the pathways in order to address the following aims: avoiding unnecessary hospital admissions; providing alternatives to the acute hospital setting; introduction of risk stratification to identify vulnerable patients and providing preventative and self-management options. By focussing on pro-actively managing clients with long term conditions, the work of the ICPs will begin to influence the delivery of services and the real impact of the shift left agenda in transforming patient care should be realised in the shift of resources to the primary and community care sector.

Delivering Choices

A key element of TYC is the delivery of care closer to home and enhanced patient choice. Marie Curie Cancer Care and the HSCB are working in partnership to deliver the Delivering Choice Programme for palliative and end of life care in Northern Ireland. Locally, the Northern Health and Social Care

Trust (Northern Trust), the Northern LCG and other partners from the voluntary and community sector are working closely with the Integrated Care Partnerships to participate in the roll out of the Delivering Choices Programme.

Reform of Community Services for Older People

Reablement is designed to prevent or reduce dependency on services by focussing on intensive short term rehabilitative inputs. Within the Northern area, reablement has been introduced across all localities and to date a significant proportion of clients have been discharged with no further need for a service. There remains however an increasing demand on domiciliary care both in numbers of people requiring packages and in the complexity of need presented by the clients. Further work is required to understand the nature of this increasing demand and the challenges it presents.

In order to address the need to provide additional support and care for older people, supported living units will be built in the Greenisland area with plans for further units to be built in Ballycastle and Newtownabbey.

Infrastructure

With the on-going shift of care to the primary and community sector there is recognition that additional infrastructure is required. In order to address this need, planning has been on-going with primary care, the Northern LCG and the Northern Trust to prioritise the proposed location of new hubs or health and care centres which will deliver a service model specifically designed to meet the needs of a particular population catchment area. The first health and care centre is being built in Ballymena and work is on-going to assess the requirements of the spokes or practices in the surrounding area. Work is on-going to prioritise proposals for the development of further health and care centres (hubs) across the Northern area.

Service Reform

The Northern Trust has been the subject of the implementation of an Improvement Plan. As a result, a Turnaround Team has been working in the Trust and reporting directly to the DHSSPS in respect of the on-going implementation of key recommendations to improve performance. Elements of performance have already been significantly enhanced, for example for the past 4 months breaches of the 12 hour target have been greatly reduced for both the Emergency Departments in the Trust. A range of alternatives to attendance at ED have been developed in partnership with the NLCG and primary care colleagues and further initiatives are planned to ensure on-going improvements to patient care and the development of appropriate and efficient service models across a range of services throughout the Trust. The Northern LCG will continue to support the Northern Trust on this journey.

As the reforms outlined above continue to progress, the impact on the acute sector together with increased efficiency and service improvements, should all combine to result in opportunities to consolidate the number of intermediate and acute beds and the sites on which they are provided, in order to address the changing model of care. Underlying this, there is a need to examine day case surgery and theatre productivity in order to ensure that the best value for money is being achieved and the optimum service is being provided for patients in the Northern area. As highlighted in the Population Plan, when benchmarked with the rest of the UK, fewer Intermediate Care beds are required. Within the Population Plan change in the service model for Intermediate Care was signalled, in that, providing more reablement based care in the person's own home will allow alternatives to bed-based intermediate care to be developed.

7.3 Ensuring Financial Stability & Effective Use of Resources

Use of Resources

The Northern LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £692.3m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Baseline investment by Service Area in 2014/15

Table 318

Programme of Care	£m	%
Acute Services	275.0	39.72
Maternity & Child Health	32.3	4.66
Family & Child Care	46.2	6.67
Older People	154.9	22.37
Mental Health	55.5	8.02
Learning Disability	52.5	7.58
Physical and Sensory Disability	22.8	3.30
Health Promotion	20.8	3.01
Primary Health & Adult Community	32.3	4.67
POC Total	**692.3**	**100.0**

This investment will be made through a range of service providers as follows:

Table 33 Proposed investment by Service Provider in 2014/15

Provider	£m	%
BHSST	131.0	18.9
NHSST	501.7	72.5
SEHSST	5.2	0.8
SHSST	5.8	0.8
WHSST	7.3	1.0
Non-Trust	41.3	6.0
Provider Total	**692.3**	**100.0**

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2014/15 in respect of Emergency Care by the Northern Trust is £15.7m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2014/15 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation and additional funding to take account of the demographic changes in the population of the Northern area. It should be noted that the Learning Disability and Mental Health funds are indicative only at this stage.

Financial Pressures in 2014/15

Table 34

Pressures	**£m**
Demography – Acute Elective > 55 years	1.121
Demography Non Elective > 55 years	1.568
Demography General	7.032
Learning Disability	1.385
Mental Health	1.490
Non Pay	6.063
Pay	4.804
PHA	0.817
RCCE	1.461
Service Pressures	18.647
NICE Drugs	4.571
Total	**48.961**

7.4 Commissioning Priorities and Requirements by POC

7.4.1 POC 1: Acute Services (Non-specialist)

Introduction

Acute non-specialist services are those which provide emergency and planned patient care, from investigation and treatment through to rehabilitation and palliative care. They therefore include radiology, endoscopy and other diagnostic services, outpatients, planned day case procedures or inpatient surgery, and care of patients with acute illness that requires hospital admission. In the Northern area, these services are provided in both Antrim Area Hospital and Causeway Hospital. Day case surgery, outpatient services and rehabilitation are provided in Whiteabbey and Mid Ulster Hospitals. A range of other services are provided in Inver, Robinson and Dalriada Hospitals.

Overview of Local Needs

<u>Elective Demand</u>

GP Referrals

GP referrals to Consultant Led outpatient services account for the majority of the demand to acute services. Over the two years, 2011/12 to 2012/13, there has been approximately a 6% increase in demand across the LCG (from 100,853 to 106,908). Routine referrals increased by 4%, Urgent by 7% and red flags by 25%.

New Outpatient Appointments

The number of new outpatient appointments held has increased significantly, by 13%, (106,463 – 120,577) from 2008/09 to 2012/13 in the Northern area. The average increase across Northern Ireland between 2008/09 to 2012/13 was 14%.

In line with the increase in GP referrals there has been an 8% increase in new outpatient activity between 2011/12 and 2012/13.

Due to identified gaps in capacity and demand the HSCB has purchased additional activity over the last few years. This additionality has been provided by both in house initiatives and also additional activity purchased within the Independent Sector. All activity delivered regardless of the how it was purchased has been included here as this constitutes the demand upon the service.

Review Outpatient Appointments

Between 2008/09 and 2012/13 there has been a 6% increase in review appointments held by Northern LCG residents. There was a 5% increase between 2010/11 and 2011/12, and a subsequent increase of 3% between 2011/12 and 2012/13. The average increase across NI Northern Ireland between 2008/09 to 2012/13 was 8%.

Elective Admissions

Demand for Outpatient services will impact on elective admission and day case activity carried out. As with outpatients above additional activity has been purchased either via additional in house activity or activity being purchased from the Independent Sector and all activity has been included here. The move to meet efficiency targets, such as improved day case rates should have an impact on the admission / day case splits.

Over the five years there has been a 17.2% reduction in elective admissions across the region. Similarly over the last two years in the Northern area, 2011/12 to 2012/13 there has been a 2.9% decrease in elective admissions.

Day case Admissions

As well as increased demand in outpatients with improved efficiency targets there has been an increase in the number of day case admissions. Over the five year period there has been a 20.9% increase and over the last two years

the increase has been 5.3% with the largest increase within Northern LCG residents.

Non Elective Demand

Over the last five years Emergency Department attendances (new and unplanned review) have reduced across the region by 2.1% (from 696,832 to 683,386). Emergency Department attendances in the Northern area have reduced from a high of 171,002 to 164,384 in 2012/13.

Non Elective Admissions

Over the last five years there has been an increase in non-elective admissions of approximately 12% (40,930 - 45,616).

Non Elective Occupied Bed days

While the number of non-elective admissions has increased, the corresponding number of occupied bed days has decreased, possibly suggesting either an improvement in length of stay or an increase in zero day lengths of stay. Over the five years, the number of occupied bed days has decreased by approximately 8%.

Key issues in addressing local needs as highlighted above are:

- to reduce waits at all stages of a patient's journey from their GP to, and through, secondary care;
- to enable GPs to complete more of a patient's management through timely support from secondary care;
- review and take forward opportunities to consolidate the intermediate and acute beds and/or sites, to enable investment in early intervention and intensive acute care.

Addressing these issues will require a transformation in the way in which secondary care is provided across the local health economy. A focus on consolidating capacity and resources over the next 24 months will ensure the continued delivery of effective, efficient, safe and high quality services for the

local population. This will result in significant changes to current patient pathways across secondary (unscheduled and elective), community and primary care.

The Northern LCG will identify current capacity deficits across local Elective and Unscheduled Services and address any deficits to ensure that the local demand is met, within expected timeframes.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. Targets of particular note for the local area are:

Unscheduled care (Ministerial Target 7)

From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.

Hospital readmissions (Ministerial Target 9)

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

Elective care – outpatients / diagnostics/ inpatients (Ministerial Target 11)

From April 2014, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken.

Unplanned admissions (Ministerial Target 21)

By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions (using 2012/13 data as the baseline).

Commissioned Services

The following changes are anticipated for 2014/15.

Current areas for planned investment include:

- Gynaecology and related sub specialties
- Rheumatology
- Cardiology – Rapid Access Chest Pain Clinic
- Dermatology.

The Northern LCG is committed to improving patient access times and to developing enhanced patient pathways across:

- General Surgery (including Day Surgery)
- Pain Services
- ENT
- Gastroenterology
- 7 Day working models for key Diagnostic services
- 7 Day working models for key AHP services.

Unscheduled patient pathways will continue to be developed to ensure existing 4hr and 12hr access times are achieved. The Northern LCG is committed to providing patients with the assessment, investigation and treatment they need, when they need it, through greater Consultant support to enable GPs to manage more of their patients without formal outpatient referral, ED attendance or admission; through active inpatient management and avoiding delays during their hospital stay.

The LCG will focus on:

- Expanding and enhancing the acute assessment unit, which should include both Antrim and Causeway
- Expanding 7-day AHP and Social Work assessment of patients to allow 7-day discharge
- Enhancing 7-day district nursing support with support from specialist staff as required.

- Establishing a Home Oxygen Service for assessment and review
- Implementation of evidence based Obstructive Sleep Apnoea Service
- Development of local support services for long term ventilation in the community
- Enhancing and reforming the stroke service across both the acute and community settings
- Increasing access to insulin pumps for both paediatric and adults
- Enhancing access to self-management programmes for both children and their families and adults who are newly diagnosed with diabetes.

POC 1 – Acute (non-specialist)	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to reduce/flatten demand for outpatients, and Emergency Department attendances.	A dedicated assessment area has been developed on the Antrim site, staffed by the Acute Medical Team, for assessing and diagnosing patients referred by GPs. This service is currently available every weekday between 9am and 5pm, rapid outpatient clinics have also been commissioned aligned to this service. The Northern Trust is expected to take opportunities to build on these arrangements. The Northern Trust is expected to work with commissioners to ensure that opening times and capacity is available to meet demand for this service, and thus reduce demand and pressures on Emergency Department and outpatient clinics. The Northern Trust is also required to work with commissioners to ensure that a model which adopts the same aims and principles can be developed in Causeway.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior	The Northern Trust is expected to ensure that models are developed to allow services to be in place on a 7-day basis on

decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions.	both acute sites. This must include the senior medical decision-makers, radiology, pharmacy, nursing and other key staff necessary to allow a fully functioning 7-day service delivery. Pilots are currently being tested to promote closer liaison with staff within and across the acute sites and those in community and primary care.
Enable district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present.	Northern Trust is expected to continue to work with commissioners to develop and reform community and district nursing services so that patients can either be managed at home and hospital attendance avoided or returned home earlier allowing quicker discharge. Work has already commenced in this area through rapid response nursing developments and Northern Trust must ensure that models are developed in line with commissioner requirements and expectations.
Review and take forward opportunities to consolidate intermediate and acute care beds and the sites on which they are provided	The Northern Trust is expected to : - work to optimise performance across a range of service indicators; and - work with primary and community care to introduce alternative care pathways to, as appropriate, prevent

	admission and facilitate timely discharge.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The Northern Trust is expected to establish a fully functioning GP Access Hub at both Antrim and Causeway sites. This hub will include a fully functioning Acute Medical Assessment Service, available each day on a 9am to 9pm basis. The Access Hub will include both telephone and email advice service for the following specialties: • Care of Elderly • Cardiology • Endocrine & Diabetes • Specialist Palliative Care • Respiratory • Nephrology • Gastroenterology • Diagnostics This Access Hub will provide GP direct access to a senior decision maker at both sites with the aim of preventing ED attendances by allowing rapid outpatient assessment or ambulatory assessment and treatment within 1-2 days. GP direct access to a full range of diagnostic services will

	facilitate the management of patients within Primary Care. The Northern Trust will ensure that models are developed to allow services to be in place on a 7-day basis on both acute sites. This must include the senior medical decision-makers, radiology, pharmacy, nursing and other key staff necessary to allow a fully functioning 7-day service delivery. Pilots are currently being tested to promote closer liaison with staff within and across the acute sites and those in community and primary care.
Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.	The Northern Trust is expected to work with commissioning to improve productivity and efficiency of the commissioned bed capacity and thus achieve a reduction in LOS and thus excess bed days.
Local Priority By March 2015, secure a 5% reduction in the number of emergency readmissions within 30 days (using 2012/13 data as the baseline).	The 30-day readmission level is currently about 10% in Antrim and 7% in Causeway. Commissioning staff will work with NHSCT to reduce this rate in line with the target, by enhancing the scope and level of alternative services available throughout community settings.

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	4,835	33	4,868
	Daycases	13,872	696	14,568
	New Outpatients	51,907	2,279	54,186
	Review Outpatients	95,871	2,286	98,137
Unscheduled	**Non Elective admissions - all**	34,069	1,860	35,929
	ED attendances	130,456	0	130,456
	NIAS Journeys	32,671	696	33,367
	VALUE OF COMMISSIONED ACTIVITY[41]	£275m	£18m	£293m

[41] This includes activity in addition to that set out above.

7.4.2 POC 2: Maternity and Child Health Services

Introduction

The number of births regionally has plateaued in recent years and is now slightly decreasing. Births in the Northern area mirror this regional trend. During 2012/13 there were 4,053 births in maternity units in the Northern Trust, 2,640 in Antrim Hospital and 1,413 in Causeway Hospital. A sizeable number of mothers living in the Northern LCG area choose to deliver in maternity units outside the Northern area. In 2012/13 1,537 Northern LCG mothers delivered in Belfast maternity units, 254 in Southern Trust units, 117 in South Eastern Trust units and 72 in units in the Western Trust. The Northern Trust provides community midwifery services to Northern LCG mothers regardless of whether they deliver in a unit within or outside the Northern area.

Overview of Local Needs

The Northern Trust is now the only Trust in Northern Ireland that does not have a midwife-led maternity unit, however, it is recognised that there is a need for a stand alongside midwife-led unit at Antrim Hospital.

There continue to be very few home births (5 in the Northern area in 2012/13). There has been an increase in births in minority ethnic and migrant mothers and this can pose challenges for maternity, primary care and interpreting services in meeting the needs of these mothers. Caesarean section rates in maternity units in the Northern Trust are relatively high – 30% overall in 2012/13, with Antrim Hospital having a caesarean section rate of 32% and Causeway Hospital 29%.

The teenage birth rate per 1,000 of the female population aged 13-19 in the Northern LCG /HSCT decreased by 4 between 2001 to 2012 from 16 to 12. The Northern Ireland teenage birth rate per 1,000 of the female population aged 13-19 decreased by 3.9 for the same period, from 16.9 to 13.0.

There are challenges in staffing the consultant obstetric unit at Causeway

Hospital to a safe level. The TYC 'Vision to Action' consultation document (2012) stated that it is probable that there will be change in obstetric services at the Causeway Hospital over the next 3 to 5 years as it is not likely to be possible to maintain a safe and sustainable consultant-led service there.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. Targets of particular note for the local area are:

Family Nurse Partnership (Ministerial Target 2)

By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

The Northern LCG will work with the Trust to implement the strategic shifts recommended in TYC and the Strategy for Maternity Care in Northern Ireland 2012/2018 to provide more antenatal care closer to home in the community; and for women with straightforward pregnancies care will be provided primarily by the midwife with greater continuity of care.

The Northern Trust is taking part in a regional maternity quality improvement collaborative and a regional review of community maternity services, and is also working towards an agreed regional approach to the management of multiple pregnancies in line with a recent NICE guideline. The Northern Trust has developed a very active Maternity Services Liaison Committee 'Maternity Matters' that gives service users the opportunity to influence maternity services.

POC 2 – Maternity and Child Health	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: - written and oral communication for women to enable an informed choice about place of birth; - Services in consultant led obstetric and midwife-led units available dependent on need; - Promotion of normalisation of birth, leading to reduction of unnecessary interventions.	The Northern Trust is expected to develop proposals for sustainable service models for maternity units that meet the standards of the Maternity Strategy.
Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129.	The Northern Trust is expected to work with other Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129.
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife led antenatal care in the community for women with straightforward pregnancies.	The Northern Trust is expected to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife-led antenatal care in the community for women with straightforward pregnancies.
Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained	The Northern Trust is expected to continue to benchmark their local obstetric intervention rates against peer units

variation in intervention rates throughout Northern Ireland.	and to reduce unexplained variation in intervention rates.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The Northern Trust is to continue with the provision of a Smoking and Pregnancy Service for antenatal clinics in addition to satellite booking clinic referrals within the Northern area. - All antenatal bookings will have their smoking status recorded with the information held on the Trust NIMATs. - The NIMATs information is screened by the smoking cessation specialist working within the antenatal services at Antrim Area Hospital, Causeway Area Hospital, Mid Ulster Hospital, Braid Valley Hospital site and Larne, Carrickfergus and Whiteabbey Hospital sites. - Specialist cessation support services to pregnant smokers and their partners will be offered by four pregnancy stop smoking specialists across all sites.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	Births	4,072	-72	4,000
	Comm Midwives	Contacts	110,663	0	110,663
	Health Visiting	Contacts	98,956	0	98,956
	Speech and Language Therapy	Contacts	31,714	0	31,714
		VALUE OF COMMISSIONED ACTIVITY[42]	£32.3m	£1.5m	£33.8m

[42] This includes activity in addition to that set out above.

7.4.3 POC 3: Family & Child Care

Introduction

The Children and Families Commissioning remit includes all statutory social work services and, as such, the functions are prescribed within legislation and remain subject to a high level of monitoring and scrutiny, internal and external to the Health and Social Care Trusts, to be assured that these functions are effectively discharged.

In addition, the Health Visiting Service, AHP services for children, Child and Adolescent Mental Health as well as children with a disability, including autism, sit within this programme of care.

Overview of Local Needs

The Northern Trust has the highest population of children (aged 0-17 years of age) in Northern Ireland at 108,700 which represent 23% of the total. There were 5,052 children in need on 31st March 2013 of whom 1,593 had a disability (36.5% of all children in need in Northern Ireland). This represents the second highest in the region. There were 525 children on the Child Protection Register, the highest in the region and 701 looked after children, the highest figure of all Trusts.

In the Northern Trust, there has been a large increase in the number of looked after children in the last 10 years from 548 in 2001/2002 to 701 in 2012/2013.

In addition, there has been an Increase in the number of children on the Child Protection Register from 281 in 2001/02 to 525 in 2012/13.

The number of children in need has risen from 3,137 in 2009/10 to 5,052 in 2012/13 representing an increase of 61%.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

Children in need, children on the Child Protection Register, and those in care are among the most vulnerable and disadvantaged in society with significantly reduced life chances.

As a result of dysfunctional or fractured family relationships, abuse and neglect these children and young people encounter significant obstacles to having a stable family life and to progressing in education to enjoying learning and achieving and reaching their potential. Work undertaken within the Trust indicated that children on the child protection register did not exclusively reside in areas of highest deprivation.

In line with the TYC recommendations and Board policy, five Family Support Hubs are operational within the Trust area with a further one to be become operational during 2014/15. The Northern Outcomes Group in line with the CYPSP is in place with a focus on early intervention and commissioning aligned to priorities identified within the locality plan. The current priority is early intervention and family support to children with a disability.

In keeping with Departmental direction for CAMHs services the Trust is progressing proposals for service enhancement in line with Board commissioning requirements.

POC3 – Family and Child Care	
Regional Commissioning Priority	**Local Commissioning Requirement**
Enhance the Health Visiting workforce to provide the full Core Universal Service as set out in Healthy Child Health Future.	The Northern Trust is expected to work with the LCG to achieve this regional objective.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

7.4.4 POC 4: Older People's Care

Introduction

The main focus in this programme of care is the need to reform services in order to respond to a growing older population who seek to retain optimum health and independence for as long as possible. Transforming Your Care highlights the need to focus on prevention and supporting people at home. There is also the need to address the challenges presented by the growing numbers of people with dementia.

Overview of Local Needs

According to the 2012 Mid-Year Estimates:
15% (272,819) of the NI population are aged 65+ years.
Of the 65+ population, the Northern Trust has the highest proportion at 26.8% (73,251).

- 1.8% (32,713) of the NI population are aged 85+ years.
  Of the 85+ population, the Northern Trust has the highest proportion at 26.1% (8,541).
- Life expectancy for males in the Northern Trust area for 2008- 2010 is 77.9 years; for females is 82 years.

In the Northern area, the rise in the number of older people is placing significant demands on domiciliary care. The numbers of clients requiring packages has risen from 4,038 in 2010/11 to 4,762 in 2013/14. The average domiciliary care package per service user has also increased reflecting the increasing levels of complexity. However, it is also the case that admissions to nursing and residential care have decreased in light of the drive to maintain people in their own homes when this is a safe and appropriate option.
The number of permanent care residents has fallen from 2,486 in 2011/12 to 2,319 in 2013/14.

Alzheimer's Society Dementia UK states that 1 in 14 people over the age of 65 years have dementia. This rises to 1 in 6 over the age of 80. In 2012, the

diagnostic rates for Northern Ireland showed that 51.4% of people with dementia have received a diagnosis. The Northern Trust is ranked 52nd across the UK for diagnosis rates.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

The introduction of reablement has been a key feature in the promotion of independence for older people in the Northern area. Reablement is operational in all areas and during the period October 2012 to September 2013, 1,514 clients have been through the reablement service. This represents 2.07% of the 65+ population and 39% of this cohort of clients required no on-going care.

During 2013/14 the NLCG invested significantly in domiciliary care and reablement, recognising both the on-going pressures and the need for transformation. The LCG also worked with the Northern Trust, the PHA, local government and the voluntary and community sector to form a partnership arrangement in the Causeway area – the Causeway Community/Voluntary Sector Partnership. Funding has been allocated to a Community Navigator post which will be based in the voluntary and community sector to act as a resource for both signposting and capacity building. This is a pilot and evidence gathered will inform the future roll out of this model across the area. The NLCG has formed links with voluntary organisations such as Causeway Older Active Strategic Team (COAST), Mid and East Antrim Agewell Partnership (MEAPP) and Agewell Mid Ulster to build greater collaboration with this sector and engage in meaningful dialogue in respect of commissioning decisions.

Transforming Your Care highlighted the on-going trend towards independent living, at home, or in supported accommodation. Within the Northern area there are two existing supported housing developments, Barn Halt Cottages with 26 units and The Brook with 55 units. Work has commenced to develop a Supported housing development of 36 units in Greenisland and planning is on-going for further developments in Ballycastle and the Newtownabbey area.

In recognition of the growing numbers of people with dementia, the NLCG has invested significantly in services to support people with dementia and their carers with the overall aim of enabling people to live at home for as long as possible. The Dementia Home Support team provides a service to people whose behaviour has become challenging, thereby preventing unnecessary hospital admissions, placement breakdown for people in care homes and admissions to care homes for people living at home. The Northern Local Enhanced Service (LES) was implemented at the beginning of 2013 in order to ensure that patients on relevant registers would be reviewed and offered advice as appropriate regarding dementia. Memory clinics offering early assessment in collaboration with primary care professionals have also been introduced. As Integrated Care Partnerships develop and GPs risk stratify their high risk populations, this will assist in the identification of high risk people with dementia. Investment has been allocated to the development of respite for carers with an emphasis on exploring innovative ways of delivering respite with the voluntary and community sector.

A multidisciplinary group has been formed under the Integrated Care Partnership framework locally, in order to take forward developments for the frail elderly population. This group has begun work on a wide variety of issues ranging from the introduction of rapid response teams and initiatives to prevent social isolation and improve nutrition, to enhanced telecare/ telemonitoring arrangements and exploring the potential for virtual wards. The group is also examining the journey for the frail elderly who need acute care with the aim of enhancing this experience as part of the overall pathway.

POC4 – Older People	
Regional Commissioning Priority	**Associated Local Commissioning Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The NHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The NHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase uptake of direct payments.	The Northern Trust is expected to achieve an increase on the uptake of direct payments equivalent to a 5% increase on the 2013/14 baseline. This would equate to an additional 39 payments,
Working with ICPs to improve the care of the frail elderly.	The Northern Trust is expected to continue to participate as a member of the ICP for Frail Elderly.
Enhancement of dementia services	The Northern Trust is expected to work with local and regional commissioners and within the ICP framework to apply new funding streams for dementia as agreed.

Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements.	The Northern Trust is expected to work with local and regional commissioners to develop an appropriate model for intermediate care in the Northern area. This should progress the reforms highlighted in the Northern area Population Plan moving towards a consolidation of beds and facilities in line with benchmarked information from across the UK.
Continued roll-out of targeted Public Health Agency (PHA) preventative health and well-being improvement programmes.	The Northern Trust is expected to continue to work with PHA on preventative health and well-being improvement programmes.
Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The NHSCT is expected to work with local and regional commissioners to evaluate the reablement arrangements and structures which the Trust has implemented to date.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied Beddays	48,609	0	48,609
	Day Care	Attendances	31,066	0	31,066
	Domiciliary Care	Hours	2,141,149	13,184	2,154,333
	Residential & Nursing Homes	Occupied Beddays	956,996	18,980	975,976
	Community Nursing & AHPs	Face to face contacts	452,217	0	452,117
	Social Work	Caseload	7,461	0	7,461
		VALUE OF COMMISSIONED ACTIVITY[43]	£154.9m	£6m	£160.9m

[43] This includes activity in addition to that set out above.

7.4.5 POC 5: Mental Health

Introduction

Within mental health services, the Bamford vision remains fundamental to the development of modernised services which address the needs of the local population. To make this a reality for people with mental illness, we need to ensure the provision of recovery focussed, person-centred, community-based services, informed by the views of service users and their carers. Early intervention is a key priority alongside protecting and promoting people's mental health.

Overview of Needs

The Quality and Outcomes Framework (QOF) measures general practice achievement against a range of evidence-based indicators and provides raw disease prevalence data by a total of 17 clinical areas. In 2013, the raw prevalence of patients (per 1,000 patients) on the Mental Health Register was 7.5 and on the Dementia Register was 8.0 for the Northern Trust.

In the Northern LGD/Northern Trust, there were 103 admissions to hospital as a result of mood or anxiety disorder in 2009/10. The data is extracted from the Northern Ireland Hospital Inpatients System (HIS), but excludes mental health specialities as not all mental health information is recorded on PAS.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. Targets of particular note for the local area are:

Mental health services (Ministerial Target 33)

From April 2014, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

- Building on the success to date, in the coming year, the Northern Trust should resettle 5 mental health long stay patients and 13 delayed discharges from hospital into community placements with suitable social care and community services infrastructure to support them.
  In keeping with regional strategic direction, the Northern Trust should establish integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of Primary Care Psychological Therapy Services.
  The Northern LCG will commission an integrated care pathway for the care and treatment of patients with common mental health needs including continuing to work with the Northern Trust, primary care and the community and voluntary sectors to establish a pilot Referral Hub and Primary Care Coordinator across two sites. The pilot will be evaluated on completion in order to roll out across the Trust area in due course.

  An adult Autism Diagnostic service has been established for adults with autism, without an identified learning disability.

- The appointment of a Recovery Facilitator to enhance recovery focused work in the Trust has created a drive and impetus within mental health services. This work is progressing with the full involvement of service users, voluntary sector providers and staff from both in patient care and community services.
- Additional funding has secured to enable the psychiatric liaison service to be modernised. The enhanced care pathway, new triage format and amended assessment tools are being piloted to improve access to mental health assessment, for those presenting with self-harm, prior to discharge from Emergency departments.

POC 5 – Mental Health	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The NHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The NHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase the uptake of direct payments.	The Northern Trust is expected to achieve an increase on the uptake of direct payments equivalent to a 5% increase on the 2013/14 baseline. This would equate to an additional 5 payments per month.
Implementation of the Protect Life Strategy	The Northern Trust is expected to work to achieve the regional objectives including:

	• Contributing to the development of an improved model of support for those who self-harm. • Specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. • Supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed memorandum of understanding
Establishment of integrated care arrangements for the care and treatment of patients with common mental health needs	The Northern Trust is expected to work with the regional team to roll out the model for integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of Primary Care Psychological Therapy Services over the period of the next 2 years.
Implementation of the Crisis Resolution Home Treatment services for CAMHs	The Northern Trust is expected to work to achieve the regional objectives as specified.
Further development of specialist community services	The Northern Trust is expected to work to develop Specialist Community Services including the introduction of Adult Autism Advice Service in Ballymena initially.

Improve Psychiatric Liaison Services to ensure a maximum 2 hours response time in Emergency Departments	The Northern Trust is expected to work to achieve the regional objectives as specified.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied Beddays	69,012	0	69,012
	CPN	Contacts	45,995	0	45,995
	Res & Nur Homes + Supported Housing	Occupied Beddays	57,172	0	57,172
	Day Care	Attendances	21,415	0	21,415
	Dom Care	Hours	54,561	602	55,163
		VALUE OF COMMISSIONED ACTIVITY[44]	£55.5m	£2m	£57.5m

[44] This includes activity in addition to that set out above.

7.4.6 POC 6: Learning Disability

Introduction

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

Overview of Local Needs

In January 2013, 4.97 per 1,000 people over 18 years were recorded as having a learning disability in the Northern area. The regional figure is 5.16.

The population of people with learning disability is continuing to rise in line with the increase in the average lifespan. Consequently there are greater numbers of people with a learning disability reaching adulthood and requiring day opportunities and appropriate community support.

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. A target of particular note for the local area is:

Learning disability (Ministerial Target 32)

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

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

Building on the success to date, in the coming year, the Northern Trust should resettle 5 Learning Disability long stay patients and 7 delayed discharges from hospital into community placements with suitable social care and community services infrastructure to support them.

There has been a Public Consultation on a regional day opportunities model for adults with a learning disability. The day opportunities currently provided in the Northern area are well established with 9 Bases in operation providing day opportunities to more than 500 people with learning disabilities, further opportunities should be explored to build on this successful model.

The Northern Trust is currently developing a Short Breaks Strategy for carers of people with a learning disability, involving key stakeholders in the review of current provision which includes bed-based services, Share the Care and use of direct payments. This will be further developed during 2014/15.

POC 6 – Learning Disability	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The NHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The NHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
Delivery of day services in line with the Regional Day Opportunities Model	The Northern Trust is expected to further enhance existing day opportunities model. This model which has resulted in the development of “bases” across the area should continue to be rolled out. Further work is planned for the Larne, Carrickfergus and Newtownabbey area. Satellite units are being developed.

Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	The Northern Trust is expected to work to achieve the regional objectives as specified.
To increase the uptake of direct payments.	The Northern Trust is expected to achieve an increase on the uptake of direct payments equivalent to a 5% increase on the 2013/14 baseline. This would equate to an additional 36 payments during 2014/15.
Development and implementation of health promotion initiatives for people with a learning disability.	The Northern Trust is expected to work to achieve the regional objectives as specified.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied bed days	32120	0	32120
	Day Care	Attendances	135146	3690	138736
	Domiciliary Care	Hours	77021	471	77492
	Residential & Nursing	Occupied bed days	115386	0	115386
	Community Nursing and AHPs	Face to face contacts	38253	0	38253
	Social Work	Active Caseload	1989	0	1989
		VALUE OF COMMISSIONED ACTIVITY[45]	£52.5m	£5m	£57.5m

[45] This includes activity in addition to that set out above.

7.4.7 POC 7: Physical disability & sensory impairment

Introduction

The Northern area has participated in the work streams arising from the roll out of the Physical and Sensory Disability Strategy 2012-2015. The key themes are: Personalisation; Service Redesign; Transition Support and Planning; Equipment – Procurement and Standardisation; Rehabilitation; Transport; Respite/Short Break Care; Information, Advice and Advocacy; Provision of Skilled Workforce; Day Opportunities and Housing.

Progressing all of these themes will be key to the further development of innovative services locally.

The Northern area will also participate in the development of self-directed support as a new and innovative model locally.

Overview of Local Needs

The following tables provide an overview of the current prevalence of a range of long term conditions and indicate where adaptations to accommodation have been required. There is also a growing need associated with the number of complex cases where patients are discharged home with high cost packages. Further work is required to analysis this trend.

Prevalence of a range of Long term conditions for the Northern Ireland Population and for LGDs in Northern Trust /LCG area from the 2011 Census.

Table 35

	Antrim	Ballymena	Ballymoney	Carrickfergus	Coleraine	Cookstown	Larne	Magherafelt	Moyle	Newtownabbey	NHSCT	Northern Ireland
All usual residents	53428	64044	31224	39114	59067	37013	32180	45038	17050	85139	**463297**	1810863
Deafness or partial hearing loss (%)	4.68	5.17	4.76	6.06	5.5	4.4	5.86	4.21	5.49	5.5	**5.17**	5.1
Blindness or partial sight loss (%)	1.38	1.54	1.5	1.74	1.58	1.46	1.83	1.4	1.81	1.69	**1.58**	1.7
Communication difficulty (%)	1.58	1.35	1.47	1.56	1.44	1.58	1.44	1.44	1.76	1.53	**1.49**	1.7
A mobility or dexterity difficulty (%)	10.01	10.1	11.13	11.98	10.33	11.53	11.22	9.44	11.61	11.14	**10.72**	11.4
A learning, intellectual, social or behavioural difficulty (%)	2.23	1.67	1.93	2.2	1.96	2.03	2.04	1.97	2.06	1.94	**1.98**	2.2
An emotional, psychological or mental health condition (%)	4.96	4.53	4.72	5.65	4.92	6.38	4.89	4.58	4.95	5.19	**5.05**	5.8
Long-term pain or discomfort (%)	9	8.79	9.86	11.07	9.52	10.34	10.53	8.42	10.41	9.91	**9.65**	10.1
Shortness of breath or difficulty breathing (%)	8.03	7.73	8.01	9.45	8.03	8.41	9.17	7.69	8.35	9.06	**8.38**	8.7
Frequent periods of confusion or memory loss (%)	1.63	1.73	1.57	1.99	1.66	1.91	1.71	1.51	1.77	1.75	**1.72**	2.0
A chronic illness (%)	6.04	6.66	6.25	7.6	6.66	5.86	7.44	5.45	6.91	7.06	**6.6**	6.6
Other condition (%)	4.99	4.97	5.2	5.48	5.01	4.86	5.51	4.82	5.03	5.34	**5.12**	5.2
No condition (%)	70.56	70.37	69.42	66.34	68.69	69.59	66.96	71.99	68.32	68.46	**69.21**	68.6

Source: Census, 2011 NISRA

Adaptation of Accommodation – Northern LCG

Table 36

LCG	All households	Wheelchair usage (%)	Other physical or mobility difficulties (%)	Visual difficulties (%)	Hearing difficulties (%)	Other (%)	No adaptation (%)
Northern LCG	**177914**	**6.1%**	**6.2%**	**0.2%**	**0.4%**	**0.2%**	**88.5%**
Antrim	20064	6.6%	6.2%	0.2%	0.4%	0.2%	88.1%
Ballymena	24817	6.5%	5.7%	0.2%	0.5%	0.2%	88.6%
Ballymoney	11508	7.8%	5.4%	0.2%	0.3%	0.1%	87.8%
Carrickfergus	16200	4.5%	6.9%	0.3%	0.6%	0.2%	89.5%
Coleraine	23508	5.4%	5.8%	0.2%	0.5%	0.2%	89.5%
Cookstown	12904	9.0%	7.7%	0.3%	0.3%	0.1%	84.4%
Larne	13297	4.7%	5.5%	0.3%	0.3%	0.4%	90.2%
Magherafelt	15037	9.2%	5.8%	0.3%	0.4%	0.2%	85.8%
Moyle	6608	7.5%	6.7%	0.3%	0.4%	0.2%	86.5%
Newtownabbey	33971	3.9%	6.5%	0.3%	0.5%	0.2%	90.2%

Source: Census, 2011 NISRA

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15.

Commissioned Services

The Northern LCG has invested in additional respite for young adults with physical disabilities, including those with brain injury and MS. These are specialist placements at Cuisle and Corrymeela. The Commissioner would want to see the continuing development of more innovative respite placements for people with a physical disability and/or sensory impairment.

Investment has also been targeted towards those clients with more complex needs in order to enable these clients to return home following treatment in a timely manner.

With the increasing demographic pressures and earlier hospital discharges, there is also on-going pressure on the wheelchair budget. The Northern LCG has invested in the wheelchair budget but acknowledges the service improvement work on-going locally to improve the efficiency and effectiveness of the service in the Northern area.

POC7 – Physical Disability and Sensory Impairment	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The NHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The NHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase the uptake of direct payments	The Northern Trust is expected to achieve an increase on the uptake of direct payments equivalent to a 5% increase on the 2013/14 baseline. This would equate to an additional 38 payments.
Review Trust progress in relation to the review and reform of day opportunities in alignment with personalisation strategies.	The Northern Trust is expected to continue to participate in the roll out of the Self Directed Support Initiative.

Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability and SI	**Hospital services**	Occupied beddays	6,660	0	6,660
	Day care	Attendances	18,985	0	18,985
	Domiciliary care	Hours	325,448	2,000	327,448
	Resid & Nursing Home	Occupied beddays	33,581	0	33,581
	Community nursing & AHPs	Contacts	49,528	1,167	50,695
	Social work	Active caseload	1,322	0	1,322
		VALUE OF COMMISSIONED ACTIVITY[46]	£22.8m	£1.1m	£23.9m

[46] This includes activity in addition to that set out above.

7.4.8 POC 8: Health Promotion & Disease Prevention

Introduction

Amongst the aims of this programme locally are the need to ensure the delivery of programmes to promote the health and wellbeing of older people by reducing social isolation (including engaging with the Arts and Health Project); improving signposting and referrals to relevant support services; falls prevention services; reducing the risk of malnutrition and dehydration; increase the provision of targeted health and wellbeing approaches within the care of individuals with dementia; provide opportunities for people to participate in physical activity and work with others to reduce the effects of poverty.

There is also a requirement for the Northern Trust to continue to engage with PHA and others to reduce the impact of poverty on clients and patients, particularly those with mental health issues, addictions, older people and families with young children.

The issue of Accident Prevention remaining a key focus and the Northern Trust should continue to work with PHA and others to reduce the incidences of unintentional injuries in the home, communities and health care settings.

Overview of Local Needs

The Northern area shows a mixed profile of prevalence of patients on registers of all key measures. Mental health, learning disability, and dementia show a lower prevalence, with a higher than average in heart disease, stroke, hypertension, obesity and diabetes

The following tables highlight particular local information for example, there were 15 obesity-related deaths in the Northern HSCT from 2007 to 2011.

Comparison of Key Health Indicators against NI Total

Table 37

Comparisons	Northern Area	NI
Alcohol related deaths (2011)	51	252
Drug related deaths (2011)	18	102
Obesity related deaths (2007-2011)	15	43
Raw prevalence of patients (per 1,000) on the Obesity Register aged 16 and over (2013)	108.1	110.8
Percentage of people who had self-reported they had successfully quit smoking at 4 weeks (2012/13)	53.0%	56.6%
Teenage birth rate (per 1,000 of the female population aged 13-19) (2012)	12	13.0

Source: NISRA

Hospital Admissions due to Accidents, 2009

Table 38

	2009			
LGD	Admissions due to accidents	Admissions due to injuries from Road Traffic Collisions	Admissions due to accidental injuries in the Home	Admissions due to accidents occurring at School
Antrim	463	44	71	11
Ballymena	505	73	82	9
Ballymoney	218	33	44	5
Carrickfergus	308	41	55	12
Coleraine	446	47	98	18
Cookstown	325	43	59	11
Larne	276	26	32	9
Magherafelt	346	50	47	10
Moyle	118	19	28	3
Newtownabbey	649	59	111	20
Northern Trust	**3654**	**435**	**627**	**108**
Northern Ireland	**14928**	**1579**	**3423**	**480**

Number of alcohol related deaths by Health and Social Care Trust and registration year, 2002-2012

Table 39

Registration Year	Northern	Total
2002	50	**238**
2003	39	**214**
2004	39	**255**
2005	49	**246**
2006	59	**248**
2007	60	**283**
2008	67	**276**
2009	58	**283**
2010	53	**284**
2011	51	**252**
2012[P]	44	**270**
Total (2002-2012)[P]	**569**	**2,849**

Source: NISRA

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however the following developments are anticipated.

A number of highly effective programmes, Maximising Access in Rural Areas (MARA), community grants programmes and the Farm Family Check Scheme, have delivered real improvements to the health and wellbeing of rural communities. It is important that the potential of these programmes is maximised during the coming year.

Emotional Wellbeing and Suicide Prevention

The Deliberate Self Harm Registry is now operational within the Northern Trust area and this unique data system is being used to inform service development and efforts to reduce deaths by suicide. Northern area also has in place a community response plan which enables an effective multi-agency response

within communities should there be a potential suicide cluster or community concern, the activation of this plan during this year was thankfully limited but effective when needed. The Public Health Agency (PHA) in Northern area works very closely with sub regional rural community networks to support community grants and community development posts to help build community capacity and reduce suicide.

Tobacco

Smoking cessation services have continued to remain effective with the quit rate steady at over 50% at 4 weeks. Three new regional public information campaigns have been successfully developed and evaluated to accompany action programmes on the ground; obesity prevention, stop smoking, and mental health and wellbeing. Within the Northern area services will continue to particularly target disadvantaged communities, workplaces and pregnant women.

Sexual Health Services

The Northern Trust and Northern Regional College have established a very successful model for sexual services within the Further Education Sector, which is reaching out to many young people who would not access services within the more traditional health and social care setting.

Joint Working with Local Government

Joint working continues across all of our local government areas and in particular with the cluster groups which have come together to reflect the proposed new local council areas. The following examples of work during this year with local government will continue to be developed and expanded on in the coming year.

Causeway Coast and Glens and Mid and East Antrim Cluster (CCGMEA)

On 17 January 2013 the work of the Cluster was officially launched as a model of good practice at a 'Tackling Fuel Poverty Together' event in Stormont. This work has included a Community Oil Drop Scheme, a Home Energy

Efficiency Service, an Energy Detectives school based awareness programme, and Motivational Interviewing Training for local Energy Efficiency Advisers. The Community Oil Drop Scheme has been rolled out in a number of other council areas and there are now 13 schemes active in the CCGMEA area, with a hope for an additional 10 to be up and running during 2014.

Launch of New Mossley Community Allotments

The Public Health Agency in partnership with Newtownabbey Borough Council, NI Housing Executive and New Mossley Community Group has launched the 'New Mossley Community Allotments.

Parkrun at Carnfunnock Country Park

The Public Health Agency provided funding to support the introduction of the Parkrun initiative in Carnfunnock Country Park within Larne Borough Council.

POC 8 – Health Promotion	
Regional Commissioning Priorities	**Local Commissioning Requirements**
Expansion of the early years intervention programme.	• Co-ordinated approach developed across relevant areas of Trust Business. • Extend Roots of Empathy in all Trust areas. • As per FNP targets. • Delivery of infant mental health training as per agreed action plan. Implementation of 5 new Early Intervention programmes to support parents.
Incremental expansion of social economy businesses and community skills development.	Report detailing numbers of social economy businesses engaged. Poverty – Northern Trust is expected to engage with PHA and others to reduce the impact of poverty on clients and patients, particularly those with mental health issues, addictions, older people and families with young children.
Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	• A Co-ordinated approach should be developed across relevant areas of Trust Business and in conjunction with other statutory, community and

	voluntary partners. • Improved access and uptake of targeted health and wellbeing improvement services and programmes by older people.
LCGs to monitor Trust performance in relation to the HSCB / PHA Community Development strategy	The Northern LCG will work with the Northern Trust to monitor performance on an ongoing basis.
Implementation of the "Fitter Futures for All Framework".	• Weigh to a Healthy Pregnancy Programme for women with BMI >40 established in Trusts. • Report on implementation of new 'Baby Friendly' standards. • Report on provision of weight loss programmes for adults and children as appropriate. • Report on contribution to implementation of new standardised Regional Activity Referral Programme • Report from regional working group on progress towards healthier catering and vending provision in all HSC facilities.

Implementation of key public health strategies.	• Northern Trust is expected to work towards becoming smoke free at all campuses and sites within their estate, in addition "Pregnant smokers, pre-op smokers, patients with long term conditions and cancer and staff and clients within the mental health setting will avail of stop smoking support with uptake increased and quit rates at a minimum of 45% at four week follow up" • Smoking Cessation services should be available with identified groups. Brief Intervention Training should be delivered to key staff working with priority groups. • A Progress report on smoke free premises should be made available. • New service model for substance misuse liaison services is in place. • 7 days services which prioritise individuals presenting to Emergency Departments, acute

	medical/ surgical admission wards and other settings within the acute sector for identification/ health improvement (screening/ brief intervention), treatment and support for substance misuse and associated mental health; • Update of Registry and new service model developed and delivered. Northern Trust is expected to provide evidence of services pro-actively reaching out to more vulnerable groups.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	Northern Trust is expected to provide monitoring report outlining range of specialist sexual health services available, numbers and age groups accessing services.
Local Priority	Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.

7.4.9 POC 9: Primary Health and Adult Community

Introduction

This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability.

GMS in the Northern area are delivered by 78 general medical practices. There are 90 general dental practitioners and 117 community pharmacies.

Overview of Local Needs

(Please see section 7.1 LCG Population)

Ministerial Targets

The Northern LCG will seek to commission services consistent with the delivery of the Ministerial targets for 2014/15. Targets of particular note for the local area are:

Integrated Care Partnerships (Ministerial Target 26)

By March 2015, 95% of patients within the four ICP priority areas [frail elderly, diabetes, stroke, respiratory] will have been identified and will be actively managed on the agreed Care Pathway.

Commissioned Services

The vast majority of services in this POC will be commissioned as per 2013/14, however, the following developments are anticipated.

Following an analysis of current prescribing patterns within Northern LCG GP practices and taking account of the Pharmaceutical Clinical Effectiveness Programme, a number of priority therapeutic areas continue to be of highest

cost within the Northern locality and have the greatest potential to release efficiencies. In light of this, the NLCG has funded protected time to all GP practices until March 2015. Additional funding has also been allocated to a practice support pharmacist, a medicines management dietician and to extend a pharmacist prescriber led medication review in nursing homes.

During 2013/14, non-recurrent prescribing savings were made available to the Northern LCG to fund a number of initiatives. These have included: support for the Musculoskeletal (MSK) pathway development by training and development for GPs on pain related prescribing and the use of ultrasound guided injections; the extension of the dermatology photo triage service; direct access audiology and training for GPs participating in memory assessment for people with dementia. All of these initiatives clearly demonstrate an adherence to the principles of TYC.

The Northern LCG will continue to work to improve its position with regard to prescribing costs.

Primary Care Infrastructure

In recent years, there has been relatively modest investment in primary and community care infrastructure in the Northern LCG area. An assessment of existing Trust and GP estate indicates that a significant proportion of the infrastructure is well below current standards and not fit for purpose. A new-build Health and Care Centre is being constructed in Ballymena which will accommodate a number of GP practices and a range of other community services. It is recognised that the development of primary and community infrastructure is pivotal to the delivery of TYC. In light of this, the Northern LCG has been working with GPs and Northern Trust colleagues to assess the need for hubs and spokes across the Northern area. The emphasis is on projects which will support service integration, modernisation and reform and which will be acceptable to the local population and the communities served. In addition to the Health and Care Centre in Ballymena, it is likely that health and care centres of differing scale would be required in locations throughout

the Northern area. There will also be work required to bring other practices, known in this model as spokes, up to standard, particularly with regard to space requirements for any additional services/clinics.

MSK/Pain

A project has been developed locally with the aim of identifying a solution which will provide sustainable MSK/Pain services for patients, will deliver world class outcomes, support and reduce demand from other clinical services and improve equity of access to high quality care. The project has involved a wide range of stakeholders from the Northern LCG, Primary and Secondary care and service users and carers. The pathway is being developed across 3 levels: self-help, psychological education/analgesics and health promotion; injections; surgical nerve treatment and individual psychological therapy. Across these levels scrutiny is applied to the aspects of referral management / triage; diagnostics; prescribing support/medicines management; self-management; assessment/recall/review and treatment/interventions. A group of service users has met twice to date, to provide very valuable insight into their experiences of the current services and to suggest improvements from their perspective. A draft pathway has been developed and is currently with the project team for further refinement. This will be rolled out during 2014/15.

POC 9 - Primary Health and Adult Community	
Regional Commissioning Objectives	**Local Commissioning Intent 2014/15**
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility. A Regional Commissioning Framework for Community Nursing will be developed.	The Northern Trust is expected to work with the LCG to achieve this regional objective.
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	LCG to work with ICPs to implement LES to achieve this objective.

8.0 South Eastern Local Commissioning Group (LCG) Plan

8.1 LCG Population

Demographic Drivers

The South Eastern LCG covers an area which can be characterized as a mix of urban and rural settlements. The main population centres include Lisburn, Downpatrick, Bangor and Newtownards and covers the current local government districts of Ards, Down, Lisburn and North Down. These areas are co-terminus with the boundaries of the South Eastern Health & Social Care (HSC) Trust.

- The population of the South Eastern LCG in 2012 was 350,000 this is anticipated to rise by 5% to 368,000 by 2023.

- Across the ICP areas the largest increase in population is in the Lisburn area with an 8% increase (119,000-129,000) and the smallest increase is in North Down with just a 1% change in the population (80,000-80,117). Ards and Down population is expected to rise by 5% and 6% respectively.

- Currently, people 65 years old and over account for 16% of the total population of the South Eastern LCG (57,000 people). The south east locality hosts a proportionately larger share of Northern Ireland's older population as its 65 and over population accounts for 21% of all older people in Northern Ireland (273,000 people). This fact is to be welcomed as it reflects the advances that have been made in health and wellbeing allowing current generations to enjoy longer lives.

- However, it is inevitable that as people grow older, the likelihood of illness increases as does their need for health and social care services. Older people are increasingly more likely to be living with more than one long term chronic conditions.

If we look at population projections for our older population, it is clear that there will be a sharp increase in this demographic. Our over 85 year old population (highlighted in Table 42) is increasing at a faster rate than other age bands. By 2015 there will be a 21% increase in the 85+ population compared to 2011 and by 2019 there will have been a 48% increase in that age group compared to 2011.

Population Trends by Locality (0-64 population)
Table 40

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Belfast	284,754	284,949	285,215	285,617	285,898	286,103	286,375	286,349	286,398	286,277	285,993	285,513	284,816
Northern	391,993	392,555	393,337	394,142	394,819	395,483	396,066	396,591	397,079	397,503	397,672	397,657	397,438
South Eastern	292,788	292,856	292,831	292,876	292,972	293,232	293,401	293,620	293,625	293,738	293,484	293,189	292,610
Southern	315,925	319,230	322,531	325,770	329,015	332,352	335,694	338,858	341,941	344,905	347,654	350,170	352,519
Western	262,872	263,290	263,703	263,967	264,134	264,254	264,376	264,393	264,264	263,968	263,560	263,101	262,497
Northern Ireland	**1,548,332**	**1,552,880**	**1,557,617**	**1,562,372**	**1,566,838**	**1,571,424**	**1,575,912**	**1,579,811**	**1,583,307**	**1,586,391**	**1,588,363**	**1,589,630**	**1,589,880**

(Source: NISRA, 2008 Based Population Projections)

By 2023, it is projected that the 0-64 population in NI will be approximately 1.59 million; an estimated increase of 2.7% from 2011.The South Eastern area however indicates a small projected decrease in population (0.06%) within this age band. The Southern area is projected to have the highest growth (11.6%) and the Western the lowest, with a projected decrease of 0.1%.

Population Trends by Locality (65+ population)
Table 41

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Belfast	52,285	52,697	53,017	53,183	53,467	53,836	54,143	54,744	55,268	55,936	56,734	57,683	58,802
Northern	71,527	73,876	75,912	77,834	79,785	81,725	83,706	85,693	87,661	89,630	91,777	94,024	96,386
South Eastern	55,220	57,095	59,016	60,810	62,493	63,979	65,524	66,983	68,598	70,043	71,792	73,506	75,419
Southern	48,069	49,646	51,198	52,790	54,346	55,810	57,250	58,829	60,437	62,102	63,890	65,818	67,818
Western	39,660	41,071	42,415	43,847	45,300	46,750	48,148	49,582	51,086	52,683	54,312	55,898	57,537
Northern Ireland	**266,761**	**274,385**	**281,558**	**288,464**	**295,391**	**302,100**	**308,771**	**315,831**	**323,050**	**330,394**	**338,505**	**346,929**	**355,962**

(Source: NISRA, 2008 Based Population Projections)

By 2023, it is projected that the 65+ population in NI will be approximately 356,000; an estimated increase of 33.4% from 2011. The South Eastern area is projected to witness a significant population increase (37%) within this age band. The Western area is projected to have the highest growth (45%) and the Belfast area the lowest growth (12%).

Population Trends by Locality (85+ population)
Table 42

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Belfast	6,690	6,867	7,038	7,185	7,383	7,586	7,745	7,910	8,039	8,234	8,442	8,692	8,939
Northern	8,340	8,882	9,232	9,584	10,065	10,590	11,064	11,538	12,073	12,608	13,185	13,935	14,660
South Eastern	6,937	7,236	7,502	7,843	8,127	8,449	8,786	9,146	9,546	9,970	10,426	10,927	11,419
Southern	5,430	5,715	6,009	6,306	6,651	6,995	7,296	7,675	8,072	8,463	8,951	9,473	9,915
Western	4,320	4,573	4,783	5,039	5,203	5,440	5,734	5,987	6,279	6,537	6,893	7,328	7,733
Northern Ireland	**31,717**	**33,273**	**34,564**	**35,957**	**37,429**	**39,060**	**40,625**	**42,256**	**44,009**	**45,812**	**47,897**	**50,355**	**52,666**

(Source: NISRA, 2008 Based Population Projections)

By 2023, it is projected that the 85+ population in NI will be 53,000; an estimated increase of 66% from 2012.The Southern area is projected to have the highest growth (73%) and the Belfast area the lowest growth (30%) with the South Eastern area indicating a 57% population growth, for this age group.

Population Trends Northern Ireland (0-64, 65+, 85+population)
Table 43

Age	2012	2017	2022	2027	2032	2037	2041	2046	2051	2056	2061	2062
0-64	1,550,815	1,565,184	1,574,754	1,564,277	1,538,686	1,515,427	1,507,453	1,499,769	1,488,029	1,471,007	1,457,445	1,455,059
65+	272,819	306,025	343,731	392,449	445,904	489,122	510,411	531,791	551,388	569,108	577,785	578,820
85+	32,713	39,107	47,992	58,800	75,802	89,894	100,251	118,674	140,726	157,365	164,056	164,333
Northern Ireland	**1,823,634**	**1,871,209**	**1,918,485**	**1,956,726**	**1,984,590**	**2,004,549**	**2,017,864**	**2,031,560**	**2,039,417**	**2,040,115**	**2,035,230**	**2,033,879**

(Source: NISRA, 2012 Based Population Projections)

By 2062, it is projected that the total population in N. Ireland will be 2,034,000, an estimated increase of 12% from 2012. Older people aged 85+ are projected to have the highest growth (402%) whereas the 65+ population will increase by

110% from 2012. The 0-64 population is projected to fall by 6% from 2012 to 2062.

Births

In 2012 there were 4,526 registered births to the South Eastern resident population. The Lisburn area comprised of 39% of this total and accounted for 1,7537 births. In relation to maternity services 4,069 births were recorded at the Ulster Hospital Maternity Unit, however many of the births were to residents from the Belfast and other LCG areas. The number of births at the Ulster has been impacted in recent years by the introduction of midwife led services at the Lagan Valley and Downe Hospitals and other changes to the configuration of maternity provision in Belfast.

64% of the births at the Ulster Hospital are to residents of the South Eastern LCG and a further 32% are to Belfast residents. Similarly, 64% of South Eastern births were in South Eastern Trust units.

30% of south eastern residents' births were in Belfast units (Royal Victoria and Mater Hospitals)

Life Expectancy

Average life expectancy for males in the south east is 78.5 years which compares favourably with the N. Ireland average of 77.1 years. For females the average life expectancy is 82 which again compares favourably with the N. Ireland average of 81.5 years. While there are some signs of general improvement in life expectancy, not everyone has been able to avail fully of the benefits of this progress. Unfortunately, social inequality has endured to the extent that health outcomes for some groups remain poorer than for others, and smoking, obesity, misuse of drugs and alcohol, teenage conception rates, poor mental health are disproportionally concentrated amongst particular deprived groups.

Health Inequalities–Lifestyle and Behaviour

Smoking rates are highest among people who earn the least and lowest amongst those on higher incomes, for example while smoking prevalence amongst the general population is now 24%, amongst manual workers it remains high at 31%. Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in N. Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 49 individuals every week.

South eastern residents experience the lower mortality rates due to smoking related causes when compared across N. Ireland.

Alcohol related admission rates to hospital have also been on the increase in N. Ireland over the past decade. South eastern area has seen a 32% increase in alcohol related admission rates since 2000/01 which is higher than the increase of 21% observed in N. Ireland.

Chronic Illness/Long Term Conditions

South east residents reported lower than average long term limiting illness and they perceived their health to be good or very good.

Percentage of SELCG population with a long term limiting illness, good or very good general health and providing unpaid care. Comparison with NI Table 44

LCG/Trust Area of Residence	Long term limiting Illness	General health: Good or Very Good	Providing Unpaid care
SE	19.82	80.84	12.82
NI	20.69	79.51	11.81

(NISRA)

Across N. Ireland the most prevalent long-term conditions are hypertension, asthma and diabetes. Using QOF data for 2012/13 it can be seen that the south eastern population has a higher rate of hypertension compared to the

regional rate (135.39/1,000 in South Eastern area against 128.7/1,000 in NI) and similarly with diabetes (43.37/1,000 in south eastern area against 41.41/1,000 in NI.)

The provision of unpaid care is higher (12.82%) than the average for N. Ireland (11.81%)

Cancer Incidence

Cancer incidence rates measure how much more or less an individual is likely to develop cancer in a specific geographic area compared with the N. Ireland average, having taken in to account the age and gender profiler for that area. Data shown in the table below suggests that incidence rates in the south eastern area are now marginally lower than the N. Ireland average.

Cancer Incidence Rates 1993-99 to 2003-09
Table 45

LCG/ Trust Area of Residence	1993-99	2003-09
SE	94	99
NI	100	100

Deaths

There were 2,856 recorded deaths in the south eastern locality in 2012. Lisburn had the highest number of deaths at 7.4 deaths per 1000 (893).. An analysis of the crude death rate (death rate per 1000 population) shows that North Down at 9.2 deaths per 1000 had the highest death rate in the south east locality and this was the second highest in N. Ireland next to Belfast with a crude death rate of 9.9 per 1000.

Each year in N. Ireland approximately half of all deaths take place in hospital. In recent years through the implementation of the Palliative Care and End of Life Strategy, this situation has shown a change with the proportion of deaths

taking place in hospital falling as individuals and families indicate their preference to die at home. Figures for 2011 indicate that 49% of N. Ireland deaths took place in hospitals compared to 51% during 2009. There is variation by area of residence, with the percentage of deaths in hospitals across the Northern, Belfast and Western LCGs being higher than average (53%, 51% and 50% respectively in 2011) and South Eastern and Southern being lower than the Northern Ireland average (46% and 45% respectively).

Deaths by Cause

The main causes of death in 2012 in the south east area were cancer, diseases of the circulatory system and diseases of the respiratory system. Standardised mortality ratios (SMRs) for 2012 show that the South Eastern LCG had a higher than average SMR for circulatory diseases, but lower than average SMRs for cancer, with the exception of breast cancer, and lower than average SMR for respiratory disease.

Table 46
Mortality Ratios in South Eastern Area

LCG/Trust Area of Residence	All deaths	Malignant Neoplasms			Circulatory			Respiratory	
		All sites	Trachea, bronchus and lung	Breast (female only)	All	Ischaemic Heart Disease	Cere-brovascular disease	All	Pneumonia
SE	96.0	93.2	83.0	103.3	105.1	88.8	95.9	85.5	94.5
NI	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: NISRA

Deprivation

The South Eastern LCG has an important role to play in addressing inequalities, particularly as it relates to our significant rural population in terms of accessing services. In 2010, NISRA updated the NI Multiple Deprivation Measure (NIMDM). The NIMDM outputs results at a number of geographies including local government district. The table below highlights the most deprived areas within the South Eastern Trust area. The data ranks Local Government District council areas based on their level of deprivation (1 most deprived, 26 least

deprived). Belfast Council is the most deprived in N Ireland while Magherafelt is the least deprived.

Council deprivation rank by ICP area

Table 47

South Eastern Area	Rank of Deprivation
Lisburn	6
Down	16
Ards	18
North Down	24

The table above presents the position of each of the ICP areas in the South Eastern Trust LCG areas which are co-terminus with Local Government District areas. Out of the 26 current council areas Lisburn is among the most deprived area in the south east, the other Local government areas within the South Eastern area are placed above the average and in the case of North Down is in the top three least deprived areas Local Government Districts in N. Ireland.

Personal and Public Involvement (PPI)

The South Eastern LCG proritises the need to have a strong engagement arrangement in place so that we are in touch with the health and social care need of our population and to ensure that they are appriopaitely involved in the planning and design of local services. The South Eastern LCG held a PPI workshop in October 2013 to develop a model for future engagement with local community and voluntary organisations, service users and carers. In addition the South Eastern LCG has recently lead an engagement excerise in the south east on the future prevision of dementia services and work is on-going in regard to stakeholder involement in the redesign of palliative and end of life care. The South Eastern LCG holds its monthy meetings in public, these meetings are rotated around the south eastern area to ensure access by the public who have an opportunity to contribute to the debate.

The South Eastern LCG also has arrangements in place to meet with our local political representatives, meetings with local councils on an on-going basis,

while arrangements to meeting with MLAs and MPs are also in place. South Eastern LCG officers also have a close link with officers from all four current Councils across the south eastern locality, namely Ards Borough Council, the Down District Council, the Lisburn City Council and North Down Borough Council. The reshape of local councils in 2014 under RPA will underscore the importance of this arrangement in the context of new community planning arrangements.

8.2 Key Challenges and Opportunities within the SE LCG Locality

This section considers the key topics which the South Eastern LCG will have to focus its attention on in the next number of years.
The urgent care model in the south east continues to be problematic with breeches in waiting time targets at Ulster Hospital and sustainability issues evident at the consultant lead services at the Downe and Lagan Valley Hospitals and at the Minor Injury Units at Ards and Bangor Hospitals. The South Eastern LCG will highlight the need to address these issues with new proposed commissioning arrangements for Ministerial consideration.

The unscheduled care patient pathway is one which is complex and continues to pose issues in regard to its responsiveness to patient demand. The South Eastern LCG will also prioritise this issue in 2014/15 and acknowledges that there are significant opportunities in working with primary care through the Intregrated Care Partnerships, Northern Ireland Ambulance Service, Trusts and other partners to address the pattern of demand for urgent care. The South Eastern LCG will be seeking to maximise the opportunities associated with seven-day working (both in hospital and in the community) and the opportunities where appropriate to run key community services on a 24/7 basis. There is also a need to review our community staffing infrastructure to ensure that it is responsive to the initiatives proposed under TYC.

The South Eastern LCG recognises the difficulties the South Eastern Trust faces in providing services from five hospital sites across the south east, with the main acute hospital – the Ulster Hospital geographically in Belfast, it is also providing acute hospital services for the east Belfast population. In the context of Transforming Your Care, there is a challenge for the South Eastern LCG to ensure that it commissioning services that are: safe and of a high quality; that are sustainable and not susceptible to disruption for whatever reason and that allow our population to understand where they can access the appropriate level of care at the right time. The South Eastern LCG endorses the “Choose

Well Campaign" in supporting the public to make the right choices and their urgent care requirements

These requirements need to be balanced with ensuring that services are accessible to our local populations and that appropriate services are available locally when it is feasible and safe to do so. The South Eastern LCG views our service hubs in the Downe Hospital, the Ards Hospital site and the Lagan Valley Hospital site as key enablers to ensuring good community access to future local services. The Minister has already approved a major new Health and Care Centre in Lisburn .

South Eastern LCG is very focused on the ministerial targets associated with the provision of elective care services. The South Eastern Trust continues to perform consistently across most specialities, however this performance relies on additional capacity provided 'in-house' by clinicians and by the transfer of patients to the independent sector. The provision of care in the independent sector can often be more problematic. The South Eastern LCG would see opportunities in 2014/15 to support additional investment in some speciality area to address shortfalls in capacity.

The South Eastern LCG was unable to lead on the evaluation of the Downe Hospital Midwife Led Unit (MLU) as proposed in 2013/14. While we undertook a procurement exercise to identify an evaluator, we had a disappointing response. However, the South Eastern LCG will re-tender and included in the tender proposal the evaluation of the Lisburn MLU which will in 2014/15 have been operational for three years. This evaluation process will be important both locally and regionally in understanding the contribution that freestanding MLU's provide to new mothers and families. The South Eastern LCG will continue to work with the South Eastern Trust in respect of the general pressures within maternity services and will seek to enhance the recurrent level of baseline funding.

The South Eastern LCG has been in discussion for a prolonged period with the South Eastern Trust regarding the modernisation of acute inpatient mental health provision. The current proposal put forward from the Trust has been assessed and the South Eastern LCG looks forward to finalising arrangements in regard to this important service area in 2014/15

The South Eastern LCG has affirmed its support for the development of new Learning Disability facilities in both Bangor and Newtownards. In addition the South Eastern LCG looks forward to the implementation of improved day opportunities for people with mild to moderate disabilities as part on the reshape of services in North Down and Ards in the next number of years and generally for all clients who can benefit from new community based options.

The South Eastern LCG has systems in place to monitor the overall health and well-being of our population and in this respect we work very closely with our colleagues in the Public Health Agency (PHA). While the overall health and well-being of the population continues to improve and we continue to live longer than previous generations, we are still faced with threats to maintaining this improvement as the number of older people living with more complex long term conditions grows. Strategies are also in place to address the many lifestyle factors which impact on our health and the South Eastern LCG has noted in particular the growing prevalence of obesity within the population and the impact this has on our need to commission additional services right across programmes of care. The South Eastern LCG has brought this issue to the fore in discussion with our local councils and our voluntary providers with a view to addressing the issue collaboratively.

8.3 Ensuring Financial Stability & Effective Use of Resources

Use of Resources

The South Eastern LCG's baseline funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £507m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 48 Baseline investment by Service Area in 2014/15

Programme of Care	£m	%
Acute Services	185.2	36.6
Maternity & Child Health	28.4	5.6
Family & Child Care	38.9	7.7
Older People	120.1	23.7
Mental Health	37.0	7.3
Learning Disability	46.3	9.1
Physical and Sensory Disability	18.1	3.6
Health Promotion	14.8	2.9
Primary Health & Adult Community	17.9	3.5
POC Total	**506.7**	**100.0**

This investment will be made through a range of service providers as follows:

ICP budgets 2014/15

Table 49

Provider	£m	%
BHSST	122.0	24.1
NHSST	1.0	0.2
SEHSST	346.8	68.4
SHSST	5.5	1.1
WHSST	0.6	0.1
Non-Trust	30.8	6.1
Provider Total	**506.7**	**100.0**

Whilst emergency department (ED) services have not been assigned to LCGs as these are regional services, the planned investment in 2014/15 in respect of Emergency Care by the South Eastern Trust is £17.7m.
The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

The Commissioning Plan for 2014/15 indicated a significant range of service pressures/developments and other additional pressures most notably inescapable pressures such as pay and price inflation as well as additional investment to take account of the demographic changes in the population. The South Eastern LCG share of these indicative investments areas is noted below:

South Eastern LCG share of indicative investments 2014/15
Table 50

Pressures	**£m Full Year Effect**
Pay & Non Pay	7.9
Demography	7.5
NICE Drugs	3.7
Revenue Consequences of Capital Expenditure	0.8
Mental Health Resettlements	0.4
Learning Disability Resettlements	1.6
Service Pressures/Developments	13.8
Public Health Agency	0.6
Total	**36.3**

8.4 Commissioning Priorities and Requirements 2014/15 by Programme of Care (POC)

This section of the Local Commissioning Plan provides an overview of the South Eastern LCGs commissioning priorities for 2014/15 and beyond and is set out to address the nine programmes of care area as follows:

8.4.1 POC 1 – Acute

This programme covers both specialist and non-specialist services. In the main, non-specialist acute services are the focus for provision for the LCG in respect of our population. Specialist services are mostly provided outside the south eastern locality, by the Belfast Trust as N Ireland's regional service provider, although some regional services are provided by the South Eastern Trust, for example plastic surgery.

SET is currently managing five hospital sites: Ulster Hospital, Dundonald, (this facility is in the Belfast LGD and provides services to a significant proportion of the Belfast LCG population living in East Belfast and Castlereagh); Lagan Valley Hospital which services the Lisburn population; the Downe Hospital, services the Down population and two community hospitals in Bangor and Newtownards.

Introduction
In respect to non-specialist services, the LCG commissions both unscheduled (or emergency) and elective (or planned) acute care.

In regard to **unscheduled care**, there are a range of issues that need to be addressed in 2014/15 to improve services for our population – specifically the performance of emergency departments, the management of the patient flow through the hospital care system and general access to urgent care services. A revised service model and clear information to the public about where, when and how emergency and urgent care can be accessed is required.

In regard to elective or planned services (as they relate to outpatients, inpatient, day-case treatments and access to diagnostics and Allied Health Professionals services), there have been improvements in the waiting time performance in the south east in several speciality areas. However there remain a number of speciality or services areas where there are gaps in the current capacity when measured against the service demand. While additional non-recurrent investment, in additional in-house capacity and with the independent sector has alleviated waiting time pressures, specific gaps still need to be addressed in general surgery, gynaecology and rheumatology among others. The LCG also acknowledges that there are emerging pressures in regard to the provision of some aspects of cancer care and improvements required in the patient pathway associated with sleep disorders.

The LCG, as part of its engagement processes, has received clear feedback on elective care both directly from patients, from general practice on behalf of their patients and from elected representatives. Comments reflect the need to continue to improve waiting times and reduce the reliance on independent sector services. In addition, the potential to improve access to elective services (specifically outpatient services) is one that has been noted in the context of an increasing number of Trust services now being provided on a busy Ulster Hospital site, located in east Belfast.

Overview of Local Needs

In terms of addressing future needs, the following statements highlight the current challenges in the south eastern locality:

- Attendances at SET's Emergency Departments increased to 148,655 in 2012/13 from 146,380 in 2008/09 (up 1.6%). Whilst attendances at Downe, Lagan Valley, Ards and Bangor fell (-8,900), more people attended the Ulster Hospital (+10,300).
- Non-elective admissions increased across all localities and there was a 9% increase from 2008/09 to 2012/13, most notably from the Ards

locality which has seen a 16% increase in non-elective admissions during this period.

- In the last five years the number of occupied bed days has decreased, however in 2012/13 there has been a 1% increase (31,727-32,867).
- GP referrals to elective out-patient services have seen a 4% increase (76,141 to 79,312) over the last two years. The most pronounced increase (23%) has been in red flag (suspected cancer referrals). Urgent referrals increased by 4% and routine by 3%.
- The number of review appointments has risen 9% (131,430-142,897) in the last three years linked to the rise in new outpatient activity.
- Admissions for treatment (in-patients) have reduced by 14.4% (10,749 – 9,222) in the south east area over the last five years. In the last two years this has reduced by 3% reflecting a regional drop of 3%.
- Day case admissions, as a proportion of treatments, have increased as more treatments are delivered as day case rather than inpatient. The SET day case activity has increased by 6.3% (34,035-36,204) in the last two years.

Ministerial Targets

The LCG expects the South Eastern Trust to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The LCG will focus on the following aspects of acute service provision in its dialogue with the Trust and where appropriate the ICP:

- Commissioning additional capacity in a range of elective specialities to address gaps in the demand and capacity for services.
- In line with TYC, reform of the unscheduled care pathway. This will require meaningful discussion with the local population and other stakeholders on options for change.
- The LCG will commission an increasing number of services through the ICP; as such we will look to achieve the requirements identified in TYC of shifting from hospital based services to primary and community based alternatives where this is safe to do so.

- In 2013/14 the LCG invested in additional fracture operating capacity. The LCG/Board will expect the Ministerial target on fractured neck of femur to be achieved and will be closely monitoring it during 2014/15.
- The LCG will continue to work with the Trust in regard to cancer services and will seek to prioritise investment in General Surgery services and other aspects of cancer provision at the Ulster Hospital.

Commissioned Services

During 2013/14 the South Eastern LCG has taken forward initiatives with the ICPs to secure direct access to DEXA (or bone) scanning and explored opportunities to enhance primary care services. These initiatives have provided better local direct access to services for our population. Further opportunities in elective care will be pursued in gynaecology, cardiology, palliative care, psychiatry of older people, sexual health and within community care during 2014/15. The over-arching strategy is to develop initiatives between primary care and the Trust who are provider partners in the ICPs.

The LCG has in recent years has made significant investments in unscheduled care services at the Ulster Hospital in response to changes in demand. In commissioning services in 2014/15 the LCG has prioritised the requirement to commission seven day working to facilitate early discharge and reduce the length of stay for patients in the Ulster Hospital. Extending medical, AHP, social work and pharmacy services to weekends will ensure that patients get timely intervention and support improved health outcomes.

In the recent past the emergency and urgent care arrangements commissioned at other sites by the LCG have been subject to significant change at short notice, due to the challenges for the Trust in the retention and recruitment of junior doctors and specialist nurses to work in their emergency departments. The EDs at the Lagan Valley and Downe Hospitals are now subject to temporary arrangements, curtailing their opening hours to 8am – 8pm weekdays, as opposed to the previous seven day limited opening hours

service. Similarly the Minor Injuries Unit (MIU) at Bangor Community Hospital has moved to weekday only provision on a temporary basis.

In response to this the LCG/HSCB and the SET are developing proposals to support access to urgent care services in Lisburn and Downpatrick and set out a position to support other service provision at both hospitals for the next two to three years. These proposals are likely to seek to maintain the weekday medically led ED service while enhanced arrangements at the weekend are covered by General Practitioners working in the out of hours services. The LCG supports the potential of Emergency Nurse Practitioners (ENPs) to provide a local urgent care response to those patients who will require treatment for ailments of a lower acuity or severity. The LCG is pleased that the SET has already commenced an ENP led service at the Downe Hospital at weekends from early March 2014 and plans to establish similar arrangements at the Lagan Valley Hospital later in 2014/15 upon completion of the co-location of the GP out of hours centre with the current emergency department.

In to the future, we need to ensure that as far as possible we avoid situations which might destabilise our local healthcare system and have potential implications on other LCG areas.

The LCG has made it clear that the emergency and urgent care model in the south east needs reformed. While the Ulster Hospital is the main provider of consultant-led 24/7 emergency care services, new urgent care arrangements in Downpatrick, Lisburn, and North Down and Ards should now begin to evolve. To support this process the LCG will bring forward an Unscheduled Care Improvement Plan in 2014/15 in conjunction with the SET and other stakeholders. In response, the LCG will be seeking the SET to respond with appropriate proposals to ensure that safe, sustainable and clinically appropriate arrangements are in place for the delivery of unscheduled care to the discrete populations in the south east. Relevant consideration in this regard will include - opportunities under TYC to shift services from the hospital

to primary and community care; and in regard to staffing, promoting new roles and skill mix arrangements.

Change in the pattern of use of Emergency Departments in the south east may impact on the provision of acute medicine. The LCG sees opportunities for new service arrangements with medical consultants working both in hospital and in the community, supported by enhanced roles for primary and community care in the management of patients whose profile continues to be older, frailer and often contending with more than one long term condition.

Importantly, the public needs to be assured that services can be accessed when they are required and that the best clinical care will be provided when it is needed. Service transformation will not be easy, but putting off difficult decisions will only exacerbate current difficulties. The LCG, and all HSC organisations, will continue to fully engage and debate, now and into the longer term, on the issues associated with service change with the public. Proposals developed will be in line with TYC and supported by the Integrated Care Partnerships.

Any future subsequent proposals for change will be subject to full public consultation and Ministerial approval.

Specific Commissioning objectives for 2014/15 and 2015/16

POC 1 – Acute (non-specialist)	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to stabilise demand for outpatients, and Emergency Department attendances.	South Eastern Trust already provides direct consultant advice for a limited number of specialties. The South Eastern LCG working with the ICP will seek to commission an extended service across specialties throughout the year and monitor the benefits of such initiatives.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions.	The South Eastern Trust is expected to develop and resource 7 day diagnostics, AHP services and senior clinician decision making service to reduce inpatient length of stay and support early discharge.
Enable district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present	The South Eastern LCG Trust is expected to work with commissioners from the ICPto develop appropriate services in response to the clinical priority areas allowing the shift of services from secondary care to primary care to ensuring that the appropriate infrastructure is in place to support community teams to be responsive.
Review and take forward opportunities to consolidate	The South Eastern Trust is expected to develop alternative

intermediate and acute care beds and the sites on which they are provided	care plans and work with GPs to ensure that community care alternatives are in place which would enable the consolidation of intermediate care beds and sites allowing for improved medical management of patients. This will be part of the hospital reconfiguration programme proposed within the plan.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The South Eastern LCG is expected to work with the South Eastern Trust and Primary Care throughout 2014/15 to develop this Unscheduled Care Improvement Plan. The UCIP will focus on expanding and establishing improved communication between Secondary Care Consultants and GPs, 7 day working practices, direct GP access to, for example, diagnostics, assessments unit and Allied Health Professions, Social Work, Pharmacy and Laboratory Support and enable 7 day discharge.
Local priority	From April 2014, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.
Local priority	From April 2014, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their

	first definitive treatment within 62 days.
Local priority	The South Eastern Trust is expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.
Local priority	The South Eastern Trust is expected to deliver improvements in the LoS associated with stroke patients. Under TYC the LCG will support investment in 2014/15 for early supported discharge.
Local priority	In 2014/15 the South Eastern Trust is expected to deliver comprehensive arrangements for the provision of sleep services.
Local priority	Unscheduled Care Improvement Plan – in response to the pressure on unscheduled care services the South Eastern LCG is expected to work with the South Eastern Trust and Primary Care throughout 2014/15 to develop an Unscheduled Care Improvement Action Plan. The LCG will expect the Trust to implement the out-workings of the plan.
Local priority	The South Eastern LCG will be commissioning increased GP

	direct access to hospital services. The LCG will seek an implementation plan from the ICP.
Local priority	The South Eastern LCG will seek to commission a shift in the number of outpatient clinics (where it is safe to do so) provided at the Ulster Hospital to the Community Hubs or to GP practices where this is feasible. The South Eastern LCG will look to the ICP / Trust to bring forward proposals in this regard.
Local priority	The South Eastern LCG will continue to work with the Trust in respect to the increasing demands on cancer services and will commission to address this demand.
Local priority	The Trust has identified the potential number of beds they can transfer in 2014/15 as a result of their proposed TYC 'shift left' initiatives associated with the Clinical Priorities. The LCG will commission services this year and beyond on the basis of that shift.
Local priority	The South Eastern LCG (supported by the Board) has shared with the Trust opportunities for further service efficiencies which among other things will allow for the Trust to release beds from the Trust's current bed numbers with no impact on service capacity.

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	5,866	113	5,979
	Daycases	28,843	34	28,877
	New Outpatients	207,646	1,953	209,599
	Review Outpatients	118,090	2,237	120,363
Unscheduled	**Non Elective admissions - all**	36,225	1,061	37,286
	ED attendances	137,181	0	137,181
	NIAS Journeys	43,020	406	43,426
	VALUE OF COMMISSIONED ACTIVITY[47]	£185.2m	£12.5m	£197.7m

[47] This includes activity in addition to that set out above.

8.4.2 POC 2 – Maternity and Child Health

Introduction

Maternity and Child Health services cover care and treatment from ante natal to 16 years of age. Maternity services address the needs of women and their babies from pregnancy to post natal stages.

The south eastern locality has two freestanding Midwife Led Units (MLU's). These support the obstetric unit at the Ulster Hospital which also has a stand alongside MLU. The midwife led births in the SET during 2012/13 were 1,158 (over the 3 units) and obstetric births were 3,214. This is the highest number of midwife led births of all Trusts in N. Ireland. There has been an increase in births within the south eastern area within the last number of years and recent changes to services within Belfast (transfer from obstetric led to freestanding MLU at the Mater Hospital) may have a further impact on the number of babies delivered in the south eastern area. The LCG anticipates that the new build maternity unit within Belfast, scheduled to open in late 2016, will offset a volume of the births of Belfast mothers currently being delivered in the Ulster Hospital Maternity Unit.

The regional maternity strategy and the regional commissioning objectives set the direction for the delivery of maternity services in the south east.
To meet these objectives and demands the South Eastern LCG has been working with the SET to build capacity for safe and sustainable maternity services at the Ulster Hospital Maternity Unit. The Trust is currently providing for approximately 200 births above the recurrent capacity commissioned by the South Eastern LCG. The Trust has carried out interim works to develop a six bedded bay for women undergoing induction of labour and two further labour rooms within its obstetric labour ward to improve flow and improve the experience for women.

Of particular concern to both the South Eastern LCG and the Trust is the capacity within the Ulster Hospital Maternity Unit outpatient clinics to deal

with the volume of Gynaecology, fertility and maternity clinics required. The South Eastern LCG continues to work with the Trust to address this concern. Under Child Health services, SET is commissioned to deliver a range of acute and community services for children. Paediatric medicine includes general medical care and treatment for children as well as care for those who have been diagnosed with debilitating or life threatening illnesses, children with special needs, or who are terminally ill and who require palliative care. In addition to these areas of care which may sometimes require admission, the Trust provides outpatients and community care services for allergies and asthma, epilepsy, home intravenous treatment etc.

In November 2013 the initial report on the regional review of paediatric services was issued for consultation. This review covers a wide range of paediatric services across all Trusts. The South Eastern LCG along with colleagues in the HSCB and PHA has contributed to its recommendations. Once the final review is issued in 2014/15 the LCG will work with the Trust and others to implement the recommendations.

Overview of Local Needs

- In 2012 there were 4,526 births to the south eastern resident population. Mothers from the Lisburn area accounted for 39% (1,753) of these births.
- 4,069 births were recorded in 2012/13 at the Ulster Hospital Maternity Unit. 1482 births (36%) were to residents from the Belfast and other LCG areas.
- The number of births in N. Ireland has decreased by 3% in the last three years from 25,273 to 24,429. The number of births in the south eastern locality has remained the same over the last three years (circa 4,500).
- The projected births in Norther Ireland are expected to fall by 5% (24,966 – 23,439 from 2012 to 2023, this trend is also projected in the south eastern locality with a 3% (5,840-5,675) decrease in births.

- The LCG acknowledges the growing demand for paediatric diabetes services.

Ministerial Targets

The South Eastern LCG expects the SET to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of maternal and child health services in its dialogue with the Trust and where appropriate the ICP:

- Address the recurrently funded capacity with the Trust, as births are above the 4,007 births commissioned.
- Assess the requirement for additional midwife provision in the south east in response to on-going analysis of current midwife levels in both the Ulster Hospital Maternity Unit and community services.
- The South Eastern LCG will commission improvements in children's asthma and allergy services and will look to commission appropriate services to address epilepsy as it relates to children.

Commissioned Services

The South Eastern LCG commissions a range of maternity and child health services from SET. Maternity care includes ante-natal, delivery and post-natal care. In the SET this can be midwife led, consultant led or shared depending on the woman's needs and preferences. The Service Budget Agreement 2013/14 is for 4,007 births in the Ulster Hospital Maternity Unit - a volume increased from 3,507 births in 2012/13 with South Eastern LCG investment of £1m recurrent funding. The Ulster hospital maternity unit had 4069 registered births in 2012/13 and as at October 2013 is projecting 4166 by the end of March 2014.

In relation to Paediatric Diabetes, children with diabetes have a lower life expectancy than children without diabetes. Diabetes is more common in

children with learning disability. High quality diabetes care and early detection of complications in diabetes can reduce the frequency of disability. Diabetes can affect people over long period of their lives and requires regular treatment and medication.

Paediatric Asthma and Allergy services

The incidence of asthma and allergies among children has increased in recent years. The South Eastern LCG will work with the Trust during 2014/15 to fully implement a specialist asthma and allergy service that will be delivered by an integrated team. This service led by a consultant with an interest in asthma and allergy and supported by specialist nurses trained in paediatric asthma/allergy, dieticians with paediatric experience and other skill mixes as required.

POC 2 Maternal and Child Health	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
The Trust is to develop a sustainable service model for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	The South Eastern Trust has a model of maternity units that is currently in line with the regional maternity strategy. The South Eastern LCG will be taking forward with the Trust and other stakeholders arrangements for the independent evaluation of the two MLU in the south east in 2014/15.
Trust to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	A regional project to develop a pathway for multiple pregnancies is being taken forward by the PHA and South Eastern LCG and SET will take forward actions to meet this recommendation.
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife led antenatal care in the community for women with straightforward pregnancies.	The South Eastern Trust is expected to participate in a regional project being taken forward between the PHA and NIPEC reviewing community maternity care in order to progress these recommendations.
Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce	Trusts are part of the maternity quality improvement collaborative carrying out work regionally to normalise birth

unexplained variation in intervention rates throughout N. Ireland.	and reduce unexplained variation.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The South Eastern LCG will also consider the commissioning implications of the scoping study of the maternity needs of black and minority ethnic (BME) and migrant women in Northern Ireland, highlighting the growing number of births in Northern Ireland to BME and migrant women, and that there are particular sub-groups of very vulnerable migrant pregnant women who have difficulty accessing services and have worse pregnancy outcomes.
Local Priority	The South Eastern Trust is expected to relocate an appropriate number of outpatient clinics from the Ulster Hospital Maternity Unit (or other speciality out patients), where it is safe to do so, to the Community Hubs to alleviate pressure within the current out-patients area and to improve access to maternity outpatient services for the south eastern population. This should be expressed as part of the shift left agenda under TYC.
Local priority	The South Eastern Trust is expected to continue to look for further service efficiencies in 2014/15 which will have an impact on current service capacity.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	**Births**	4,827	0	4,827
	Comm Midwives	**Contacts**	54,200	0	54,200
	Health Visiting	**Contacts**	14,723	0	14,723
	Speech & Lang Therapy	**Contacts**	29,856	0	29,856
		VALUE OF COMMISSIONED ACTIVITY[48]	£28.4m	£1m	£29.4m

[48] This includes activity in addition to that set out above.

8.4.3 POC 3 – Family and Childcare

Introduction

The Children and Families Commissioning remit includes all statutory social work services and as such the functions are prescribed within legislation and remain subject to a high level of monitoring and scrutiny, internal and external to the Health and Social Care Trusts, to be assured that these functions are effectively discharged.

In line with TYC there continues to be a significant focus on early intervention and this agenda is being pursued on a uni-disciplinary, single agency and multiagency basis. There is a strong commitment to partnership working to progress this agenda through vehicles such as the Children and Young People's Strategic Partnership (CYPSP), Childcare Partnerships and Child Development Board. The strategic direction for the statutory social work component is taken forward through the Children's Services Improvement Board with the involvement of senior HSCB and Trust staff.

Overview of local needs

- On 30 September 2013, 3,691 children were identified by the South Eastern Trust as being 'Children in Need' across the Trust's area. Of these 596 were children with a disability. Across NI the 'Children in Need' figure rose from 23,300 to 25,720. Referrals for a 'Child in Need' assessment in the south east rose from 2,741 to 2,905. The Trust reported 17 unallocated cases at the period end out of a NI total of 219.
- The number of children on the Child Protection Register in the south east dropped slightly from 402 to 399 to 30 September 2013 continuing the trend in recent years; however 25% of child protection registrations during the period were re-registrations. The Trust received 602 child protection referrals during the period and undertook child protection investigations involving 571 children.

- Regionally the number of 'Looked after Children' increased from 2,807 on 31 March 2013 to 2,892 on 30 September 2013 continuing the trend in recent years. Regionally the number of 'Looked After Children' increased from 2,807 on 31 March 2013 to 2,892 on 30 Sept 2013 continuing the trend in recent years. The South Eastern Trust LAC population remained fairly consistent (513 on 31 March 2013 and 505 on 30 September 2013) during the same period.

Ministerial targets

The South Eastern LCG expects the SET to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan.

The themes associated with Family and Childcare will all be taken forward regionally in conjunction with LCGs as appropriate.

Commissioned Services

The HSCB commission the full range of services for children across the childcare continuum including early years services such as the registration and inspection of day care facilities; support to families both at an early intervention stage and to children designated as being Children in Need; services for the protection of children; services to children in state care either through voluntary accommodation or Court Order including the full range of care placements to meet assessed need and services to meet the therapeutic needs of LAC; leaving and after care services for young eligible and relevant young people and services for young people who are homeless. Trust services for children are largely considered as Statutory Functions which are delegated to Trusts by the HSCB and are subject to an extensive formal monitoring process.

In 2014/15 Trusts will continue to be required to fulfil their responsibilities under the Delegated Statutory Functions. In addition the Trust will be required to take forward the out workings of a number of regional developments including the Regional Review of Residential Child care; the Regional Review of

Fostering Services; revised Standards in Early Years and Kinship Care; implement the recommendations of the RQIA inspection relating to children with disability service; further developments in relation to Children's Services Planning such as the multi-agency Outcomes Group and Family Support Hubs; and take forward developments in relation to regional services hosted by the Trust such as the regional adolescent forensic service, FACTSNI, and the Regional Secure Centre, Lakewood.

Family Nurse Partnership

Family Nurse Partnership (FNP) is a voluntary preventive programme for teenage mothers, which offers intensive and structured home visiting. It is delivered by specially trained 'family nurses', from early pregnancy until the child is two years of age. The aim of FNP is to improve the health and wellbeing of our most disadvantaged families and children, and to prevent social exclusion.

During 2014/15 the programme will be expanded to the South Eastern Trust.

Specific Commissioning Objectives for 2014/15 and 2015/15

POC 3 Children and Families' Services	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Family Nurse Partnership (Ministerial Target 2) By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust.	It is planned by the Public Health Agency to develop Family Nurse Partnership within the South Eastern LCG area within 2014/15 The South Eastern LCG will seek the Trusts proposals for a FNP in the Lisburn area**.**
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

8.4.4 POC 4 – Older People

Introduction

This Programme of Care applies to people aged 65 years of age and older only.

The population of older people in NI is projected to increase by one third (33.34%) by 2023; however the growth is expected higher than the NI average i.e. 36.6%. As a result of improving health outcomes, both internationally and locally, the older population is living much longer than previous generations. This is to celebrated, however the needs of our ageing population also pose the most significant challenge to the responsiveness of Health and Social Care services.

Older People Population Projections

Table 51

Aged 65+	2011	2023	Change	% Change
BHSCT	52285	58802	6517	12.5%
NHSCT	71527	96386	24859	34.8%
SEHSCT	55220	75419	20199	36.6%
SHSCT	48069	67818	19749	41.1%
WHSCT	39660	57537	17877	45.1%
NI	**266761**	**355962**	**89201**	**33.4%**

South Eastern LCG is clearly set to experience demographic growth in the 65+ and the number of frail elderly people (i.e. those aged over 85 years of age) is projected to increase significantly in the South Eastern LCG area. A variety of flexible and innovative responses will be required ranging from an increased emphasis on promoting healthy ageing, providing tailored support for those who wish to remain at home, developing diversionary services to maintain independence and targeted intensive support for more dependent individuals requiring specialist care.

The South Eastern LCG is cognisant of the Service Framework for Older People and will work with providers to ensure that services are delivered in a person-centred manner, promote health and well-being, provide support for carers,

safeguard vulnerable older people and ensure high quality palliative and end of life care.

Of particular concern for the South Eastern LCG is the potential increase in older people in the local population who may suffer from dementia related conditions in the future.

The South Eastern LCG will continue to focus upon early intervention, including falls prevention and intensive support for those older people at risk of hospitalisation or long term care. Care pathways have been developed that support early intervention, rehabilitation and support, emphasising the avoidance of long term dependence on statutory services or unplanned hospital admission. The South Eastern LCG has issued a range of commissioning specifications to the new Integrated Care Partnerships (ICP) and the LCG will be seeking to evaluate these in 2014/15.

Transforming Your Care (TYC) clearly identifies 'home as the hub of care for older people' – with a corresponding shift away from hospital or other 'institutional' based interventions towards community based services where possible.

Reablement, since its implementation in the South Eastern LCG area, has been vital in promoting and affirming the independence of older people. Reablement has been incrementally 'rolled out' across the SET and is accessible in all 4 sectors; and this has been in partnership with the Voluntary sector i.e. with the funding of a number of Community Navigator posts. The activity has grown incrementally since initiation and has now reached 109 new referrals in October 2013 from 55 new referrals in November 2012 which reflects 100% increase.

Carers continue to play a very significant role in the overall provision of care which enables many people to remain at home. Carers NI have estimated that there are as many as 44,460 carers within the South Eastern LCG; TYC 'recognises the importance of carers' and recommends 'increased provision of respite and short breaks'.

Overview of Local Needs

The largest increase is in the 85+ category which sees a 35% (7,236-11,213) and the area most affected by this rise is Lisburn with a 42% (1,891-3,271) rise in over 85's. NI average life expectancy in 2008/10 is 77.1 for males and 81.5 for females, in the south eastern locality its 78.5 for males and 82 for females.

65+ population change in south eastern locality

Table 52

Population Projections - South Eastern LCG				
Area	**Age Group**	**2012**	**2022**	**% Change**
SE LCG	65-74 yrs	31,800	36,900	16%
	75-84 yrs	18,000	25,700	43%
	Sub total 65-74 yrs	*49,900*	*62,600*	*25%*
	85+	7,200	11,000	53%
	Total aged 65+	57,100	73,500	29%
	Elderly as a % of total Popn	16%	20%	
Ards	Age 65-84 yrs	12,500	15,900	27%
Down		9,200	11,800	28%
Lisburn		15,100	19,000	26%
North Down		13,100	15,900	21%
Ards	Age 85+ yrs	1,600	2,300	44%
Down		1,500	2,300	53%
Lisburn		1,900	3,300	74%
North Down		2,200	3,000	36%

The number of hours of domiciliary care has increased in the past 3 years by 11% to 52,570 in the south eastern locality. There has however been a shift from statutory [Trust provided] (-13%) to independent (+16%) care homes. The average hours offered to clients saw a slight decrease from 11.8 to 11.6 in the last 3 years. The number of clients receiving domiciliary care has increased by 13% in the past 3 years from 3,954 to 4,544 in the south eastern locality.

There has been a slight increase in the number of care packages in effect in the south eastern locality from 2,063 to 2,093 in the last 3 year period. When applying a weighted 65+ population, the South Eastern Trust provides approximately 4% of care packages in effect for older people, above the NI average of 3.6%.

Ministerial Targets

The South Eastern LCG expects the South Eastern Trust to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of older peoples services' in its dialogue with the Trust and where appropriate the ICP:

Domiciliary care packages received an up lift in funds from demography money during the 13/14 year. The table below showing a modest increase in domiciliary care packages is in line with the substantial investment of over £1m in reablement services in 13/14 in the South Eastern LCG locality.

No. of Domiciliary Care Packages Delivered in South Eastern Area
Table 53

Care Packages in place Age 65+	**on 31st March 2012**	**on 31st March 2013**	**Variance**
Domiciliary Care Managed	2144	2199	+55
Domiciliary Non-Care Managed	2365	2283	-82
Domiciliary Total	4509	4482	+27

(Source DSF returns from SET)

Commissioned services

The majority of services in this POC will be commissioned as per 2013/14, however, it should be noted that the following areas are under development:

- In addition to commissioning services to respond to the Ministerial targets, the South Eastern LCG will commission a range of additional activity in 2014/15 to respond to the needs of the growing older population. This will involve working very closely with the ICPs.
- South Eastern LCG will continue to support the Trust in its provision of supported living facilities for Older People vis-a-vis i.e. the re-provision for Ravara House.
- South Eastern LCG will, as part of the ICPs, commission from the Down Integrated Care Partnership a Frail Elderly Integrated Care Pathway to initially target the 85 and over age group in that locality. It should also support the shift toward prevention, self-care, co-ordination and integrated care provided in the home or close to home that is a key part of the Transforming Your Care (TYC) approach and materially reduce demand for acute health services.
- In recognition of the on-going growth in numbers of people with dementia, the South Eastern LCG will work closely with the Trust and others to apply the regional investment was secured to enhance local services for people with dementia. During 2012/13, a total investment of £400k was secured to expand memory clinics and in 2013/14, further investment of £200k was sought to introduce a Navigator role for signposting and provide enhanced access to psychological support.
- The South Eastern LCG continues to recognise the important role played by carers in our community and will continue to place carers at the centre of its future transformation plans.

The table below demonstrates the on-going work within the SET to ensure that Carers are offered assessments; the number of carers offered has dropped marginally but more concerning is the drop of almost 3% in those accepting the offer of assessment - this should be addressed in order to meet the legislative requirement and Ministerial Objective.

Overview of Carers and Direct Payments Made within the South Eastern Area
Table 54

CARERS AND DIRECT PAYMENTS within POC4	2011-12	2012/13	% variance
Number of adult carers offered individual carers assessments during the year	2063	2001	(-) 3%
Number of adult individual carers assessments undertaken during the year	406	340	(-) 16%
Number of adults receiving direct payments @ 31st March	5	87	(+) 1640%
Number of one off Carers Grants made in-year	67	77	(+) 15%

(Source DSF returns from SET)

Care management of older people is a clinical priority for the ICPs and the LCG will be evaluating a range of proposals throughout 2014/15 to deliver more primary and community care support.

Overview of Care Packages Delivered within the South Eastern Area
Table 55

Care Packages in place on 31st March 2013 for Age 65+	2011/12	2012/13	variance
Residential Home Care	667	686	+10
Nursing Home Care	1342	1362	+20
Domiciliary Care Managed	2144	2199	+55
Domiciliary Non-Care Managed	2365	2283	-82
Supported Living	0	36	+36

Specific Commissioning Objectives for 2014/15 and 2015/15

POC4: Older People	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The SEHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The SEHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase uptake of direct payments	The South EasternTrust is expected to achieve this target and will expect the offer of a Direct Payment as an alternative to direct statutory provision to be an integral part of the Trust's standard assessment and service delivery process.
Working with ICPs to improve the care of the frail elderly.	The South Eastern LCG has with the ICP a set of commissioning specifications which include a requirement to develop a Partnership response to the frail elderly population in the south east. The South Eastern LCG expects the ICP to implement this significant proposal when agreed in-year.

Enhancement of dementia services	The South Eastern LCG has prioritised the need to have a responsive dementia and old age psychiatry model in the south east. Significant investment has been made latterly in response to our need assessment. The South Eastern Trust is expected to implement the new model and an overall improvement in the current provision.
Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements.	The South Eastern Trust is expected to develop intermediate care services in line with the delivery of appropriate clinical care for patients in order to meet the 'shift left' objective of TYC.
Continued roll-out of targeted Public Health Agency (PHA) preventative health and well-being improvement programmes.	The South Eastern LCG will support PHA preventative programmes as required.
Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The South Eastern Trust is expected to ensure that reablement is having a positive impact on the independence levels of our older population and the Trust's ability to manage demand for domiciliary care services. The South Eastern Trust is expected to complete the roll out of reablement during 2014/15 to ensure full coverage (7 teams) by 31st March 2015.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The Trust will therefore take forward all opportunities to develop

	primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

Values and Volumes

Programme of Care	**Service Description**	**Currency**	**2013/14 Baseline**	**Indicative Additionality 2014/15**	**Total indicative commissioned Volumes 2014/15**
Older People	**Geriatric Hospital Services**	Occupied Beddays	46,499	0	46,499
	Day Care	Attendances	33,001	0	33,001
	Domiciliary Care	Hours	2,123,382	25,947	2,149,329
	Residential & Nursing Homes	Occupied Beddays	693,949	10,950	704,899
	Community Nursing & AHPs	Face to face contacts	379,058	3476	382,534
	Social Work	Caseload	4,471	0	4,471
		VALUE OF COMMISSIONED ACTIVITY[49]	£120.1m	£4m	£124.1m

[49] This includes activity in addition to that set out above.

8.4.5 POC 5 – Mental Health

Introduction

Mental Health services aim to promote wellbeing and recovery and also provide care and support to those in distress or suffering ill health. Population based initiatives, i.e. mental health promotion, aim to enhance awareness of good mental health and enable people to better deal with day-to-day life stresses; targeted initiatives aim to promote resilience and prevent illness among at risk population groups, self-harm and/or substance misuse. The provision of mental health care and support includes direct care provided within primary care, community mental health and in-patient care settings. A key aim is to promote independence and recovery and the provision of such care within the usual primary/community care setting where possible. The South Eastern LCG area will work with the Regional Commissioning objectives to ensure these translate at local level. The priorities from a regional perspective relate to:

- Addressing the continual high level of suicides in NI and the co-morbidity with substance misuse.
- Stigma associated with Mental Health issues.
- Increase in talking therapies in primary care.
- Improving the patient experience in secondary Mental Health by implementing more recovery focused approaches working in partnership with service users and carers.
- Reduction in hospital beds as resettlement ends.
- Improve the quantity and quality of Crisis Resolution and Home treatment services.

Overview of Local Needs

- The number of mental health patients receiving direct payments in the south east is small (less than ten). This is indicative of the region and there is a need to make further improvements to increase this number.
- The remaining patients for resettlement within 2014/15 are inclusive of a number of patients with a forensic history; SET will need to continue to work towards achieving this target. The Trust is required to resettle eight long stay patients during the next year.
  Over the last three years the number of patients referred for assessment of social care needs with mental health issues has fallen by 37% (9,372 to 5,049).
- There has been a recorded increase in the number and rate of suicide[50] in the last ten years in Northern Ireland. The data for 2010 showed an increase of 6% (Total 290).
- There was some variation in suicide rates by Trust. The highest rate of suicide was in the Eastern area, which includes SET, at 17.8 per 100,000 of population.
- From 2001 until 2011, there were 713 suicides in Northern Ireland identified as mental health patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. This represented an average of 65 patient suicides per year.
- In Northern Ireland, there were 435 suicides in people with a history of alcohol misuse

Ministerial Targets

The South Eastern LCG expects the SET to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of mental health services in its dialogue with the Trust and where appropriate the ICP:

[50] The National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness Annula Report, England, N.Ireland, Scotland, and Wales (July 2013)

- The South Eastern LCG is currently working with the Trust to develop a new model for acute mental health services associated with proposals for a new mental health centre of excellence.
- The South Eastern LCG and Trust will progress proposals for service enhancement of CAMHS in line with Board commissioning requirements and DHSSPS guidance.

Commissioned Services

South Eastern LCG has commissioned a range of services at a local level in line with the regional commissioning objectives and TYC. The investment has been sourced from a range of funding within South Eastern LCG/ HSCB, and the investment has spanned across a number of different services within Mental Health with a particular emphasis upon community teams. Some of the more significant funding streams have focused on investment within:

- Community addictions services
- Psychological therapies
- Care management in Mental Health
- Transition from Children's services (ASD Spectrum)
- ED Psychiatric Assessment
- Mental Health community Teams

Specific Commissioning Objectives for 2014/15 and 2015/16

POC 5: Mental Health	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The SEHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The SEHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
Implementation of the Protect Life Strategy	The South Eastern Trust Protect Life Implementation Group continues to work with the Regional Working Group to progress these areas. MOU-work in progress.
Establishment of integrated care arrangements for the care and treatment of patients with common mental	The South Eastern Trust is in the initial stages of developing their Mental Health and Wellbeing Hub and will link with

health needs	Family Support Hub as a joint initiative.
Implementation of the Crisis Resolution Home Treatment services for CAMHs	Operational within the South Eastern Trust and provided by Belfast Trust.
Further development of specialist community services	Established within the South Eastern Trust and further investment forthcoming 2014/15.
Improved psychiatric liaison services	Work in progress and further investment in 2014/15. This will be reviewed in year.
Local Priority-	The South Eastern Trust is giving consideration to the rationalisation of Acute Inpatient Mental Health Service to a single site adjacent to the Ulster Hospital. The Trust has been asked to deliver a model which is affordable and is working to conclude this process with the South Eastern LCG.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left 'agenda. The Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied Beddays	52,570	0	52,570
	CPN	Contacts	68,137	550	68,687
	Res & Nur Homes + Supported Housing	Occupied Beddays	31,020	0	31,020
	Day Care	Attendances	16,316	0	16,316
	Dom Care	Hours	13,042	0	13,042
		VALUE OF COMMISSIONED ACTIVITY[51]	£37m	£1m	£38m

[51] This includes activity in addition to that set out above.

8.4.6 POC 6 – Learning Disability

Introduction

The Bamford Report estimated that about 9.7 per 1,000 people in N. Ireland had a learning disability, with over 27% of these being severely/profoundly disabled.

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

The South Eastern LCG will work with the regional commissioning objectives to ensure these translate at local level. The priorities relate to;

- Supporting the number of people within learning disability reaching adulthood and requiring day opportunities and community support.
- Supporting older carers.
- Addressing health inequality for people with learning disability.
- Reduce hospital beds as resettlement ends
- Increasing specialist support services within community settings.

Overview of Local Needs

- Whilst SET has improved the numbers of people receiving direct payments, there is a need to continue to strengthen and grow this.
- The number of patients in the south eastern locality with a learning disability has increased by 100% in the last 3 years to 38 patients. These numbers are expected to be low as patients are normally in the system for their lifetime.

- The remaining patients for resettlement within 2014/15 are inclusive of a number of patients with a forensic history. SET is due to resettle 13 patients in 2014/15.

Ministerial Targets

The South Eastern LCG expects the South Eastern Trust to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of learning disability services in its dialogue with the Trust and where appropriate the ICP:

- Implementation of the recommendations from the Day Opportunities consultation will be prioritized by the LCG.
- The South Eastern LCG will seek to see progress (subject to Departmental approval) on the reform of Learning Disability Day Care provision in North Down and Ards.
- The South Eastern LCG will seek to ensure that commissioned services for carer are responsive to their needs.

Commissioned Services

Within learning disability the focus of commissioned services in south eastern area has also been addressed at local level in line with regional commissioning objectives and Transforming Your Care. The investment has been sourced from a range of funding within South Eastern LCG/HSCB, and the investment has spanned across a number of different services within learning disability with a particular emphasis upon community infrastructure teams.

Learning Disability specific investment has focused on;

- Community Infrastructure Accommodation based services in the community (resettlement)
- Autism Spectrum Disorder service delivery model
- Developing capacity within the Trust Learning Disability Teams

POC 6: Learning Disability	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The SEHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The SEHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
Delivery of day services in line with the Regional Day Opportunities Model	The South Eastern Trust, working with regional colleagues, is expected to ensure that day services are delivered in line with the Regional Day Opportunities Model.
Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	The South Eastern Trust is expected to work to achieve the regional objectives as specified.

To increase the uptake of direct payments.	The South Eastern LCG Trust is expected to work SEHSCT to monitor achievement of this target and will expect the offer of a Direct Payment as an alternative to direct statutory provision to be an integral part of the South Eastern Trust's standard assessment and service delivery process. From April 12 – March 13, 62 adults were receiving Direct Payments and 18 carers receiving a Direct payment. A significant training programme has been underway following a review and revised guidance for staff relating to Direct payments.
Development and implementation of health promotion initiatives for people with a learning disability.	Annual health checks underway within the South Eastern Trust. Health Promotion regional conference for people with a learning disability organised for march 2014.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. It is expected that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied Beddays	0	0	0
	Day Care	Attendances	133,988	2,125	136,113
	Domiciliary Care	Hours	69,890	0	69,890
	Residential & Nursing Homes	Occupied Beddays	113,135	2,190	115,325
	Community Nursing and AHPs	Face to face contacts	40,696	0	40,696
	Social Work	Active Caseload	1,692	0	1,692
		VALUE OF COMMISSIONED ACTIVITY[52]	£46.3m	£3m	£49.3m

[52] This includes activity in addition to that set out above.

8.4.7 POC 7 – Physical Disability and Sensory Impairment

Introduction
This Programme of Care applies to people aged 18 – 64 years of age only.

According to results from the Northern Ireland Survey of Activity Limitation and Disability conducted by NISRA in 2006/07, 18% of all people living in private households in Northern Ireland have some degree of disability.
By 2023, it is projected that the 0-64 population in NI will be approximately 1.59 million; an estimated increase of 2.7% from 2011.The south eastern area, however, indicates a small projected decrease in population (0.06%) within this age band from 211,908 to 210,457.

Developments in services for people with Physical and Sensory Disabilities have received a renewed impetus with the recent publication of Departmental and OFMDFM strategies. Implementation has benefitted from the involvement of voluntary sector partners and emphasis on the participation of service users. There has been a strong emphasis on the importance of inter-agency working in the fields of housing, transport and employment.

There is also a need to review and reform traditional models of service delivery through an increased emphasis on giving people more control over their support needs through the promotion of personalised budgets, support for carers and advocacy. In terms of specific initiatives there is a need to remain focussed on improving and sustaining performance in the provision of wheelchairs and equipment, reviewing and piloting initiatives to progress the reform of existing day care provision, establishing appropriate links with reablement, building on the recent service enhancements in sensory services and promoting community based accommodation options for people with brain injury.

The TYC recommendations specific to Physical and Sensory Disability are reflected in the commissioning priorities for 2014/15 and 2015/16: promoting

independence and control through self-directed support, advocacy and Direct Payments, support for carers and joint planning across sectors and agencies. The main strategic driver for developments within PoC 7 is the Regional Physical and Sensory Disability Strategy Action Plan (2012-15). In addition, the RQIA report of the Review of Sensory Support Services in NI (2011) is relevant to the development of sensory impairment services and the outstanding recommendations are being addressed alongside the Regional Disability Strategy actions.

The Physical & Sensory Disability Strategy is being implemented via three project-managed work streams; Supporting Independent Living, Information and Training and Sensory Impairment. Trusts, service users and carers and independent sector stakeholders are represented on all work stream groups and the overarching Strategy Implementation Group.

All work streams are prioritising the promotion of independence, reablement and self-directed support. Service redesign is underway across the system involving streamlining care pathways, cross-agency collaboration, improvements in equality of access, focus on prevention and early intervention and improved support for carers.

Capacity and demand gaps continue in respect of the provision of an appropriate range of supported living options for individuals with very complex disabilities including brain injury. Scoping work in relation to the Regional Disability Strategy has highlighted variation across Trusts in the delivery of physical and sensory disability services such as communication support for deaf people, rehabilitation, training and the provision of equipment including wheelchairs and prosthetics.

Overview of Local Needs

- As of June 2013 there were 413 care packages in effect in NI, South Eastern Trust accounts for 60 of these which is a slight decrease over the last 3 years from 64. (Source DSF returns from SET)

- SET had 503 Direct Payments in place at 31 March 2013 which was an increase of 105 from 31 March 2011. During 2012/13 there was an average of 485 Direct payments in place. The amount paid at 31 March 2013 was £675,136 which reflected an increase of £153,414 from 31 March 2011 with a total amount of £2,601,304 being paid out during 2012/13. The number of people receiving direct payments within PoC7 has fallen from 115 to 95. The number of one off Carers Grants made in-year was 91 compared with 67 in the previous year a% increase of 36. (Source DSF returns from SET) In the first 6 months of 2013/14 there have been 194 carers assessments completed throughout SET but this includes all PoCs. In addition there are carers reviews undertaken on an on-going basis.
- There is also a need to review and reform traditional models of service delivery through an increased emphasis on giving people more control over their support needs through the promotion of personalised budgets, support for carers and advocacy.
- In terms of specific initiatives there is a need to remain focussed on improving and sustaining performance in the provision of wheelchairs and equipment. In SET there are 136,698 households and 5.7% (7,792) of the population has had their house adapted to suit wheel chair access (NI census 2011 information). The South Eastern Trust last year had a budget of £593,506 for wheel chair provisions. The actual cost for wheel chairs last year reached £626,522 i.e. over commitment of £32,996 which was 6% of the original budget. Wheel chair provisions received an up lift of funds with an estimated £30,000 of demography monies allocated to the service which equated to the over commitment i.e. demographic pressure.
- The number of people who have complex needs and require significant packages of care is increasing and has been flagged by the trust as a pressure - these packages can cost between £250,000 and £500,000 patients.

Overview of Care Packages Delivered within the South Eastern Area
Table 56

Care Packages in place on 31st March 2013	Age 18 - 65
Residential Home Care	28
Nursing Home Care	47
Domiciliary Care Managed	516
Domiciliary Non-Care Managed	317
Supported Living	2

In SET 5.56% of the population suffer partial or complete hearing loss. This is above the 5.1% regional average. 1.66% (NI average 1.7) of the population suffers blindness or partial sight issues and 11.09% (NI Average 11.4) suffer some form of mobility issue.

Table 57

People in contact with SET	*Category*	*Category*	*Category*	*Category*	*Category*
Age	*Deaf with Speech*	*Deaf without Speech*	*Hard of Hearing*	*Blind*	*Partially sighted*
0-4	*0*	*0*	*8*	*0*	*5*
5-15	*0*	*0*	*27*	*9*	*23*
16-24	*10*	*4*	*7*	*0*	*10*
25-44	*10*	*12*	*15*	*38*	*46*
45-64	*0*	*12*	*45*	*65*	*133*
65-74	*0*	*13*	*71*	*39*	*154*
75+	*0*	-	*23*	*153*	*873*
unknown	*1*	-	*0*	*0*	*0*
Totals	*47*	*41*	*409*	*304*	*1244*
Deaf Blind Source DSF returns from SET 15 in total aged 18-65(NISRA)					

Ministerial Targets

The South Eastern LCG expects the South Eastern Trust to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan.

Commissioned Services

The majority of services in this POC will be commissioned as per 2013/14 and the South Eastern LCG will continue to commission the provision of a range of services to adults a physical disability or sensory impairment and their carers and families. In addition it should be noted:

- The South Eastern LCG will monitor discharge delays from Specialist Units from within the SELCG area; Regional funding from the P&SD Strategy into the Regional Rehabilitation Services at Musgrave Park Hospital will ensure that there is sufficient medical cover for service continuity on site as well as outreach to local rehabilitation centres and support for Community Rehabilitation teams. Belfast and South Eastern LCGs are working together to ensure that Thompson House is able to accept new patients transferred from the specialist services.
- The South Eastern LCG, in response to the direction of travel signalled in TYC, will continue to support the 'Reform and Modernisation' of day care provision to providing day opportunities.
- The South Eastern LCG welcomes the various new investments into Physical and Sensory Disability Programme of care from the P&SD Strategy Implementation Group:
- Recurrent Funding of Regional (RNIB) Eye Care Liaison Officer Posts
- Recurrent Funding of Regional Additional (BDA)Advocacy Post
- Non- Recurrent Funding of Regional of Tinnitus awareness raising(AoHL)
- Non- Recurrent Funding of (AoHL)Hear 2 Help Pilot
- Recurrent Funding of Regional Wheelchair Therapist Post
- Recurrent Funding of Regional Wheelchair Equipment - Buggy Covers
- Additional Recurrent Funding of Wheelchair Approved Repairer Contract
- Non- Recurrent Funding of E-NISAT roll out within PoC 7

- Non- Recurrent Funding of SET Community Access Pilot Posts within PoC 7 x 2
- Non- Recurrent Funding of Regional Deaf Blind Needs Analysis

The South Eastern LCG continues to recognise the important role played by carers in our community and will continue to place carers at the centre of its future transformation plans.

Specific Commissioning Objectives for 2014/15 and 2015/16

POC 7: Physical Disability and Sensory Impairment	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The SEHSCT is expected to continue to improve access to carer assessments, paying particular attention to those not yet recognised as carers. The Trust should also continue to ensure that information is widely available to ensure that carers are fully informed about the value and benefits of assessment. The Trust should also take steps to ensure that the assessment process is undertaken in a way which fully embraces the personalisation approach
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The SEHSCT should continue to develop innovative, person centred respite/short breaks options based on best practice and learning from pilots undertaken to date and feedback from carers.
To increase uptake of direct payments	The South Eastern Trust is expected to achieve this target and will expect the offer of a Direct Payment as an alternative to direct statutory provision to be an integral part of the South Eastern Trust's standard assessment and service delivery process.
Review Trust progress in relation to the review and reform of day service opportunities to ensure alignment	The South Eastern Trust is expected to consolidate the on-going reform and modernisation of day opportunities.

with personalisation strategies.	
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability	**Hospital Services**	Occupied Beddays	17,438	0	17,438
	Daycare	Attendances	23,292	0	23,292
	Domiciliary Care	Hours	314,916	0	314,916
	Residential & Nursing Homes	Occupied Beddays	27,192	0	27,192
	Community Nursing & AHPs	Face to face contacts	19,802	0	19,802
	Social Work	Active caseload	1,929	0	1,929
		VALUE OF COMMISSIONED ACTIVITY[53]	£18.1m	£0.5m	£18.6m

[53] This includes activity in addition to that set out above.

8.4.8 POC 8 – Health Improvement

Introduction

Improving health and social wellbeing and reducing the risk of health inequalities is a key priority for the South Eastern Local Commissioning Group and PHA. The priorities focus on four key areas;

- Giving every child and young person the best start in life;
- Ensuring a decent standard of living for all;
- Building sustainable communities; and
- Making healthier choices easier.

In seeking to improve health and social wellbeing there is a need to maximise the contribution of all sectors and to ensure effective collaborative approaches that target both local needs and regional strategic priorities. Addressing the wider social determinants of health together with work to encourage and support individual lifestyle choices is critical to seeing the continued improvements in health that have been realised by those experiencing least disadvantage but not by all.

Within the challenges and opportunities of the "Transforming Your Care" agenda there is a need for all Programmes of Care to embed health and social wellbeing improvement as a key focus within their services and programmes. In adopting a person centred approach all those involved in the delivery of health and social care services need to ensure they consider the totality of need of the individuals and provide effective help and support to ensure these needs are addressed as appropriate.

In addressing the four key building blocks for Health and Social Wellbeing Improvement outlined above there is a need to continue to embed services and programmes within key settings such as communities, schools, early year's settings, workplaces, primary care and acute care that maximise the potential for individual engagement and involvement. Building policies, services and programmes that are conducive to improving health and have a sound

evidence base will continue to provide the foundation for this work within the south eastern locality.

Overview of Local Needs

The south eastern locality shows a mixed profile of prevalence of patients on registers per 1000 of all key QOF measures with the highest rate in the region for hypertension and stroke and the lowest prevalence in mental health.

The SMR for South Eastern LCG has stayed the same over the past decade at 95 making it one of the lowest in the region. The under 75 SMR has moved from 90 to 89.

There were 7 obesity-related deaths in the South Eastern Trust area from 2007 to 2011. The definition of obesity-related deaths is any death where the underlying cause of death is recorded as obesity.

Data on individuals availing of specialist smoking cessation services shows that in the South Eastern Trust area in 2012/13, 55.8% of people who set a quit date had successfully quit (self-report) at 4 weeks.

In the ten years since 2002, there has been an increase in the number of alcohol related deaths in Northern Ireland, and this is also reflected in an increase in deaths from alcohol in the South Eastern Trust, as the table below shows.

Alcohol Related Deaths
Table 58

Registration Year	South Eastern	Total
2002	35	**238**
2003	43	**214**
2004	58	**255**
2005	50	**246**
2006	41	**248**
2007	43	**283**
2008	50	**276**
2009	56	**283**
2010	42	**284**
2011	51	**252**
2012[P]	52	**270**
Total (2002-2012)[P]	**521**	**2,849**

Ministerial Targets

The HSCB/PHA expects the Trust and other commissioned service providers to deliver the targets, objectives and priorities contained within this plan.

Commissioned Services

In relation to Giving every child the best start on-going support has been provided during 2013/14 to develop the two "Early Years Intervention Projects" in the Colin Neighbourhood and Greater Lisburn. These projects represent a very significant investment by a range of partners together with local communities to develop and deliver a shared agenda for children and families. Work has also been taken forward to embed the health and social wellbeing improvement priorities across a range of early years settings such as maternity services, nurseries, playgroups, Sure Starts and schools addressing issues such as maternal smoking, alcohol and drug use, play and development, emotional development, nutrition and accident prevention.

In seeking to ensure a Decent standard of living for all the PHA together with DARD has expanded the provision of the Maximising Access in Rural Areas programme (MARA) to address the needs of rural communities. The service seeks to help individuals and families in rural areas access advice, help and support in areas such as maximising income and benefit uptake. Work has also

been undertaken to support the formation of a poverty network aimed at improving coordination and collaboration across community, statutory and voluntary groups and organisations who are seeking those experiencing the impact of acute poverty.

In seeking to Build sustainable communities there has been an on-going investment in some 15 dedicated Community Health Development Workers working across key areas of disadvantage in the south eastern area to address local health and social wellbeing needs.. A new Healthy Living Community Project has been launched with the Resurgam Community Association in Lisburn and also within the Kilcooley area in Bangor to help address local needs of the communities across the Greater Lisburn area as part of this approach.

The focus on making healthier choices easier aims to get all those groups and organisations that can help improve health and wellbeing to work collaboratively to target their services and support effectively to individuals and communities. Work has continued during the year to increase the provision of a range of evidence based programmes to address issues such as the misuse of alcohol and drugs, the need to reduce the growing levels of obesity, reducing the risk of accidents, improving mental health and reducing the risk of suicide, increasing physical activity levels, improving sexual health and reducing smoking.

The HSCB/PHA will work with partners to support the implementation of the new Regional Public Health Strategic Framework 'Making Life Better' which is expected in 2014/15. This framework will seek to build on the need for effective collaborative working across all sectors and organisations to make a difference in the health and social wellbeing of individuals and communities.

Continuing to build effective interventions in the early years will be a key priority within the south eastern area and there will be significant new investment to deliver evidence based early years programmes such as "Incredible Years," "Parenting UR Teen" and "Strengthening Families" across

the area as well as supporting the growth of the "Early Years networks and communities" approach There will also continue to be a focus on developing the capacity of the five Sure Start programmes across the area to help provide children with a healthy start.

Within the current economic climate there continues to be a challenge to long term health and wellbeing for those individuals affected by poverty and unemployment. The HSCB/PHA will continue to work closely with local groups and organisations to maximise the help and support that can be made available for individuals and families most in need. Critical within this work will be the on-going development of the partnerships with local community groups and networks and the responses that need to be realised from all those who can help address the needs within local areas.

In relation to making healthier choices easier service development priorities in 2014/15 will focus on:

- Reducing the risk of obesity and increasing physical activity across all ages but in particular with children, pregnant mums and adults
- Providing on-going access to a range of drug and alcohol services to address the specific needs of various age groups;
- Improving the opportunities to develop positive mental health and to target help at those at risk of suicide or impacted by suicide;
- Reducing the numbers of people who continue to smoke;
- Improving sexual health and access to family planning and sexual health services; and
- Improving the health and wellbeing of older people by providing targeted health improvement programmes and services, developing mechanisms to improve information and help to access services, working with partners and communities to reduce the risk of isolation and loneliness and delivering services and programmes to reduce the current level of falls amongst those most at risk.

Specific Commissioning Objectives for 2014/15 and 2015/16

POC8 – Health Promotion	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Expansion of the early years intervention programme.	Additional investment will be made within the Trust to ensure the development and delivery of early intervention as a key priority across the area. The South Eastern Outcomes Group will ensure an effective multi-sectorial action plan is implemented in line with the regional strategic programme priorities. The Trust will also deliver the suite of PHA programmes and support the development of locality based "Early Intervention Communities."
Incremental expansion of social economy businesses and community skills development.	The South Eastern Trust is expected to engage with the Public Health Agency and others to reduce the impact of poverty on clients and patients, particularly those with mental health issues, addictions, older people and families with young children. The South Eastern LCG is committed to supporting initiatives which offer opportunities to social economy businesses to participate in public procurement of Health and Social Care services.

Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	A co-ordinated approach should be developed across relevant areas of Trust Business and in conjunction with other statutory, community and voluntary partners. Improved access and uptake of targeted health and wellbeing improvement services and programmes by older people.
LCGs to monitor Trust performance in relation to the HSCB / PHA Community Development strategy	The South Eastern LCG will work with the South Eastern Trust to monitor performance on an ongoing basis.
Implementation of the "Fitter Futures for All Framework".	Tackling obesity is a pilot project developed by the PHA to reduce obesity in pregnancy. The SE Trust has successfully commenced this project by recruiting the required staff and began to recruit women to the project. New investment has been made within the Trust's Community Dietetic Services to develop capacity and resource to ensure delivery of the ''Fitter Future for All'' Framework over the next three years. In addition the Trust will lead the development of a new range of programmes and initiatives to address the need to increase levels of physical activity across all ages. o
Implementation of key public health strategies.	The South Eastern LCG will support Public Health Agency colleagues to ensure South Eastern Trust implementation of key public health strategies including tobacco cessation,

	treatment and support for substance misuse and associated mental health, emotional wellbeing and suicide prevention.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	The South Eastern Trust is expected to provide monitoring report outlining range of specialist sexual health services available, numbers and age groups accessing services by the end of March 2015.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.
Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The South Eastern LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

8.4.9 POC 9 - Primary Health and Adult Community

Introduction

This programme of care includes all work (except screening) carried out by General Medical Practitioners, Out of Hours, General Ophthalmic Practitioners, and pharmacists as well as community based AHPs and nursing services. There are presently 54 GP practices delivering services across the South Eastern LCG area. The South Eastern LCG resident population is circa. 350,000 with a GP practice registered population of 315,664. The South Eastern LCG area has 90 community pharmacies, 47 optometry practices and 70 dental practices

Primary care and adult community services play a critical role in terms of supporting people in staying well as long as possible.

Integrated Care Partnerships (ICPs) have been established across Northern Ireland as a key recommendation of TYC. There are 4 ICPs in the South Eastern LCG area (17 in total across NI) covering the localities of Ards, Down, Lisburn and North Down and they are responsible for the coordination and provision of patient pathways and improving care, with an early focus on frail elderly, Chronic Obstructive Pulmonary Disease (COPD), stroke, diabetes and end of life care as it relates to those conditions. Each ICP represents a population base of around 100,000 practice based residents. The ICPs are managed by a GP Clinical Lead and are supported by a small business support team. In addition, ICP partnership committees have been established for each locality, to include representation from the primary care, Trust, service users/carers, Northern Ireland Ambulance Service and local community and voluntary sector organisations. Multi-disciplinary teams have also been established for each of the 4 clinical priority areas to redesign patient pathways.

Overview of Local Needs

While primary care is usually the first point of contact for all ages; a higher proportion of the older population will need to access primary care services.

The South Eastern LCG area has a proportionately larger share of Northern Ireland's older population than any other LCG area. There are 59,016 people (17% of the total South Eastern LCG population) who are 65 years and older in the area which accounts for 21% of all people 65 years or older in Northern Ireland. It is inevitable that older people are increasingly more likely to be living with more than one long term chronic conditions. Section 8.1 provides details on demographic change across the south east.

Ministerial Targets

The South Eastern LCG expects the SET to achieve all Ministerial targets and objectives for 2014/15 and to address all of the regional themes set out in the Board's Plan. The South Eastern LCG will focus on the following aspects of Primary Health and Adult Community Services in its dialogue with the Trust and where appropriate the ICP:

- Working with the ICP to ensure that the clinical priority areas are addressed. The ICP has already shared with the South Eastern LCG their initial considerations with the expectation that a substantive proposal in regards to the establishment of a community ward is delivered in 2014/15.
- In regards to end of life care the ICP's will also be contributing to the Transforming Your Palliative and End of Life Care Programme (which is supported by Marie Curie).

Commissioned Services

In addition to the baseline community nursing, AHP, and Family Practitioner Services commissioned in 2013/14 the South Eastern LCG invested in the roll out of primary care based sexual health services. This investment builds on the North Down sexual health pilot which focused on the asymptomatic testing of patients in GP practices for STIs. This service is now being established in the Lisburn locality and in 2014/15 will be rolled out to the rest of the LCG localities. During 2014/15 the South Eastern LCG will, on the basis of an initial scoping exercise carried out this year, develop a plan, in co-operation with SET

and Belfast Trust (which currently provides the majority of family planning services in the South Eastern LCG locality), to integrate family planning and sexual health services within our locality.

The LCG will work with HSCB / PHA colleagues and relevant Trust management to ensure that the recommendations of the 'RQIA Review of Specialist Sexual Health Services in Northern Ireland' are implemented, particularly in relation to Improving access to services and better integration of sexual health and family planning services.

The South Eastern LCG will monitor the roll-out and early audit and evaluation of the re-modelled cataract referral pathways in Belfast & Southern LCG Areas, and the community-based "red eye" service being piloted in Southern LCG. Ophthalmology remains a high-demand specialty, often involving our frail elderly population, and the South Eastern LCG recognises the increasing role high street optometrists play in managing this demand, and delivering safe and accessible services closer to home, in line with TYC and Developing Eye care Partnerships.

The South Eastern LCG is in the process of commissioning a pilot in the North Down locality to provide GP direct access to DEXA scanning. This will use the existing scanner in the Bangor Community Hospital. Currently access to DEXA scanning is via consultant referral; this will allows GP practices to directly refer those patients with appropriate musculoskeletal conditions. As with the pain management service, funding was made available via South Eastern LCG prescribing savings.

Initiatives about to be commissioned from the ICP include:

- An Atrial Fibrillation (AF) pathway to include access to and interpretation of ECG, 24 hour ECG recording, event monitoring, confirmation of diagnosis and decisions about anti-coagulation and management of rate and rhythm available on a 7 day basis

- A diabetes programme to ensure patients/ carers receive a structured education programme that fulfils the nationally agreed criteria from the time of diagnosis, with annual review and access to on-going education.
- Health and well-being programmes targeted at the frail elderly in their locality, include a focus on nutrition, falls prevention, social isolation, physical activity, information and medication
- For frail elderly patients, community-based urgent care multi-disciplinary teams with a single point of referral where a same day assessment of need can be carried out.

In order to shift resources from hospital to community a priority will be to review the demand and capacity in the community nursing workforce to ensure the workforce is sufficient and suitably qualified to deal with the complexity of cases that are to be managed at home. The South Eastern LCG will work with the ICPs to improve the care of frail elderly and those with long term conditions to reduce unplanned admissions and provide acute care at home that is supported by robust community nursing and specialist nursing teams

The services in relation to this POC were commissioned as per 2012/13. In response to the shift of services from secondary to primary care, the South Eastern LCG is looking at future infrastructure requirements, under the Primary and Community Infrastructure Development (PCID) programme. During 2013/14 the South Eastern LCG has worked closely with GPs to progress the development of the primary care hub and spoke model in line with HSCB and Departmental policy. The South Eastern LCG aims in the near future to have an agreed prioritisation of hub and spoke developments including service models for each. The hub and spoke service models will provide the catalyst for the shift left agenda involving the transfer of clinically appropriate services, including outpatient diagnostics, from the acute to community settings, thus providing communities with closer to home improved access.

Prescribing

The South Eastern LCG continues to seek efficiencies in the cost of prescribing, both in primary and in secondary care dispensing costs, as well as in GP out-of-hours.

GP Out-of-Hours (GP OOH) Services

In 2014/15 the South Eastern LCG is likely to assume responsibility for directly commissioning GP OOH Services within its locality. As the commissioning priorities and requirements table below shows, the LCG will play a key role in the commissioning and co-ordination of those community based unscheduled care services, in particular nursing, that interface with GP OOH.

Within this programme of care palliative and end of life care is a priority area for the South Eastern LCG and in particular we would seek to ensure that where possible, and if clinically appropriate, people in the final year of life are given the opportunity to remain at home, including nursing homes. We will continue to work with both statutory and community and voluntary providers in this area to ensure that these patients maintain, and where possible, improve the quality of care that they receive.

Direct Referral to AHP services

The Public Health Agency (PHA) with support from Transforming Your Care (TYC) is working to introduce the option of Self-Referral Physiotherapy for patients in the South Eastern area in early 2014/15

The South Eastern area has been selected as an early adopter site for this service which it is hoped can be rolled out to the other Trusts from 2015. The service development means patients will be able to refer themselves to a physiotherapist without first having to see a GP or a healthcare professional.

Similar initiatives in Great Britain have shown that it direct referral can deliver

- High levels of service user satisfaction and confidence

- Improved patient self-care/self-manage to meet needs
- Greater patient compliance
- Better clinical outcomes
- Freeing up GP time
- Reducing in waiting times
- Reducing Did Not Attend

Specific Commissioning Objectives for 2014/15 and 2015/16

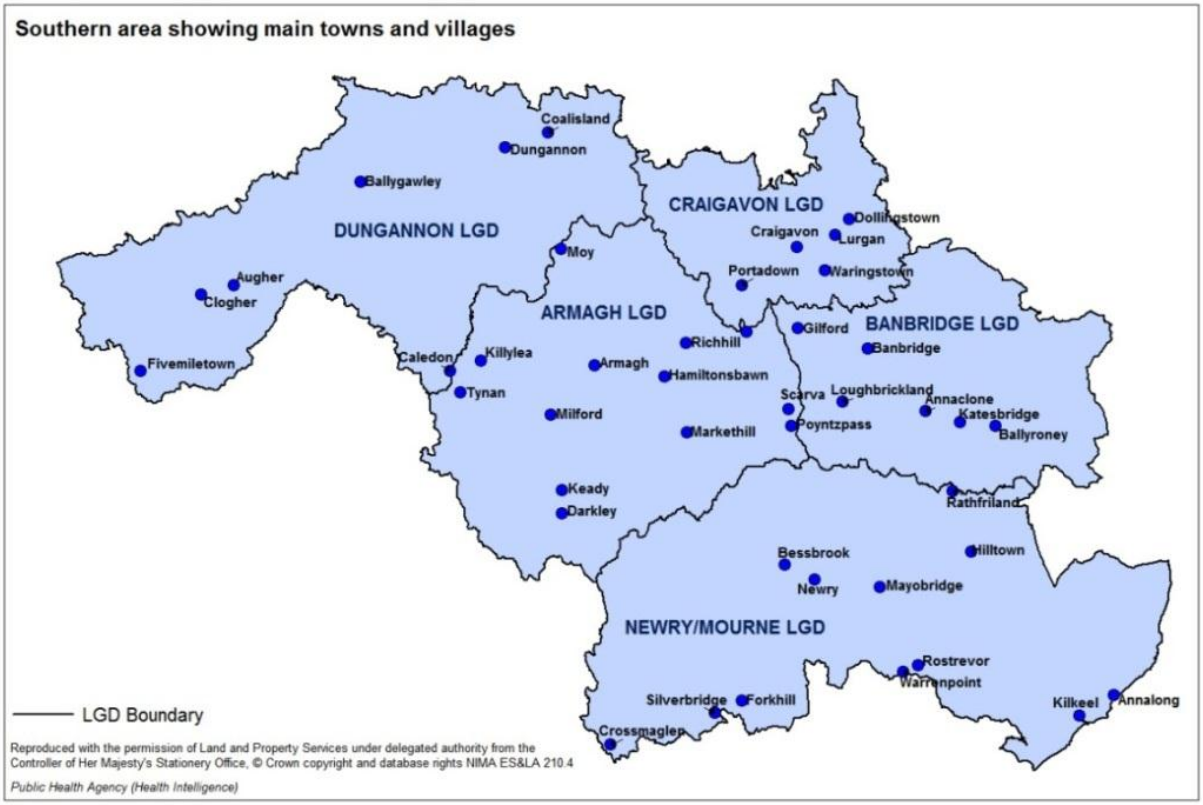
POC 9 - Primary Health and Adult Community	
Regional Commissioning Priorities	**Associated Local Commissioning Requirements**
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	The South Eastern LCG will work with regional colleagues and Integrated Care Partnerships to ensure relevant Local Enhanced Services are developed with GPs in line with ICP clinical priorities and LCG commissioning requirements
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility.	The South Eastern Trust is expected to work with the South Eastern LCG to achieve this regional objective.
Local Priority	Ensure roll-out and evaluation of pilot on primary care facing advice and treatment of non-sight-threatening Minor Eye Conditions in South Eastern LCG Area.
Local Priority	The South Eastern LCG will work with the South Eastern Trust and others on the implementation of the TYC 'shift left ' agenda. The South Eastern Trust will therefore take forward all opportunities to develop primary and community based services as an alternative to hospital or institutionalised based care.

Local Priority	The South Eastern LCG has shared with the South Eastern Trust opportunities for service efficiencies. The South Eastern LCG expects that these, or other efficiencies identified by the South Eastern Trust will be applied within the programme.

9.0 Southern Local Commissioning Group Plan

This section provides an overview of the assessed needs of the population of the Southern Local Commissioning Group (SLCG). This assessment is based on demographic change, information relating to health inequalities and deprivation and will inform the commissioning of services at local level.
The SLCG is responsible for commissioning local health and social care, in line with strategic and regional direction, across the five local government district areas of Armagh, Dungannon and South Tyrone, Banbridge, Craigavon and Newry and Mourne.

Map of SLCG area showing main towns and villages[54]
Figure 14



[54] Land and Property Services

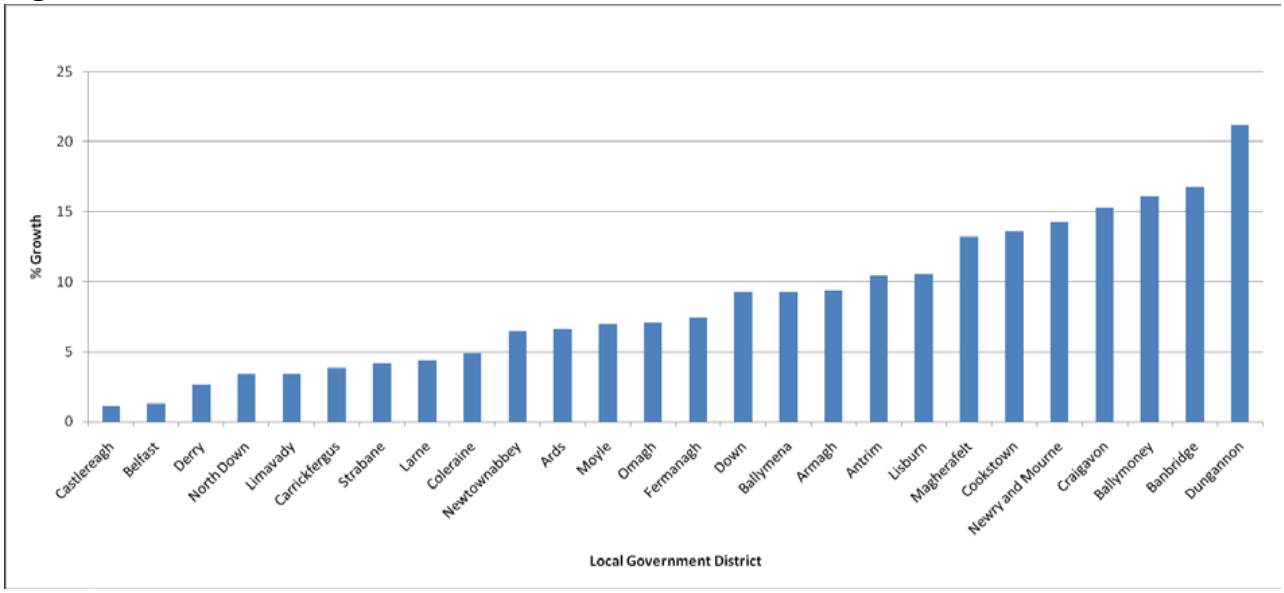
9.1 LCG Population

Demography

The SLCG has a population size of 363,145[55] which represents 20% of Northern Ireland's total population. The SLCG population size has continued to grow steadily each year. Between 1991 and 2012 there has been a 25% increase in the SLCG population size, compared with a 13% increase for Northern Ireland as a whole. Of the 4 fastest growing areas in Northern Ireland, 3 of these (Craigavon, Banbridge and Dungannon/South Tyrone) are in the SLCG area, as illustrated in the Figure 15 below.

Percentage Population Change between the 2001 and 2011 Censuses by Local Government District – All People[56]

Figure 15



The number of children (people aged 0-15 years) in Northern Ireland has in general fallen by 5% between 2001 and 2011. This decrease in the number of children can be seen in 19 of the 26 LGDs. However 7 LGDs have shown increases with the highest growth being recorded in Banbridge (11%) and Dungannon (9%). The LGDs of Banbridge, Dungannon/South Tyrone and

[55] NI Neighbourhood Information Service (NINIS) Population Estimates, 2012

[56] NISRA Statistics Bulletin: Census 2011: Population and Household Estimates for Local Government Districts in Northern Ireland

Craigavon have all seen at least a 25% increase in the number of small children (aged 0-3 years) in the same period.

The number of people aged 85 years and over in Northern Ireland has increased since the 2001 Census in all areas, however the Armagh and Dungannon/South Tyrone districts have seen a higher increase in this age group, recording growth rates in excess of 50%.

Table 59: SLCG Population Growth (2001 – 2023)[57]

Local Government District (LGD)/ SLCG/ NI	Total Population 2001[1]	Total Population, 2012[2]	Population Projection 2023[3]	% increase from 2012 to 2023
Craigavon	81,000	94,600	111,700	18.1%
Banbridge	41,500	48,700	53,600	10.1%
Newry & Mourne	87,600	100,900	118,500	17.4%
Armagh	54,500	60,100	66,700	11.0%
Dungannon/ STyrone	47,800	58,800	69,800	18.7%
SLCG	**312,400**	**363,100**	**420,300**	**15.8%**
Northern Ireland	**1,688,800**	**1,823,600**	**1,945,800**	**6.7%**

Table 59 above shows that the combined Craigavon and Banbridge LGDs population in 2012 equates to 143,300, whilst the combined Armagh and Dungannon/South Tyrone LGDs population is 118,900. The areas of significant growth for 2023 will include Newry and Mourne LGD with a projected growth of 17.4%, followed by Craigavon and Banbridge LGDs which combined have a growth rate of 15.4%. These population projections are significantly higher than the 6.7% predicted growth rate for Northern Ireland as a whole.

[57] Source: NISRA – Mid Year Estimates of Population, 2001; Source[2]: NISRA – Population, 2012 (revised June 2013); Source[3]: NISRA – LGD Pop Projections, based on 2008 Pop.

Table 60 below evidences the much higher proportion of people living in the SLCG area from Central and Eastern European (A8) countries, almost double the Northern Ireland average.

Table 60: Central & Eastern European Migrant Population, 2009[58]

	2009	
HSCT	**A8 Population**	**A8 % of Population**
Northern Ireland	39,000	2.2
Belfast	7,100	2.1
Northern	9,500	2.1
South Eastern	3,400	1.0
Southern	14,700	4.2
Western	4,400	1.5

The SLCG is the highest user of interpreters, during 2012/13 there were 37,880 requests received and dealt with through Northern Ireland Health and Social Care Interpreting Service (NIHSCIS), this represents 50% of the Northern Ireland total number of requests received and dealt with through NIHSCIS as a whole.

Deprivation

Northern Ireland Multiple Deprivation Measure 2010 Summary Measures indicate that 25 of Northern Ireland's top 20% deprived Super Output Areas (SOAs) fall within the SLCG area with ranks of Multiple Deprivation Measure Scores ranging from 31 to 175[59].

Health outcomes are generally worse in the most deprived areas of the Southern area, compared to the overall area. However male life expectancy in the most deprived Southern areas has seen the inequality gap improve from 3.2 years lower in 1999/2001 to 2.3 years lower in 2008-2010. For women however, the inequality gap has widened from 1.9 years lower to 2.1 years

[58] NINIS, Population, 2007-2009

[59] NINIS NIMDM 2010

lower in the same period. Other health outcomes are similarly poorer, for example the proportion of obese children in deprived SLCG areas is 1.5 times that of the LCG as a whole. In addition, the inequality gaps for mood and anxiety disorder rates are around 25% higher in the most deprived Southern areas. Of particular significance is the almost doubling of the inequality gap for standardised death rates for circulatory disease from 26% in 1997-2001 to 49% in 2006-2010[60]

Patient and Public Engagement

The SLCG is fully committed to ensuring that its commissioning decisions are directly informed by the views of patients, service users, their advocates and the community and voluntary sector. At its November 2013 meeting in public, the SLCG outlined its future engagement plan and committing to holding 4-5 engagement events annually, supplemented by specific meetings with users, carers and other key stakeholders as appropriate. This commitment will need to be further developed and refined as we move into the implementation phase of the change projects outlined in the SLCG Locality Population Plan.

During 2013/14, the SLCG engaged directly with elected representatives, held specific issue meetings with MLA's and community and voluntary sector organisations. The SLCG has also had the opportunity to hear at its public meetings the experience and expectation of service users and carers for the services and supports that they would wish to receive. In December 2013, the SLCG hosted a significant engagement event in Armagh to update key stakeholders and members of the public on the changes being taken forward under the TYC agenda. This was extremely well attended and further events are being planned. During 2014/15, the SLCG hopes to establish a forum for local people with physical and/or sensory disabilities the outcome of the discussions of which will help inform our commissioning decisions.

[60] NI Health and Social Care Inequalities Monitoring System: Sub Regional Inequalities – HSC Trusts 2012 (NISRA)

9.2 Key Challenges and Opportunities within the SLCG Area

This section provides an overview of the key challenges faced by the SLCG within 2014/15 and 2015/16 which inform and underpin SLCG commissioning priority for 2014/15 and 2015/16. The challenges described in this section, are, if addressed and responded to, also opportunities for the SLCG and as such have the potential to impact on the health and social care outcomes for all southern residents.

Transforming Your Care (TYC)

The SLCG will continue to work in partnership with the Southern Health and Social Care Trust (Trust) to deliver on the transformation agenda through the local TYC project structure. This will include progressing a number of specific projects including:

- Following regional consultation processes, implement locally the resultant regional TYC recommendations on statutory residential home care and day opportunities in the southern area
- Develop plans for the centralisation / future delivery of non-acute hospital care for older people in the SLCG area
- Develop plans for the future delivery of a centralised model for the care of stroke patients in the SLCG area
- Following establishment of 3 Integrated Care Partnerships (ICPs) in the Southern area during 2013/14, the SLCG will continue to progress a commissioning relationship with these groups to secure appropriate service delivery for the clinical priorities they are to take forward in 2014/2015.

Safety and Quality

The Francis Report highlighted that the fundamental responsibility of the NHS is to provide safe, compassionate care and treatment and it reasserted the importance of commissioning in defining safety and quality specifications and supporting and managing the performance of providers to ensure these standards are met. The DHSSPSNI Quality 2020 Strategic Framework ensures that patients and their experiences remain at the heart of service design and

delivery and they identify 3 specific areas namely – safety, effectiveness and patient/client focus. The SLCG is committed to ensuring all its commissioned services are provided safely, effectively and to the quality standards as identified in Quality 2020, NICE guidance, Service Frameworks, Commissioning Specifications and Departmental Strategies.

Personal and Public Involvement (PPI)

Engagement and user involvement must be at the heart of all that the SLCG does. The SLCG has held significant engagement events across the Southern area in recent months with the public, users, community, voluntary, statutory, local government and independent contractors to consult on the strategic themes in TYC. The SLCG recognises that difficult decisions will have to be taken regarding future service commissioning and engagement with the public, users and their advocates and political representatives will be vital in taking forward these very complex issues.

Demography

A significant challenge for the SLCG locality is our growing and ageing population. The SLCG is the second largest locality population in Northern Ireland and is projected to increase by 14% (compared to 6.5% regionally) by 2020. In addition it has a high number of births, with an anticipated 12.6% increase in our 0-17 population by 2020 (compared to a 2.4% increase regionally). This demographic pressure at both ends of the population scale, combined with our increasing life expectancy, will mean more people, and more people living longer. This has the potential to put strain on already pressurised health and social care services.

Information Systems

Much of the focus over recent years has been on the delivery of acute-based services and significant investments have delivered a series of information systems which support the provision of monitoring and performance information, as well as a picture of capacity within a range of services. There remains a significant deficit in the quality and consistency of the community

information and work will be taken forward in 2014 -2015 to improve the robustness and comparability of data to support the negotiation of service and budget agreements.

Developing the Community

A number of policy direction and procurement challenges still exist which can be barriers to enabling a "shift left" i.e. more care being provided in or as close to a patient's home as possible and more management of long term conditions available in primary care from HSC provision to development of contracts with community and voluntary sector organisations.

As health is not the sole remit of the health and social care system, collaborative working with other public sector, statutory, community and voluntary and independent sector agencies and organisations will be central to delivering the shift left agenda. There is a clear need to develop the community infrastructure, not just within health and social care, but amongst the community and voluntary sector to support the transformation agenda.

9.3 Ensuring Financial Stability & Effective Use of Resources

Use of Resources

The SLCG's baseline funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £532m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 61: Baseline investment by Service Area in 2014/15

Programme of Care	£m	%
Acute Services	197.6	37.2
Maternity & Child Health	27.1	5.1
Family & Child Care	36.4	6.8
Older People	118.1	22.2
Mental Health	45.2	8.5
Learning Disability	50.6	9.5
Physical and Sensory Disability	18.8	3.5
Health Promotion	17.9	3.4
Primary Health & Adult Community	20.1	3.8
POC Total	**531.8**	**100.0**

This investment will be made through a range of service providers as follows:

Table 62: SLCG Funded Providers 2014/15

Provider	£m	%
BHSST	50.8	9.6
NHSST	0.8	0.1
SEHSST	6.7	1.3
SHSST	436.2	82.0
WHSST	4.2	0.8
Non-Trust	33.1	6.2
Provider Total	**531.8**	**100.0**

Whilst Emergency Department services have not been assigned to LCGs as these are regional services, the planned investment in 2014/15 in respect of Emergency Care by the Southern Trust is £14.8m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

The Commissioning Plan for 2014/15 indicates a significant range of service pressures/developments and other additional pressures most notably inescapable pressures such as Pay and Price Inflation as well as additional investment to take account of the demographic changes in the population. The SLCG share of these indicative investments areas is noted below:

Table 63: Southern LCG share of indicative investments 2014/15

Pressures	£m Full Year Effect
Pay & Non Pay	8.0
Demography	9.7
NICE Drugs	3.4
Revenue Consequences of Capital Expenditure	0.5
Mental Health Resettlements	0.6
Learning Disability Resettlements	2.6
Service Pressures/Developments	14.3
Public Health Agency	0.7
Total	**39.8**

9.4 Commissioning Priorities and Requirements by Programme of Care

9.4.1 POC 1: Acute

Introduction

Acute services are provided on two sites in the SLCG locality, Craigavon Area Hospital (CAH) in Portadown and Daisy Hill Hospital in Newry, with 24 hour emergency departments (EDs) at both sites. Supporting non-acute in-patient services are provided in Lurgan Hospital and in Loane House on the South Tyrone Hospital site. Nurse-led Minor Injury Units are located at South Tyrone Hospital and Armagh Community Hospital. Day case surgery, outpatient clinics, diagnostics and day procedures including endoscopy are provided in South Tyrone Hospital, with outreach clinics provided at Armagh Community Hospital, Banbridge polyclinic and Kilkeel.

Transforming Your Care provides a strategic direction of travel for the commissioning and provision of acute services with a focus on shift left. The process establishment of Integrated Care Partnerships (ICPs) in the SLCG area is central in achieving this. The SLCG will directly commission activity from ICPs in 2014/2015, commencing with the identified four clinical areas, frail elderly, respiratory, diabetes, stroke and including an overarching theme of palliative care across all clinical areas. This will impact on its commissioning from the Trust and of evidencing a shift in commissioning, with a corresponding resource shift from secondary care to primary and community care will be developed in 2014/2015.

Significant regional commissioning direction, as evidenced by Ministerial targets, commissioning specifications, NICE clinical and technical guidance, service frameworks and Departmental strategic direction provides the commissioning context for this section. In broad terms, Trust performance against these strategic and clinical standards and targets is acceptable, but there remains room for improvement. Of significance for the commissioner in 2014/2015 will be Trust performance against the 4 hour ED target, which is

projected to achieve 82.8% by March 2014 (based on April to Nov 2013) and reflects a decrease on the 2011/12 performance against the 4 hour target which was 85.6%.

Overview of Local Needs

The Southern area continues to experience a rising population with challenging and changing health and social care needs and the need to continue to commission responsive, efficient, value for money secondary care services remains a priority for the SLCG.

The SLCG is committed to ensuring that the two acute hospitals within the Southern area i.e. CAH and DHH, continue to provide acute services to the 360,000 people in the population. The SLCG will continue to commission the delivery of unscheduled and elective care at both acute sites and in supporting sites, which are in line with waiting times set by the DHSSPSNI and to the required clinical standards.

In terms of new and unplanned A&E attendances, there were 111,115 in total during 2012/13, with 71,746 presenting to CAH ED and 39,372 presenting at DHH. This represented an increase of 0.3% in CAH and an 8% increase in DHH on the previous year 2011/2012.

In CAH there were 27,504 scheduled and unscheduled inpatient admissions and 15,088 day cases during 2012/2013 representing a 1.5% and 4% increase against the previous year. In DHH there were 11,602 inpatient admissions and 6684 day cases during 2012/2013 representing a 6.5% and 4% increase on the 2011/12 position. In terms of outpatients there were 60,226 new outpatient attendances in CAH during 2012/13 representing a 16% increase on 2011/12 and 84,683 review outpatient attendances reflecting a 3% increase on 2011/12. In DHH there were 17,511 new outpatient attendances representing a 6% increase on 2011/12 and 30,180 review outpatient attendances in 2012/13 representing a 2% increase on 2011/12.

The SLCG recognises the need to work towards the rebalance of elective specialties between the Trust's acute sites in order to reflect the need of interdependent clinical services, such as Intensive care. It also anticipates the need to centralise, where necessary, services such as stroke and non-acute Medical In-patient care currently provided on a range of sites in the in both the acute and non-acute sector. The SLCG would also anticipate that the Trust will need to review the provision of day case surgery across the Southern area and undertake a cost benefit analysis to ascertain if it is preferable to consolidate the provision of day case surgery.

There are clear links between long term conditions, deprivation, lifestyle factors and the wider determinants of health. People living with a long term condition are likely to be more disadvantaged across a range of social indicators, including employment, educational opportunities, home ownership and income. Someone living in a disadvantaged area is more than twice as likely to have a long term condition as someone living in an affluent area, and is more likely to be admitted to hospital because of their condition. Tackling the inequalities in health outcomes for the population will continue to be a focus of the SLCG's commissioning intent. An audit[5] of self-management during 2013 revealed that there are currently 15 different programmes operating for people with long term conditions in the SLCG area, 12 of which are condition-specific and 3 are generic.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Unscheduled Care (Ministerial target 7) – From April 2014, 95% of patients attending any type 1,2 or 3 Emergency Department are either treated and discharged home or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours

- Elective Care (Ministerial Targets 1011 and 12) – From April 2014, at least 80% of patient wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 15 weeks; and From April 2014, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken; and From April 2014, at least 80% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks
- Allied Health Professionals (Ministerial Target 19) – From April 2014, no patient waits longer than nine weeks from referrals to commencement of AHP therapy
- Unplanned admissions (Ministerial target 21) – By March 2015, reduce the number of unplanned admissions to hospital for 5% for adults with specified long term conditions using 2012/2013 data as the baseline
- Unnecessary hospital stays (Ministerial target 29) – By March 2015, reduce the number of excess bed days for the acute programme of care by 10% (using 2012/2013 data as the baseline)

Commissioned Services

In addition to commissioning services to respond to the Ministerial targets, the SLCG will commission a range of additional activity in 2014/2015 to respond to the anticipated increased demand for secondary care services due to the rising population. (See Values and Volumes Tables)

- The SLCG will work with the Trust during 2014/2015 to enhance the Trauma and Orthopaedic service to address the current gap between capacity and demand and enable residents of the Newry and Mourne area to have elective and trauma treatment in their local Trust.
- The SLCG expects the Trust to demonstrate a move toward 7 day working in 2014 / 2015, initially on the CAH site focusing on having enhanced Diagnostic, AHP, Social Work, Pharmacy and Laboratory support. It is anticipated that this will facilitate reduced lengths of stay,

weekend discharge and ensuring that patients get timely intervention and support to improve their outcomes.

- The SLCG will work with the Trust to agree a service model for stroke services which the Trust will implement to deliver on the Ministerial Target for thrombolysis and secure the full range of services locally to support both the rehabilitation of patients in the most appropriate setting and early supported discharge from hospital. The SLCG anticipates that there will be a shift in the balance of services provided on both the CAH and DHH hospital sites to facilitate the most efficient and effective model of care.
- The SLCG believe that there is significant scope for a reduction in hospital bed days linked to long term conditions (specifically diabetes, stroke and COPD). Care and treatment should be provided where possible, in the patient's usual place of residence and the SLCG expects the Trust to evidence a shift of both activity and resources into increased delivery of community services to support people with long term conditions. This includes increased promotion of self- management programmes. As a consequence of this work the SLCG anticipates that there will be opportunities to consolidate beds and sites on which such in-patient care is currently provided.
- Central to achieving these changes will be the work taken forward by ICPs and during 2014 /2015 and beyond the SLCG will work with its three local ICPs to commission services aimed at achieving this TYC direction of travel.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Associated Local Commissioning Requirement
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to reduce/flatten demand for outpatients, and Emergency Department attendances	The SLCG will work with ICPs and Primary and Community Care sectors to develop and implement patient pathways to improve patient outcomes in an appropriate and timely way. This work will be incorporated within the Unscheduled Care Improvement Plan.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions	The Trust is expected to move towards 7 day working, commencing on the CAH site and ensuring appropriate diagnostic provision, AHP, Social Work, Pharmacy and Laboratory provision to facilitate this. The Trust should also evaluate the improvement gained through the implementation of the enhanced recovery model in reducing length of stay, improving outcomes and increasing productivity for the 6 (appropriate for DGHs) identified procedures
Enable district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present	The Trust is expected to explore with GPs and their District Nursing teams appropriate patient pathways in order to respond quickly and flexibly to patient needs.
Review and take forward opportunities to consolidate	The Trust is expected to develop a consultation paper, based on the

intermediate / acute care beds and / or the sites on which they are provided.	discussions with SLCG, on the future of non-acute hospital in-patient service provision, with a view to reconfiguring and consolidating provision.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The SLCG is expected to work with the Trust and Primary Care during 2014 / 2015 to develop this UCIP which will focus on expanding and establishing improved communication between secondary care Consultants and GPs, 7 day working practices, direct GP access to e.g. diagnostics, assessments unit and AHPs, Social Work, Pharmacy and Laboratory support to enable 7 day discharge
Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.	The SLCG will engage with the Southern Trust during 2014/15 to achieve top quartile performance.
Local Priority	In line with TYC direction, during 2014/; 2015 the Trust is expected to further develop its T&O service to address the current demand-capacity gap, thereby improving productivity and ensure a 24/7 fracture service thus enabling residents of Newry & Mourne LGD to

	have access to local treatment
Local Priority	• During 2014/2015, the Trust is expected to work towards achieving peer average LOS across specialities • The SLCG expects the Trust to maximise theatre productivity on both CAH and DHH sites and bring forward proposals to consolidate day surgery • The SLCG anticipate that there may be opportunities to consolidate the provision of non-acute in-patient beds including stroke • The Trust is expected to improve its New : Review Out-patient ratio, to reduce DNA/CNAs and to maintain and where possible improve its pre-operative assessment rate
Local Priority	• During 2014 / 2015 the Trust is expected to work to enhance community service provision to facilitate the implementation of the indicative opportunities above • The Trust is expected to also, as part of ICPs, to develop further patient pathways to achieve a shift left in service provision, with more services moving into primary and community care settings where clinically safe and appropriate to do so. A concomitant level of resource should be identified

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Non-elective	Inpatients			
	ED attendances			
	Non-elective admissions			
	NIAS Journeys			
Elective	Inpatients			
	Daycases			
	New Outpatients			
	Review Outpatients			
	VALUE OF COMMISSIONED ACTIVITY			

9.4.2 POC 2: Maternity and Child Health

Introduction

Maternity services in the southern locality are currently provided in consultant led obstetric units in both CAH and DHH and in the alongside Midwife Unit in CAH since 2000. Following SLCG commissioning direction in the 2013/2014 Commissioning Plan, midwife-led births were commenced in DHH in 2013/ 2014. In response to rising birth numbers, demographic funding was used in 2013 / 2014 to enhance midwifery capacity to ensure the safe delivery of these births. The SBA has been uplifted to reflect these.

A Strategy for Maternity Care in Northern Ireland 2012 / 2018, published in 2012, has provided the strategic framework for the commissioning and provision of Maternity services and the SLCG will both contribute to and be guided by the regional implementation of this strategy, to ensure that safe, high quality maternity services are commissioned on behalf of the SLCG population. Paediatric Services in Northern Ireland have also been the subject of a review by DHSSPSNI, and a consultation document "A Review of Paediatric Health Care Services Provided in Hospitals and in the Community" has been issued along with a supporting consultation document addressing palliative care for children. The recommendations and standards outlined in these documents have been taken into consideration in setting the commissioning priorities for Paediatric services in the SLCG locality.

The SLCG is committed to ensuring that service-users, patients and clients, their advocates and community and voluntary groups have meaningful engagement with the commissioning process. In relation to Maternity and Child Health services, the SLCG has had input at recent meetings in public on neonatal services, child health and child care services and through specific engagement events and opportunities, has heard directly from young people, their carers and parents on their experience of and aspirations for services relevant to them. Specifically in 2013/2014 the SLCG was made aware of the strong views of carers for children on support that they would wish to see in place in the southern area to help them in their caring role and specific

services were commissioned and supported by the SLCG in response. This process of direct engagement will continue in 2014/2015 with specific programme of care events planned.

Overview of Local Needs

The SLCG locality is the second largest locality in Northern Ireland and is projected to continue to see a population growth of 14% by 2020, which is in excess of the Northern Ireland average of 6.5%. This, in combination with a previous increased birth rate during the first decade of the 21st century will result in a 0-17 year old population in the SLCG locality growing at 5 times the Northern Ireland average by 2020.

The birth rate in the SLCG locality continues to rise, with 6098 babies being born in SHSCT maternity Units in 2012 / 2013, 4194 in CAH and 1904 in DHH. Whilst the numbers of births appeared to be stabilising, births in the southern area rose again last year and in response, the SLCG commissioned additional services and will continue to closely monitor demographic trends.

The increasing number of births means a growing child population in the SLCG area, with the full expectation of the need for increased child health service input. Contributing to this increased child population has been the significant inward migration to the SLCG locality over the last decade, with individuals and families from outside UK/ROI choosing to come to live and work in the southern area and establish families here. This has placed increasing demand on all services in the area, including maternity and child health services. The SLCG is aware that national reports and research have indicated that women from certain migrant and minority ethnic groups, including Irish Travellers, are more likely to have maternal ill health and be at higher risk of poorer pregnancy outcomes. The SLCG will carefully monitor these sub-populations within emerging demographic trends.

Ministerial Targets

The SLCG will commission services within this PoC in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Family Nurse Partnership (Ministerial Target 2) – By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site for the Family Nurse Partnership (FNP) Programme within each Trust
- Tackling Obesity (Ministerial target 4) – By March 2015, all eligible pregnant women, aged 18 years or over with a BMI of 40 or more at booking are offered the "Weigh to a Healthy" Pregnancy programme with an uptake of at least 65% of those invited

Commissioned Services

Tackling inequalities in health outcomes for mothers and babies within this programme remains a priority for the SLCG and during 2013 a Family Nurse Partnership (FNP) was established in the southern locality. It is currently working to achieve a registration of 100 first time teenage mothers to the programme.

The SLCG notes the on-going development of an alongside Midwifery Led Unit in DHH and during 2014 / 2015 will work with the Trust to agree a baseline number of Midwife led births to be included in the SBA.
Baseline data (up to 27 November 2013) indicates that there have been 37 referrals to the Weigh to a Healthy Pregnancy programme in the Trust (via CAH and DHH) and the uptake rate is 65%. The continued focus on this programme remains a priority for the SLCG.

Following investment in recent years in both health visiting and midwifery services, the SLCG will continue to ensure it commissions safe and sustainable maternity and child health services at both maternity units and in the community. It will work with the Trust in this regard and ensure that the recommendations of the Maternity strategy continue to be implemented in the southern area over the coming years in a way which responds to local

needs and in line with regional consistency. In particular the SLCG wishes to see:

- The full implementation of the Trust's Normalisation of Birth Action Plan with the resultant reduction in variation in intervention rates within the two local maternity units
- The Trust develop further work to move towards facilitating midwife as the first point of contact
- The SLCG expects the Trust will continue to support the regional work in ensuring a consistent approach to the implementation of the NICE Clinical Guideline 129 on Multiple Pregnancies.
- The SLCG awaits the publication of the Departmental Paediatric strategy, the final recommendations of which will direct its commissioning intent in coming years for paediatric and child health services. However, in the interim the SLCG will continue to work with the Trust to develop paediatric and child health services in the southern area in response to demographic pressures over the last decade resulting in a significantly above Northern Ireland average child population. Of significance within these discussions will be the availability of capital funding to support infrastructure developments on both the CAH and DHH sites.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	• The Trust is expected in 2014/2015 to provide safe and sustainable maternity services in both CAH and DHH Maternity Units. Early indications of any inability to do so must be highlighted to the local commissioner immediately. A SBA level of activity for midwife-led births in DHH will be agreed in year • The Trust is expected to work towards achieving the standards for communication with women and parents on informed choice about place and options for birth • The Trust is expected to demonstrate an increased in referrals for an uptake of midwife-led care, including delivery.
Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	The Trust is expected to fully contribute to the development of a network service model and care pathway for management of multiple pregnancies in line with NICE Clinical Guideline 129, ensuring compliance with this Guideline.
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and	The Trust is expected to work towards facilitating midwife as first point of contact and also in providing more antenatal care in the

providing more midwife-led antenatal care in the community for women with straightforward pregnancies	community for those women for whom this is clinically appropriate. The Trust is to provide evidence of their progress to achieve this.
Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained variation in intervention rates throughout Northern Ireland	The Trust is expected to benchmark their local obstetric intervention rates in both CAH and DHH against peer units, with the aim of reducing the variation in intervention rates between both units and compared to other units in Northern Ireland.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The SLCG will work with the Southern Trust to enhance the experience and outcome for vulnerable groups of pregnant women in the Southern area, focussing initially on the experience of BME women.

***Will be subject to equality screening**

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	6,283	448	6,731
	Daycases	30,262	739	31,001
	New Outpatients	72,952	4,641	77,233
	Review Outpatients	123,054	5,452	128,506
Unscheduled	**Non Elective admissions – all**	33,852	-744	33,108
	ED attendances	129,961	0	129,961
	NIAS Journeys	30,036	1,695	31,738
	VALUE OF COMMISSIONED ACTIVITY[61]	£197.6m	£13m	£210.6m

[61] This includes activity in addition to that set out above.

9.4.2 POC 2: Maternity and Child Health

Introduction

Maternity services in the southern locality are currently provided in consultant led obstetric units in both CAH and DHH and in the alongside Midwife Unit in CAH since 2000. Following SLCG commissioning direction in the 2013/2014 Commissioning Plan, midwife-led births were commenced in DHH in 2013/ 2014. In response to rising birth numbers, demographic funding was used in 2013 / 2014 to enhance midwifery capacity to ensure the safe delivery of these births. The SBA has been uplifted to reflect these.

A Strategy for Maternity Care in Northern Ireland 2012 / 2018, published in 2012, has provided the strategic framework for the commissioning and provision of Maternity services and the SLCG will both contribute to and be guided by the regional implementation of this strategy, to ensure that safe, high quality maternity services are commissioned on behalf of the SLCG population. Paediatric Services in Northern Ireland have also been the subject of a review by DHSSPSNI, and a consultation document "A Review of Paediatric Health Care Services Provided in Hospitals and in the Community" has been issued along with a supporting consultation document addressing palliative care for children. The recommendations and standards outlined in these documents have been taken into consideration in setting the commissioning priorities for Paediatric services in the SLCG locality.

The SLCG is committed to ensuring that service-users, patients and clients, their advocates and community and voluntary groups have meaningful engagement with the commissioning process. In relation to Maternity and Child Health services, the SLCG has had input at recent meetings in public on neonatal services, child health and child care services and through specific engagement events and opportunities, has heard directly from young people, their carers and parents on their experience of and aspirations for services relevant to them. Specifically in 2013/2014 the SLCG was made aware of the strong views of carers for children on support that they would wish to see in

place in the southern area to help them in their caring role and specific services were commissioned and supported by the SLCG in response. This process of direct engagement will continue in 2014/2015 with specific programme of care events planned.

Overview of Local Needs

The SLCG locality is the second largest locality in Northern Ireland and is projected to continue to see a population growth of 14% by 2020, which is in excess of the Northern Ireland average of 6.5%. This, in combination with a previous increased birth rate during the first decade of the 21st century will result in a 0-17 year old population in the SLCG locality growing at 5 times the Northern Ireland average by 2020.

The birth rate in the SLCG locality continues to rise, with 6098 babies being born in SHSCT maternity Units in 2012 / 2013, 4194 in CAH and 1904 in DHH. Whilst the numbers of births appeared to be stabilising, births in the southern area rose again last year and in response, the SLCG commissioned additional services and will continue to closely monitor demographic trends.

The increasing number of births means a growing child population in the SLCG area, with the full expectation of the need for increased child health service input. Contributing to this increased child population has been the significant inward migration to the SLCG locality over the last decade, with individuals and families from outside UK/ROI choosing to come to live and work in the southern area and establish families here. This has placed increasing demand on all services in the area, including maternity and child health services. The SLCG is aware that national reports and research have indicated that women from certain migrant and minority ethnic groups, including Irish Travellers, are more likely to have maternal ill health and be at higher risk of poorer pregnancy outcomes. The SLCG will carefully monitor these sub-populations within emerging demographic trends.

Ministerial Targets

The SLCG will commission services within this PoC in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Family Nurse Partnership (Ministerial Target 2) – By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site for the Family Nurse Partnership (FNP) Programme within each Trust
- Tackling Obesity (Ministerial target 4) – By March 2015, all eligible pregnant women, aged 18 years or over with a BMI of 40 or more at booking are offered the "Weigh to a Healthy" Pregnancy programme with an uptake of at least 65% of those invited

Commissioned Services

Tackling inequalities in health outcomes for mothers and babies within this programme remains a priority for the SLCG and during 2013 a Family Nurse Partnership (FNP) was established in the southern locality. It is currently working to achieve a registration of 100 first time teenage mothers to the programme.

The SLCG notes the on-going development of an alongside Midwifery Led Unit in DHH and during 2014 / 2015 will work with the Trust to agree a baseline number of Midwife led births to be included in the SBA.
Baseline data (up to 27 November 2013) indicates that there have been 37 referrals to the Weigh to a Healthy Pregnancy programme in the Trust (via CAH and DHH) and the uptake rate is 65%. The continued focus on this programme remains a priority for the SLCG.

Following investment in recent years in both health visiting and midwifery services, the SLCG will continue to ensure it commissions safe and sustainable maternity and child health services at both maternity units and in the community. It will work with the Trust in this regard and ensure that the recommendations of the Maternity strategy continue to be implemented in

the southern area over the coming years in a way which responds to local needs and in line with regional consistency. In particular the SLCG wishes to see:

- The full implementation of the Trust's Normalisation of Birth Action Plan with the resultant reduction in variation in intervention rates within the two local maternity units
- The Trust develop further work to move towards facilitating midwife as the first point of contact
- The SLCG expects the Trust will continue to support the regional work in ensuring a consistent approach to the implementation of the NICE Clinical Guideline 129 on Multiple Pregnancies.
- The SLCG awaits the publication of the Departmental Paediatric strategy, the final recommendations of which will direct its commissioning intent in coming years for paediatric and child health services. However, in the interim the SLCG will continue to work with the Trust to develop paediatric and child health services in the southern area in response to demographic pressures over the last decade resulting in a significantly above Northern Ireland average child population. Of significance within these discussions will be the availability of capital funding to support infrastructure developments on both the CAH and DHH sites.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	• The Trust is expected in 2014/2015 to provide safe and sustainable maternity services in both CAH and DHH Maternity Units. Early indications of any inability to do so must be highlighted to the local commissioner immediately. A SBA level of activity for midwife-led births in DHH will be agreed in year • The Trust is expected to work towards achieving the standards for communication with women and parents on informed choice about place and options for birth • The Trust is expected to demonstrate an increased in referrals for an uptake of midwife-led care, including delivery.
Trusts to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	The Trust is expected to fully contribute to the development of a network service model and care pathway for management of multiple pregnancies in line with NICE Clinical Guideline 129, ensuring compliance with this Guideline.
Trusts to continue to progress the move towards facilitating midwife as first point of contact, and	The Trust is expected to work towards facilitating midwife as first point of contact and also in providing more antenatal care in the

providing more midwife-led antenatal care in the community for women with straightforward pregnancies	community for those women for whom this is clinically appropriate. The Trust is to provide evidence of their progress to achieve this.
Trusts to continue to benchmark their local obstetric intervention rates against peer units and to reduce unexplained variation in intervention rates throughout Northern Ireland	The Trust is expected to benchmark their local obstetric intervention rates in both CAH and DHH against peer units, with the aim of reducing the variation in intervention rates between both units and compared to other units in Northern Ireland.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The SLCG will work with the Southern Trust to enhance the experience and outcome for vulnerable groups of pregnant women in the Southern area, focussing initially on the experience of BME women.

***Will be subject to equality screening**

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Maternity and Child Health	**Obstetrics**	Births	5,875	120	5,995
	Comm Midwives	Contacts	87,025	0	87,025
	Health Visiting	Contacts	116,073	0	116,073
	Speech and Language Therapy	Contacts	18,099	0	18,099
		VALUE OF COMMISSIONED ACTIVITY[62]	£27.1m	£1.4m	£28.5m

[62] This includes activity in addition to that set out above.

9.4.3 POC 3: Child & Family Care

Introduction

The Families Matter Strategy (DHSSPS, March 2009) is a 10 year strategy which prioritises prevention and early intervention in providing support to families and sets the commissioning intent for this Programme of Care.

The SLCG have been working in partnership with the Trust to deliver on the recommendations of Transforming Your Care in relation to family and child care. In the SLCG area, the focus has been on developing early intervention and prevention services which will provide alternatives to residential care and support families at times of crisis.

Care Matters in Northern Ireland (DHSSPS, 2007) outlines a strategic vision for wide-ranging improvements in services to children and young people in and on the edge of care. It seeks to increase support for vulnerable children and improve outcomes for care-experienced young people through a range of measures including prevention services, support for vulnerable families and improving placement options for children who cannot live at home and improving opportunities in terms of education and extra-curricular activities. The SLCG have already invested significantly in services which offer alternatives to residential care and in early intervention and preventative services.

Enhancing Healthcare Services for Children and Young People in NI: A Review of Paediatric Healthcare Services Provided in Hospitals and in the Community (DHSSPSNI, Nov 2013) and A Review of Children's Palliative and End of Life Care in Northern Ireland (DHSSPSNI, Jan 2014), are both currently out for consultation and the SLCG will await the final recommendations to inform their commissioning intentions for 2014/15 and beyond.

Overview of Local Needs

There are 93,000 children aged 0-17 living in the Southern area, 21.5% of the Northern Ireland total (431,547)[63]. According to the 2011 Census, the SLCG area has the highest percentage of households with dependent children – 37.39%, compared to the Northern Ireland average of 33.86%[64]. The child population of the Southern area is expected to grow by 17.9% between 2008 and 2023. This is significant as the Northern Ireland child population for the same period is expected to increase by only 3.2%. The need to commission the full range of health and social care services for these children, including those with specific and complex needs will continue to increase in line with these demographic changes.

At 31st March 2013, there were 2,807 [65]looked after children in Northern Ireland, about 6 in every 1,000 children (0-17 year olds). This rate is slightly lower in the SLCG area, where there are currently 456 looked after children, about 5 in every 1,000. Two localities in the SLCG area have a higher than NI average percentage of children living in relative low poverty (after housing costs) – Newry and Mourne has 32% of its children living in low income, while Dungannon has 29%. The Northern Ireland average is 27%[66].

The SLCG locality has seen notable inward migration over the last decade with significant numbers of individuals and families choosing to come to live and work in the Southern area. This has placed increasing demand on all services in the area, including health and social services and services have been working hard to adapt to and support their health and social care needs. Craigavon (8.2%) and Dungannon (12.6%) have the highest percentage of children with English as an additional language, well above the Northern Ireland average (3.4%)[67].

[63] NISRA 2012 Mid Year Estimates
[64] Census 2011, KS106NI (administrative geographies)
[65] HSC Corporate Parenting Return
[66] CYPSP Family Resource Survey

Ministerial Targets

The commissioning of services to deliver Ministerial targets is led regionally by the Directorate of Social Care and Children. The SLCG will support their regional direction of travel for commissioning services within this Programme of Care. All communication and monitoring of performance against these targets is led through that directorate.

Commissioned Services

A significant challenge for the SLCG is the overall growth in our child population as discussed in section 1. A key TYC focus for this Programme of Care, is the development and promotion of foster care both within and without families. To support this development, investment was made available in 2013/14 to secure 5 additional front line specialist foster care places for age group 12 plus, and a further 5 additional specialist intensive places for age group 12-17 years with complex needs and require intensive support /wrap-around service.

The SLCG has also developed Therapeutic Services locally though our share of regional funding.

In recognition of the specific needs of children with complex healthcare needs, the SLCG has also invested in the Trust to enhance the existing Community Children's Nursing (CCN) Service by providing dedicated availability of community nurses for children and young people with complex needs at times to include early morning, twilight and weekends.

In the 6 month period March to August 2013, 367 contacts have been made, 93 IV antibiotic doses have been delivered and 29 nasogastric tubes have been replaced, all avoiding hospital admissions/ED attendances. The SLCG expect that this service will continue to support children to be cared for at home and reduce the need for acute admissions.

Supporting carers for children with a disability and complex needs has been a focus of SLCG for a number of years. Given an increasing uptake in carer's assessments, this identified the need to enhance service provision and to ensure continued provision of support for those carers caring for child in transition to adult services up to the age of 20. Regional funding was made available for short breaks for carers support in 2012/13 which was used to support Children with a Disability, Autism and CAMHS. This investment was used to enhance the contract with community and voluntary sector which delivers a programme of social outreach for children and young people.

Regional Commissioning Priority	Local Commissioning Requirement
All Trusts are expected to implement the Crisis Resolution Home Treatment services for CAMHs with associated primary care teams/services including full implementation of the DHSSPSNI strategy for CAMHs.	Should have its Trust Action Plan in place and the full investment deployed for the establishment of PMH and CRHT Teams as agreed leading to reduction in demand for in patient admission and improving access to the service by achieving a reduction to the 9 week target.
Local priority - Children's Palliative and End of Life Care	Pending the outcome of the consultation on the Review of Children's Palliative and End of Life Care in Northern Ireland, the SLCG will undertake an analysis of the existing arrangements in the Southern area which will inform future commissioning intent.
Local priority - Fostercare Places	The SLCG will continue to prioritise the development of additional foster care places as a means of providing alternatives to residential care.
Local priority - High Cost Cases – Children with Complex Needs	The SLCG is aware of the on-going need to support children with highly complex needs. A number of such cases were supported in 2013/14 and the SLCG will continue to be aware of the need to commission services for these children in the future.

9.4.4 POC 4: Older People

Introduction

Transforming Your Care (TYC) sets a clear direction for a range of services required for our older population, with home as the hub of care being at the forefront. The report recommends that steps are taken to ensure that a greater proportion of care is delivered in a home or community setting. It also supports the trend towards independent living, signalling reduced demand for residential home care and a shift of resources to home-based care. TYC references the potentially detrimental effect that an admission to hospital can have on independence and confidence levels of our older population. It endorses models such as reablement, intermediate care which will encourage and protect independence and the establishment of Integrated Care Partnerships which will focus on improving pathways for our frail elderly population, those with long term conditions (initially COPD, stroke and diabetes) and palliative/end of life care.

Three Integrated Care Partnerships (ICPs) have been developed across the Southern area during 2013/14 involving a number of key stakeholders including patients/carers, GPs, secondary care teams, community and voluntary sector organisations, AHPs, social workers and other specialist community staff.

The Dementia Strategy for NI (DHSSPSNI, Nov 2011) sets out actions for a number of organisations focussing on delaying the onset of dementia/reducing risk of development of dementia, raising awareness, promoting early assessment and diagnosis and supporting people with dementia and their carers. It is thought that there could be as many as 3,465[68] people with dementia living in the SLCG area, many may not yet be known to services. According to Alzheimer's Society, about two thirds of those with dementia are females and the proportion of the population with dementia doubles with

[68] http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1667

each 5 year age gap. By the time a person reaches the age of 95, they have a one in three chance of having dementia. In the UK, around 60,000 deaths a year are directly attributable to dementia and if the onset of dementia could be delayed by 5 years, it would reduce deaths directly attributable to dementia by 30,000 a year[69].

Overview of Local Needs

In 2012, there were 48,922 people living in the SLCG aged 65 or over, representing 13% of the total SLCG population and 17.9% of the total 65+ population of Northern Ireland. It is projected that our local 65+ population will rise to 63,000 people (representing 15.5% of the SLCG population) by 2021. Population projections also indicate that by 2021 the SLCG population aged 85 years and over will grow by 69% to reach 9,000.

In 2011, 15.7% of the 228[70] persons aged 100+ living in NI, resided in the SLCG area. Over 40% of our population aged 75+ live alone, with the Armagh Local Government District having a higher percentage of 75 year olds living alone in comparison to other localities in the SLCG area[71]. A wide range of community based services are delivered to our older population across the SLCG area. Currently, 1,707 people are in receipt of a care home package (1,340 nursing and 367 residential) and over 3,538 are in receipt of a domiciliary care package. There are 40,607 unpaid carers in the SLCG area, with a quarter of these providing at least 50 hours of care each week and recent engagement by the SLCG with carers has highlighted the importance of the commissioning and provision of support to them.

In the SLCG area in 2013, 2,215 people were registered with GPs as having dementia. Alzheimer's Society prevalence rates applied to SLCG residents would suggest that there may be as many as 3,465 people with dementia and that this will increase to 4,677 by 2021[72].

[69] http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=341
[70] Census 2011, Usually Resident Population by single year of age and sex (administrative geographies)
[71] Census 2011, Demography, Household Composition - Households
[72] http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1667

In the SLCG area, 18% of Emergency Department/Minor Injuries Unit attenders during 2011/12 were aged 65 and over, whilst 50% of those attenders resulted in a hospital admission. In the SLCG Emergency Departments, during 2012/13, there were 24,537 attendances by people aged 65 and over and there were 10,537 unplanned hospital admissions in the same period for people aged 65+. Currently, there are 96 non-acute assessment and rehabilitation beds based across 2 sites, including a small number for stroke patients. Day hospital and rapid access clinic facilities are also located in a range of sites across the SLCG area.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets.

Commissioned Services

In addition to commissioning services to respond to the Ministerial targets, the SLCG will commission a range of additional activity in 2014/15 to respond to the needs of the growing older population as identified in Section 4.1.2 above. Working closely with the ICPs, the SLCG anticipates the development of patient pathways to enhance care provided to frail older people and promote independence and wellbeing. The SLCG has invested in 2013/14 in 5 reablement teams, with the capacity to deal with 1,000 cases per year (based on an average of 2 weeks reablement per client). The SLCG wishes to see full implementation of the Trust's reablement service in 2014/15, with all 7 teams being in place in year. Each team should deliver services 7 days a week. The SLCG will therefore consider the appropriate balance of new investment across both reablement and domiciliary care, ensuring there is evidence of a shift in provision, including commissioning from other sectors.

The SLCG have over recent years invested significantly in improved and more flexible respite options, such as short breaks and will continue to do this by looking to the potential of other providers and other sectors in delivering this.

In 2013/14, the SLCG invested funding in the Trust to develop a rapid response team and expect this to be operational by April 2014, with a view to further enhancing this across other localities on a phased basis. The first team is expected to take a minimum 5 referrals per day (1,050 per year) to provide timely intervention in either the patients home or a community setting. It is expected that this investment will bring about a reduction in lengths of stay and a reduction in unplanned hospital admission for older people.

The SLCG anticipates that during 2014/15, as a result of investing in community infrastructure, demand for inpatient medical assessment/rehabilitation and statutory residential care will reduce, resulting in a reduction in the number of statutory residential home beds required and opportunities to consolidate the provision of non-acute assessment and rehabilitation beds.

The SLCG recognises that with the increasing population of older people anticipated, including an increase in the number of people with dementia (as discussed in section 4.1.2) a continued commissioning focus is required for this ever growing population and its disease specific sub-populations. During 2012/13 and 2013/14, regional investment was secured to enhance local services for people with dementia. During 2012/13, investment was secured to expand memory clinics and in 2013/14, further investment was sought to introduce a Navigator role for signposting and provide enhanced access to psychological support.

POC4 – Older People	
Regional Commissioning Priority	**Associated Local Commissioning Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The Trust will be expected to increase the number of carers assessments offered by 10% using the 2013/14 outturn as a baseline. According to Carers Matters , 42% of carers surveyed in Northern Ireland said they had missed out on financial support as a result of a lack of advice and information. To support people in meeting unplanned costs of their caring role, the LCG have since 2012/13 allocated funding to the Southern Trust to increase the budget for cash grants to carers. This should continue to be supported by the Trust. The Trust is also expected to fully deliver on the investment made in 2013/14 to provide programmes which focus on prevention and early intervention for people who have a caring role.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The Trust should work towards further innovation in the respite model and actively seek the inputs of other sectors in the delivery of respite care. During 2014/15 the SLCG will take forward a project to develop innovative short breaks for older people.
To increase uptake of direct payments	The Trust is expected to increase the number of direct payments by 5% using the 2013/14 outturn as a baseline. Those programmes of

	care performing less well than others within the Trust should raise their performance beyond the 5% target.
Working with ICPs to improve the care of the frail elderly.	The SLCG will continue to work with our local ICPs and will during 2014/15 commission further pathway development in line with agreed ICP specifications. Monitoring systems will be established to measure the progress that ICPs are making towards improved patient care and shift left.
Enhancement of dementia services	The Trust will be expected to implement investments to date and work with a range of partners to develop proposals against remaining allocations. The focus for 2014/15 will be on training, information and support to carers and people with dementia and respite/ short breaks.
Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements.	During 2014/15, the SLCG will undertake a review of intermediate care service locally and the role it plays in managing demand for a range of services for older people. The Trust will be expected to participate in this.
Continued roll-out of targeted Public Health Agency (PHA) preventative health and well-being improvement programmes.	The Trust is expected to work towards delivering an increased focus on work to promote healthy ageing, individual resilience and independence. In particular the SLCG would wish to support the development of a local programme which tackles the issue of social

	isolation amongst our older population. The "combat loneliness" programme is an exemplar in this regard and the Trust should develop plans to take this forward locally, making particular use of the contribution of community and voluntary sector organisations.
Review of emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The LCG will work with the Trust during 2014/15 to ensure that reablement is having a positive impact on the independence levels of our older population and the Trust's ability to manage demand for domiciliary care services. The Trust is expected to complete the roll out of reablement during 2014/15 to ensure full coverage (7 teams) by 31st March 2015.
Local Priority	• The Trust is expected to put bring forward options for the future provision of non-acute hospital services for older people with a view to consolidating provision, based on an increased community services focussing on prevention of admission and facilitating early discharge. • The Trust is expected to demonstrate the availability of appropriately skilled professionals working across both hospital and community settings on a 7 day basis, to ensure that our older people are able to maximise their potential following a period of ill health.

Local Priority	• The Trust is expected to have the first phase of this service established by 31st March 2014. SLCG expects this team to be in a position to evidence a reduction in unplanned admissions and a reduction in lengths of stay for our older population. • The SLCG will work closely with the Southern Trust during 2014/15 to evaluate the impact of this service model and plan the further implementation across the remaining localities within the SLCG area. The SLCG anticipates this team will be funded through a shift of resources from hospital to community.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied Beddays	64,835	0	64,835
	Day Care	Attendances	51,025	0	51,025
	Domiciliary Care	Hours	2,149,929	110,000	2,259,929
	Residential & Nursing Homes	Occupied Beddays	611,740	0	611,740
	Community Nursing & AHPs	Face to face contacts	462,985	0	462,985
	Social Work	Caseload	6,920	0	6,920
		VALUE OF COMMISSIONED ACTIVITY[73]	£118.1m	£6m	£124.1m

[73] This includes activity in addition to that set out above.

9.4.5 POC 5: Mental Health

Introduction

Inpatient mental health services are provided in the Southern area in the 74-bedded Bluestone Unit, located on the CAH site. The Trust has implemented the stepped care model for mental health and significant investment, both regional and local, continues to see these services developed. A full range of community mental health services are provided by a range of multi-disciplinary teams across the Southern locality, with a focus on prevention and early intervention and maintaining individuals as close to home as possible.

TYC references the higher mental health needs of Northern Ireland in comparison to other parts of the UK and links this to deprivation and the troubled history of the region. Mental health is a key aspect of inequality and is related to both physical health and socio-economic deprivation. Recommendations from TYC include increased focus on suicide prevention and promotion of mental wellbeing, establishment of early intervention programmes, improved pathways for people who require help for a mental health problem, progress with the resettlement programme and increased involvement of community and voluntary sector organisations.

The Northern Ireland Suicide Prevention Strategy – Protect Life: A Shared Vision 2012 – 2014 notes that suicide is now one of the leading causes of death in young adults, with significantly more young men than women taking their own lives. The Mental Health Promotion and Suicide Prevention Action Plan for the SLCG area has seen increased outreach provision, improved communication and joint working with key priority groups including LGBT (Lesbian, Gay, Bisexual and Transgender), Travellers and Black and Minority Ethnic (BME) groups and increased training provided across a range of settings including key employers and sporting organisations. There has also been increased support to communities in the aftermath of suicides and increased access and referral to services for individuals at risk of mental health, suicide and self-harm.

The Bamford Review, Commissioning Plan and TYC requires that there should be no long-stay patients in mental health hospitals by March 2015. The overarching aim of resettlement is to provide suitable alternative community placements in which meet individual need and an improved quality of life.

The Health Minister launched his Department's Service Framework for Mental Health and Wellbeing on World Mental Health Day, Monday, 10 October 2011. The Framework takes forward the values and principles of the Bamford Review. It sets out clearly the key standards in services that mental health patients and clients can expect and that service commissioners and providers must seek to deliver. The Framework provides standards of care that are underpinned by robust evidence, regional/national Policy, the findings of regional Inquiries, the experience of service users and also relevant legislative requirements.

The Framework sets out performance standards and targets in respect of day-to-day service delivery across the HPSS. This includes reference to the desired clinical and social care outcomes and timeframes across a range of service sectors and settings. The Framework will therefore provide a potential vehicle against which the quality of services/service provision may be judged by members of the public, Commissioners and other organisations which are required to report on the performance and quality of services and care.

Overview of Local Needs

There are 2,979 [74] people currently registered with the Southern LCG GPs as having mental illness including Schizophrenia, Bipolar Disorder or other psychoses. This equates to approximately 7.6 people in every 1,000.

In terms of hospital services, the SLCG have been experiencing higher than average levels of admissions. During the period April 2010 to March 2013 the Trust had the highest average number of all mental health monthly ward

[74] NINIS Health & Social Care, Health of the Population, Disease Prevalence, 2013

admissions in comparison to the other 4 HSC Trusts, seeing an average number of 130 admissions per month , representing 29% of the NI average number of 442 monthly admissions. In the same period, the Trust experienced the highest number of mental health admissions to acute wards and represented 27% of the NI total in 2012/2013[75]. During 2009 the SLCG area saw the highest level of hospital admissions related to mood or anxiety disorder which represented 31% of 709 total admissions for N. Ireland[76]. The SLCG area also experienced the second highest number of self-harm hospital admissions in 2009 which accounted for 19% of the total Northern Ireland self-harm hospital admissions[77]. During 2012, within the SLCG there were 308 mental health compulsory admissions which represented the highest number across Northern Ireland and accounted for 28.6% of the total for N. Ireland[78].

The Trust's community addictions service experience demand of around 42 new patients every week, who will require either 1:1 therapy or group sessions. In 2011/12, the Trust primary mental health care service received 5,022 referrals. At this stage, a waiting list for assessment and treatment was developing and in 2012/13, the SLCG invested significantly to enhance this team to cope with demand, securing an additional 7,340 contacts per year. As referenced below, The SLCG has also recently invested to secure independent sector input to assist with demand pressures.

In the SLCG area, there are 46 people with mental health difficulties living in residential care, 121 living in nursing home care and 87 living in supported living arrangements. 117 people were in receipt of day care (all sectors) and 285 people were in receipt of domiciliary care [79].

Suicide continues to be a major source of concern to all agencies and organisations committed to promoting positive mental health and developing

[75] HSCB Mental Health and Learning Disability Monthly Information Bulletin 2012-13, March 2013
[76] NINIS Health & Social Care, Health of the Population, Hospital Admission due to Mood or Anxiety Disorder, 2009
[77] NINIS Health and Social Care, Social Care, Hospital Admissions due to Self Harm, 2005-2009
[78] NINIS Health & Social Care, Health of the Population, Mental Health – Compulsory Admissions, 2012
[79] SHSCT Delegated Statutory Functions Return 2012/13

resilience and individuals and communities to cope with the challenges and changes of life. Within Northern Ireland, of the top 10 LGDs with the highest suicide rates (i.e. deaths per 100,000 population), 3 of these are in the SLCG area, namely Dungannon (17.1), Newry and Mourne (17.0) and Armagh (16.8), compared to a NI average of 14.7[80]

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Direct Payments (Ministerial Target 23) – By March 2015 secure a 5% increase in the number of direct payments across all programmes of care.
- Carers Assessments (Ministerial Target 22) – by March 2015, secure a 10% increase in the number of carers' assessments offered.
- Substance misuse (Ministerial Target 3) - By March 2015, services should be commissioned and in place that provide seven day integrated and coordinated substance misuse liaison services within all appropriate HSC acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention programmes.

Commissioned Services

During 2013/14, a consultation on the regional review of Tier 4 addictions service was carried out. Pending the outcome of the consultation, it is likely that the Southern area will lose inpatient addictions beds in the near future. As a consequence, the SLCG will commission arrangements to ensure that our residents have equitable access to beds provided regionally. During 2014/15 and beyond, the SLCG in partnership with the PHA, will work with the Trust to consider the supports needed across a range of sectors to enable the development of community services (tier 1-3), focussing on prevention, early intervention and community based treatment.

[80] The NI Suicide Prevention Strategy – Protect Life: A Shared Vision 2012 – 2014

Following significant investment in 2012/13, the SLCG continued in 2013/14 to invest in primary mental health care services in the Trust to increase capacity by an additional 150 initial assessments and 600 review appointments to improve access to mental health assessment and treatment services.
The SLCG also invested in specialist staffing to support individuals with an eating disorder to avail of local inpatient treatment and is pleased to note that in 2013/14, no patient required an extra contractual referral for such treatment outside Northern Ireland. In addition, the SLCG invested non-recurrently in inpatient mental health nursing services (bank nurses) during 2013/14, to respond to the Trust's identification of increased pressure.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	Transforming your Care (2011) recognizes the need for more practical support for carers through improved access to respite, which should become more community based, provided largely through the independent sector. The Trust will be expected to increase the number of carers assessments offered by 10% using the 2013/14 outturn as a baseline. The Trust should continue to support the local carer's forum in ensuring that their voices are heard and that they are involved in service development within the Trust. Information around respite and short breaks services should be made available in accessible formats to ensure it reaches all carers and service users. The Trust is also expected to fully deliver on the investment made in 2013/14 to provide programmes which focus on prevention and early intervention for people who have a caring role.
Access to more options for carers in the provision or	The provision or arrangements to improve support to

arrangement of their respite/short breaks.	carers of Short breaks is intended to achieve some of the following: • Minimise the risk of possible breakdown in the carer support to the service user • Help the carer to deal with crisis situations which might prevent them from continuing in the caring role • Prevent the social isolation of the carer • Enable the carer to sustain family/social relationships • Provide positive benefits for both carer and service user. The Trust should work towards further innovation in the respite model and actively seek the inputs of other sectors in the delivery of respite care.
Increase uptake of direct payments.	The Trust will increase the number of direct payments by 5% using the 2013/14 outturn as a baseline. The SLCG would wish to see the mental health Programme of Care increase their performance beyond the 5% target.
Implementation of the Protect Life strategy	The Trust should ensure that the "Protect Life Strategy is both refreshed and fully implemented to include: • Contributing to the development of an improved model

	of support for those who self-harm. • Specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. Supporting the on-going delivery of the Lifeline Service and implement the regionally agreed memorandum of understanding.
Establishment of integrated care arrangements for the care and treatment of patients with common mental health needs	• During 2014/15, the Southern Trust should ensure the roll out of the model and further training. • The Trust should provide a monitoring report to the SLCG by the end of March 2015, outlining the numbers trained and how numbers of Psychological Therapy Sessions in primary care have been increased. During 2013/14, the SLCG established a talking therapies project team and it is anticipated that a consortium comprising a range of representatives will be underway by 2014/15. This structure will inform how investment is made locally to support the development of a primary care talking therapies service.

Further development of specialist community services	The Trust should report on current funded WTE ASD Services in Adults. The Trust should continue to ensure that all patients with Eating Disorders are treated locally and report at the end of March 2014 on the numbers of local ED admissions with Trust facilities.
Improved Psychiatric Liaison Services	The Trust will ensure a maximum 2 hours response time in Emergency Departments. The Regional Commissioning Team is currently developing this model for implementation in 14/15.
Local Priority	• The Trust will ensure that waiting time targets for assessment and treatment in adult mental health, dementia and psychological therapies services are met. • Following on from non-recurrent investment during 2013/14, by 30th April 2014, the Southern Trust should provide the SLCG with evidence to support their nursing pressures created through increased demand for inpatient mental health services.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied Beddays	36,100	0	36,100
	CPN	Contacts	26,908	0	26,908
	Res & Nur Homes + Supported Housing	Occupied Beddays	58,400	0	58,400
	Day Care	Attendances	31,745	0	31,745
	Dom Care	Hours	120,505	0	120,505
		VALUE OF COMMISSIONED ACTIVITY[81]	£45.2m	£2m	£47.2m

[81] This includes activity in addition to that set out above.

9.4.6 POC 6: Learning Disability

Introduction

Within the Southern Area, there are 16 inpatient assessment and treatment beds currently located on the Longstone site in Armagh. A capital build programme is currently underway adjacent to the Bluestone Unit on the CAH site, which will provide 10 beds. The transfer of these beds will provide an integrated approach to the care of patients with Learning Disabilities. IN addition, a range of support services are provided, including day care, day opportunities, respite and domiciliary care are provided across the Southern area.

The Bamford Review of Mental Health & Learning Disability for Northern Ireland (August 2007), sets the vision for services for people with mental health problems and learning disability. Central to the Bamford vision is valuing people with mental health needs or a learning disability, ensuring their right to full citizenship, equality of opportunity and self-determination. To make the Bamford vision a reality for people with learning disability, Trusts need to ensure that they provide a person-centred, seamless community-based service, informed by the views of service users and their carers, making early intervention a key priority and protecting and promoting people's mental health.

By the end of March 2014, all remaining long stay patients with Learning Disability in the SLCG will have been resettled into the community. This represents a significant step forward in the long term care of people with a Learning Disability and has been completed a year ahead of schedule. During 2013/14, 30 people have been resettled within the Trust with a total of 31 planned by the end of March 2014. The priority for the Trust in the years ahead is to start identifying those individuals who live in the community with parents and or families and support then to live independently with the right support.

TYC builds on the Bamford Review, by recommending further development of a more diverse range of age appropriate day support and respite/short break services. Recently the HSCB consulted on a Regional Review of Day Opportunities. The consultation document considers a regional model which sets out the need to both improve day centres for people with complex healthcare and behavioural support needs, and community based day opportunities. This consultation comes to an end on Friday the 10th of January 2014. It is anticipated that the post consultation report will be presented to the Regional Bamford Board in March 2014 with a view of developing a regional implementation group in early April 2014.

The Service Framework for Learning Disability standards has been developed over the past 3 years. The standards were widely consulted on during this time led by the 'Association For Real Change' (ARC). The Framework was launched by the Minister on the 27th of September 2012. Each standard has Performance Indicators along with quantifiable measures that assess/measure the extent that each standard is implemented.

The Framework aims to set out clear standards of health and social care that are both evidence based and measurable. They set out the standard of care that service users and their carers can expect, and are also to be used by health and social care organisations to drive performance improvement through the commissioning process.

People with Learning Disabilities have a variable range of health and social care needs. In general, people with learning disabilities experience greater health and wellbeing inequalities than the general population. In general they have poorer health but have difficulties accessing the services they need. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. A Direct Enhanced Service (DES) for learning disability service has been in place for a number of years to facilitate access to primary health care services for people

with a learning disability and 67 of the 77 GP practices in the Southern area are currently registered to provide this service.
Health problems which are more common in people with Learning Disability include: respiratory disease epilepsy, mental health problems, communication problems, visual and dental problems and coronary heart disease. Life expectancy is shortest for those with the greatest support needs and the most complex and/or multiple (co-morbid) conditions. This change in demographics referenced above and improvements in treatment and care not only means that there will be a growth in the population of people with Learning disabilities but an increase in the numbers of those with more severe disabilities.

Overview of Local Needs
In 2005, the Bamford Report estimated that about 9.7 per 1000 people in Northern Ireland had a Learning Disability, with over 27% of these being severe or profound. Increased life expectancy, added to the significant increase in births in the SLCG area over recent years will cause this to increase further.

The Trust report contact with 1,627 people with learning disabilities at end of March 2013, 1,201 of these were aged 16+. The adult population in the Southern area has increased by 24% between 2001 and 2012 and is expected to increase by a further 12% over the next ten years. Bamford estimates, that there may be approximately 2580 people with Learning Disability in the SLCG area, an increase of over 500 during the last 10 years and an increase of 300 during the next ten years.

Currently, 126 people with Learning Disabilities in the SLCG area live in residential care and 180 people live in nursing care. 466 people are regular users of day care, the vast majority through Social Education Centres[82].
There are currently 232 individual Supported Living placements in the Trust locality provided by a range of providers and housing associations. The Trust

[82] DHSSPSNI/NISRA Statistics on Community Care for Adults in NI 2012-13 (Dec 2013)

has recently undertaken a further piece of work to start identifying future need as well as the care and support needed to maintain the placements.

There are currently 167 individuals receiving Day Opportunities from total weekly available places of 405. There are also an additional 157 individuals availing of community access which includes college courses and community services.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Direct Payments (Ministerial Target 23) – By March 2015 secure a 5% increase in the number of direct payments across all programmes of care.
- Carers Assessments (Ministerial Target 22) – by March 2015, secure a 10% increase in the number of carers' assessments offered.

Commissioned Services

During 2013/14, the SLCG through its engagement processes was made clearly aware of the challenge facing carers of individuals with Learning Disability in providing care for their loved ones. The SLCG is committed to ensuring that carers have access to adequate short break and respite services.

In order to support individuals with Learning Disability in the community, the SLCG anticipates that the Trust will work closely with other sectors to develop a range of age appropriate, meaningful and developmental day opportunities and short break/respite services which meet the needs of individuals. In addition, the SLCG wish to see a further increase in the uptake of direct payments within this programme of care, enabling individuals to have more control over the services which they require to meet their needs.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The Trust will be expected to increase the number of carers assessments offered by 10% using the 2013/14 outturn as a baseline. The Trust is also expected to fully deliver on the investment made in 2013/14 to provide programmes which focus on prevention and early intervention for people who have a caring role. The Trust should continue to support the local carer's forum in ensuring that their voices are heard and that they are involved in service development within the Trust. Information around respite and short breaks services should be made available in accessible formats to ensure it reaches all carers and service users.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The provision or arrangements to improve support to carers of Short breaks is intended to achieve some of the following: • Minimise the risk of possible breakdown in the carer support to the service user • Help the carer to deal with crisis situations which might prevent them from continuing in the caring role • Prevent the social isolation of the carer

	• Enable the carer to sustain family/social relationships • Provide positive benefits for both carer and service user. The Trust should work towards further innovation in the respite model and actively seek the inputs of other sectors in the delivery of respite care.
Delivery of day services in line with the Regional Day Opportunities Model	The Trust is expected to specify the percentage of community based services available/uptake figures.
Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	The Trust is expected to develop their specialist community services to respond to the needs of people whose behaviours challenge services and those with offending behaviours including 2 hour response 7 days per week and high support beds in the community. This will be measured through 28 day breaches monitoring systems.
Increase uptake of direct payments	The Trust is expected to increase the number of direct payments by 5% using the 2013/14 outturn as a baseline. The SLCG expects to see Programmes which are performing less well raise their performance beyond the 5% target.
Development and implementation of health promotion	The Trust is expected to ensure continued development and

initiatives for people with a learning disability.	implementation of Learning Disability specific Health Promotion initiatives within their overall Health Promotion Strategy.

***Will be subject to equality screening**

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Learning Disability	**Hospital Services**	Occupied Beddays	17,440	0	4,672
	Day Care	Attendances	95,905	0	95,905
	Domiciliary Care	Hours	213,638	4,800	218,438
	Residential & Nursing Homes	Occupied Beddays	98,915	0	98,915
	Community Nursing and AHPs	Face to face contacts	47,274	0	47,274
	Social Work	Active Caseload	2,122	0	2,122
		VALUE OF COMMISSIONED ACTIVITY[83]	£50.6m	£4.6m	£55.2m

[83] This includes activity in addition to that set out above.

9.4.7 POC 7: Physical Disability & Sensory Impairment

Introduction

The DHSSPS Physical Disability & Sensory Impairment Strategy (2010) brings forward a number of recommendations to improve the range of services available for people with a disability. The Strategy sets out a number of actions for commissioners and providers, through a multi-agency approach, to ensure a range of opportunities and supports are available to individuals to enable them to maintain independent lifestyles, by providing flexible budgets (e.g. self-directed support) using person centred approaches.

TYC builds on this and sets the themes of personalisation and independence, with more control for service users over budgets and health and social care organisations taking on the role of enabler and information provider. TYC also recommends a greater availability of respite and short break options for people with disabilities and sensory impairments.

The Northern Ireland Survey of Activity Limitation and Disability conducted by NISRA in 2006/07 identifies that 18% of all people living in private households in Northern Ireland have some degree of disability. The prevalence rate is 21% for adults and 6% for children (NISRA, 2007). The 2011 Census also tells us that in the SLCG area, 7.87% of households have been adapted to accommodate a wheelchair user, above the NI average of 6.4% and 5.92% of households have been adapted to accommodate other physical or mobility difficulties.

Estimates for Northern Ireland show that in 2010 there was approximately 8,900 people who are deaf blind equating to a prevalence rate of 0.5% of the population. Using population projections extrapolations indicate that this will rise to 14,700 people or a prevalence rate of 0.75% of the population by 2030.

Overview of Local Needs

The Physical Disability & Sensory Impairment Strategy suggests that 21% of adults in Northern Ireland, or 322,000 people, have some form of disability

(based on NISRA 2007 data), an increase on the estimated rate for 1992 (18%). The SLCG population aged 20+ has grown by 40% in the past twenty years and is projected to increase by a further 12% by 2021. This growing adult population added to the increasing numbers of children with disabilities progressing to into adult services is and will continue to place increasing pressure on adult disability services.

During 2012/13, 2,141 adults were in receipt of a range of social care services for people with disabilities. 156 people with a physical disability were registered in day care placements in the Southern area provided in a range of facilities. A further 100 individuals were availing of day opportunities, 2 people with a physical disability were living in a supported living facility, 5 living in an independent residential care home and 52 living in an independent nursing home[84]. In total, 700 people with a physical or sensory disability were in receipt of over 300,000 hours of domiciliary care.

Engagement with people with physical and sensory disability is central to developing the SLCG commissioning intent. At a recent event held in Armagh in December 2013, SLCG members had an opportunity to engage with a group of young adults with a physical disability and hear their views on the services currently provided to them and those they would wish to see in the future. During 2014/15, the SLCG plan to establish a forum for individuals with physical and sensory disabilities, to empower them to contribute to the commissioning agenda.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Direct Payments (Ministerial Target 23) – By March 2015 secure a 5% increase in the number of direct payments across all programmes of care.

[84] SHSCT DSF Return 2012/13

- Carers Assessments (Ministerial Target 22) – by March 2015, secure a 10% increase in the number of carers' assessments offered.

Commissioned Services

In addition to commissioning services to respond to the Ministerial targets, the SLCG will commission a range of additional activity in 2014/15 to respond to the needs of individuals with physical and sensory disability and their carers. In particular, the SLCG continues to expect the Trust to increase the uptake of direct payments in this programme.

The SLCG in response to the direction of travel signalled in TYC continues to support the move from day care to providing day opportunities, with the vision for the future to ensure that individuals with a disability will have appropriate support to enable them to be as independent and socially active as possible. The SLCG anticipates that the Trust will work closely with other sectors to develop a range of age appropriate, meaningful and developmental day opportunities which meet the needs of individuals.

During 2014/15 the SLCG anticipates carrying out a review of services to individuals with brain injury in the Southern locality. This will inform commissioning intent and future investment in this service area in 2015/16.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The Trust will be expected to increase the number of carers assessments offered by 10% using the 2013/14 outturn as a baseline. According to Carers Matters, 42% of carers surveyed in Northern Ireland said they had missed out on financial support as a result of a lack of advice and information. To support people in meeting unplanned costs of their caring role, the LCG have since 2012/13 allocated funding to the Southern Trust to increase the budget for cash grants to carers. This should continue to be supported by the Trust. The Trust is also expected to fully deliver on the investment made in 2013/14 to provide programmes which focus on prevention and early intervention for people who have a caring role.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The Trust should work towards further innovation in the respite model and actively seek the inputs of other sectors in the delivery of respite care. Information around respite and

	short breaks services should be made available in accessible formats to ensure it reaches all carers and service users.
To increase uptake of direct payments	The Trust will be expected to increase the number of direct payments by 5% using the 2013/14 outturn as a baseline. The LCG would wish to see Programmes which are performing less well raise their performance beyond the 5% target
Review Trust progress in relation to the review and reform of day opportunities in alignment with personalisation initiatives in line with both TYC and the Physical and Sensory Disability Strategy.	During 2014/15, the Trust should review existing availability and uptake of day opportunities within this programme and ensure the continued development of community access team to focus on building relationships and creating an environment where day opportunities can be realised.
Local Priority	During 2014/15 the SLCG will undertake a review of local service provision (all sectors) for people with a brain injury, with a view to ensuring equity of access and improved provision throughout the statutory and non-statutory sector.

***Will be subject to equality screening**

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability	**Hospital Services**	Occupied Beddays	0	0	0
	Daycare	Attendances	21,993	0	21,993
	Domiciliary Care	Hours	348,092	17,000	365,092
	Residential & Nursing Homes	Occupied Beddays	17,520	0	17,520
	Community Nursing & AHPs	Face to face contacts	26,978	0	26,978
	Social Work	Active caseload	2,526	0	2,526
		VALUE OF COMMISSIONED ACTIVITY[85]	£18.8m	£1m	£19.8m

[85] This includes activity in addition to that set out above.

9.4.8 POC 8: Health Promotion & Disease Prevention

Introduction

Health and wellbeing improvement refers to any activity which aims to prevent ill health and improve the health and wellbeing of our population. Prevention, early intervention and tackling health inequalities continues to be a key focus of the work of the SLCG and all programmes and interventions in this programme will adopt a proportionate universalism approach, i.e. where actions must be proportionate to the scale and intensity of disadvantage, to tackle rising rates of obesity, smoking and promoting positive mental health and wellbeing. The primary focus of this programme is to reduce health inequalities, with emphasis placed on services commissioned within health and social care, as well as the development of effective partnerships with other sectors, including communities, in order to influence the wider determinants of health.

The Public Health Agency for Northern Ireland is the overarching body that takes forward the regional and local implementation of departmental health improvement and disease prevention work. The SLCG, through its local commissioning intent can support and where appropriate enhance services delivered within this programme and is represented on the local Strategic Health Improvement Partnership forum, which includes all 5 District Council Chief Executives.

Overview of Local Needs

Within the SLCG locality, life expectancy has risen over the last decade. A male aged 65 years would have been expected to live for a further 16.6 years in 2001-03 and this had risen to 17.2 years by 2008-10. A female aged 65 years would have been expected to live for a further 19.3 years in 2001-03 and this had increased to a further 20.2 years by 2008-10[86]. However, there is continued need for improvement. For example, the Southern area has 40% of

[86] Source: Office for National Statistics via NISRA – http://www.nisra.gov.uk/demography/default.asp130.htm

the Traveller population for Northern Ireland resident in its area. For male Travellers, life expectancy at birth is 61.7 years and for females it is 70.1 years, both markedly less than the settled population.

However, in terms of general health and wellbeing, indictors taken from data from the Northern Ireland Health Survey 2011/2012,it is evident that the population in the Southern area shows more positive results than other areas i.e. 18% drink above the recommended weekly limit compared to 25% in Northern Ireland.

The increasing child population in the SLCG area, already noted, provides both challenges and opportunities to ensure every child is given the best start in life. A particular emphasis needs to be put on supporting parents in their role and to assist them in acquiring skills and knowledge for infant and child mental wellbeing, breastfeeding, healthy eating and smoking cessation. Programmes such as the Family Nurse Partnership (4.2) will play an important role in helping young mothers in this respect.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Bowel cancer screening (Ministerial Target 1) - the HSC will extend the bowel cancer screening programme from April 2014 to invite, by March 2015, 50% of all eligible men and women aged 60-74, with an uptake of at least 55% of those invited.
- Tackling obesity (Ministerial Target 4) - by March 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.

Commissioned Services

During 2013/14, the SLCG commissioned a range of services focusing on prevention and early interventions to address the demographic pressures across a range of programmes.

In 2014/15 and beyond the SLCG will continue to promote the earliest possible intervention in individuals and families and will continue to support the Family Nurse Partnership in the Southern area and the Roots of Empathy infant mental health training and parenting support.

The SLCG is fully committed to the empowerment of local communities, community and voluntary organisations to contribute to the delivery of support and community based services. It therefore continues to work towards supporting social enterprise approaches and community development.

Central to this will be tackling health and social wellbeing inequalities and ensuring that by the actions of the SLCG, these are not exacerbated but rather that the outcomes for all residents of the Southern area are equalised, regardless of geographical location, deprivation, education, poverty and housing. The SLCG is committed to ensuring that every individual in the Southern area is supported to reach their full potential, regardless of ability/inability, social, racial and equality status and would want every person to feel valued, of worth and supported to fulfil their hopes and expectations for life.

The SLCG will be guided in its commissioning intent by the range of key Departmental public health strategies in 2014/15. The SLCG will particularly focus on Tobacco Control, The NI Suicide Prevention Strategy – Protect Life: A Shared Vision 2012 – 2014 and the Breastfeeding Strategy. However, in terms of the overall strategic direction for this programme, the SLCG looks forward to the publication of the forthcoming Public Health Strategic Framework and will be guided by its recommendations in the future commissioning of services and

interventions in this programme. The SLCG remains fully committed to exploring the best practice in prevention and early intervention at European and world level in health and wellbeing interventions and programmes.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioning Requirement
Expansion of the early years intervention programme.	By 31st March 2015, the Trust is expected to have demonstrated: • A coordinated approach has been developed across relevant service areas of Trust activity in this programme • An extension of the Roots of Empathy programme • Achievement of FNP targets • Delivery of infant mental health training as per agreed action plan. • Implementation of 5 new Early Intervention programmes to support parents.
Incremental expansion of social economy businesses and community skills development.	The Trust is expected to provide a report to the SLCG which details numbers of social economy businesses engaged by the end of 2014/15.
Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	The LCG will work with the PHA to develop a monitoring report, which will be sought by the end of 2014/15 in regard to this. A coordinated approach should be developed across relevant

	areas of Trust business and in conjunction with other statutory, community and voluntary partners. The Trust will be expected to produce a full year report demonstrating how funding provided during 2013/14 for health improvement for carers and children with disabilities has been used and what outcomes were delivered. The Trust is expected to provide a report which evidences improved access and uptake of targeted health and wellbeing improvement services and programmes by older people by the end of March 2015, using 2013/14 as a baseline. Community Navigator services funded by both the PHA and LCG in 2013/14 should be fully operational by 1st April 2014 and an evaluation of year 1 to be provided by the end of March 2015. Local health action plans relevant to this service should be produced during 2014/15 and shared with the LCG.
LCGs to monitor Trust performance in relation to the HSCB /	The Southern PHA office will liaise with the Trust in relation

PHA Community Development strategy	to this regional priority
Implementation of the "Fitter Futures for All Framework".	The Trust is expected to ensure that by 31 March 2015 they: • Can demonstrate full implementation of the Weigh to a Healthy Pregnancy Programme for women with BMI >40 • Report on the implementation of new 'Baby Friendly' standards. • Report on provision of weight loss programmes for adults and children as appropriate. • Report on contribution to implementation of new standardised Regional Activity Referral Programme • Report from regional working group on progress towards healthier catering and vending provision in all HSC facilities.
Implementation of key public health strategies	By 31 March 2015, the Trust is expected to: • Ensure that smoking Cessation services available with identified group. Brief Intervention training should be delivered to key staff working with priority groups. • Ensure the use of carbon monoxide monitors in ante-natal and pre-operative assessments. • Provide a progress report on smoke free campuses.

	• Have in place a new service model for substance misuse liaison service • Update of Registry and new service model should be developed and delivered.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	The Trust is expected to provide monitoring report outlining range of specialist sexual health services available, numbers and age groups accessing services by the end of March 2015.

***Will be subject to equality screening**

9.4.9 POC9: Primary Health & Adult Community

Introduction

There are presently 77 GP Practices delivering services across SLCG area. The total geographical area of SLCG is 3,188 km^2. As referenced in Section 1.1, NINIS population estimates for 2012 indicate the SLCG population as 363,145. An average GP Practice within the SLCG area will cover an area of 41 km^2 and have an average list size of 4,716[87]. The SLCG area is home to 72 community pharmacies, 37 optometry practices and 58 dental practices.

Out of hours GP services are provided at a range of sites across the Southern area and these are commissioned regionally by the HSCB Directorate of Integrated Care. Demand for these services continues to rise.

Integrated Care Partnerships (ICPs) have been established across Northern Ireland as a recommendation of TYC. These groups each cover populations of c.100,000 people and will be responsible for the coordination of patient pathways and improving care, with an early focus on frail elderly, Chronic Obstructive Pulmonary Disease (COPD), stroke and diabetes. Three ICPs have been developed in the SLCG area – covering the localities of Craigavon & Banbridge, Armagh & Dungannon and Newry & Mourne. The ICPs are managed by a GP Clinical Lead and are supported by a small business support team. In addition, ICP partnership committees have been established for each locality, to include representation from the primary care, Local Medical Committee (LMC), Trust, service users/carers, Northern Ireland Ambulance Service and local community and voluntary sector organisations. Multi-disciplinary teams have also been established for each of the 4 clinical priority areas.

The HSCB tasked the SLCG to take forward work in 2013 /2104 to identify Primary and Community Care infrastructure needs (Hub and Spoke developments) for the delivery of an integrated serviced model to reflect the

[87] Business Services Organisation (BSO)

commissioning direction outlined in TYC and in line with Ministerial direction to HSCB.

Overview of Local Needs

Table 59 illustrated the population sizes of the combined Local Government Districts of our 3 ICP populations. The areas of significant growth for 2023 will include Newry and Mourne LGD with a projected growth of 17.4%, followed by Craigavon and Banbridge LGDs which combined have a growth rate of 15.4%. The SLCG will take account of these growing populations in commissioning decisions, to ensure it is able to meet the primary care needs of this changing population in the future.

The SLCG has completed a detailed locality profile for Armagh, Dungannon and Lurgan in order to inform the prioritization of future hub and spoke developments in the Southern area. This profile has highlighted a range of pressures across the SLCG area including demographic pressure on list sizes, inward migration and infrastructure inadequacies. An integrated primary and community care hub is operational in Portadown and a community hub is currently being built in Banbridge and the Newry City primary and community care hub is at the procurement stage. During 2014/15, the SLCG hopes to work with local stakeholders to prioritise and develop proposals in other localities.

Ministerial Targets

The SLCG will commission services within this programme of care in 2014/15 – 2015/16 in line with relevant Ministerial targets. Of particular note for the SLCG in 2014/15 are the targets on:

- Integrated Care Partnerships (Ministerial Target 26) - By March 2015, 95% of patients within the four ICP priority areas [frail elderly, diabetes, stroke, respiratory] will have been identified and will be actively managed on the agreed Care Pathway.
- Unplanned admissions (Ministerial Target 21) - By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions (using 2012/13 data as the baseline).

Commissioned Services

During 2013/14, the SLCG has worked closely with GPs in all localities of the Southern area, in particular with Newry GPs, to progress the development of the primary care hub and spoke developments in line with HSCB and DHSSPSNI direction. In 2014/15, the SLCG looks forward to having an agreed prioritisation order for future hub and spoke developments including the development of detailed service models for each.

These service models will outline the shift left of activity from secondary to primary and community care with associated shift of resource and the impact of this on services currently provided in inpatient facilities and sites across the Southern area. Central to the success of this approach will be the provision of increased GP access to diagnostics, 7 day community support, improved access to district and community nursing, AHPs, pharmacy and social work and the ability to support individuals in their own homes to prevent unnecessary admissions to hospitals.

Within the Southern area, a number of specialist teams are in place to support people with long term conditions, including heart failure, stroke, diabetes and COPD. The SLCG has also previously invested in an Intra Venous at home service aimed at avoiding the need for admission. However, increasing levels of unplanned admissions over recent years is concerning and commissioning community based services to address this will be a key focus for the SLCG and ICPs. The SLCG has bridge-funded the development of a rapid response model of care for frail elderly and will during 2014/15 be considering how this and other community based models can impact on reducing unplanned admissions and reducing lengths of stay.

During 2013/14, the SLCG invested in additional hours for the local COPD service, to ensure a presence over weekends, this will increase capacity by another 460 referrals (936 contacts) per year. This investment should deliver reduced levels of unplanned admissions/ED attendances and facilitate earlier discharge from hospital.

The SLCG will continue to support, through allocation of its prescribing savings, funding to enhance GP capacity in Primary Care to enable patients to be managed closer to home in line with the direction signalled in TYC and the DHSSPSNI's Commissioning Plan Direction. In addition, opportunities to support Independent Contractors to implement patient pathways that will facilitate early intervention or the management of disease specific conditions for patients will continue to be explored.

The SLCG looks forward to the full implementation and evaluation of the Southern Primary Eye-care Assessment and Referral (SPEARS) pilot currently being implemented by Community Optometrists in one locality for patients with acute eye problems. A report will be presented to the SLCG in 2014 / 2015 enabling it to consider the future commissioning of this pathway.

The SLCG recognises the need to continue engagement with community pharmacists and community dentists to ensure their participation in the development of relevant patient pathways.

Commissioning Priorities and Requirements

POC9: Primary Health & Adult Community	
Regional Commissioning Priority	**Local Commissioning Requirement**
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	The SLCG through its use of prescribing savings will continue to commission in 2014/15, the GP capacity LES, based on £1 per patient registered, to enhance Practices' ability to provide services for patients closer to home and appropriately manage long term conditions in the community.
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility.	The SLCG will work with SHSCT to agree baseline information and bring this service into line with future regional direction for the delivery of 24/7 community nursing services.

10.0 Western Local Commissioning Group Plan

10.1 LCG Population

Demographic Drivers

On Census Day (27 March 2011), the resident population of the Western LCG area was 294,417 persons accounting for 16.26% of the NI total. Mid-Year Estimates show projected increase in population to 296,610 persons.

The age profile on Census Day includes:

- 22.1% were aged under 16 years and 13.1% were aged 65 and over;
- 49.6% of the usually resident population were male and 50.4% were female; and
- 36 years was the average (median) age of the population.

The older people population is lower proportionately than the NI average (13.1% and 14.6% respectively) although the Western area is projected to see the greatest increase in 65+ persons in the next ten years, i.e. 40.1% increase compared to 29.7% for NI as a whole. There were 4,268 births to Western families during 2011.

Mortality and Morbidity

In total, 2,188 people died in 2012 in the Western area, of these 851 (38.9%) were under 75 years old. Of all deaths, 628 (28.7%) were to malignant neoplasms; 335 (15.3%) were to respiratory disease; and 581 (26.6%) were to circulatory disease. (Note: Deaths data for 2012 are provisional.) The median age at death was 78 in 2011.

Potential Years of Life Lost (PYLL) is a measure of premature death, measured as the number of years of life 'lost' from a death when a person dies before the age of 75. A death at age 25, for example, has lost 50 potential years of life. In the Western area, the PYLL per year per 100 population for 2006 to 2008 was 8.0 years for males and 4.3 years for females.

The Standardised Mortality Ratio is a method of comparing mortality in different populations, while allowing for differences in the age structure of these populations. The Northern Ireland rate is set equal to 100 and a value greater than 100 indicates above average mortality. In the West, the Standardised Mortality Ratio from 2008-2010 for all ages was 99.8. The SMR (all ages) for Western LCG area has improved from 106 to 102 over the past decade. The Under 75s SMR has moved from 105 to 103.

Average death rates are available from 2004-2008 standardised for age to the 2004-2008 Mid- Year Population Estimates. In the Western area, the standardised death rate (per 100,000 population) for the population under 75 years of age was 438.5 for males and 283.7 for females.

There were 7,282 incidences of all cancers (excluding non-melanoma skin cancer) in the West in the 5 year period 2007-2011.

The NI Cancer Registry provides a five-year standardised cancer incidence ratio. The Northern Ireland rate is set equal to 100 and a value greater than 100 indicates above average incidence of cancer. The latest dataset available is for 2007-2011 and the standardised cancer incidence rate for all persons in the Western HSCT was 97.9.

On Census Day 2011, the population in the West reported that 21.85% or 64,330 of people had a long-term health problem or disability that limited their day-to-day activities and 11.04% or 32,386 of people stated that they provided unpaid care to family, friends, neighbours or others.

Life expectancy in the West is slightly below the NI average for both men and women (76.7 years for Western men compared to 77.1 years for NI and 81.4 years for Western women compared to 81.5 years for NI) (Source: Life Expectancy, DHSSPSNI).

It is of concern that the West remains among the highest rates for deaths for smoking related causes, above the NI average standardised death rates.

Notably the rate has reduced in recent years by 4% to 141.2 deaths per 100,000 population (Source: PSAB, DHSSPS). Standardised alcohol-related admissions in the West has risen by 41% from 476 admissions in 2000/01-2002/03 to 670 admissions in 2008/09-2010/11. Standardised death rates due to alcohol are also above the NI average.

There were 272 admissions as a result of injuries due to road traffic collisions in 2009/10. This represents 12.3% of all hospital admissions due to accidents and is higher than the NI average of 10.6%. There were 620 admissions as a result of injuries in the home in 2009/10 which represents 27.9% of all hospital admissions due to accidents, again higher than NI average of 22.9%. There were 69 admissions to hospital due to accidental injuries occurring at school, 3.1% of all hospital admissions due to accidents in 2010. There were 860 road traffic collisions in Western LGD in 2012 which resulted in 9 people being killed. In total there was a rate of 45 road traffic casualties per 10,000 population in 2012.

Raw prevalence of patients (per 1,000) on the Obesity register age 16 and over in 2012 was 119.3 which is considerably higher than the NI rate of 110.3. (Source: Health Survey NI, DHSSPSNI, 2012).

Deprivation

The Western area, and particularly Derry City and Strabane Council areas, experiences some of the highest rates of multiple deprivation. Only Belfast has more people living in the highest deprivation decile than the Western area. Derry City and Strabane Council areas are most deprived in terms of income and employment rates. In 2012/13, 24.2% of post-primary school pupils were entitled to free school meals (a rise on the previous year of 23.9%) and 12,940 people over 16 years were claiming income support with a further 4,880 (16-64 years) receiving Incapacity Benefit. Based on 2011 Census figures, 6.4% of the population was unemployed of which almost half were long-term unemployed (two years or more).

Rurality

DHSSPSNI strategy *Fit and Well - Changing Lives 2012-2022* notes that health outcomes in rural areas tend to be better than in NI overall but that "evidence suggests that health inequalities have a significant impact on people living in rural communities". In particular, the strategy identifies key challenges faced by many people living in rural areas, including:

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

Patient and Public Involvement

The LCG flagship engagement programme, *Voice of Older People*, seeks to engage 1,000 older people between January and March 2014. With support from Public Health Agency, the LCG is committed to working with a range of Community Networks, asking them to undertake PPI work with the aim to carry out an engagement exercise, working with constituent community and voluntary groups, that provides service users with the opportunity to talk about their experiences of using Primary Care, Secondary Care and Community Care, and their views on Transforming Your Care, to ascertain their expectations of future services. Each network, covering its respective council area, will engage at least 200 older people and draw together views on a series of questions set by the LCG. The LCG will receive a report in Spring 2014 and consider the implications for HSC services. The Networks will convene a feedback session in each of the 5 Council areas in October 2014 to inform and discuss with participants the outcomes and findings of the engagement process. In terms of future planning the LCG will take into consideration these outcomes and recommendations when developing the Local Commissioning Plan for 2015/16 in relation to commissioning of Older People's Services.

During 2013, the LCG received presentations from each Community Network and has reflected on the range of issues raised in relation to HSC services. A strong theme across the presentations was the issue of rurality and the LCG is

planning a workshop with key interests, including community and voluntary groups, patient representatives, ICPs, GP representatives and Western Trust to develop a deeper understanding of the challenges facing people in rural areas in accessing and receiving services.

The LCG is very supportive of the development of self-directed support and the increasing emphasis on the role of carers. In recognition of this the LCG has executive representation on the Board's Self Directed Support Programme Board, the Regional Carers Strategy Implementation Group (CSIG) and the Western Trust's Carers steering group. The LCG initiated a Western area Carers Short Breaks Group involving a range of local carers to respond locally to a regional commissioning specification in attempting to create more choice, control and flexibility for aging carers (aged over 50 years) of learning disabled clients.

LCG staff attended WHSCT respite review meetings across all 5 district council localities and input was secured to the Western LCG short breaks break group which met on a number of occasions in 2013. The LCG considered and approved a Trust Investment proposal which took account of discussions and broad agreement at the short breaks group. This short breaks pilot is now being implemented by the WHSCT and ongoing evaluation will be reported through to the LCG as appropriate in addition to local and regional short breaks groups.

10.2 Key Challenges and Opportunities 2014/15

Delivery of successful outcomes in Health and Social Care is underpinned by collaboration among key stakeholders – commissioners, providers, patients/clients and carers/families. In recent years, the Western area has consistently delivered success through collaboration: in Primary Care Partnerships; in Primary Care prescribing efficiency; in integrated pathway development; and in progressing service transformation. It is my view that with these foundations the Western area is well-placed to continue to reform services, in line with *Transforming Your Care,* in the face of increasing financial constraints and in support of local people.

Integration is the key, recognising that patients will have better outcomes where GPs can plan care with social workers, community nurses, community pharmacists, community and voluntary groups, and so on with a focus on promoting independence and maintaining people at home for as long as possible. The LCG has placed a great emphasis on growing the community nursing service; investing in Reablement; and supporting initiatives such as community falls prevention programmes and carers respite.

The LCG has maintained a focus on driving efficiency. The LCG continues to promote efficiency in Primary Care prescribing and through the efforts of Western GPs has realised a release of almost £1 million for reinvestment in local services, such as GP services, GUM services and neurology diagnostics. During 2013, the LCG has encouraged GPs to review requests for laboratory tests to ensure compliance with guidance and hopes to see a reduction in requests in 2014/15. The LCG is also investing in placing centrifuges in Southern Sector practices in an effort to reduce blood contamination that can lead to the need to re-test and/or unnecessary Emergency Department attendance.

The coming year will bring challenges but also important developments. The introduction of Primary Percutaneous Coronary Intervention at Altnagelvin Hospital; commencement of building work on both Omagh Local Enhanced Hospital and Altnagelvin Radiotherapy Unit; and emerging plans for a number

of primary care hubs and related improvement to existing primary care accommodation together clearly signal considerable investment in local services. The LCG is determined to maximise these opportunities, both to improve services in line with *Transforming Your Care* and to deliver efficiencies through savings in running costs and improved productivity.

Key challenges for the LCG in 2014/15 include:

- Fulfilling the potential of Western Integrated Care Partnerships in driving the *Transforming Your Care* agenda through integrated care pathways based on multi-disciplinary collaboration and an ethos of self-reliance and share responsibility;
- Driving further primary care prescribing savings leading to additional reinvestment in primary care services;
- Delivering the proposed Primary Care Infrastructure programme for the Western area in line with agreed priorities;
- Developing the healthy ageing agenda;
- Further enhancing carers support and respite services;
- Progressing plans towards having in place appropriate 24-hour community nursing services, including acute care at home;
- Meeting domiciliary long-term care demand supported by the roll-out of reablement model;
- Introducing of a comprehensive fall prevention services with appropriate integrated care pathways, building on PHA Community Falls Prevention Pilot;
- Tackling impact of alcohol on HSC services, particularly Emergency Services;
- Putting in place across key acute specialties processes to allow GPs to gain consultant and specialist professional advice which might prevent the need for referrals and improve management of patients in primary care;
- Achieving Ministerial waiting times for outpatient and treatment;
- Ensuring 4-hour and 12-hour Emergency Department performance is achieved;

- Maximising utilisation of hospital theatres and in-patient beds;
- Securing a way forward in the delivery of acute mental health services; and
- Identification of opportunities to consolidate the provision of intermediate and acute beds and/or sites.

10.3 Ensuring Financial Stability & Effective Use of Resources

The Western LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2014/15 is £487.1m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Baseline investment by Service Area in 2014/15

Table 64

Programme of Care	£m	%
Acute Services	189.3	38.9
Maternity & Child Health	25.1	5.2
Family & Child Care	38.8	8.0
Older People	106.9	21.9
Mental Health	44.0	9.0
Learning Disability	34.3	6.9
Physical and Sensory Disability	15.7	3.2
Health Promotion	14.1	2.9
Primary Health & Adult Community	19.4	4.0
POC Total	**487.6**	**100.0**

This investment will be made through a range of service providers as follows:

WLCG Funded Providers 2014/15

Table 65

Provider	£m	%
BHSCT	27.0	5.5
NHSCT	1.7	0.3
SEHSCT	1.8	0.4
SHSCT	2.3	0.5
WHSCT	425.2	87.2
Non-Trust	29.6	6.1
Provider Total	**487.6**	**100.0**

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2014/15 in respect of Emergency Care by the Western Trust is £12.2m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2014/15 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation and additional funding to take account of the demographic changes in the population of the Northern area. It should be noted that the Learning Disability and Mental Health funds are indicative only at this stage.

Western LCG share of indicative investments 2014/15

Table 66

Pressures	**£m**
Demography – Acute Elective > 55 yrs	0.781
Demography NonElective > 55 years	1.024
Demography General	4.084
Learning Disability	0.487
Mental Health	0.287
Non Pay	4.528
Pay	3.420
PHA	0.567
RCCE	1.756
Service Pressures	13.378
NICE Drugs	3.172
Total	**33.484**

10.4 Commissioning Priorities 2014/15 – 2015/16 by Programme of Care (POC)

10.4.1 POC 1 - Acute Care

Introduction

Acute care is provided at Altnagelvin Hospital and South-West Acute Hospital with a range of specialties available on both sites. Altnagelvin provides a number of key regional specialties to patients in the Western and Northern areas, including Trauma & Orthopaedics and Oral Maxillofacial. In the past year has also seen the development of hospital care and treatment undertaken by the Independent Sector in the South-West Acute Hospital in order to address waiting times challenges.

Overview of local needs

Elective Demand

GP referrals to Consultant Led outpatient services account for the majority of the demand to acute services. Over the two years, 2011/12 to 2012/13, there has been approximately an 8% increase in demand across the LCG (from 62,323 to 67,599). Routine referrals increased by 7%, Urgent by 8% and red flags by 43%.

The number of new outpatient appointments held for Western residents has increased significantly, by 19%, (62,000 to 73,716) from 2008/09 to 2012/13. The average increase across NI Northern Ireland between 2008/09 to 2012/13 was 14%. Between 2011/12 and 2012/13 there was a 3% increase in new outpatient activity.

Due to identified gaps in capacity and demand the HSCB has purchased additional activity over the last few years. This additionality has been provided by both in-house initiatives and also additional activity purchased within the Independent Sector. All activity delivered regardless of the how it was purchased has been included here as this constitutes the demand upon the service.

Demand for Outpatient services will impact on elective admissions and day case activity carried out. As with outpatients above, additional activity has been purchased either via additional in house activity or activity being purchased from the Independent Sector and all activity has been included here. The move to meet efficiency targets, such as improved day case rates should have an impact on the admission / day case splits.

Between 2008/09 and 2012/13 there has been a 12% increase in review appointments held by Western residents, with an 11% increase between 2010/11 and 2011/2012. The average increase across NI Northern Ireland between 2008/09 to 2012/13 was 8%.

Over the five years, there has been a 17.2% reduction in elective admissions across the region. At Western LCG level, the change over the last 5 years the reduction in elective admissions represents a 15% reduction. Similarly over the last two years, 2011/12 to 2012/13, there has been a 2.9% decrease in elective admissions across the region and a decrease of less than 1% for the Western LCG.

As well as increased demand in outpatients with improved efficiency targets, there has been an increase in the number of day case admissions. At regional level, over the five year period, there has been a 20.9% increase and over the last two years the increase has been 5.3%. The change for the Western area was 19% over the 5 year period and 4.3% between 2001/12 and 2012/13.

Non-Elective Demand

Over the last five years Emergency Department attendances (new and unplanned review) have reduced across the region by 2.1% (from 696,832 to 683,386). There has been an increase in the number of ED attendances for Western residents from 94,017 to 94,623 equating to an increase of 0.6%. ED attendances at Western Trust hospital have increased by 3.6% over the 5 year period and by 1.8% over the two year period 11/12-12/13.

Over the last five years there has been an increase in non-elective admissions of approximately 16% (29,623 to 34,257). At LGD level within the LCG area, the greatest % increase was for Omagh LGD (27%) and Limavady LGD (16%) residents. All other LGDs (Derry, Fermanagh and Strabane) increased by 13%.

The greatest % change was over the last year (2011/12 to 2012/13) when the overall increase for the LCG was 5% and at LGD level it was 8% and 4% for Limavady, 6% for Derry, 5% for Omagh, and 3% for Fermanagh and Strabane.

While the number of non-elective admissions has increased, the corresponding number of occupied bed days has decreased, possibly suggesting either an improvement in length of stay or an increase in zero day lengths of stay. Over the five years, the number of occupied bed days have decreased by less than 1% for the LCG. At LGD level within the area, there has been an overall increase in the non-elective bed days for residents of Fermanagh (13%) and Omagh (20%).

Ministerial Targets

Western LCG will commission acute services in line with Ministerial targets set out in the Commissioning Plan Direction 2014/15.

In particular, the LCG is keen to ensure the development of alcohol liaison services in both acute hospitals, building on investment in 2013/14 with additional investment in alcohol liaison nursing to support Emergency Departments (ED).

The LCG continues to work closely with Western Trust to ensure the delivery of the Western share of the TYC transfer from secondary care. The LCG is leading the Primary Care Infrastructure Western Programme and is actively driving opportunities to reprovision acute services in these community settings. Efforts to put in place Acute Care at Home and 24-hour community nursing model will also deliver a significant element of re-provisioned service. Bed reductions in acute hospitals due to, for example, introduction of Day of

Surgery Unit and the roll-out of Older People's Assessment and Liaison Service will be pivotal in realising the shift.

Commissioned services

Western LCG will continue to commission the provision of a broad range of acute services, in the main at Altnagelvin and South-West Acute Hospitals with some outreach to Tyrone County Hospital and primary care locations, as appropriate. More specialist services are provided at Belfast acute hospitals and patient requiring care and treatment for more complex conditions will receive this further afield, whenever deemed necessary.

The opening of the South-West Acute Hospital has presented unforeseen difficulties, not least the challenge of nursing care in a hospital made up entirely of single rooms. The scale of the hospital compared to the Erne Hospital has also presented staff the need to work differently.

Driving the *Transforming Your Care* agenda, including delivering the shift of services and resources, remains the priority and the LCG has promoted the development of 24-hour integrated community nursing services; the establishment of the first Clinical Intervention Centre with more planned at key primary care locations across the area; the introduction of an elective Day of Surgery Unit and Short-Stay Paediatric Assessment Unit; an integrated Musculoskeletal Pathway in place with full support from all GP practices; and the establishment of outreach chemotherapy service at Tyrone County Hospital as examples of the evident 'shift' taking place in the West. Moreover the considerable enthusiasm for Integrated Care Partnerships and for the Primary Care Infrastructure programme provides considerable opportunities to achieve the TYC vision.

Hospital performance, while among the best in Northern Ireland, nonetheless falls short of Ministerial targets, particularly in unscheduled care. Breaches of the 12-hour target to complete treatment in an Emergency Department has been a more frequent occurrence at Altnagelvin Hospital in the past year and,

more significantly, 4-hour performance has fallen yet further below the 95% target.

In Elective Care, the Trust has continued to reduce waiting times for initial outpatient assessment and treatment in most specialities, and whilst Ministerial targets for assessment and treatment have been met in many areas, there are still a number of areas where this is proving problematic.

The commissioner continues to work with the Trust to increase core capacity to meet demand for services through recurring investment, service redesign, or improved productivity. Recurring investment has been made in 2013/14 in Pain Management, Gynaecology and MSK Physiotherapy, with further plans to invest in General Surgery and Orthopaedics in 2014/15. Redesign of ophthalmology ICATS services to implement the Glaucoma model has already increased core capacity within the service by over 10% with no investment. The introduction of revised care pathways within Primary Care in a number of areas including General Surgery and Gastroenterology has already had an impact on reducing demand in secondary care. Within General Surgery and Orthopaedics work is progressing to shift the treatment of varicose veins and dupuytrens contracture from day case theatres to treatment rooms. There is also significant work on-going with the Trust to improve productivity across a range of areas, by reducing cancellations, increasing pre-operative assessment, increasing day case rates and reducing length of stay.

As well as changes to systems and processes to deliver improved productivity, the introduction of planning assumptions for a range of specialities has been an important factor in increasing capacity. In line with the work done in other areas, the PHA has developed a Job Planning Toolkit for Clinical Nurse Specialists which sets out agreed activity levels for Nurse Led activity and MDT contribution. Where appropriate these should be added or reflected within current service SBAs.

Western Trust continues to have challenges in recruitment and retention of senior medical staff and in attracting junior doctors to take up training posts

across a number of acute specialties. While the Trust has been fortunate to attract locum doctors in some cases, cost and clinical limitations have proven problematic in maintaining services.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioner Requirement
Enable GPs to complete more of a patient's management through timely (same/next day) advice, assessment and/or diagnostic support from secondary care clinicians. This should help to reduce/flatten demand for outpatients, and Emergency Department attendances	The LCG is committed to improving working practices which enable GPs to appropriately manage patients in Primary Care. To date, the LCG has sponsored a series of care pathways which enhance GP direct access to imaging; support efficient Primary Care use of laboratory tests; and extend 'virtual clinics' approach in key specialties. The LCG, working with ICPs, will seek to go further across a broader range of acute specialties and in line with TYC. Key examples will include respiratory virtual clinic; GP-led head pain clinics with direct access to radiology; and Primary Care management of suspected DVT.
Reduce waits during the inpatient stay and support earlier discharge through 7-day proactive management by senior decision-makers in hospital with support from 7-day diagnostic services, social care and Allied Health Professions	The commissioner has committed to invest funds to allow an additional two Emergency Care consultants can be recruited which will extend hours of senior decision making at Altnagelvin Emergency Department. Additional investment in radiology during 2013/14 will also underpin efforts to deliver radiology services 7-days per week. The LCG is committed to developing the Unscheduled Care Improvement Plan (as outlined) and will work collaboratively

	with Western Trust, ICPs, GPs and other interests to ensure this a comprehensive response in line with Ministerial priorities. The LCG will give consideration to the recommendations of the Western Trust review of its Emergency Care pathway which reported in December 2013. The LCG recognises the significant importance of the introduction of Primary Percutaneous Coronary Intervention in supporting the 7-day response.
Enable district nursing teams to respond quickly and flexibly to GP referrals. This should prevent some acute illness, and allow patients to return home from hospital earlier than at present	The LCG has invested in additional capacity of district and community nursing services for the past three years and is committed to putting in place 24-hour community nursing services in line with TYC timeframe. As an integral part of this, the LCG recognises that GP referral to district nursing should be as straightforward as making a referral to an Emergency Department. The LCG will work with Western Trust, ICPs and GPs to develop a model during 2014/15 which supports effective GP referral to district nursing in order to avoid unnecessary hospital admissions and to support earlier discharge, including district nursing in-reach to acute hospitals.
Review and take forward opportunities to consolidate the provision of intermediate care beds/acute beds and/or	The LCG, working with ICPs and Western Trust, will seek to ensure acute and intermediate care beds are maximised in line

sites.	with IPOP assumptions and in light of developments in community services, such as acute care at home and Reablement. The LCG will seek proposals from Western Trust on consolidation of bed provision and opportunities to reduce bed numbers.
Local commissioners should work with their Trust, local GPs and the Regional Unscheduled Care Team to develop an Unscheduled Care Improvement Plan (UCIP).	The LCG is committed to developing collaboratively the Western Unscheduled Care Implementation Plan, building on its work on integrated care pathways; promotion of 7-day working; commissioning of GP out-of-hours services; and Western Trust recent review of Emergency Care at Altnagelvin Hospital.
Trusts are expected to put plans in place to ensure that during 2014/15 commissioned services are delivered at least in line with the relevant average peer benchmarks for efficient and effective service provision, working towards top quartile performance by March 2015.	The LCG notes IPOP comparisons which highlight significant opportunities to reduce beds, particularly through reducing average length of stay; extend day surgery procedures; reduce 'Did Not Attend' rates in outpatients and day surgery across a range of acute specialties, including reducing cancelled operations. Reduction in excess bed days to reach the peer average would equate to requiring approximately 70 fewer beds in the Western area. Going beyond this to be a high performing Trust, i.e. 75th percentile performance compared to peers, would mean requiring more than 100 acute beds less. Cancelled elective procedures is also an area for attention.

	Cancelled operations exceed 10% and the LCG would wish to a reduction to 5% in line with Audit Commission 2002 recommendations. The LCG also wishes to continue the drive to maximise acute elective capacity in line with HSCB direction. It is essential that consultant job plans seek to give priority to clinical activity.

Values and Volumes

Programme of Care	Service Description	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Elective	**Admissions**	15,975	422	16,397
	Daycases	24,155	389	24,544
	New Outpatients	74,699	5,300	79,999
	Review Outpatients	137,503	12,661	150,164
Unscheduled	**Non Elective admissions - all**	34,983	1,034	36,017
	ED attendances	101,700	1,473	103,173
	NIAS Journeys	26,644	1,354	27,998
	VALUE OF COMMISSIONED ACTIVITY[88]	£189.3m	£14m	£203.3m

[88] This includes activity in addition to that set out above.

10.4.2 POC 2 – Maternity and Child Health

Introduction

Maternity services are provided at both Western acute hospitals with appropriate neo-natal support on site and outreach to ensure access to ante-natal care. Health visiting remains at the heart of Child Health services, underpinned by specialist services, such as Family Nurse Partnership.

Overview of local needs

Across NI, the Western LCG has seen the smallest increase with 4,168 births in 2012, a 7% increase from the 3,911 births in 2002.

Births data for 2012 shows that the teenage birth rate per 1,000 of the female population aged 13-19 was 11.2 (provisional figure) in the Western area. The teenage birth rate per 1,000 of the female population aged 13-19 in the Western HSCT decreased by 4.9 between 2001 to 2012 from 16.1 to 11.2. The Northern Ireland teenage birth rate per 1,000 of the female population aged 13-19 decreased by 3.9 for the same period, from 16.9 to 13.0.

In 2012 (NISRA projected), there were 2,741 births in Altnagelvin Hospital and 1,226 births in Erne and South-West Acute Hospitals (combined)

The number of births in Northern Ireland is projected to continue decreasing. Estimated figures published by NISRA indicate that up until mid-2017, around 24,500 births are projected. After this 5-year period, the number of births is projected to fall steadily to 22,600 births in the year ending mid-2027, 11% below the number of births that occurred in the year ending mid-2012 (NISRA, 2013).

It is anticipated that the Western area will see a reduction in births from 4,268 births in 2008 to 3,692 births projected for 2023, i.e. 13.5% reduction over the 15 year period.

There are 74,200 persons under 18 years living in the Western area of whom 21,300 are under five years. (Census 2011, NISRA)

Ministerial targets

The LCG continues to support the Western HSC Trust-led. Family Nurse Partnership programme running in the North-West. The programme has shown considerable success, recently graduating its first intake following babies reaching the age of 2 years. The LCG Commissioning Lead is the chair of the Western FNP Advisory Board and the LCG is looking at opportunities to extend the programme across the Western area in the next three years.

Commissioned services

Western LCG will continue to commission the provision of Maternity and Child Health Services in line with current services.

Challenges in staffing maternity units in the face of difficulties in attracting junior doctors to Western hospitals continue to affect delivery of services. In South-West Acute Hospital in particular, where delivery numbers are lower and senior medical staffing limited, it has been necessary to consider if the Unit can deliver higher risk babies, particularly given neo-natal care is for the lowest risk newborns. The commissioner remains committed to maintaining the Unit but continues to review with Western Trust specific exclusions due to patient safety concerns. The Local Commissioning Group, working with regional colleagues and Western Trust, will ensure that maternity services here are endorsed in line with the requirements outlined within the Maternity Strategy.

The LCG recognises the need to ensure adequate medical cover in provision of services and is mindful of the challenges facing Western Trust in attracting and retaining senior and junior doctors which have put women and children's acute services under pressure in recent years. Moreover, specialisms within paediatric services are proving more difficult to provide locally and it has become necessary to increasing look at networked provision from regional hospitals which has reduced access to some degree.

The LCG has welcomed Western Trust efforts to test and introduce a short-stay paediatric assessment unit at Altnagelvin Hospital. The pilot initiative has shown considerable potential to reduce in-patient admissions and to shorten lengths of stay and the LCG will work with Western Trust to see the unit established, supporting the delivery of quality and efficient services.

Commissioning Priorities and Requirements

Regional Commissioning Priority	Local Commissioner Requirement
Trusts to develop sustainable service models for maternity units that meet the standards of the Maternity Strategy including: • Written and oral communication for women to enable an informed choice about place of birth • Services in consultant-led obstetric and midwife-led units available dependent on need • Promotion of normalisation of birth, leading to reduction of unnecessary interventions	The LCG, working with regional colleagues, will seek assurance from Western Trust that it is putting in place the necessary arrangements to meet standards of the Maternity Strategy.
Trusts are expected to develop a regional networked service model and care pathways for the management of multiple pregnancies in line with NICE CG 129	The LCG, working with regional colleagues, has agreed a protocol for the management of multiple pregnancies and will keep under review its implementation.
Trusts are expected to continue to progress the move towards facilitating midwife as first point of contact, and providing more midwife led antenatal care in the community for women with straightforward pregnancies	The LCG, working with regional colleagues, will seek assurance from Western Trust that midwife is 'first point of contact' and proposals to deliver more midwife-led antenatal care in the community for women with straightforward pregnancies.
Trusts are expected to continue to benchmark their local obstetric intervention rates against peer units and to	The LCG will work with regional colleagues and Western Trust to ensure the reduction of unexplained variation in

reduce unexplained variation in intervention rates throughout Northern Ireland	intervention rates.
Trusts to take forward work to reduced inequalities in the experience and outcomes of vulnerable groups of pregnant women.	The LCG, working with regional colleagues, will seek to commission targeted responses to meet the needs of vulnerable groups of pregnant women, in line with available evidence and drawing on best practice.

Values and Volumes

Programme of Care	**Service Description**	**Currency**	**2013/14 Baseline**	**Indicative Additionality 2014/15**	**Total indicative commissioned Volumes 2014/15**
Maternity and Child Health	**Obstetrics**	Births	4009	0	4009
	Comm Midwives	Contacts	72,576	581	73,157
	Health Visiting	Contacts	62,253	0	62,253
	Speech and Language Therapy	Contacts	26,015	0	26,015
		VALUE OF COMMISSIONED ACTIVITY[89]	£25.1m	£1.2m	£26.3m

[89] This includes activity in addition to that set out above.

10.4.3 POC 3 – Family and Childcare

Introduction

Family and Childcare Services are commissioned regionally and Western LCG has a limited role in relation to commissioning of these services locally.

Overview of local needs

Based on NI Statistics and Research Agency publication of outputs of the 2011 Census the total child (aged 0-17) population in Northern Ireland is 430,763. The Western Trust has a population of 74,354 or 17.3% of the child population which is the second lowest of the five HSC Trusts. Based on Discharge of Statutory Functions Report 31 March 2013 the Western Trust had 6,422 children in need, the highest number in the region. The majority of these children were in the 0-11 age range. Regionally there was a total of 1,961 children on the Child Protection Register, 297 of these children were in the Western Trust. There were 468 children in care in the Western Trust which represents 16.7% of the total number of children in care. The number of children in care in the Trust has increased by 68 since March 2011.
The Trust reports significant pressure on the Children Services programme in the current economic climate with the requirement for substantial savings against a backdrop of increasing demand. Compared to September 2012 there has been an increase of 215 in the number of children in need, an increase of 31 on the Child Protection Register and an increase of 24 in the number of children who are looked after.

Particular areas of Children and Families identified as posing particular challenges include:

- Unallocated cases arising from increased demand and complexity of cases
- Growth in kinship care and compliance with recently issued kinship standards

- Late care entrants arising from older adolescents who present as homeless being admitted to care
- Meeting the needs of children with high and complex health care needs through the provision of substantial and intensive support home care packages

Key policy directions include the development of early intervention and family support to prevent family breakdown and admissions to care. For children who are looked after the emphasis is on promoting the more extensive use of foster care and minimising the use of residential care. Recruiting specialist carers for looked after children with complex needs will be an integral part of this.

Ministerial Targets

The LCG continues to support the Western HSC Trust-led Family Nurse Partnership programme running in the North-West. The programme has shown considerable success, recently graduating its first intake following babies reaching the age of 2 years. The LCG Commissioning Lead is the chair of the Western FNP Advisory Board and the LCG is looking at opportunities to extend the programme across the Western area in the next three years.

Commissioned Services

In line with regional and ministerial priorities for Children and Families and aligned to statutory functions contained within the Children (NI) Order 1995 and direction of TYC commissioning emphasis will be on:

- The development of early intervention and family support to strengthen parenting, prevent family breakdown and admissions of children to care including development and delivery of the Early Intervention Transformation Programme
- The promotion of foster care for children looked after within their kinship network where appropriate as a first consideration
- The recruitment of professional / specialist foster carers for children with complex needs

- Responses to concerns pertaining to child sexual exploitation, including joint working arrangements as well as protective and therapeutic services for these children
- Robust needs assessment and delivery of localised service for children with complex needs including those with learning disabilities or challenging behaviour

Commissioning Priorities and Requirements

Enhance the Health Visiting workforce to provide the full Core Universal Service as set out in *Healthy Child Health Future*.	The LCG recognises the significant role of Health Visiting and has provided additional resources in 2013/14 to extend capacity in the face of rising caseloads. The LCG is keen to ensure that it maximises the health visiting resource to deliver *Healthy Child, Healthy Future* requirement in coming years.

10.4.4 POC 4 – Older People Services

Introduction

In the face of rapid growth of the older population and in light of *Transforming Your Care*, it is imperative that services for older people change and grow. The priority will be to provide support to enable all older people to remain independent and living in their own home for as long as possible. This will require social support with important roles played by community and voluntary groups. Home-base care will be key with an increasing emphasis on 24-hour support and support and respite for carers. Traditional acute geriatric medicine services will increasingly underpin community services and, in particular, General Practice and community nursing. As Integrated Care Partnerships (ICPs) roll out their programmes to support frail elderly; clinical priorities of diabetes, respiratory and stroke conditions; and end of life care, the LCG recognises the need to give greater emphasis to transforming older people's services in line with health and wellbeing goals.

Overview of local needs

The older person population has been increasing year-on-year for the past two decades. In the West, the rise has been 15.8% in the past five years (2007-2012 MYE); 28.3% in the past 11 years (2001-2012 MYE); and 40.3% in the past 21 years (1991-2012 MYE).

Projecting forward, the rise in older people will continue. The rise in over 65 years will be 38% in the next decade and 42% in total for the next two decades. The rise in the over 75s and 85s is also marked in the coming 20 years.

Average life expectancy measures the expected years of life at birth based on the mortality rates of the period in question. The Northern Ireland average life expectancy for 2008-2010 is 77.1 years for males and 81.5 years for females. Life expectancy for males in the Western HSCT for 2008-2010 is 76.7 years, and for females is 81.4 years.

Ministerial targets

The LCG recognises the potential to further develop telecare and telehealth in line with ministerial targets and will seek to ensure that Western Trust maximises potential in collaboration with ICPs.

Commissioned services

Western LCG will continue to commission the provision of a broad range of services for older people, with a particular emphasis on providing Primary and Community Care which minimises the necessity for acute hospital care. Crucial in this will be commissioning initiatives with Integrated Care Partnerships which offer opportunities to transform care pathways through collaboration between General Practice, Western Trust, community and voluntary bodies, and service users and carers.

The LCG has placed considerable effort on addressing the impact of demographic change on HSC services and has deployed Demographic funding to both meet the demand of traditional services and to drive transformation. In the face of considerable pressures in Trust domiciliary care services, the LCG allocated a large proportion of funding to buy more than 100,000 additional domiciliary hours thereby closing the capacity/demand gap in respect of older people's services. Moreover the LCG, for a second year, invested in the development of Reablement services, emphasising the Occupational Therapy approach which seeks to return older people to independence following a period of illness or hospitalisation. There has been considerable benefits of Reablement to date but it has not been roll-out beyond Derry/Londonderry and the LCG is working with Western Trust to ensure this happens in the next year. An important aspect will be involvement of the community and voluntary sector who can provide considerable support to maintain independence beyond the period of Reablement.

In hospital services, the LCG has recognised the importance of taking a holistic approach to meeting the needs of older people and has commissioned the Older People's Assessment and Liaison (OPAL) service which is now in place in Altnagelvin Hospital and will shortly be introduced to South-West Acute

Hospital. The service provides a comprehensive assessment for all older people on admission with a view to provide more joined up service in response, thereby shorten lengths of stay and improving health outcomes.

The LCG is aware of challenges facing Western Trust to recruiting and retaining senior medical staff in both geriatrics and older people's psychiatry. The LCG intends to work with Western Trust to put in place alternative models of care in order to overcome service vulnerabilities.

As the focus of our service model moves towards supporting people to remain healthier for longer and, when they become unwell, providing as much of their care as close to home as possible, we should see opportunities to consolidate the provision of intermediate and acute care beds and / or sites.

The LCG has also piloted greater involvement in nursing home care and has supported the appointment of 2 dieticians to link with nursing homes across the Western area to advise on nutrition and the use of supplements. Another initiative to review medication of nursing home patients took place in Limavady. Pharmacy prescribers reviewed medication of nursing home patients, identifying clinical issues of multi-prescribed drugs and opportunities to switch to generic alternatives. The LCG will roll this initiative out further in 2014/15.

A key area for work has been falls prevention and the LCG has been fortunate that Public Health Agency has developed and pilotted locally a community-based programme to identify older patients who have previously had a fall and offer them education and physiotherapy intervention at a community setting. The LCG hopes to link this programme with efforts to develop a dedicated Osteoporosis Clinic linked to fracture liaison services in both hospitals.

The LCG, with regional colleagues, has commissioned a significant development in adult safeguarding and has provided additional funding to enable Western Trust to put in place an Adult Safeguarding Gateway Team

which will screening referrals and put in place adult protection plans as required.

Building on investment in the previous year, the LCG has extended the Early Support Discharge Team to South West Acute Hospital which will provide dedicated support to patients following a stroke to assist them to return home and to independent living. Success is evident in the service in place in Altnagelvin Hospital and the LCG Is optimistic that similar benefits will be delivered in the Southern sector.

The LCG will continue to consolidate palliative and end of life care with an emphasis on development of home-based care and Hospice care in line with the Delivering Choice programme.

Commissioning Priorities and Requirements

Regional Commissioning Priority	**Local Commissioner Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The LCG has sought to improve support for carers through increased access to carer assessments and respite options. The LCG will seek proposals from Western Trust on approaches to earlier identification of carers and assurance of provision of necessary carer assessment as appropriate.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The LCG is promoting carers' short breaks and is working closely with carers' representatives and voluntary providers to ensure additional resources provide maximum benefit for service users and families. The LCG is working with regional colleagues to ensure short breaks approach continues to develop in coming years.
To increase uptake of direct payments	The LCG, working with regional colleagues, will seek proposals from Western Trust on how an increased uptake of direct payments can be achieved.
Working with ICPs to improve the care of the frail elderly.	The LCG is commissioning Western ICPs to improve the care of frail elderly. Risk stratification will underpin the development of integrated care pathways which seek to support independence and home-base care and to improve care planning and management and reduction of unscheduled hospital attendances and admissions. In particular, ICPs will take forward: • A range of targeted health and wellbeing programmes;

	• Extended medicines review by community pharmacists; • Improvements to discharge letters; • Coordinated falls prevention programmes; • A range of initiatives to overcome social isolation, led by local community and voluntary organisations; • Improved intermediate care; • Additional carers short breaks and carers personal development programmes; and • Establishment of multi-disciplinary groups to look at best practice in the care of frail elderly.
Enhancement of dementia services	The LCG has worked closely with regional colleagues to ensure the recommendations of the Dementia Strategy are realised in the West. A full memory service has now been established, Monday to Friday, 9am to 5pm in the Southern sector of the Western area to facilitate early detection and intervention in cases of dementia. The funding will also enhance the current service within the Northern sector, providing dedicated occupational therapy input. It will enhance the current SLA with Alzheimer's Society to provide a 'navigator' type role for signposting to help clients and their families access the full range of services available when required.
Development of a more coordinated understanding of and approach to intermediate care provision underpinned by more effective monitoring arrangements to improve discharge arrangements.	The LCG, working with Western ICPs and Western Trust, will seek to improve intermediate care provision in the context of efforts to put in place 24-hour community nursing.

Continued roll-out of targeted Public Health Agency (PHA) preventative health and well-being improvement programmes.	The LCG will support PHA preventative programmes as required.
Review emerging reablement arrangements and structures to ensure adherence to the agreed model and assess the financial and service impact	The LCG will seek to build on progress in Western Trust towards rolling out Reablement across the Western area in line with agreed regional model.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Older People	**Geriatric Hospital Services**	Occupied Beddays	36,088	-3822	32,266
	Day Care	Attendances	72,991	0	72,991
	Domiciliary Care	Hours	1,606,331	103,020	1,709,351
	Residential & Nursing Homes	Occupied Beddays	549,248	0	549,248
	Community Nursing & AHPs	Face to face contacts	314,912	5,826	320,738
	Social Work	Caseload	9934	0	9934
		VALUE OF COMMISSIONED ACTIVITY[90]	£106.9m	£5m	£111.9m

[90] This includes activity in addition to that set out above.

10.4.5 POC 5 – Mental Health

Introduction

Mental Health Services in the Western area have seen considerable reform in recent years with a marked shift from acute care to Primary Care services with a significant reduction in acute in-patient beds across the area. The opening of Grangewood Hospital in Derry has seen a step change in acute care. Consideration of providing a similar facility, either in Omagh or Enniskillen, continues in line with TYC recommendations.

Child and Adolescent Mental Health Services have also seen considerable reform and the drive to provide CAMH Services to young people up to their 18th birthday are in line with regional requirements.

Overview of local needs

The Quality and Outcomes Framework (QOF) measures general practice achievement against a range of evidence-based indicators and provides raw disease prevalence data by a total of 17 clinical areas. In 2013, the raw prevalence of patients (per 1,000 patients) on the Mental Health Register was 9.0 and on the Dementia Register was 5.9 for the Western area.

Information collected via the GMS Quality and Outcomes Framework, highlight that there are 2,843 patients on the Mental Health register maintained within GP Practices. In 2011/12 there were 1,203 in-patients to Gransha (583) and Tyrone & Fermanagh (620) Hospitals, with occupancy of approximately 90.8% and average length of stay of 46.7 days.

In Western Trust, there were 93 admissions to hospital as a result of mood or anxiety disorder in 2009/10. The data is extracted from the NI Hospital Inpatients System (HIS), but excludes mental health specialities as not all mental health information is recorded on the Patient Administration System. More than half of these were by residents of Derry.

Aggregated hospital admissions data is also available for the age standardised rate of admissions due to self-harm. The Northern Ireland rate is set equal to 100 and a value greater than 100 indicates an above average admission rate. From 2005/06-2009/10 the admission rate was 89.0 in Western Trust.

Data is recorded on the number of deaths due to suicide and undetermined intent from 1999 to 2012. In the West, there were 46 such deaths in 2012 (provisional figure).

All deaths data supplied by Demography and Methodology Branch is based on the year of registration rather than the year of occurrence unless otherwise stated. Events such as suicide are likely to be referred to the coroner. This can take some time; therefore deaths recorded each year may have occurred prior to the registration year.

In 2011, there were 1,402 self-harm presentations to Emergency Departments (ED) in the Western Trust, an increase of 11% from the 2009 figure.

Information collected as part of the Health Inequalities Monitoring System (2010) on Mood & Anxiety Disorders estimate that 159 persons per 1,000 population in the West are receiving drugs for mood and anxiety disorders.

Addiction and mental health are also interrelated phenomena in Northern Ireland. Drug and alcohol abuse often coexist with poor mental health. The majority of users take sedatives, tranquillisers or anti-depressants daily or mostly daily. Benzodiazepines are the second most common substance of referral for people with addictions in Northern Ireland.

Ministerial targets

The LCG is committed to securing a 10% increase in the number of carers' assessments offered within the Mental Health programme and will seek assurances from Western Trust that this will be delivered during 2014/15 in line with Ministerial requirements.

Commissioned services

Western LCG, supported by regional colleagues, will continue to commission the provision of the range of mental health services for adults and children across the Western area.

In line with the *Transforming Your Care, Bamford Review* and *New Strategic Direction for Drugs and Alcohol*, it is evident of the importance to intervene earlier where alcohol abuse is concerned and to reduce hazardous and harmful drinking with associated targets such as reducing attendances at Emergency Departments. The LCG has commissioned the expansion of alcohol liaison services within Emergency Departments, particularly to reduce impact on in-patient beds, and to drive the use of appropriate short-term therapeutic intervention which seeks to reduce alcohol abuse. This investment will build on previous investment in both Emergency Depts.

The LCG has also commissioned Western Trust to begin to implement Recovery Approaches in line with *Transforming Your Care* which states that "At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives." Additional investment in 13/14 will deliver additional capacity in the Trust Recovery Team to meet growing demand due to demographic change.

Transforming Your Care places a particular emphasis on support for carers and families. It states that "There will be a need to provide more respite care and short breaks in the community, to support individuals and carers… All of this intervention is designed to respond to the patient's and carer's needs." TYC recognises the need for more investment in respite care services in Mental Health Services in line with the *Bamford Review* recommendations. The LCG has committed additional funds to provide more respite care within the Adult Mental Health Programme.

Commissioning Priorities and Requirements

Regional Commissioning Priority	**Local Commissioner Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The LCG has sought to improve support for carers through increased access to carer assessments and respite options. The LCG will seek proposals from Western Trust on approaches to earlier identification of carers and assurance of provision of necessary carer assessment as appropriate.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The LCG is promoting carers' short breaks and is working closely with carers' representatives and voluntary providers to ensure additional resources provide maximum benefit for service users and families. The LCG is working with regional colleagues to ensure short breaks approach continues to develop in coming years.
Increase uptake of direct payments.	The LCG, working with regional colleagues, will seek proposals from Western Trust on how an increased uptake of direct payments can be achieved.
Implementation of the Protect Life Strategy	The LCG will support PHA colleagues to ensure Western Trust provides the necessary actions to fully implement the refreshed *Protect Life* strategy.
Establishment of integrated care arrangements for the	The LCG has been central in the establishment of a

care and treatment of patients with common mental health needs	collaborative to take forward Primary Care Talking Therapies, drawing together existing HSC services, such as GP-commissioned therapies through voluntary providers, and seeking to commission additional capacity from the community and voluntary sector going forward. Initially, the LCG has directed Western Trust to undertake scoping which will provide clarity on opportunities and constraints and it is hoped to develop the service in 2014 with a single point of contact and clear referral pathways.
Implementation of the Crisis Resolution Home Treatment services for CAMHs	The LCG will support regional colleagues to ensure the implementation by Western Trust of Crisis Resolution Home Treatment Mental Health services for children and young people.
Further development of specialist community services	The LCG, with regional colleagues, will seek to further develop adult autism services, including supporting transition for young people with ASD. The LCG will also ensure further enhancement of adult and children's mental health services in line with *Transforming Your Care* and the *Bamford Review*.
Improved psychiatric liaison services	The LCG will support regional colleagues to ensure timely response of Psychiatric Liaison Services in both Western

	Emergency Departments.
Consolidation of inpatient mental health beds to single sites in Belfast Trust and Southern Trusts and to two sites within Western Trust.	The LCG will take forward the outcome of the Board's review of acute mental health in the southern part of the Western area as required.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Mental Health	**Hospital**	Occupied Beddays	38759	0	38759
	CPN	Contacts	49349	0	49349
	Res & Nur Homes + Supported Housing	Occupied Beddays	326	0	326
	Day Care	Attendances	78418	0	78418
	Domiciliary Care	Hours	29294	0	29294
		VALUE OF COMMISSIONED ACTIVITY	£44m	£1.5m	£45.5m

10.4.6 POC 6 – Learning Disability

Introduction

Learning Disability Services are provided across the Western area and include support services in schools and adult day opportunity services, ranging from traditional day care to vocational opportunities. In-patient services, provided in Lakeview Hospital, focus on assessment and treatment.

Overview of local needs

The Quality and Outcomes Framework (QOF) measures general practice achievement against a range of evidence-based indicators and provides raw disease prevalence data by a total of 17 clinical areas. In 2013, the raw prevalence of patients aged 18 plus (per 1,000 patients) on the Learning Disabilities Register was 6.17 for the Western LCG which is the highest prevalence in Northern Ireland (NI average – 5.16).

There were approximately 2,260 people with a learning disability on the informal register held by the Western Trust in 2010. The number of people with a severe learning disability is rising and there has been an increase of almost 30% since 2000.

Ministerial Targets

The LCG recognises the importance of providing timely carer's assessments and will work with regional colleagues to ensure Western Trust increases assessments undertaken in line with Ministerial targets.

Commissioned services

Western LCG, working with regional colleagues, will continue to commission the provision of a range of services to adults and children with a learning disability and their carers and families.

While resettlement of adults who had been living inappropriately in hospital for many years is largely complete in the Western area, challenges exist due to

people coming into hospital for assessment and treatment who, following a period in hospital, are unable to return home and experience lengthy stays in hospital. Work to develop community teams to prevent caring arrangements breaking down has shown some benefit in recent years.

The shift from centre-based day care to person-centred day opportunities has been a feature of services for adults with a learning disability in the West for a number of years. However centre-based services have nonetheless come under pressure due to growing demand and extended life expectancy among service users. Western Trust has faced challenges to provide day opportunities for school leavers and has worked with the LCG to maximise capacity, including seeking alternative provision for older people. Similarly, providing community support as an alternative to admission to hospital remains of great importance.

Commissioning Priorities and Requirements

Regional Commissioning Priority	**Local Commissioner Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The LCG has sought to improve support for carers through increased access to carer assessments and respite options. The LCG will seek proposals from Western Trust on approaches to earlier identification of carers and assurance of provision of necessary carer assessment as appropriate.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The LCG is promoting carers' short breaks and is working closely with carers' representatives and voluntary providers to ensure additional resources provide maximum benefit for service users and families. The LCG is working with regional colleagues to ensure short breaks approach continues to develop in coming years.
Delivery of day services in line with the Regional Day Opportunities Model	The LCG, working with regional colleagues, will seek to ensure that Western Trust day services are delivered in line with the Regional Day Opportunities Model.
Development of 7 day specialist community services to respond to the needs of people whose behaviour challenges services.	The LCG, working with regional colleagues, will seek to ensure that Western Trust specialist community services respond to the needs of people whose behaviours challenge services and those with offending behaviours, including 2-hour response 7-days per

	week and high support beds in the community.
Increase uptake of direct payments	The LCG, working with regional colleagues, will seek proposals from Western Trust on how an increased uptake of direct payments can be achieved.
Development and implementation of health promotion initiatives for people with a learning disability.	The LCG will support regional colleagues in taking forward health promotion initiatives for people with a learning disability.

Values and Volumes

Programme of Care	**Service Description**	**Currency**	**2013/14 Baseline**	**Indicative Additionality 2014/15**	**Total indicative commissioned Volumes 2014/15**
Learning Disability	**Hospital Services**	Occupied Beddays	16187	-6570	9617
	Day Care	Attendances	162564	0	162564
	Domiciliary Care	Hours	107510	0	107510
	Residential & Nursing Homes	Occupied Beddays	100719	4044	104763
	Community Nursing and AHPs	Face to face contacts	18233	0	18233
	Social Work	Active Caseload	1278	0	1278
		VALUE OF COMMISSIONED ACTIVITY[91]	£34.3m	£1.2m	£35.5m

[91] This includes activity in addition to that set out above.

10.4.7 POC 7 – Physical and Sensory Disability

Introduction

The LCG has recognised the importance of investing in the development of

Overview of local needs

The 2011 Census notes that almost 22% of residents reported a long-term health problem or disability which limited their day-to-day lives, a figure above the NI average of under 21%. At June 2011, there were 75 people with a physical and sensory disability being cared for in residential/nursing facilities, of this 87% live in nursing homes.

Prevalence of a range of physical and sensory disabilities for the Western LCG (from 2011 Census information) includes:

- Deafness and partial hearing – 4.8 compared to NI average of 5.1
- Blindness or partial sight loss – 1.72 compared to NO average of 1.7
- Communication difficulty – 1.76 compared to NI average of 1.7
- Mobility or dexterity difficulty – 11.85 compared to NI average of 11.4

Ministerial targets

The LCG will seek to ensure that Western Trust provides a 10% increase in the number of carers' assessments during 2014/15.

Commissioned services

Western LCG will continue to commission the provision of a range of services to adults and children with a physical disability or sensory impairment and their carers and families.

In recent years, the LCG has invested additional funds to support community-based services, such as dedicated sensory support services for deafblind people. In 2013/14, The LCG has recognised the considerable value of the pilot Community Access project, funded through CAWT and has invested Demographics funding to ensure the continuation and development of the

project which is providing day opportunities for adults with a physical and sensory disability as an alternative to centred-based daycare. The LCG, in response to the direction signalled in TYC, will continue to support the Reform and Modernisation of day care provision to providing day opportunities As well as improved choice for service users directly engaged in the Community Access service, the model has freed up places in day centres, allowing service users with more complex needs to engage in more beneficial activities.

The LCG will monitor discharge delays from Specialist Units from within the Western area. Board funding, from the P&SD Strategy into the Regional Rehabilitation Services, to support Spruce House, Altnagelvin Hospital will ensure that there is sufficient consultant and medical cover for service continuity on site as well as outreach to local rehabilitation centres and support for Community Rehabilitation teams.

Commissioning Priorities and Requirements

Regional Commissioning Priority	**Local Commissioner Requirement**
Improved support for carers through earlier identification of those not yet recognised as carers; more accessible information on caring so that carers take informed decisions about the value of assessment; and greater personalisation of the assessment process so that it is experienced by carers as supportive.	The LCG has sought to improve support for carers through increased access to carer assessments and respite options. The LCG will seek proposals from Western Trust on approaches to earlier identification of carers and assurance of provision of necessary carer assessment as appropriate.
Access to more options for carers in the provision or arrangement of their respite/short breaks.	The LCG is promoting carers' short breaks and is working closely with carers' representatives and voluntary providers to ensure additional resources provide maximum benefit for service users and families. The LCG is working with regional colleagues to ensure short breaks approach continues to develop in coming years.
To increase uptake of direct payments	The LCG, working with regional colleagues, will seek proposals from Western Trust on how an increased uptake of direct payments can be achieved.
Review Trust progress in relation to the review and reform of day service opportunities to ensure alignment with personalisation strategies.	The LCG, working with regional colleagues, will seek to ensure that Western Trust day services are delivered in line with personalisation strategies.

Values and Volumes

Programme of Care	Service Description	Currency	2013/14 Baseline	Indicative Additionality 2014/15	Total indicative commissioned Volumes 2014/15
Physical Disability & Sensory Impairment	**Hospital Services**	Occupied Beddays	9800	0	9800
	Daycare	Attendances	24420	0	24420
	Domiciliary Care	Hours	298781	0	298781
	Residential & Nursing Homes	Occupied Beddays	25692	0	25692
	Community Nursing & AHPs	Face to face contacts	18529	0	18529
	Social Work	Active caseload	1700	0	1700
		VALUE OF COMMISSIONED ACTIVITY[92]	£15.7m	£1m	£16.7m

[92] This includes activity in addition to that set out above.

10.4.8 POC 8 – Health Protection

Introduction

Pressures on Health and Social Care services are exacerbated by choices made by local people which can have detrimental impact on their health and wellbeing. The impact of alcohol is now recognises as being a major societal issue requiring multi-agency response. Obesity is also recognised as contributing the rising long-term conditions, such as diabetes and heart disease. Smoking cessation remains a high priority.

Overview of local needs

Western area shows a mixed profile of prevalence of patients on registers per 1000 of all the key QOF measures. Mental health, learning disability, obesity and COPD showing higher prevalence, with lower than average in heart disease and stroke.

Another key indicator showing deaths amenable to intervention shows that in 2001-05 West had a higher than average indicator of 104.6 deaths per 100,000 population whereas in 2006-10 it has dropped to 77.2, below the NI average, 77.9.

There were 3 obesity-related deaths in the Western HSCT from 2007 to 2011. The definition of obesity-related deaths is any death where the underlying cause of death is recorded as obesity. The Quality and Outcomes Framework (QOF) measures general practice achievement against a range of evidence-based indicators and provides raw disease prevalence data by a total of 17 clinical areas. In 2013, the raw prevalence of patients aged 16 plus (per 1,000 patients) on the Obesity Register was 118.6 for the Western area.

Data on individuals availing of specialist smoking cessation services shows that in the Western HSCT in 2012/13, 60.9% of people who set a quit date had successfully quit (self-report) at 4 weeks.

Ministerial targets

The LCG will support regional colleagues in implementing the Ministerial target that all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme.

The LCG continues to support the Western HSC Trust-led. Family Nurse Partnership programme running in the North-West. The programme has shown considerable success, recently graduating its first intake following babies reaching the age of 2 years. The LCG Commissioning Lead is the chair of the Western FNP Advisory Board and the LCG is looking at opportunities to extend the programme across the Western area in the next three years.

Commissioned services

Western LCG will continue to support PHA colleagues to commission the provision of a range of Health Protection services.

The LCG has placed an emphasis on ensuring the implementation of the TB Action Plan in the Western area. The Group has invested Demographics funding in providing additional nurse capacity to support the setting up of a community team, linking with secondary care, which will support patients to manage the condition. The service will provide screening, treatment, HIV risk assessment, and advice and information to patients.

The emergence of Integrated Care Partnerships offers an opportunity to enhance preventative initiatives involving the range of interests who provide Health and Social Care services. With a greater emphasis on self-reliance and self-care, the LCG is committed to ensuring that ICPs place prevention and wellbeing centrally in its programme.

Commissioning Priorities and Requirements

Regional Commissioning Priority	**Local Commissioner Requirement**
Expansion of the early years intervention programme.	The LCG will support regional colleagues to implement the Early Years Intervention Programme. In particular, the LCG will continue to play an active role in the delivery of the Family Nurse Partnership in the North-West.
Incremental expansion of social economy businesses and community skills development.	The LCG is committed to supporting initiatives which offer opportunities to social economy businesses to participate in public procurement of Health and Social Care services.
Ensuring that health promotion provision is tailored to meet the needs of vulnerable groups.	The LCG will continue to ensure tailored service provision to meet the needs of vulnerable groups. In particular, the LCG is committed to extending support to Travellers through multi-agency collaboration, applying prescribing savings to fund health and social care initiatives to meet the needs of Travellers in the Western area.
LCGs to monitor Trust performance in relation to the HSCB / PHA Community Development strategy	The LCG will continue to monitor Western Trust performance in relation to the HSCB / PHA Community Development strategy.
Implementation of the "Fitter Futures for All Framework".	The LCG will work with regional colleagues to ensure Western Trust delivers the implementation of *Fitter Futures for All*

	framework
• Implementation of key public health strategies.	The LCG will support PHA colleagues to ensure Western Trust implementation of key public health strategies including: • Tobacco cessation services and BIT in particular for pregnant women and other vulnerable groups; e.g. Looked After Children; • Working towards smoke free campuses and sites; • 7 days services which prioritise individuals presenting to Emergency Departments, acute medical/ surgical admission wards and other settings within the acute sector for identification/ health improvement (screening/ brief intervention), treatment and support for substance misuse and associated mental health; • Trust should continue to support the delivery of emotional wellbeing and suicide prevention strategy including continuing to collect data for attendances at ED related to self-harm and contributing to the development of an improved model of support for those who self-harm. • Specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME

	communities and Travellers. • Supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed memorandum of understanding.
Provision of timely access to specialist sexual health services to take forward the recommendations of the RQIA "Review of Specialist Sexual Health Services in Northern Ireland"	The LCG is committed to maintaining current sexual health services provided by Western Trust and GPs. In particular, the LCG will ensure the maintenance of sexual health clinics for young people. Moreover the LCG has invested in the continuation of additional Genitourinary Medicine (GUM) services at Altnagelvin and Tyrone County Hospitals, previously piloted with EU funding from CAWT.

10.4.9 POC 9 – Primary Health and Adult Community

Introduction

Opportunities to develop Primary Care services and, in particular, enhanced services provided by General Practice have been evident across the Western area for some years. Western GPs have embraced integrated care pathways and shown considerable commitment in driving down the cost of primary care prescribing enabling a significant release of resources to enable the LCG to commission additional local services. Similarly, Western Trust has working collaboratively with the LCG to improve community nursing services with a view to having in place 24-hour services in coming years and the context of improving Primary Care accommodation in line with *Transforming Your Care* recommendations.

Overview of local needs

Based on GP data, the Western area has below average rates for key long-term conditions except COPD which is among the highest rates in NI. Moreover, based on Census 2011, almost 22% of the population reported they had a long-term condition of whom 78% reported they felt in good or very good health. It is also notable that across those key long-term conditions (asthma, COPD, Diabetes, heart failure and stroke) Western patients had lower than average rates of emergency admissions with heart failure and stroke emergency admissions where the lowest rate across the 5 LCG areas. The West also has slightly lower than average incidence rates for cancer.

Ministerial targets

The LCG is developing effective working relationships with the Western Integrated Care Partnerships and has constructively developed a programme of work which reflects the ICP Clinical Priorities Commissioning Specifications. The LCG recognises considerable progress locally in developing a shared agenda among primary and secondary care and community and voluntary

providers. Involvement of service users and carers is also taking place and will be an important focus for the next year.

During 2013/14, the two ICPs in the Western area have established multi-disciplinary groups to identify the best pathways to care for frail elderly, diabetes, stroke, respiratory service users. The development and implementation of these pathways will be supported by the commissioner in 2014/15 within available resources.

Identification of the patients in these service areas will be achieved by working closely with the General Medical Practitioners and taking a top down, bottom up approach to Risk Stratification. General Practice will be provided with tools and support to extract data from practice systems. This data will be analysed to proactively identify the patients most at risk within these groups, and the information provided back to the individual practices so that they can ensure patients are placed on the appropriate part of the pathway, shifting left. In addition, at local level, practices will continue to develop advanced care planning based on extended practice meetings.

The LCG has set the following objectives for Western ICPs in line with regional commissioning specifications and has received a comprehensive response within the ICP programme proposals:

Care for People with Diabetes

1. ICPs will undertake an education campaign with General Practitioners and Practice Nurses on best practice in diabetes care and proposed integrated care pathways in place to support patient self-management and primary care condition management.
2. ICPs will raise awareness among Primary Care practitioners re. early diagnosis of diabetic ketoacidosis among children leading to a reduction of emergency admissions, ICU care, and shorten lengths of stay.
3. ICPs will give consideration to extending access to insulin pumps among young people and seek to have in place the necessary staff to support new and ongoing patients using pumps.

4. Following the successful CAWT project providing pre-pregnancy support to women with diabetes, ICPs will ensure that Primary Care practitioners are aware of this important service which is likely to be mainstreamed by the commissioner.
5. ICPs will have in place processes for engaging with people with diabetes who are non-compliant, including those who fail to attend for planned condition review.
6. ICPs will ensure the provision of an ongoing programme of courses for adults deemed at risk of developing diabetes in the near future.
7. ICPs will have in place Diabetes Foot Pathway, ensuring resources necessary coordinate this are available and raising GP awareness of its contribution to patient care.

Care for People who are Frail Elderly

1. ICPs, working with Health Improvement Teams, will ensure the provision of a range of targeted health and wellbeing programmes, delivered across the Western area.
2. ICPs will coordinate and lead local initiatives to improve medicine compliance, including linking secondary care and community pharmacy and focusing on compliance among patients in nursing homes.
3. ICPs will improve communication between secondary care and General Practice, including focused work to improve hospital discharge letters to GPs.
4. Working with Western LCG, ICPs will describe current falls services and seeks to have in place an integrated falls prevention pathway.
5. ICPs will bring forward an action plan to put in place a consortium to overcome social isolation among older people living independently, building on the work of community and voluntary organisations and on Flexicare, aimed at measurably reducing social isolation.
6. ICPs will consider the need for additional intermediate care provision in the community, taking account of plans to establish acute care at home services in the context of 24-hour community nursing provision, providing an assessment to the commissioner.

7. ICPs will bring forward plans to extend carers' support services, including respite care, putting in place up to six initiatives.
8. ICPs will consider how carers could benefit from plans to introduce a consortium to deliver Primary Care Talking Therapies collaboratively between GPs, Western HSC Trust and community and voluntary organisations.

Care for People with COPD

1. ICPs will ensure the provision of home oxygen for appropriate patients with COPD in order to maintain home-based care.
2. ICPs will consider enhancing existing Community Respiratory Teams in support of integrated respiratory care pathways.
3. ICPs will bring forward proposals to put in place a pulmonary rehabilitation programme across the Western area to support patients with COPD.
4. ICPs will consider physiotherapy requirement of COPD patients supported by the Respiratory Early Supported Discharge Team and extend the service as required.

Care for People who have had a Stroke

1. ICPs will ensure patients who have had a stroke receive optimal medication to manage their condition in line with the Medicines Management Programme with a process of medicines review in place.
2. ICPs will ensure patients at most risk who have modifiable risk factors for stroke are given lifestyle advice by Primary Care practitioners.

Care for People who are receiving End of Life Care

1. ICPs will extend the GP-based palliative care register to include non-cancer conditions relating to respiratory, diabetes and stroke conditions.
2. ICPs will make available resources to support GPs to coordinate advanced care planning in line with ICP clinical priorities with Practices developing action plans and commencing practice-based palliative care planning meetings with appropriate input from Western Trust professionals.

3. ICPs will seek to build on Western Trust GP Facilitation initiative, providing support to GPs in advance care planning and training on palliative and end of life care.
4. ICPs will give consideration to the role of community pharmacy in supporting palliative care, including urgent response out-of-hours.
5. ICPs will provide advanced communication skills training for relevant Primary Care staff, including General Practice, offering a programme of events across the Western area.

Commissioned services

Western LCG, in line with regional colleagues as appropriate, will continue to commission the provision of a range of Primary Care services in line with *Transforming Your Care* and underpinned by Western Integrated Care Partnerships.

The emergence of Integrated Care Partnerships during 2013/14 has marked an important development in driving the shift of services from secondary to primary care. The LCG had successfully built integrated pathways on its Primary Care Partnerships and has made considerable strides supporting effective patient management in Primary Care through GP direct access to diagnostics (i.e. MRI, CT and ultrasound); application of clinical guidelines; and improved communication between primary and secondary care clinicians. Moreover the LCG has been keen to put in place practical solutions in the face of unnecessary pathways to secondary care, e.g. extending GP minor surgery to patients whose own GP practice did not provide the service. This practical approach has yielded considerable dividends and has been buoyed up by the LCG having additional funding to deploy in light of successful reductions in Primary Care Prescribing following an LCG-led campaign supported by Western GPs.

The LCG has sought to develop community nursing in recent years, investing additional funds in District Nursing and Rapid Response Nursing and initiating work to develop a model of 24-hour community nursing which seeks to prevent hospital admissions and aid timely hospital discharge. The LCG has

also encourage the development of ambulatory care which maximises Rapid Response Nursing capacity through bringing patients to Primary Care centres to receive treatments previously delivered at home. The first centre, opened in Omagh, has proven popular with patients who receive IV infusions, etc in recliner chairs and in the company of other patients with added social benefits.

Commissioning Priorities and Requirements

Regional Commissioning Priority	**Local Commissioner Requirement**
Development and commissioning of LES which support the transformation and integration of care in relation to the ICP clinical priority areas.	The LCG will work with regional colleagues and ICPs to ensure relevant Local Enhanced Services are developed with GPs in line with ICP clinical priorities and LCG commissioning requirements.
Provision of primary care aligned 24/7 Community Nursing Services, including District Nursing, to deliver acute and complex care at home and Palliative and End of Life Care at home or in the most appropriate Community facility. A Regional Commissioning Framework for Community Nursing will be developed.	The LCG has sought to develop community nursing in recent years, investing additional funds in District Nursing and Rapid Response Nursing and initiating work to develop a model of 24-hour community nursing which seeks to prevent hospital admissions and aid timely hospital discharge. The LCG has also encouraged the development of ambulatory care which maximises Rapid Response Nursing capacity through bringing patients to Primary Care centres to receive treatments previously delivered at home. The first centre, opened in Omagh, has proven popular with patients who receive IV infusions, etc in recliner chairs and in the company of other patients with added social benefits. Plans for similar centres aligned with planned Primary Care hubs are progressing.

10.5 Other Commissioning Priorities 2014/15 – 2015/16

The LCG remains committed to driving efficiency in HSC in the Western area. An incentivised approach is under way in ensuring GP demand on laboratories is in line with NICE guidelines and the LCG is keen to ensure that the outcome of this project leads to reduction in demand.

The LCG has provided funding to Western Trust during 2013/14 to place centrifuges in each GP practice in the Western area to reduce deterioration of blood tests and prevent unnecessary hospital attendances. Practices will receive training and support and it is anticipated that there will be a reduction in repeat blood tests and unreliable results.

The LCG will seek to extend the successful LCG Extended GP Minor Surgery Scheme to include additional appropriate procedures based on the competence of GP providers.

The LCG continues to seek efficiencies in the cost of prescribing in the West. Following a successful drive to reduce GP prescribing costs, the LCG recognises that other drivers must be addressed, such as secondary care prescribing, dispensing costs, and prescribing in GP out-of-hours. A plan is being developed as part of the Medicines Management Partnership Initiative. This includes further protected time for GPs, a focus on mental health prescribing and up-scaling reviews of medication prescribed to nursing home patients.

The LCG is now responsible for the commissioning of GP Out-of-Hours and will work with Western Urgent Care to ensure it maximises its resources in the delivery of GP services. The LCG recognises opportunities to integrate out-of-hours services, linking GPs, community nursing, social services, etc. and will work with providers to develop plans, drawing on opportunities inherent in the Primary Care Infrastructure programme.

The LCG has developed its programme to take forward the Western Primary Care Infrastructure Programme in line with *Transforming Your Care* recommendations. The LCG programme is overseen by a steering group involving a range of stakeholders, including Western Trust and Local Medical Committee. The LCG will continue to work with local stakeholders to develop combined health and wellbeing hubs which provide the opportunity to provide services as locally as possible, optimising integrated working and support health improvement in areas of greatest need.

11.0 Opportunities & Enablers

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

11.1 Integrated Care Partnerships

Significant progress has been made throughout 2013/14 in the establishment of Integrated Care Partnerships (ICPs) as laid out in the DHSSPS Policy Implementation Framework. Seventeen Integrated Care partnership committees have been established. A number of multidisciplinary task and finish groups have been set up within the ICP structures to review existing pathways for the clinical priority conditions and to design integrated approaches to care and identify opportunities for service improvement. In 2014/15 ICPs will focus on delivering integrated care for the clinical condition areas through the ICP committees.

A clinical leadership development programme is being delivered by the HSC Leadership Centre to enable leaders of ICPs to effectively develop and implement ICP working (see Section 11.4). There will also be a considerable emphasis on carrying out risk stratification activity at primary care level in line with the CPD target that; 'By March 2015, 95% of patients within the four ICP priority areas (frail elderly, diabetes, stroke, respiratory) will have been identified and will be actively managed on the agreed care pathway'. It is envisaged that this risk stratification at primary care level will be delivered via an enhanced service which will allow ICPs to put targeted case management approaches in place for those patients where appropriate interventions can prevent development of or exacerbation of chronic conditions.

11.2 Capital Investment

Key to the effective delivery of reform will be the HSC's ability to invest capital in a range of projects from refurbishing existing hospital and community facilities to developing new infrastructure and investing in new equipment such as ambulances and diagnostic scanners.

A total £247m capital investment is required during 2014/15 to support planned reforms. Table 67 summarises the capital schemes approved for 2014/15 under a number of reform banners. During the period 2015/16 to 2020/21 capital schemes requiring a total expenditure of £1,084m are planned.

Summary of Contractually Committed, Approved and Annual Recurring Capital Costs

Table 67

Banner Heading	**2014/15 Planned Capital Spend** **£m**	**Planned Spend 15/16 – 20/21** **£m**
Hospital and related services	150	362
Children	19	236
Diagnostics	9	2
Home as hub	30	234
ICT	30	220
Mental Health & Learning Disability	5	30
Primary PCI	4	0
TOTAL	**247**	**1,084**

In addition to the projects summarised in Table 67 above there are a number of projects identified by HSCB as being a key enabler to reform. These projects are not yet approved or funding agreed. Planned spend for them would likely commence in 2015/16 or 2016/17.

Hospital & Related Services

Key reform projects within hospital and related services that have been committed to in 2014/15 include the renewal of the ambulance fleet and eleven major building projects; these include the redevelopment of a number of

existing hospital sites (RVH Maternity; the Ulster Hospital; Tyrone County Hospital and Altnagelvin) and the development of a new radiotherapy suite within Altnagelvin.

In addition, the HSCB has identified three hospital infrastructure schemes which would require investment from 2015/16 (one scheme in Craigavon, one in Antrim and Causeway and one at Altnagelvin) and further three requiring investment from 2016/17 (one in Antrim and Causeway, one at Altnagelvin and one at Belfast City Hospital Laboratories). These schemes, totalling £362m, do not yet have DHSSPS approval to proceed and are not included in the costs outlined in Table 67.

Children's Services

Schemes in relation to Children's services that have already been committed during 2014/15 include the development of a new Regional Children's Hospital at the Royal Victoria Hospital site at total cost of £237m (funding of £15m is required for this in 2014/15).

In addition, the following schemes are assessed as essential to support the commissioning agenda in the short to medium term - the development of a Respite Centre for Children with Disabilities within the Northern HSC Trust) and the refurbishment of two children's homes (Glenmona, BHSCT and Ballee, NHSCT). These schemes have not yet been approved for funding, and their costs are not included in Table 67.

Diagnostics

Key projects already committed to within diagnostic services during 2014/15 include the purchase of MRI Scanners for BHSCT, NHSCT and SHSCT and the roll out of Regional Digital Mammography (total cost £9m).

In addition, the HSCB has identified the need to invest in direct access to diagnostics by GPs through further investment in CT and MRI scanner purchases

beyond 2014/15. Capital funding for these scanners has not yet been approved and is not included in the funds identified in Table 67.

Home as the Hub

To facilitate patient care closer to home Primary Care Infrastructure development is essential across the whole of Northern Ireland. £138m of capital investment is planned to support the development of primary care hubs and spokes in the period 2014/15 to 2020/21. These costs are included in Table 67. There is also a planned commitment of £65m of through the provision of loan capital for Primary Care.

In addition, a further £61m may be required to commence a number of projects that would come on line in 2015/16 or 2016/17. This includes the refurbishment of statutory residential homes across the province. Confirmation of this requirement will be made following completion of the 'Making Choices' consultation.

Information and Communication Technologies (ICT)

Key capital priorities within ICT already committed to during 2014/15 include the roll out of Electronic Care Records, implementation of E-prescribing and employee hardware updates.

Mental Health & Learning Disability

A key part of the mental health reform programme is the development of new mental health inpatient facilities. Three schemes have already been committed to (Gransha in WHSCT, Bluestone in SHSCT and a further one at BCH).

Three further units in SET, NHSCT and a second facility in WHSCT are HSCB priority areas for investment to fulfil the reform programme but do not have DHSSPS approval to proceed at the time of writing. These three units would require further capital investment (over and above that stated in Table 67) in the region of £100m over the period 2015/16 to 2020/21.

Finally there are two projects, considered to be priority areas for investment by the HSCB, but which would not come on line until 2016/17. These are a Mental Health Inpatient Addictions unit in SEHSCT and a new Adult Centre in NHSCT with associated total costs of £8m. At the time of writing they do not have DHSSPS approval to proceed and are excluded from the figures included in Table 67.

Percutaneous Coronary Intervention (PCI)
2014/15 will see the completion of expansion works to two Catheterisation Laboratories, one in BHSCT and one in WHSCT, with no further capital requirement beyond this year.

11.3 Cross-sector collaboration

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

11.4 Personal and Public Involvement

The HSCB and PHA recognise that Personal and Public Involvement (PPI) is core to the effective and efficient commissioning, design, delivery and evaluation of Health and Social Care services. PPI is about the active and meaningful involvement of service users, carers and the public in those processes. PPI operates at different levels, from information provision through to joint decision making. It is underpinned by a set of values and principles (PPI Circular HSC (SQSD) 29/07) and at its' core it is about changing culture and improving quality.

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

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

- Lifeline is a project led by the PHA to provide crisis support to people who are at risk of suicide. Service users and carers have been recruited to sit on the Lifeline Clinical and Social Care Governance Group contributing to their decision making process.
- Integrated Care Partnerships (ICPs) - recruitment of service users and carers has been undertaken. A minimum of two service users will be actively involved on the partnership committees and the working groups.
- Children and Young Peoples Strategic Partnership (CYPSP) 40 young people involved in the design and content of new web pages for CYPSP web site, P6 and P7 school children involved in making a DVD explaining in their words about CYPSP and how it helps children and young people. The Northern Outcomes Group has over the past 18 months involved over 1200 young people in the planning process.
- Promoting the Needs of Looked After Children through the active participation of young people and carers of looked after young people, in the development of a personal health journal called “About Me” which has helped to shape the development of services.

- Personalisation – Service users and carers have told us they want more control of who, how, when their services are delivered. Self - Directed Support (SDS) and Direct Payments are the main vehicles to enable this to happen. Both the SDS Programme Board and the direct payments working groups have service users and carers actively promoting and advancing the individualisation agenda.
- NI Formulary Pharmacy and Medicines Management - The HSCB has run a series of public workshops in relation to medicines. Feedback from service users and carers has shaped the production of a number of patient leaflets aimed at improving medicines safety and compliance and reducing waste: Your Child's Medicines; Medication Reviews; Your Medicines – Your Responsibility (adult); Your Medicines (partners in care).

However, we also acknowledge that there are still areas where we can strengthen what we do. In this context the PHA and HSCB are currently implementing a joint PPI Strategy (produced in 2012 and aligned to the aims of the Regional Health and Social Care PPI Forum). Delivery of our complementary PPI action plans is underway, with opportunities for joint working between the two organisations being taken forward through our Joint Implementation Group.

Increasing our capacity to engage with service users, carers and the public
In its capacity as regional lead for PPI for the HSC, the PHA has secured Ministerial permission to commission the design and development of a PPI awareness raising and training programme for all HSC staff. We will be working with service users and carers as part of this initiative and aim to have it completed in 2014.

The PHA has also, since 2010/11, committed almost £350,000 to initiatives which aim to advance and promote PPI across the HSC. After evaluation, best practice is identified and shared across the HSC, with a view to embedding it into normal culture and practice.

As individual organisations the HSCB and PHA are fully committed to involving its staff, service user, carers and the wider public, in the commissioning process and recognise that staff may need additional skills to engage with service users and carers in a meaningful and productive way. In an attempt to do this, the HSCB and PHA have made significant recurrent investment in training initiatives for staff and service users, including the Involving People Programme (an in-depth PPI and community development training programme) and an E-Learning programme for PPI. This investment in training will continue in 2014/15.

Both organisations have also established groups of staff across the respective Directorates who act as leads for PPI, helping to embed the concept and practice of Involvement into our ethos. In May 2013, the HSCB group held an event to allow service users and carers who have been involved in service planning with the HSCB to share with the senior management team their experiences of that involvement. The event, attended by around 80 service users and carers has resulted in the HSCB making six commitments aimed at improving the experience of involvement. These ranged from simple measures, such a producing a simplified form and guidance to make it easier for service users and carers to claim back expenses (now completed) to a commitment to using plain English in all its communications (a new communications policy is due to be issued in January 2014 and the HSCB is looking at options around provision of plain English training for staff [DN update prior to publication]).

Involving service users and carers in the development of standards and mechanisms for monitoring and evaluation

The PHA working with HSC partners through the Regional PPI Forum, has developed a set of Indicative Standards and Key Performance Indicators for PPI. These have been considered by the DHSSPS and subsequently endorsed by them as policy leads. These initial process based standards, will be followed by the development of more outcome focussed standards in 2014/15.

The PHA and HSCB will continue to work collaboratively to take forward the development of arrangements for the monitoring and evaluation of progress in

PPI. Service users and carers played a major part in the design of the pilot arrangements that were introduced with Trusts in terms of PPI monitoring in late 2013. They will be instrumental in evaluating the pilot and in further developing these monitoring arrangements for Involvement as we move forward. The learning from this will be key to informing the development and operation of performance management arrangements, which look at how well we are discharging our responsibilities in relation to PPI.

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

11.5 Clinical engagement

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

The Transformation Programme Board, recognising this challenge, have commissioned a Leadership Support Programme aimed at developing the leadership skills of clinicians leading change within ICPs. The programme, which commenced in November 2013, runs through to September 2014 and provides support to GPs, community pharmacy leads and to a group of hospital consultants who are working with ICPs to deliver integration and transformation. It provides four modules over 7 days:

- Personal Effectiveness Module
- Leading Integrated Care Partnerships Module
- Engaging Leadership Skills Workshop
- Personal Leadership, Presence and Impact Module

HSCB would envisage the development of clinical networking through ICPs as a real opportunity for these inspirational leaders to grow and support each other. ICPs, through the united goal of improving health outcomes through evidence informed approaches to care delivery will facilitate and nurture this engagement.

11.6 eHealth & Care and External Collaboration

11.6.1 Introduction

The World Health Organisation defines eHealth as follows:
'eHealth is the use of information and communication technologies (ICT) for health.'

N Ireland has the particular advantage of integrated health and social care, and the descriptor has therefore been extended to include social care. This broad definition encompasses all aspects of technology and information management, including remote telecommunications to support patients and clients. Following the appointment of a Director of eHealth and External Collaboration, DHSSPS have agreed the need to devise a new 5-year strategy for eHealth & Care. The development of the strategy is being led by the HSCB and PHA, supported by other HSC organisations.

In progressing external collaboration, the objective of engaging with Europe and further afield is to secure support for the adoption of best practice and the development of innovative solutions to meet our current service challenges. In addition to these benefits, in pursuing EU engagement the HSC should aim to attract additional funding from European competitive funding streams. The strategies to be pursued are set out in Transforming Your Care (TYC), Quality 2020, and other regional policies and strategies; these strategies are broadly consistent with key EU strategies including the European Innovation Partnership for Active & Healthy Ageing. The HSCB and PHA will support the development of partnerships across Europe, and promote an integrated response from the HSC in NI to maximise the opportunity for success in bidding, and the impact of those

successes by promoting alignment with the agenda set out in TYC and Quality 2020.

11.6.2 eHealth & Care and External Collaboration - Priorities 2014/15

There are five key priorities areas to be taken forward during 2014/15 which will carry forward into 2015/16.

1. Implementation of the eHealth Strategy.
2. Electronic care records.
3. Electronic care communications.
4. Development of Telemonitoring NI.
5. Implementation of the priorities within the Connected Health and Prosperity Memorandum of Understanding.

Detail regarding each of these priorities is provided below. The ICT Programme Board is currently reviewing its priorities so the information below may be subject to amendment.

1. Implementation of eHealth Strategy

The development of the strategy is underway, and is due for completion by June 2014, with implementation commencing in 2014/15. The strategy will outline the substantial role that eHealth & Care can play in supporting the transformation of service delivery and quality improvement agendas set out in Transforming Your Care, Quality 2020, and other regional strategies and policies. Amongst other aspects, the strategy will address the leadership and governance arrangements needed to ensure that the potential benefits of eHealth and Care investment may be fully realized. The implementation of the strategy will require significant associated revenue support.

Work to date on engaging stakeholders in the development of the eHealth & Care strategy highlights that across Northern Ireland there are many examples of excellent, innovative practice in the eHealth & Care sector, however much remains to be done in terms of making such initiatives available ubiquitously. Progressing these developments provide a pathway for improvement across the

HSC in N Ireland. The following paragraphs highlight the major new projects already underway or planned to start during 2014-2015, under the headings of Electronic Care Records and Electronic Care Communications.

2. Electronic Care Records

The Electronic Care Record (ECR) is now live in all Trusts. During 2014/2015 we will continue the rollout of the ECRsolution across the HSCNI exploiting opportunities to better co-ordinate patient care. The ECR Clinical Content Group will continue to prioritise data from other systems on an ongoing basis including summary Community Information System data, for inclusion in the ECR. Community summary information will be available in the ECR from Soscare, LCID (Nothern and South Eastern Trusts) and from the Belfast instance pf PARIS by the end 2014/2015. The ECR is now available to clinicians working in the newly formed Integrated Care Partnerships and will provide new functionality to assist with care planning.

The implementation of Bed Management and Patient flow systems in Trusts is underway and will be further rolled out during 2014/15. Information to support End of Life care will be enhanced with the development of a Key Information Summary (KIS) populated for selected patients with data extracted from GP systems. Rollout of KIS will begin in 2014/2015 and will be fully implemented by the end 2015/2016.

Significant resources will be made available to provide care information at the point of care in both Acute and Community settings through the use of mobile technology. This will involve investment in both the wired and wireless network infrastructure, also in technology to ensure that mobile devices are both secure and easy to use. Mobile devices to support staff working by in the community staff will be important in delivering the “shift left” agenda and will allow better use of staff resources.

The deployment of mobile devices will continue during 2014/2015 and 2015/2016.

The regional Medicines Management initiative will complete a business case to initiate the procurement of a HSCNI system to introduce ICT support for electronic prescribing and drugs administration in hospitals. The Business Case for this system will be developed during 2014/2015 and a procurement initiated. A system will be procured during 2015/2016 and implementation will commence in 2015/2016. A website to support the N. Ireland formulary has now been developed and will go live early in 2014. The new RISOH system will be implemented in all Trusts by the end of 2014/15. These initiatives will support safer and more effective prescribing.

The implementation of Community Information Systems (CIS) will continue with BHSCT completing the implementation of PARIS, by the end of 2014/2015, the SHSCT continuing with its rollout of PARIS, and the WHSCT commencing the implementation of PARIS during 2014/2015 with an expected 3 year rollout. The Northern and South-Eastern Trust have built modern community information systems through investment in legacy systems, and during 2014/2015 will bring forward a business case that considers the further development of these systems and alternatives, to deliver a Community ECR.

An enhanced data quality tool will be delivered by the end of 2014/2015 to support the Data Quality Dispute Network allowing faster and more accurate resolution of data quality issues in the HSC

Work will continue to enhance the HSCNI single Master Patient Index, and a business case will be developed to replace the Health + Care Number Index during 2014/2015.

A project to review options for replacement of the existing PAS systems will commence during 2014.

3. Electronic Care Communications

A project has been established to develop a HSC Web Portal to provide a HSC-equivalent of the NHS Choices website for England. The Web Portal will provide comprehensive information on symptoms, possible diagnoses, investigations, treatment and services. It will enable people to self-treat minor conditions and manage long term conditions more effectively. A Business Case for this development will be developed during 2014/2015.

The Electronic Referrals project has now developed the capability of this system to support electronic requests for advice. The HSCB and BSO will continue to work with GP practices and other practitioners to increase the use the electronic referrals system. The HSCB will fund further developments in this area to improve referrals workflow required to triage referrals. These developments will be trialled by the NHSCT during 2014/2015 with regional rollout complete by the end of 2015/2016.

Implementation of a new Primary Care ICT network will commence in early 2014/2015 providing higher bandwidth to GP Practices and will introduce wireless network access to staff working in and from GP practices. Further scoping will be undertaken during 2014/2015 to determine the most appropriate technical architecture to allow community pharmacists, optometrists, and dentists to the HSC network. An interim solution will be in place by the end of 2014These developments will support initiatives such as Project Echo and Developing Eyecare Partnerships.

In order to facilitate the faster transfer of documents such as Discharge Letters, the HSCB will fund a project to implement an ICT solution that will manage the electronic transfer of these documents. The technical work ill be complete by the end of 2014 with full rollout by the end of 2015.

Telemonitoring NI already incorporates a patient portal which enables patients to view and keep a track of their vital sign data. During 2014/15, this concept will be extended to enable, on a pilot basis, a small number of patients to have

access to their own records held on the ECR. This pilot will help inform future developments in this area.

The Directorate of Integrated Care will complete the business case for the DQiP project in 2014/15 and will initiate a project to procure the necessary ICT tools and support. The Data Warehouse will continue to be developed in line with the priorities set by the Regional Information Group (RIG).

Many of the above initiatives will contribute to removal of paper from care communications. A pilot Electronic Document Management project in the Western Trust is currently being evaluated and the lessons learned from this pilot project help inform any future developments in this area.

4. Expansion of Telemonitoring NI

Since commencement of the service in December 2011, 2609 patients (as at 30th Nov 2013) have been referred to the service, across the different condition groups such as heart failure, COPD, diabetes, post-stroke management. During 2013/14, healthcare professionals expanded the use of Telemonitoring NI to weight management as well as management of renal disease. Telecare services which can be used to manage and reduce risk for people in their own homes, has also been deployed across all the 5 Trusts. Individual targets for service levels and priorities for 2014/15 are set out at section 10.

5. Connected Health & Prosperity – Memorandum of Understanding between DHSSPSNI and Invest NI.

During 2012, a memorandum of understanding between DHSSPS and Invest NI highlighting the potential for growth in Life and Health Sciences to support NI's economic strategy, including the potential for jobs growth. The implementation plan has four key priorities:

- Priority Area 1 - Targeted Connected Health R&D and innovation funding, including optimising assets across the various organisations

- Priority Area 2 – The development of the NI Connected Health Eco System, along with international linkages
- Priority Area 3 - Collaboration with international regions, particularly within Europe and North America, for mutual gain
- Priority Area 4 – Promoting the Connected Health agenda internationally, particularly within Europe and North America

Priority Area 1

A core funding source in relation to Priority Area 1 is the European Commission (EC), through Horizon 2020, AAL, Health for Growth and other funding programmes. Success in this arena requires investment in reputation building, and in the development of active partnerships with partners across Europe, reflecting the requirement for collaborative working to achieve success in EC competitive bidding calls. See commentary under Priority 4 below.

Priority Area 2

The NI Connected Health Ecosystem has been strongly supported from right across the HSC, this forum has strong support from academia and industry.

Priority Area 3

The eHealth and Connected Health teams within HSCB and PHA have worked alongside DHSSPS to develop and support collaboration for care improvement with international partners. Formal memoranda of understanding are now in place with Basque Country, and with Oulu, Finland. Similar commitments are under discussion with Catalonia and Galicia. These partnerships will support collaboration on improvement work that will include application for EU funds during 2014 in response to calls from the EU.

Priority Area 4

Northern Ireland achieved accreditation as a 3* reference site as part of the European Innovation Partnership (EIP), on Active and healthy ageing (AHA) in September. Most recently, public reference to achievements in NI by European Commissioners for DG Sanco (Health) and for DG Connect (IT) reinforced this.

There has been some early success that has seen NI draw down funds for EU funded 'integration' projects.

The investment in awareness of NI achievements in the European Commission has been led by the Minister, supported by the Permanent Secretary, and by Ministerial colleagues, by OFMDFM, and by the Dept for Enterprise Trade and Investment (DETI), through Invest NI. The Horizon 2020 programme will be launched in January 2014; additional intelligence on 'competitive calls' is beginning to emerge. Other funding opportunities including the Health programme and 'Interreg 5' will launch in the first half of 2014.

During 2013/14, a work programme with the New York Department of Health on interoperability of health records is under discussion, with a view to capitalizing on NI's progress on the ECR, and to act as an exemplar for EU – US agreed strategic objective of improving interoperability across the two domains. This work will continue during 2014/2015.

In addition to these projects, teams from across the HSC have supported the work streams that arose from the Economy: Task & Finish report, which reports to the Connected Health & Prosperity Board.

By June2014, an External Collaboration engagement workplan will be submitted to the Boards of the HSCB and PHA, setting out the work ahead, the investment required to deliver on this agenda, and the expected benefits. The workplan will include activities in 2014/15/16 that should support each of the above-mentioned Priority Areas, shared learning from current EU projects for future funding opportunities, future cross-border initiatives and implementation of Task and Finish Group report for example progressing work on International Health Analytics Centre (IHAC).

11.7 Workforce Planning & Development

This Commissioning Plan and the transformation and reform agenda it sets out will reshape our service provision across health and social care over the coming

years. It is recognised that this will have implications for our workforce – and we are committed to supporting and enabling our workforce to take forward transformation and new ways of working. We need to ensure that we have the rights skills in the right place to deliver our services.

Three of the 99 TYC recommendations relate directly to workforce:

- Development of new workforce skills and roles to support the shift towards prevention, self-care, and integrated care that is well co-ordinated, integrated, and at home or close to home.
- More formal integration of workforce planning and capital expenditure into the commissioning process to drive the financial transformation.
- Re-allocation of resources estimated to equate to a 5% shift of funds from hospitals into the community.

In addition, the Francis Report made specific recommendations impacting on workforce:

- Enhancing recruitment, education, training and support for all the key contributors to healthcare, in particular nursing and leadership positions
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for patients, the public and stakeholders in the system

HSCB and PHA are taking forward a number of initiatives and strands of work to support our workforce:

Integrated Service and Workforce Planning

In order to meet the challenge of workforce/service remodelling the HSCB, in conjunction with the DHSSPS and the Trusts through Regional Workforce Planning Group, are taking forward a project to procure a regional workforce/service planning tool which can triangulate finance, activity (service) and workforce data to support service planning.

Capability Development Initiatives to support the implementation of TYC

The HSCB will invest in a range development initiatives designed to increase the wider HSC's capacity and capability to deliver the transformation agenda. These include:

- A Leadership Development programme for those leading TYC or transformation initiatives
- Change Management and core skills programme for those involved in TYC or transformation projects
- Leadership development and Effective Partnership Working and core skills programmes for those on Integrated Care Partnership Committees, or those supporting their successful operation
- The establishment of a Knowledge Exchange open to all those involved in the design, commission or provision of health and social care services across N Ireland

Profession specific workforce planning and development

Each of the key professions is looking at their workforce planning and development including the impact of the transformation agenda set out in TYC and the Commissioning Plan. This includes:

- the introduction of normative staffing levels in nursing as set out in the Commissioning Plan Direction;
- investment in nursing and midwifery re-skilling and development to support the shift into more community / primary care settings;
- increased introduction of 7 day working practices; and
- the establishment of a medical workforce planning sub-group to develop a suite of medical workforce plans for primary and secondary care for the 5-year period 2013/14 to 2018/19, taking into account increased 7 day working. This will include an incremental assessment of each sub-speciality to quantify current staffing levels by grade, and anticipated flows into and out of the specialty to 2018/19, and model future workforce needs.

11.8 Equality Good Relations & Human Rights

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

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

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

The Inequalities Action plan makes a number of commitments which are aimed at reducing inequalities. These include:

- Production of an information policy which will ensure that any communications issued by the HSCB can be accessed by all 9 equality groups.
- Maintaining and developing staff awareness, skills and confidence in relation to Section 75 equality duties.
- Looking at ways to expand our information base in relation to equality groups / issues – This has involved a review of all information systems within the HSCB and has resulted in additional information fields which relate to the 9 equality groups being added to a number of information systems including.
- Mainstreaming equality within commissioning – as part of this process a number of commissioning teams have identified specific inequalities actions. These range from trying to improve the information base within

their area of work to delivery of services which aim to target known inequalities. Some examples include:

- The maternity and child health team is currently undertaking a scoping exercise to determine the experience and issues of mothers from outside the UK who have given birth in N Ireland.
- Educational outcomes are known to be poorer for Looked After Children (LAC) than for the general population. HSCB is currently working with the Education sector to ensure that all LAC receive a Personal Education Plan. These plans are designed to establish clear targets and actions to respond effectively to each child's needs and provide a continuous record of their achievements with the aim of improving educational outcomes.
- Health outcomes are generally known to be poorer for people with a learning disability. Annual health checks have been shown to be an effective way of improving health outcomes in this group Last year the HCSB commissioned a Local Enhanced Service to provide annual health checks for people with a learning disability. This LES has been successfully evaluated and is being extended in 2014/15.

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

We have also embedded equality and diversity and human rights into the mainstream commissioning cycle. This is to ensure that, in the developmental

stage, commissioning decisions are informed by an explicit consideration of the needs, experiences of, and impacts on, those across the 9 categories protected by the equality duties.

An equality screening template detailing the overarching screening outcomes and the screening outcomes from each service team area accompanies this Commissioning Plan, which can be found on the HSCB website (www.hscboard.hscni.net/publications/Commissioning%20Plans). It is also published as part of the HSCB's screening outcome report as is required as part of the equality duties. In addition, you will note the each of the POC sections highlights those decisions where we intend to undertake a screening or EQIA during 2014/15.

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

11.9 Primary Care Infrastructure

In 2011/12 the Minister has indicated that he wishes to invest in the development of the primary and community care infrastructure as part of the strategy for improving the overall health and well-being of the community and for improving the delivery of integrated primary, community and secondary care services.

Primary and community care is considered to be the appropriate setting to meet up to 90-95% of all health and social service's needs. The services and resources available within primary and community care have the potential to prevent the development of conditions which might later require hospitalisation. They can also facilitate earlier discharge from hospital and in many instances assist with the management of conditions and provide appropriate support to prevent hospitalisation.

The development, therefore, of an integrated primary and community care service that is closely linked with secondary care provision could lead to better outcomes, improved health status and improved cost effectiveness.

It is anticipated that a hub and spoke model would be most effective in delivering a full range of services locally. Each hub would be a 'one stop shop' for a wide range of services including GP and Trust led primary care services. Larger centres should, where appropriate, also act as the 'local hub' for a network of services that could include GPs, community pharmacy, general dental services, or ophthalmic services.

Each spoke would have a defined level of services, depending on economies of scale, and will draw on the services of the hub as required. Each spoke will as a minimum contain GP services.
This model is intended to be the basis upon which Trusts, in conjunction with Local Commissioning Groups (LCGs,) can structure the local delivery of services to reflect the requirements of each area's hubs/spokes and best meet the needs of the population. This will include agreement on the appropriate physical infrastructure and its configuration required for the delivery of services.

The details of the model will vary in each area, depending on how best the existing infrastructure and service model can be augmented. While it may not be appropriate or possible to have all the services listed below in each facility, they form the basis of a model which will maximise the range of services and improve access to, and responsiveness of, primary and community care services, particularly making available more specialised services nearer to where people live and work. This includes provision of an enhanced diagnostic and treatment capability where appropriate. The proposed service model may include some or all of the services outlined in the table below.

The proposed hub and spoke configuration will also create opportunities for the wider independent contractor network (GPs, dentists, pharmacists etc), supporting practitioners to work collectively through appropriate linkages, with

access to community services provided in shared facilities. This approach should create the opportunity for greater efficiencies within integrated care pathways.

Over the coming years there will be a need for significant investment in primary care infrastructure to ensure that the physical capacity required to deliver the service model and the changes in the patterns of delivery, can be facilitated.

List of services which might be provided through hubs and spokes

Nurse Treatment	Parenting Support
Speech and Language Therapy	Diagnostics
Health & Well Being	Podiatry
Dental Services	Family and Childcare
District Nursing	Pharmaceutical Services
Social Work	Point of Care Testing
Long-term Condition Clinics	Family planning
Physiotherapy	Minor Injuries
Health Visiting	Advocacy
Services for Older People	Dietetics
Maternity Services	Sports Injury
Paediatrics	Mental Health
Occupational Therapy	GPs
Urgent Care	Audiology
Bookable Clinical Rooms	ECG
Out of Hours	Counselling
Minor Surgical Procedures	Population Screening Programmes
"Special Interest" Clinics	Community Space
Integrated Clinical Assessment and Treatment Services (ICATS).	Commercial Activities

During 2013/14 there has been significant progress in identifying the most appropriate configuration of hubs and spoke to deliver improved services to patients and support the 'shift left'. Work on the first 5 hubs commenced in

2013/14. Three schemes are in construction Banbridge, Ballymena and Omagh and two further schemes, at Lisburn and Newry, are in the procurement phase.

There are also 35 spokes associated with the 5 hubs and work commenced in 2013/14 on identifying their requirements in terms of their physical capacity and future ability to deliver services to patients.

During 2014/15 the key priorities are as follows:

- LCGs/Trusts and GPs should agree the hub and spoke configuration for each area
- LCGs/Trusts and GPs should agree the priority for implementation of each of the hubs within their area taking account of the shift left of services and how the reduced demand for hospital beds will impact on the commissioning of new facilities and the decommissioning of others
- Develop details of the impact of the proposed hub and spoke configuration on the commissioning of services and the existing delivery model.

Appendix 1 – Programme of Care Definitions

Acute Services (POC 1)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in an acute specialty. It also includes all activity, and resources used, by a hospital consultant in an acute specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

Acute specialties are all hospital specialties with the exception of the following (specialty codes in brackets); Geriatric Medicine (430), Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), GP Maternity (610) and mental health specialties (710 to 715).

Maternity and Child Health (POC 2)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), and GP Maternity (610). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts by any health professional where the primary reason for the contact was maternity or child health reasons. All community contacts to children under 16 are included as long as the contact was not in relation to mental health, learning disability or physical and sensory disability.

Family and Child Care (POC 3)
This programme is mainly concerned with activity and resources relating to the provision of social services support for families and/or children. This includes

Children in Care; Child Protection; Child Abuse; Adoption; Fostering; Day Care; Women's Hostels/Shelters and Family Centres. This is not a definitive list of the type of support which may be offered under this programme. This programme includes community contacts by any health professional where the primary reason for the contact is because of family or child care issues.

Elderly Care (POC 4)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Geriatric Medicine (430), Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts with those aged 65 and over except where the reason for the contact was because of mental illness or learning disability. All community contacts where the reason for the contact was dementia are also included, regardless of the patient's age, as well as all work relating to homes for the elderly, including those for the Elderly Mentally Infirm.

Mental Health (POC 5)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Mental Illness (710), Child & Adolescent Psychiatry (711), Forensic Psychiatry (712) and Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to mental health. If the reason for contact is that

the patient has dementia, the activity is allocated to the Elderly Care programme of care.

Learning Disability (POC 6)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in the Learning Disability specialty (710). It also includes all activity, and resources used, by a hospital consultant in this specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to learning disability. All community contacts with Down's Syndrome patients who develop dementia, for any dementia related care or treatment are included as are all contacts in learning disability homes and units.

Physical and Sensory Disability (POC 7)
This programme includes all community contacts by any health professional where the primary reason for the contact is physical and/or sensory disability. All patients and clients aged 65 and over are excluded. These contacts should be allocated to the Elderly Care programme.

Health Promotion and Disease Prevention (POC 8)
This programme includes all community and GP based activity relating to health promotion and disease prevention. This includes all screening, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisation and community dental screening and prevention work.

Primary Health and Adult Community (POC 9)
This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic

Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability.

Appendix 2 – Quality Assurance Framework 2014/15

The PHA and HSCB have a duty under Article 34 of the Health and Personal Social Services (Quality Improvement and Regulation) (N Ireland) Order 2003 to establish and maintain arrangements for the purpose of monitoring and improving the quality of the Health and Personal Social Services provided to individuals, and the environment in which services are provided. Information and intelligence is received from a wide range of sources in relation to safety, quality and patient experience and the HSCB and PHA have established an overarching Quality Safety Experience group to strengthen existing arrangements. Consideration will be given to learning identified through existing arrangements for SAI's, Complaints, Patient Experience and medicines safety and agree appropriate actions and follow-up arrangements.

The PHA and HSCB have in place a comprehensive Quality Assurance Programme which encompasses the following priorities:

(1) Quality Improvement Plans

In line with Commissioning requirements, Health and Social Care Trusts are required to submit for approval their Quality Improvement Plan (QIP). The plan focuses on those key priority areas that lead to improved quality in services and better outcomes for patients and clients through the provision of safe, effective and sustainable services. It will take account of quality improvement indicators and priorities required by the Commissioner in response to DHSSPS Commissioning Plan Direction. HSC Trusts are required to submit quarterly progress updates to the PHA which should include local quality improvement priorities in addition to the core commissioning requirements.

The core commissioning quality improvement plan priorities for 2014/15 are:

(i) Reduction of Harm from Falls in Hospital:

- Trusts will continue, in pilot areas, to improve compliance with Part B of the "Fallsafe" Bundle.

- Trusts will spread Part A of the "Fallsafe" Bundle and demonstrate an increase each quarter in the % of adult impatient ward/areas in which "Fallsafe" Bundle has been implemented.

PHA will monitor:

- compliance with Part A and B in pilot and spread areas
- % of all adult wards in which the "Fallsafe" Bundle has been implemented
- total number of falls and the number of these causing moderate or more severe harm
- rate of falls per 1000 occupied bed days

(ii) Pressure Ulcers: By March 2015 all Trusts will secure a 10% reduction in pressure ulcers. PHA will monitor:

- sustained spread of the SKIN Bundle to all adult inpatient areas / wards
- 95% compliance with SKIN bundle
- the rate of pressure ulcers per 1,000 occupied bed days

(iii) Preventing harm from Venous Thromboembolism (VTE): Trusts will achieve 95% compliance with VTE risk assessment across all adult inpatient hospital wards by March 2015

(iv) Sepsis6: The HSC Safety Forum will work with Trusts to implement and spread Quality Improvement in the Early Management of Sepsis (e.g. use of the Sepsis6) in medical assessment units (or in other pilot wards by agreement) by March 2015.

(2) Patient and Client Experience: Implementing the Standards

The DHSSPS Patient Client Standards highlights that patients are entitled to be treated with compassion, dignity and respect throughout their entire experience. The HSCB / PHA will work collaboratively with Trusts to undertake a comprehensive programme to engage patients and ensure that service improvements are patient focused; including the implementation of the regional

priorities identified in the PHA annual report (2012/13) on the Patient Experience Standards.

During 2014/15 the Patient and Client Experience Steering Group will provide strategic direction for the implementation of the DHSSPS Patient and Client Experience Standards and agree the annual work plan which will include the following:

- The PHA, in liaison with the HSCB and HSC Trusts will assist the DHSSPS to deliver a regional survey of inpatient and A&E patient experience during 2014/15, in order to baseline the position and put in place a programme of work to secure improvement.
- Trusts will be required to submit quarterly monitoring reports and detailed action plans to the PHA for approval on regionally agreed areas.
- In the final quarter of 2014/15, i.e. January-March 2015, Trusts will be required to undertake an evaluation of improvements achieved throughout the year and identify priorities for the following year. Reports on progress will be submitted to the DHSSPS and Boards of PHA/HSCB bi-annually.
- Through 2014/15 a planned programme of work will continue for the independent collection of patient stories. Each HSC Trust will continue to collect patient stories using an agreed methodology.
- The PHA will continue to lead the experience led commissioning project: **10,000 Voices** to shape and influence commissioning. The focus during 2014/15 will be to respond to some of the issues raised by Phase 1 of the project which focused on unscheduled care and nursing key performance indicators and to commence Phase 2, which will focus on patient experience of primary care and nursing key performance indicators.
- By March 2015 the PHA will work with HSC Trusts to establish a baseline of the number of wards where patients are cared for in Mixed Gender Accommodation. The PHA will develop regional guidance, definitions and work with HSC Trusts to implement and sustain improvements.

- The PHA will develop a schedule for monthly monitoring of Vacant Nursing Posts (registered and unregistered) within the HSC Trusts which will inform workforce planning.
- 'Promoting Good Nutrition Guidance' has been published in 2013 and The PHA will work in partnership with HSC Trusts to ensure that all * patients, in adult in-patient wards have nutritional screening. (* see Promoting Good Nutrition Guidance 2013 for groups of patients exempt from MUST screening)

(3) The HSC Safety Forum

During 2014/15, the Patient Safety Forum will develop a comprehensive work plan to provide mutually agreed support to providers to include the following:

- Promoting the concepts and clinical practices which underpin Normalising Childbirth in line with the 2012 Regional Maternity Strategy through a regional Maternity Quality Improvement collaborative
- A regional approach to improving the care of the deteriorating adult patient – to consolidate use of NEWS including Trust plan for audit of appropriate escalation.
- To continue the regional collaborative in Emergency Medicine, building on the agreed quality indicators and extending the work to promote enhanced patient flow.
- To continue the regional collaborative in Nursing Homes, sustaining the progress on falls prevention and spreading this across the system. Also to promote improvement in other areas of practice as identified in the themes for inspection by RQIA (Jan –Feb 2014)
- To facilitate a regional Quality Improvement collaborative for Mental Health following agreement from the Mental Health Advisory Group, on key areas of focus for improvement. Initial areas currently under discussion include crisis management and physical health.
- To facilitate a regional Quality Improvement Collaborative for paediatrics which will initially focus on:

- The improved identification and rescue of deteriorating children in acute care. This will include the development of an agreed regional, age appropriate, physiological early warning score tool and the use of enhanced communication models
- The prescription and administration of high risk paediatric medications
- To continue to build capacity and capability within HSC on patient safety and improvement science.

- HSC Safety Forum will work with Trusts to develop Quality improvement in Leadership for Safety within theatres and procedural areas.
- In addition, on request (capacity permitting) the HSC Safety Forum will support Trusts with small projects tailored for their prioritised needs.

(4) Regional Learning System

The PHA will continue to work with the DHSSPS in reviewing the most appropriate methodology for a Regional Learning System.

(5) Key Performance Indicators for Nursing and Midwifery

In 2013/14 Phase 1 of the project was completed with an initial regional set of high level key performance indicators for nursing and midwifery agreed. Definitions, reporting and monitoring arrangements have been developed.

In 2014/15 Trusts will measure and report on the agreed initial 4 Key Performance Indicators for Nursing (KPIs) which are:

- Reduction of hospital acquired pressure ulcers
- Reduction of harm from falls in hospital
- Reduction of omitted and delayed medicines in hospital
- Reduction of bank and agency use in areas that have implemented the normative staffing framework

These Indicators will lead to improved Patient and Client Experience outcomes and will provide evidence of the quality of Nursing and Midwifery care in N

Ireland. Phase 2 of the project will be taken forward by The Public Health Agency (PHA) in collaboration with the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), in partnership with key stakeholders. It will include the development and implementation of further indicators of nursing performance and the development of a regionally agreed electronic dashboard.

(6) Workforce planning within Nursing and Midwifery Services

Improving the quality of nursing services to the public in Northern Ireland: *'the right nurse, with the right skills, at the right time in the right place'.*

At the request of the Minister in July2013 the Public Health Agency (PHA) will continue to lead on the implementation, monitoring and development of The Normative Nurse Staffing framework "Delivering care" for N. Ireland. Delivering care sets out the principles for commissioners and providers of health and Social care services for planning nursing and midwifery workforce requirements.

- From April 2014, the Normative Nurse Staffing Tool should be applied to all inpatient general and specialist adult hospital medical and surgical care settings. A range of key performance indicators will be developed to monitor the implementation process. In addition E- rostering will be in place across all HSCT settings.
- By March 2015 normative staffing ranges will be developed and introduced for Community nursing and Health Visiting within a range which secures the delivery of the service model detailed with the Departmental Strategy including 'Healthy Futures'.

During 2014/15, work will also continue on the implementation of Specialist Nurse Job planning. This work is aimed at delivering on Safety Quality and Patient Experience outcomes within hospital services. Work will commence on the development of similar plans for Specialist Community Nursing services.

Appendix 3 – Breakdown of pressures 2014/15

Inescapable Funding Areas:

(i) Pay

The pay pressure £22m 2014/15 (£22m 2015/16) is based on a financial model which identifies pay expenditure and uplifts the cost by the nationally planned increase of 1% in both years.

(ii) Non-Pay

This pressure of £30m is to cover inflationary increases for goods and services. The pressure is based on a financial model which identifies non-pay expenditure and uplifts the cost by an average uplift factor of 2.5%. This was originally estimated at 3%. This figure may be subject to review when inflation indices are released in September this year.

(iii) Demography

The demography pressures identified in the plan take account of projected additional costs for each programme of care resulting from increases in population projections (see table below). This includes £3.97m pressures of re-ablement covered in *Transforming Your Care*.

Demography by POC 1

	Demography - Elective	Demography - Non-Elective	Demography - General
	14/15 £m	14/15 £m	14/15 £m
POC 1	4.3	5.7	
POC 2			0.3
POC 3			0.4
POC 4			19.1
POC 5			2.5
POC 6			1.1
POC 7			0.7
POC 8			0.7
POC 9			0.3
TOTAL	4.3	5.7	25.0

(iv) Specialist Hospital Services

The identified need for Specialist Hospital Services is currently estimated at £6m in year (£7m full year) including taking account of significant investment requirements with regard to Paediatric Congenital Cardiac Surgery, vulnerable specialties, specialist cancer developments (e.g. Brachytherapy) and ongoing development of Primary PCI. The detailed investment figures will be subject to the normal arrangements.

Specialist Hospital Services – Detail

The identified need for Specialist Hospital Services is currently estimated at £6m in year (£7m full year) including taking account of significant investment requirements with regard to Paediatric Congenital Cardiac Surgery, vulnerable specialties, specialist cancer developments (e.g. Brachytherapy) and ongoing development of Primary PCI. The detailed investment figures will be subject to the normal arrangements.

Specialist Hospital Services – Detail

Specialist Hospital Services	14/15 £m CYE	14/15 £m FYE
Apheresis	0.050	0.100
Cath labs	3.655	4.515
Rare Disease	0.025	0.050
Paediatric Oncology / Haematology	0.200	0.300
Air Ambulance additional costs from tender, provision	0.200	0.200
Neuromuscular Services to include CNS and Care Advisors	0.060	0.080
Adult and Paediatric Clinical Networks – delivering resilience	0.100	0.150
Brachytherapy	0.150	0.150
Stereotactic Radiotherapy	0.300	0.300
Paediatric Congenital Cardiac Surgery Services	1.500	1.500
Total	**6.240**	**7.345**

(v) NICE Approved Drugs

This funding requirement identified to enable the continued implementation of relevant NICE approved treatments in NI has been increased to £19m in 2014/15. This increase from previous estimates reflects pressures as a result of latest estimates of new and continuing drugs. Examples of this pressure are:

- ivacaftor £3.9m - the first of a new class of medicines, called CFTR potentiators that target the underlying cause of Cystic Fibrosis rather than simply treat its complications;
- continuing growth in patients numbers on macular, rheumatoid arthritis, multiple sclerosis, cancer, psoriasis, crohns and HIV account for an estimated additional cost of £13m;

- new drugs due to be approved by NICE in 2014/15 such as ipilumunab with recurrent costs of £4.3m - for previously untreated unresectable stage III or IV malignant melanoma and vintafolide £1.4m – for the treatment of ovarian cancer.

(vi) RCCE

The RCCE pressure (£7m) is to address those revenue costs arising from capital projects committed to, and planned to be committed to, over the Spending Review period including radiotherapy provision in the Belfast City and Altnagelvin hospitals, RVH energy centre and BHSCT theatre modernisation. This figure is largely unavoidable without significant impact on new schemes or the timing of others.

(vii) Mental Health Resettlements

This funding (£4m) will be used for the resettlement of mental health patients from hospital to a community setting. Further work is ongoing with Trusts to validate total client numbers over the Spending Review period. However there is specific detail on resettlement and this is targeted towards achieving the 2015 timetable.

(viii) Learning Disability Resettlements

This funding (£13m) will be used for the resettlement of learning disability patients from hospital to a community setting. HSCB has instigated a community integration programme to oversee the resettlement process, comprising representatives from DHSSPS, HSCB, Trusts and other stakeholders. The £13m includes £6m pressures in respect of DSD funding.

(ix) Service pressures/Service Developments

The funding under the service pressures heading has increased significantly to £77m. See table below.

The plan recognises that despite the tight financial restraints it is important to reflect a level of investment of new service developments in the final year of the Spending Review period.

Service Pressures

PoC	Pressure Area Recommended	14/15 FYE £m
Acute	Consultants to support acute oncology service	**0.3**
Acute	Oncology service gaps equating to 30 PAs or 3 WTE	**0.3**
Acute	Implementation of Cancer Care Framework	**1.5**
Acute	Fractures	**0.4**
Acute	Hospice funding	**0.4**
Acute	Introduction of FET to women who have had a cycle of IVF/ICSI since April 2012 and who have frozen embryos	**0.3**
Acute	IVF	**1.9**
Acute	LTC policy implementation	**1.0**
Acute	ED capacity planning	**5.0**
Acute	Elective	**15.0**
Acute	Radiology diagnostics	**2.0**
Acute	24/7 blood sciences	**3.3**
Acute	Regional perinatal & pediatric pathology service	**0.1**
Acute	Sleep apneoa	**0.4**
Acute	GUM SE & N	**0.2**
Acute	GMC reconition of trainers	**3.5**
Acute	Specialist nurse for neuromuscular disease	**0.1**
Acute	Workforce review of SW Hospital - 19.3 WTE nurses	**0.7**
Acute	Alcohol/substance liason services	**0.4**
Acute	Epilepsy nurses	**0.2**
Acute	Palliative care pressures	**1.0**
Acute	Tumour specific CNS	**0.2**
Acute	SAI reporting	**0.0**
Acute	Idiopathic Pulmonary Fibrosis	**0.5**
Acute	Haematology - 2 training posts	**0.2**
Acute/HP/FCC	24/7 acute & community working	**5.0**
Acute/Comm	Secure professional project support	**0.1**
Acute/Comm	Other	**2.1**
All	Normative Nursing	**12.0**
All Community	Community nursing access to clinical records	**0.0**

Elderly	Dementia strategy	**0.3**
Elderly	NIV service	**0.1**
Elderly	Fallsafe	**0.2**
Family & Child Care	CHOICE	**0.2**
Family & Child Care	Lakewood secure provision	**0.4**
Family & Child Care	Availability of personal advisers as required under the Leaving Care Act	**0.3**
Family & Child Care	Funding for Extended Fostercare Scheme	**0.3**
Family & Child Care	Supported accommodation (Young Homeless and Care Leavers).	**0.6**
Family & Child Care	Safeguarding child sexual exploitation	**1.0**
Family & Child Care	Assessment & approval support kinship foster carers	**0.3**
Family & Child Care	Therapeutic requirements for children within the child protection and looked after children systems (legislative and procedural requirements	**0.5**
Family & Child Care	Health visiting	**1.5**
Family & Child Care	Expansion of FNP to SEHSCT & NHSCT	**0.8**
Family & Child Care	School nurses for LAC	**1.0**
Family & Child Care	Safeguarding Children nurse specialists	**0.2**
Family & Child Care	NHSCT LAC specialist nurse	**0.0**
Primary Health & Adult Community	Infrastructure for GP's(Hub/Spokes)	**0.4**
Primary Health & Adult Community	OOH(GMS)	**1.9**
Health Promotion	Weight management programmes	**0.2**
Health Promotion	Support for families of patients in addiction services	**0.6**
Health Promotion	Community based Obesity Treatment Intervention Programme	**0.5**
Health Promotion	PHA Promoting Good Nutrition strategy/Living Matters	**0.1**
Health Promotion	Promoting Good Nutrition implementation	**0.5**
Health Promotion	Patient care experience	**0.2**
Learning Disability	Community forensic teams	**0.6**
Maternity & Child Health	Perinatal parent infant mental health service	**0.3**
Maternity & Child Health	Foetal medicine	**0.3**
Maternity & Child Health	Maternity support workers	**0.2**
Maternity & Child Health	Midwife for new immigrants	**0.1**
Mental Health	ASD	**0.5**
Mental Health	Pyschological therapies	**2.5**
Mental Health	Tier 4 addiction services	**0.8**
Mental Health	Psychological support for adult/kids with LTC	**0.4**
Mental Health	Specialist nurse - Domestic & sexual violence	**0.2**
Primary Health & Adult Community	Supervised swallowing (Prisons)	**0.2**

Acute	Major Trauma Network	**0.2**
Acute	EU cross border directive	**0.3**
Primary Health & Adult Community	Revalidation - Medical/GMS	**0.2**
Health Promotion	Diabetes network	**0.1**
Health Promotion	10,000 voices	**0.3**
Learning Disability	Review of AHP services in special needs schools	**0.1**
Maternity & Child Health	Implementation of paediatric stategy	**0.1**
Total		**77.2**

(x) Family Health Services (FHS)

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

(xi) Public Health Agency (PHA)

The total pressure for PHA is £6.1m. After taking account of pay and price costs of circa £2.1m there are additional pressures of £4.0m.

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

The financial analysis of Transforming Your Care is addressed in detail in Section 3.4 – Shifting Financial Resources Through Transforming Your Care. The table below details the £21m pressures in 2014/15 (£29m 2015/16).

TYC Reforms

Year	12/13 - 15/16 Net	12/13 - 15/16 Gross	2014/15 Gross	2015/16 Gross
	£m	£m	£m	£m
ICPs	21	28	7	14
Service Change: Stroke	10	10	4	4
Service Change: PCCI/Cardiac Catheterisation	1	12	4	4
Service Change: Reablement	3	17	4	6
TYC Implementation	13	13	6	2
Telecare	0	0	0	0
Prevention	0	0	0	0
Carers Respite	1	1	0	0
Bamford	2	2	1	1
Child Development	0	0	0	0
111 Urgent Care	0	0	0	0
NIAS 'See, Treat, Leave'	1	1	0	1
Self Directed Support	1	3	1	1
Workforce Reskilling	1	1	1	0
Marie Curie - Delivering Choices	0	0	0	0
Home Oxygen Services	1	1	1	0
ICT Enablers	1	1	0	0
Web Portal	1	1	0	0
Medicines Mgt Review of Care Home Clients	0	0	0	0
ICP Leadership Development Additional Costs	0	0	0	0
Local Trust Service Reforms	1	1	0	1
Application of balance of reprofiled 14-15 funds still to be confirmed	5	5	0	5
TYC VR/VER	7	8	0	8
TYC REFORMS ONLY	**70**	**105**	**29**	**48**
QICR VR/VER	15	15	0	
TOTAL TYC COSTS	**85**	**120**	**29**	**48**
Less Funded by HSCB				
PPCI from Elective			4	4
Reablement from Demography			4	6
Self Directed Support from Demography			1	1
Local Trust Service Reforms from Demography				0
TYC Benefits Realised				7
TOTAL DHSSPS FUNDING SOUGHT 14/15			**21**	**29**

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the Department of Health in N Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / longterm conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the HSCB and PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction – A document published by the Minister on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not publicly funded. Also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

Cord blood is blood that remains in the placenta and in the attached umbilical cord after childbirth. Cord blood is collected from the umbilical cord because it contains cells called stem cells, which can be used to treat some blood and genetic disorders.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Directed cord blood donations - These are collected from the umbilical cord of new born siblings of children with a condition such as acute leukaemia (sometimes referred to as saviour sibling donations). They are arranged with the haematologist treating the affected child.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a

range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector.

Lesbian, Gay, Bisexual & Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the Board arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Neoplasm – Any new and abnormal growth of tissue. Usually a cancer.

Palliative Care – The active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of N Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) – these pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Reablement - range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Service Framework - a document which contains explicit standards underpinned by evidence and legislative requirements. Service Frameworks set standards, specific timeframes and expected outcomes

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Transforming Your Care – This is a strategic assessment across all aspects of health and social care services examining the present quality and accessibility of services.

Trust Delivery Plans – In response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Ministerial targets, key themes and objectives outlined for the year ahead.

Unrelated cord blood donations - Also known as undirected or public donations, these are altruistic donations of blood taken from volunteers' umbilical cords at the time of delivery. They are processed and typed for storage in a public cord bank. Registers of public cord banks can be searched internationally to provide the best match for a stem cell transplant.