South Eastern Local Commissioning Plan 2013/14

14 March 2013

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CHAIR'S FOREWORD

This year's Local Commissioning Plan builds on the three year Population Plan published by the South Eastern Local Commissioning Group last summer. Transforming Your Care (TYC) has greatly influenced our thinking as we have been extensively involved in presenting the message of TYC and in hearing the views of the public and interested groups across the south east during the many consultation events.

Increasing demand for health care provision, with our well recognised demographic challenges in the south eastern area, in austere times, continues to provide a sharp focus for our Group. The Plan seeks to take the high level messages and translate those into understandable requirements for service provision in our four localities – Down, Lisburn, Ards and North Down. A key priority for us this year is to oversee the transition from four Primary Care Partnerships to the Integrated Care model as described in TYC. These new Partnerships will be tasked with designing or redesigning long term condition management, focusing initially on diabetes, respiratory disease and stoke services in the frail elderly population, following these through to end of life care. Improved care pathways for patients with less dependence on hospital admissions, planned or unplanned, is a key goal. We also recognise that in the coming years bold decisions in respect of the future configuration of services will have to be made by LCGs and we will endeavour to ensure that we are open and honest in communicating our intentions.

I would like to highlight a couple of initiatives we have been involved in this past year. We have promoted an exciting new model of sexual health services in our area and look forward to this being rolled out through the whole area. An enhanced primary care service will reduce demand on already overstretched secondary care clinics, enabling them to deal with more complicated cases. An enhanced model of dermatology in primary care has been reviewed and refined to provide more specialised services in GP surgeries and has led to a programme to up skill GPs across the south east on dermatological management.

Some members of the LCG will have reached the end of a 2 year extension to contracts in the coming months, and I want to pay tribute to those who will be leaving the Group, their contribution has been greatly appreciated by the team. We will need to appoint new members to these positions and reappoint others in this coming year.

Finally, I wish to thank all staff involved in this Commissioning Plan. Their commitment especially during the busy TYC consultation period was commendable. I also want to thank key stakeholders, including South Eastern Trust, all independent contractors and our friends in the voluntary and community sectors for their willing-ness to engage with us in many conversations as we have developed our Plan.

Dr Nigel Campbell
Chair, South Eastern Local Commissioning Group

1. South Eastern LCG Population & Need

Regional Demographic Overview

The recently published 2011 census figures have given us a revised analysis of demographics and social change in Northern Ireland. Some of the key statements are as follows.

There are approximately 1.81 million people living in the region and population projections anticipate this will rise to 1.94 million by 2023. This increase is characterised by a marked rise in the proportion of older people (defined as 65 years and over). By 2023 the number of people 65 and over is estimated to increase to 356,000 which will be 18% of the population. Currently the over 64 population is 15% (264,000) of the total population.

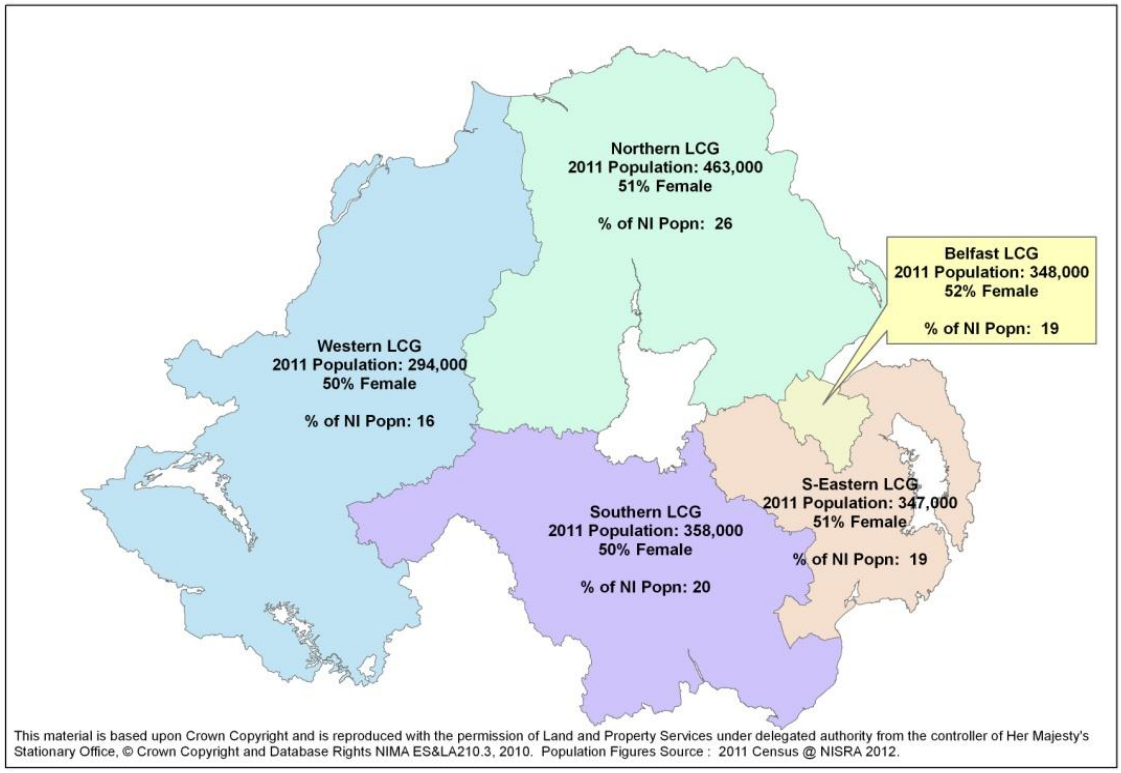
Life expectancy across the region has improved. Males can expect to live to the age of 77.1 years and females to the age of 81.5 years. As a result, the prevalence of long term conditions such as COPD, diabetes, stroke and hypertension is increasing. In conjunction the number of people coping with co-morbidities is also increasing.

Birth rates in Northern Ireland during 2011 were the lower than previous years. Deaths rates were also lower during 2011, however the number of deaths due to cancer were at the highest recorded level in the same period.

According to the latest Census, the Northern LCG has the highest share of the Northern Ireland population, with 463,000 residents or 26% of the Northern Ireland total The resident population of the Southern LCG is the second largest at 358,000 (20% of NI total). Belfast and South Eastern LCGs have similar resident total populations and both contribute 19% each to the Northern Ireland total population. The Western LCG has the smallest population of the five LCGs at 294,000 or 16 % of the Northern Ireland population (see Figure 1)

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 (18.7 % or 65,000) and the Southern LCG has the highest percentage at (22.7% or 81,000).

Figure 1: Northern Ireland Resident Populations by Local Commissioning Group: Total population (No. rounded to nearest '000), % Female, and % Share of NI total, 2011.



The Northern LCG however has the highest number of younger people within its population at 96,000 or 20.8% of its population. Persons of working age account for the highest proportions across all LCGs, ranging from 66.2% of the population in Belfast to 63.6% in the South Eastern LCG.

South Eastern Population

Demography

The 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 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 TrustThe main hospital managed by the South Eastern Trust is the Ulster Hospital in Dundonald which is **geographically in** east Belfast. Importantly, the east Belfast population access a significant level of their acute hospital care from the South Eastern HSC Trust.

The population of the South Eastern LCG in 2011 was 347,000. People 65 years and over account for 16% of the total population of the LCG (55,000 people), however 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 (264,000 people) and points to the advances that are being made in health and wellbeing allowing the older generations to enjoy their latter years.

However, it is inevitable that as people grow old the likelihood of illness increases and therefore also does the reliance on health and social care services. Older people are also more likely to be living with one or more 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.

Table 1: Current Population (2011) and Projected Population figures and % increase for 2015 and 2019 for Those aged 65 and over in the SELCG Locality (85+ highlighted)

YEARS											
AGE	**2011**			**2015**			**%+**	**2019**			**%+**
	Male	**Female**	**All**	**Male**	**Female**	**All**		**Male**	**Female**	**All**	
65-69	8,708	9,206	17,914	9,088	10,020	19,108	7%	8,909	9,607	18,516	4%
70-74	6,020	6,871	12,891	7,570	8,329	15,899	24%	8,329	9,460	17,789	38%
75-79	4,564	5,694	10,258	5,110	6,138	11,348	11%	6,297	7,357	13,554	33%
80-84	2,926	4,601	7,527	3,401	4,710	8,111	8%	3,999	5,194	9,193	23%
85+	2,077	4,645	6,722	2,733	5,394	8,127	21%	3,495	6,051	9,546	42%

Source: NISRA

Our over 85 year old population (highlighted in Table 1) is increasing at a faster rate than other age bands within the 65+ range. By 2015 there will be a 21% increase in the 85 and over population compared to the 2011 figure and by 2019 there will have been a 48% increase in that age group compared to the 2011 figure

Births

In the south eastern locality in 2011 there were 4,595 births. The Lisburn area comprised of 39% of this total and accounted for 1,789 births. In relation to maternity services 4,120 births were recorded at the Ulster Hospital Maternity Unit, however many of the births were to residents in 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.

Deaths

There were 2,836 recorded deaths in the South Eastern LCG locality in 2011. Lisburn had the highest number of births (1,789) and also the highest number of deaths (880). An analysis of the crude death rate (i.e. death rate per 1000 population) shows that North Down at 9.6 deaths per 1000 had the highest death rate in the locality and this was the second highest in Northern Ireland next to Belfast with a crude death rate of 9.7 per 1000 population.

Each year in Northern 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 indicate their preference to die at home. Figures for 2011 indicate that 49% of Northern 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 2011 in the south east area were cancer, diseases of the circulatory system and diseases of the respiratory system. Standardised mortality ratios (SMRs) for 2011 show that the 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 2: Standardised Mortality Ratios 2011 for Cancers and Circulatory and Respiratory diseases

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

Life Expectancy

Average life expectancy for males in the south east is 78.5 years which compares favourably with the Northern Ireland average of 77.1 years. For females the average life expectancy is 82 which again compares favourably with the Northern 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.

Chronic Illness / Long Term Conditions

While south east residents reported lower than average long term limiting illness and higher than average rates of perception of health as good or very good, provision of unpaid care was higher than the average for Northern Ireland.

Table 3: Percentage of SELCG population with a long term limiting illness, with good or very good general and providing unpaid care. Comparison with NI (source NISRA)

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

Across Northern Ireland the most prevalent long-term conditions are hypertension, asthma and diabetes. When we compare prevalence rates for these conditions in the south east with those regionally we find that our population has higher rates of hypertension and diabetes.

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 Northern Ireland average, having taken in to account the age and gender profiler for that area. Data shown in Table 4 suggests that incidence rates in the south east LCG are now marginally lower than the Northern Ireland average.

Table 4: Cancer Incidence rates 1993-99 to 2003-09

LCG/ Trust Area of Residence	1993-99	2003-09
SE	94	99
NI	100	100

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 Northern 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 (see Table 6).

Table 5: Standardised death rates for smoking related causes, 2001-2005 and 2006-2010 and % change.

LCG/ Trust Area of Residence	2001-2005	2006-2010	% Change
SE	122	115	-6%
NI	134	122	-9%

South eastern residents experience the lowest mortality rates due to smoking related causes when compared with Northern Ireland as per table 5.

Alcohol related admission to hospital rates have also been on the increase in Northern Ireland over the past decade. SELCG has seen a 32% increase in alcohol related admission rates since 2000/01 which is higher than the increase of 21% observed in Northern Ireland.

Deprivation

The 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 addition 18 of the 180 Super Output Areas (SOA's) in the south east now fall within the top 20% most deprived areas in Northern Ireland. It is estimated that 10.8% of the south eastern population live within these 18 most deprived areas (see Appendix 2).

2 Key Successes 2012/13

Transforming Your Care (TYC)

As part of the consultation process around the Ministerial vision for transforming health and care services in Northern Ireland, the LCG facilitated and took part in an extensive range of engagement across the south east. This consultation process involved joint working with our colleagues in the South East Trust. The LCG will have a major role to play in the implementation of TYC post the consultation period.

Population Planning

A key element within the TYC report was a request for the LCG to lead on the development of a Population Plan for the south east. This significant piece of work was completed within the timeframe stipulated and submitted to the Minister in June 2012.

Integrated Care Partnerships – Primary Care Partnerships

The LCG has recorded in previous Commissioning Plans its success in creating new structures to engagement with independent contractors, particularly General Practitioners and Community Pharmacists. These arrangements have been further enhanced in 2012/13 and the LCG looks forward to the further developments in primary care as PCP move to become Integrated Care Partnerships (ICP) in 2013/14. ICPs will have stronger links with secondary care and will have a membership forum which will include representation from the various location representative. There will be provider entities.

Patient Pathways

The LCG has taken forward a programme within our current Primary Care Partnerships to look at a range of patient pathways covering both elective and non-elective services with a view to improving their effectiveness. Some of the successes are as follows:

Sexual Health - The LCG has undertaken in conjunction with the Public Health Agency (PHA) a comprehensive review of the sexual health pilot commissioned in the North Down area. The evaluation found that uptake of the service was good and popular with both GPs and patients. The pilot also met all of its objectives in terms of providing a service with improved patient access, it freed up secondary care services to focus on more complex cases and the cost of

providing asymptomatic testing in primary care was significantly less than in secondary care. There will be an opportunity to extend the project in the North Down area into 2013/14 and the LCG will continue to work with the PHA to seek opportunities to mainstream the project across the south east and regionally.

Access to Senior Clinicians - An initiative to allow GPs to liaise promptly with hospital consultants for advice about their patients, potentially avoiding a referral to secondary care was taken forward. This work will now marry-up with the roll-out of the Electronic Care Record (ECR) in the south east. The ECR is being made available to practices across the south east and GPs will be able to liaise with consultants and seek further advice about their patients in the urology, endocrinology and neurology specialties.

Rheumatology - Starting in November 2012, five GPs commenced training to administer rheumatology soft tissue joint injections. This training is being held in hospital outpatient departments alongside consultant led clinics. It is proposed that primary care based services in each of the localities will commence in 2013/14. It is intended that early in 2013/14, these GPs, with an interest in rheumatology, will deliver a primary care based service for patients who need rheumatology treatments. GPs will be able to refer patients for treatment to the particular GP with a specialist interest in rheumatology in their locality.

Dermatology - The LCG piloted a dermatology project in the Down PCP area in 2012/13. The pilot provided all shareholders with excellent learning opportunities and as a result the LCG will seek to commission a revised version of the pilot based on the lessons learned. A major feature of the new project (which will be commissioned over a 24 month period) will be enhanced training for all practices in the Down area.

DVT Management – D-Dimer testing kits have been available to GP practices so that testing for DVTs can be carried out in primary care. This will identify those patients who require ultrasound scanning and should reduce the number of unnecessary ultrasound scans.

Primary Care Infrastructure

The LCG, in the context of TYC and proposed new service models in the primary and community sectors, has undertaken an extensive engagement

exercise with GPs and other independent contractors in respect of the future shape of service. A hub and spoke model has been proposed with hubs designated as Lisburn, Newtownards, Bangor and Downpatrick. Significantly, the LCG has plans for one of Northern Ireland's first Primary and Community Care Centres (PCCC) in Lisburn. This new centre, subject to Business Case finalisation, is likely to be on the Lagan Valley Hospital site and may lead to an extensive redevelopment and reshape of the site and the services provided there.

The agenda around the provision of improved infrastructure is also about the future spatial requirements for GP practices and this work is also being taken forward.

Investment in Services

In 2012/13 the South Eastern LCG invested over £2.4m of recurrent demography funding in a range of services designed to address pressures arising from demographic change in our population. As the population of the locality is getting progressively more elderly the majority of demographic funding was devoted to providing services for older people. Services targeted at older people included Reablement services, Psychiatry of Old Age, Domiciliary Care, Falls Prevention and the provision of Intermediate Care beds. The need to further enhance and develop the community ward concept within the Trust has also been recognised. Investment was made in the provision of Community Paediatric services and a consultant support for neonatology. Arrangements are being formulated with the South Eastern Trust to improve productivity to provide additional service capacity within the existing commissioned services. In addition, £597k of residual demand funding, designed to address pressures on existing services, was invested in 2012/13. This included additional funding for psychological therapies, adult safeguarding, carers support, physical and sensory disability and dementia services.

As part of the Commissioner's ongoing focus on improving services for people with mental health and learning disabilities, the LCG also invested a total of £366k (Bamford strategy money) in mental health services with the South Eastern Trust. The majority of this investment was to progress the on-going initiative of resettling long-stay patients into supported living accommodation within a community environment. By March 2015 all remaining long-stay patients in mental health hospitals should be resettled with appropriate

support in the community. The rest of the investment was aimed at progressing recovery based approaches in mental health services to achieve better outcomes for patients and to promote their independence and enabling them to participate as fully as possible in civic life. The largest investment of Bamford monies (£1.105million) was for the resettlement of learning disabled patients from institutional settings to supported living settings within the community. As with mental health patients, all learning disabled patients currently accommodated in learning disability hospitals should be resettled with appropriate support in the community by March 2015. A further £233k was aimed at increasing the capacity of and strengthening the community support teams that help clients to live in the community with levels of support to meet their assessed needs.

Prescribing Savings

In 2011/12 through the implementation of the Medicines Management Initiative developed by the LCG's Medicines Management and Prescribing Committee, GPs in the locality were able to achieve savings in their Prescribing budget of over £0.5m. This meant the LCG shared in the saving and received £173k. This amount was reinvested into primary care services as follows: dietetic support to nursing homes to reduce usage of oral nutritional supplements (ONS) where appropriate; to funding a pain management pilot for patients with chronic pain in the North Down and Ards areas and training to up skill GPs in the treatment of patients with rheumatology and dermatology. The LCG would anticipate further savings in coming years allowing for greater reinvestment opportunities.

An integral part of the Medicines Management Initiative that achieved the prescribing savings was the LCG investment, via its Prescribing Committee, in the Practice Based Pharmacy Local Enhanced Service (LES) and the GP Protected Time LES. These LESs provided the resources of staff and time which allowed and continues to allow GP practices to make significant reductions in their drugs budgets resulting in the prescribing savings outlined above.

Chronic Respiratory Conditions

Achievements have been made in 3 areas to improve services for patients in the community and decrease pressures on secondary care. A COPD Integrated Care Pathway has been implemented that clarifies the role of primary, secondary and specialist services. A local enhanced service for patients with

chronic respiratory conditions has been implemented within GP practices and a medicines supporting tool for the management of COPD and Asthma has been developed and sent out to Trust staff and GPs in the south east.

Falls and Osteoporosis Strategy

A falls co-ordinator has been commissioned by the LCG to support the introduction of the Falls and Osteoporosis Strategy. A key part of this role will be with regard to ensuring systems are in place to: identify people at risk of falls and fragility fractures, provide further assessment of those identified at risk and provide targeted evidence based interventions. This initiative should have an impact on reducing attendances by the older population at Emergency Departments and similarly reduce the number of admissions into hospital associated with falls and particularly in regard to fractured neck of femur.

Elective Care

During 2012/13 significant improvements have been made in reducing waiting times towards a maximum 9 weeks wait for outpatient appointments and a maximum 13 weeks wait for inpatient and day cases across all specialties. This has been achieved by a programme of non–recurrent funding in waiting list initiatives within the HSC and independent sector. During 2013/14 the Trust should be in a position to realise LCG recurrent investments in General Surgery, Gynaecology, Plastic Surgery and Cardiology.

Diagnostic Capacity (MRI, Cath Lab)

The LCG has supported investment in additional diagnostic/capacity at the Ulster Hospital. The Trust now has access to a state of the art, scanner. Furthermore the LCG recently approved a business case for a second scanner which will allow the Trust to scan additional volumes and a wider range of conditions.

The HSCB has outlined its proposals to ensure ready access to cath labs across the region. The SET has access to facilities in Belfast and has put in place, on a temporary basis, a fixed leased cath lab service operating two sessions per week. This will be reviewed as the HSCB finalises implementation of the regional cath lab arrangements.

Emergency Care Services

Across the south east in recent years there has been considerable focus on unscheduled care services, specifically in our Emergency Departments (ED). In June 2012 the LCG endorsed the SET proposals which will see a new emergency care model at Lagan Valley Hospital with a limited opening hours arrangement (8am to 8pm) with a co-located GP Out of Hours service. The SET is now moving to implement this model.

In addition, following the temporary closure of the Belfast City Hospital ED, the South Eastern Trust has had to contend with additional ED attendances and considerably more hospital admissions at the Ulster Hospital. The LCG has commissioned significant additional services from the SET to address these pressures.

Reablement

The SELCG is supporting the SET's reablement initiative through the investment of £300k in this service. This initiative within the Trust is part of a regional reablement project aimed at the redevelopment of rehabilitation and domiciliary care services in the community.

Voluntary Sector and Personal and Public Involvement (PPI)

The south east locality has a strong and vibrant community development culture and infrastructure in the form of many voluntary and community groups and networks. The LCG has been able to work with these networks to identify health and social care priorities and then to invest in services that address these areas of need. There has also been a series of engagements with local Councils. To date the LCG has initiated a number of engagements in the form of public meetings and workshops at which statutory and voluntary organizations have the opportunity to make presentations to the LCG and to represent the needs of local communities. As we continue to engage with communities our challenge is to strive to meet the objectives of PPI and ensure that local patients and carers have an opportunity to influence how future services are shaped.

3. Key Challenges 2013/14

Delivering TYC

Transforming Your Care: A Review of Health and Social Care in Northern Ireland (December 2011), states, as one of its key messages, that care should be provided at home or as close to home as possible. As TYC is implemented many of the services currently provided in an acute hospital or institutional setting will be provided in the community or in people's homes, where it is safe and appropriate to do so, making them more accessible. The challenge for the LCG in the future, in order to realise this vision, will be to commission services that: increase the role of the GP and local community pharmacist; have a stronger focus on prevention; involve an integrated, multi-disciplinary approach based more on a social as opposed to medical model of care; manage long-term conditions within the home or local community; harness the contribution that voluntary and community organisations can provide, in particular to older people, those with chronic long-term conditions and those with mental health issues; incorporate a reablement approach to care in order to provide service users with greater independence and empowerment.

The LCG awaits clarification in the specific bridging funds which will be available to support the implementation of TYC objectives, but is clear that this will represent a major workstream of the Group in 2013/14.

Integrated Care Partnerships

There has been considerable preparation for the implementation of Integrated Care Partnerships (ICPs) in 2013/14 as they take over from the role of Primary Care Partnerships. Considerable work has already been undertaken by the LCG, in conjunction with our colleagues in primary care and the South Eastern Trust in engaging with all relevant stakeholders.

During 2013/14, 17 Integrated Care Partnerships will be established across Northern Ireland, with 4 in the South Eastern LCG area. ICPs will be tasked initially with reducing avoidable hospital admissions for a range of conditions e.g. Frail Elderly, Respiratory, End of Life, Diabetes, Stroke, collectively known as FREDS.

New commissioning opportunities will be available to the LCG as ICPs are established. The LCG will be tasked to develop commissioning specifications,

supported by the regional service teams, which reflect the needs of our local populations in respect of the FREDS conditions.

Addressing Inequalities

The LCG has an important role to play in addressing inequalities in service provision, particularly for those rural communities far from major acute hospitals like the Ulster. Our plans for pathway redesign will mean that many diagnostics and treatments, currently provided in acute hospitals, could in future be provided in primary care facilities or as day procedures in local community hospitals, but only where it is clinically safe and appropriate to do so. A challenge for the LCG and our stakeholders will be to ensure that there is an appropriate mechanism to allow a shift in resources into primary and community care ('shift left') that does not destabilise the existing acute system.

The SELCG in collaboration with PHA colleagues have supported the Department of Agriculture funded benefits uptake programme aimed at identifying those in rural communities potentially at risk of or suffering from poverty and problems with access to both benefits and services. In addition to this over £350k has been invested in the south eastern area in employing community health and development workers who work with local communities, including rural communities, to address the wider social determinants of health and well-being. The community health and development staff work primarily with local community and voluntary networks including the rural networks in Down. The PHA funds the Peninsula Health Living Centre in the Ards peninsula area, which has been specifically established to target the needs of rural families. The Centre provides access to a wide range of health and well-being improvement programmes and skills based learning. Work is ongoing with the SET and a range of statutory, community and voluntary providers to improve access to services and invest in areas of high deprivation, e.g. engagement with the DSD Neighbourhood Renewal programme and supporting early years, disability and the needs of vulnerable adults and older people's programmes.

Management of Demand

As with any service, waiting times increase for elective care when there is insufficient supply of that service to meet demand. Understanding demand patterns is a key issue for the LCG. LCG officers will continue to work with the

regional elective care commissioning team to determine service capacity and demand. To date there has been a considerable focus on elective capacity and regular performance meetings between the Board and Trust have led to a timely informed understanding of hospital performance.

Part of the solution to increasing demand is understanding the referral process. Within the Population Plan a work stream is focused on referral management. The LCG will therefore continue to work with GPs to support them to enhance the quality of referrals to secondary care. During 2013/14 the Board will continue to measure Trust performance/efficiency and support the Trust in its plans to meet the levels of best performing Trusts in GB.

The LCG already has in place a structure of GP leadership across the south east which includes 7 clinical leads and identified leads in each practice. This structure has recently been augmented by a locality lead who will work 5 sessions a week across the area. GP clinical leads will have a significant role to play in assisting the LCG in understanding local demand patterns and putting in place effective arrangements with their secondary care colleagues to enhance the future quality of referrals to primary care.

Elective Care

Despite the improvements that were made in reducing waiting times in a number of specialties for outpatient appointments and treatment, it remains a challenge for the Commissioner and Trusts to secure additional capacity to meet waiting time targets. The challenge for elective care in 2013/14 will be to improve upon waiting times across all modalities and meet the DHSSPS targets for all specialities.

The LCG will need to find innovative ways to manage this increase in demand and to balance the need for elective investment with that of non-elective, primary and community services.

Further challenges for acute care will lie in reducing the level of DNAs and ensuring that only appropriate review outpatient appointments are held. From a treatment perspective, SET will be expected to maximise theatre utilisation by increasing the level of pre-operative assessments, reducing the rate of cancelled surgeries, and ensuring more inpatient operations are carried out as Day cases.

Cancer Services

The LCG in conjunction with the Cancer Regional Service Team has met with the South Eastern Trust to address emerging pressures within cancer services at the Ulster Hospital, but specifically as they relate to oncology provision. The LCG will seek in year to see how those pressures can be addressed. The need for ongoing dialogue with the Trust in regard to cancer (oncology services) has also been acknowledged and arrangements will be put in place via the cancer network to ensure future improved links.

Diagnostics

It is also intended that during 2013/14, GPs will, in conjunction with the SE Trust, develop a direct access DEXA service for osteoporosis care. This will initially be in the North Down area but it is hoped to roll out the service to other localities in the south east area when sufficient GPs receive appropriate training.

Maternity

The last few years have seen a significant change in the model of maternity services within the South Eastern Trust. The Downe Hospital opened with a new Midwife Led Unit (MLU) and the LVH changed from a consultant obstetric service unit to a stand-alone Midwife Led Unit. During this time, the SET opened a new maternity unit at the Ulster Hospital which includes a midwife led unit and an obstetric service co-located in the same building. The obstetric service has seen an increase in the number of births from 2,851 in 2009/10 to 3,559 in 2011/12. Part of the increase in the number of births at the Ulster Hospital has been attributed to an increase in the birth rate as well as changes in the maternity services model in the south eastern and neighbouring Trusts. The forecast for 2012/13 obstetric births at the Ulster Hospital is 3,444. When the current consultation process on the proposed maternity service model in Belfast is completed, further increases in demand may materialise at the Ulster and Antrim Area Hospitals. The challenge for the LCG and Trust will be to meet this increase in demand…

Overarching this need to meet the increased demand is the new regional maternity strategy and the regional commissioning objectives. Delivery of these objectives will be embedded in any proposed service development for maternity care. The LCG expects to receive in 2013/14 a capital business case to extend the maternity unit at the Ulster Hospital. This will facilitate 4,507

births per year, births in the unit are currently projected to exceed 4,200 in 2012/13.

The LCG will, through a regular performance and monitoring programme, ensure that the South Eastern Trust provides adequate standards of medical cover in obstetric units.

Just over 50% of births in Northern Ireland are normal births with no intervention whilst 30% of births are caesarean section births. This is 4% higher than in GB and within Northern Ireland the rate varies considerably from one Trust to another. In the Ulster Hospital in 2010/11 the Caesarean rate was 27%, one of the lowest in the region. The LCG will work with the regional service team and the Trust to develop and implement a Normalisation Birth Plan in 2013/14.

This normalisation in birth includes the promotion of Midwife Led Units. The South Eastern Trust's two freestanding MLUs are not working to their full capacity whilst there is greater demand than capacity at the obstetric unit in the Trust. It remains a significant challenge for the south eastern locality to realise the planned number of births at Lagan Valley Hospital MLU (500 births per year) and the Downe hospital Midwife Led Unit (350 births per year). The service at the Downe MLU (the first in Northern Ireland) will be reviewed by the LCG. This will be undertaken in conjunction with the regional service team and other stakeholders. Improvements in service delivery and performance will become more important given the increasing demand on acute services.

The LCG will work with the South Eastern Trust to further develop community midwife services that will offer reasonable access for women, confirmation of pregnancy scans and access to NIMATs for pregnant mothers within 12 weeks. The LCG will work with the Trust to ensure women with straightforward pregnancies will be cared for a midwife in the community.

Emergency Departments – Unscheduled Care

The LCG faces a range of very significant challenges in commissioning safe and effective emergency care services for the population of the south east. There Are a number of developments which are likely to impact on the future delivery of Emergency Department (ED) care. Transforming Your Care (TYC)

envisages a significant shift left in services out of hospital and into the community especially in long term conditions. The impact of 'Agenda for Change' on out of hours working will potentially put further strain on services which are already difficult to maintain, likewise the European Working Time Directive (EWTD) which regulates extended working by doctors is likely to be reviewed. At this time it is not possible to predict how these changes may impact EDs. Other changes will be the opening of the new ED at the Royal Victoria Hospital in mid-2013 and further developments associated with the Ulster Hospital ED.

In England the Department of Health is promoting the concept of larger EDs and their supporting acute infra-structure operating right through the 24 hour period. Already there is an extended working day in some locations here and for some of our busiest EDs like the Ulster and Royal Victoria Hospital, further extension of this looks to be on a future agenda.

The Ulster Hospital ED is currently the busiest in Northern Ireland. The LCG will have to work with other partners, particularly in primary care to manage demand, specifically in respect of our older and ageing population, who are high consumers of ED services. The key to it functioning efficiently depends on the ability to treat large volumes of patients safely and appropriately. This can only happen when the ED and the hospital operate as a cohesive unit processing the patients rapidly through the ED with sufficient bed capacity elsewhere in the hospital to receive those patients who require admission. Where patients do not need an acute admission then a sufficient range of safe alternatives must be provided in the community. Given that the Ulster Hospital is the major ED in the south eastern locality there will need to be a continuous dialogue between the HSCB/LCG and the Trust to ensure maximum utilisation of existing resources of space and personnel. There are also minor injury units in Ards and Bangor which support the Ulster ED. The Trust has indicated that the future role of such units requires review within the overall context of the Ulster ED.

Downe Hospital and Lagan Valley Hospital EDs have introduced new patterns of working. Operationally these depend on support from Ulster Hospital ED staff rotations and co-operation with GP out of hours on call arrangements. The LVH ED also relies on certain services from the Belfast Trust. These arrangements will need to be closely monitored to ensure they continue to respond adequately to local needs while operating safely, efficiently and address accepted clinical standards.

The SET is currently awaiting Ministerial approval for their plans to move to a limited opening hours, GP co-located ED model at the LVH. Should this model be implemented the Trust has agreed with the LCG that they will continue to keep the model under review, specifically in regard to a more sustainable staff arrangement at middle grade doctor level.

In November 2011, Belfast HSC Trust temporarily closed the ED at Belfast City Hospital resulting in changes in demand for non-elective services the Ulster Hospital. In the last 18 months, the Ulster Hospital has recorded a significant increase in both ED attendances and admissions for acute medical and surgical care. In response to these changes, the LCG approved significant funding for additional beds and staffing to support services to allow the Trust to address this additional demand. This investment has recently been further enhanced in response to changing demand.

Whilst the Belfast LCG leads a consultation process to determine the reconfiguration of ED services in Belfast, it remains a priority for the South Eastern LCG to ensure that our population has appropriate and timely access to unscheduled care services. The process will require joint working with other Trusts, notably the Belfast Trust and Northern Ireland Ambulance Service (NIAS).

Ambulance services are important in managing patient flows. To assist in more effective management of the demand across Belfast and South Eastern Trust boundaries a process of zoning patient flows has been introduced to all GP urgent admissions requiring NIAS transfer. The LCG will work closely with the HSCB's Improvement Action Group (IAG), which has oversight of the pressures across unscheduled acute services in this regard.

In addition, the LCG will undertake to work with the unscheduled care service team and NIAS in regard to the specific issue of cardiac ambulances. The LCG has noted that two such ambulances are located in the south east, one based at the Downe Hospital and the other at the Ulster Hospital servicing the Ards and peninsula areas. The appropriateness of this form of urgent care provision will be assessed in year.

Fracture Services

The LCG has been working with the Trust to improve performance in respect of fracture services. The LCG has invested in an additional session and the Trust has agreed to realign sessions within orthopaedics. The LCG will continue to work closely with the Trust in 2013/14 to ensure improvements in delivery of fracture targets.

Social Care Reform

If we are to meet the challenge of demographic change, as described in the opening of this commissioning plan and build on progress to date, the way in which services are perceived and delivered needs to be reviewed in order to achieve a balance between meeting the needs of the most vulnerable and promoting independence and self-determination. Delivering these priorities will require radical change. It will need us to shift the emphasis from traditional service models to a partnership approach; optimising inter-agency working, enhancing the capacity and role of voluntary and community organisations to support self-management and improving safeguarding arrangements.

The current model of delivery, with its emphasis on the provision of community care to and for people, rather than supporting their own independence and abilities, does not meet this demand nor is it financially supportable in the long term.

These challenges, which are essentially the drivers for change, now frequently manifest themselves in a range of pressures across our service delivery models in terms of: waiting lists for access to services and equipment, increased throughput demand on acute care services, increased prevalence of long term conditions and co-morbidities and increased expectations of a better informed society.

The HSCB has endorsed the reablement approach which requires a fundamental shift away from assessment and long term care planning to time limited assistance with everyday tasks and intervention in the first instance. The essence of reablement is to work with individuals whose independence is at risk, to rebuild their confidence, develop (or re-learn) these daily living skills and promote their social inclusion. This would be done intensively for a limited period (2-6 weeks) with the goal of a level of independence that either allows discharge needing no service; or needing ongoing services but on a reduced basis.

Therefore the LCG will, in collaboration with the South Eastern Trust, continue to support and develop the reablement model of service delivery that was set up within older people's services in the Trust in 2012/13 to more fully promote independence and better outcomes for older people.

Infrastructure Business Cases

The South Eastern Trust has been to the fore in recent years in bringing forward significant proposals to modernise its estate in response to its reshaping of services. This modernisation programme throws up significant challenges in the identification of capital resources, and the identification of additional revenue as required, which is the responsibility of the LCG. The LCG is aware that it will have to review with the SET a significant number of Business Cases in 2013/14 which includes (1) Phase B Ulster Hospital redevelopment; (2) Lisburn Health and Care Centre or Primary and Community Care Centre; (3) Proposed extension to the Ulster Hospital Maternity Unit; (4) Mental Health Centre Unit 3-1 (5) Learning and Physical Disability Day Centre Reshape North Down and Ards 3-2; (6) Potential redevelopment of the Ards Hospital site. The LCG will seek to support Trust Business Cases which are affordable and in line with strategic direction and which provide Value for Money. Within the current constrained financial environment, Commissioner support for like for like services models will represent the LCG's initial position.

Voluntary Sector and Personal and Public Involvement (PPI)

The south east locality has a strong and vibrant community development culture and infrastructure in the form of many voluntary and community groups and networks. The LCG has been able to work with these networks to identify health and social care priorities and then to invest in services that address these areas of need. There has also been a series of engagements with local councils. To date the LCG has initiated a number of engagements in the form of public meetings and workshops at which statutory, voluntary and community organizations have the opportunity to make presentations to the LCG and to represent the needs of local communities. As we continue to engage with communities our challenge is to strive to meet the objectives of PPI and ensure that local patients and carers have an opportunity to influence how future services are shaped.

4. Commissioning Intentions 2013/14

Key Commissioning Priorities

The Commissioning objectives have been developed by the HSCB's Regional Service Teams which focus on specific commissioning areas like Cancer, Children and Families etc. From these commissioning areas we have selected specific objectives and actions that we can focus on locally and which we will now take forward with the South Eastern Trust in 2013/14. These actions are set out below as far as possible in 'life cycle' order. The last commissioning area specified here is Prisoner Health which is specific to the South Eastern Trust as the regional priorities.

4.1 Cancer Care

Cancer is one of the main causes of death in Northern Ireland. While up to one in three people are likely get a diagnosis of cancer at some point in their lives, survival rates have improved dramatically for most types of cancer. The South EasternTrust must continue to develop and implement the Regional targets which have been stated in the Regional Commissioning Plan for all Cancer services.

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

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

Regional Priority	Local Commissioning Intent
During 2013/14 all Trusts will continue to address longest waits and improve the headline percentage to ensure that 95% of patients receive their first definitive treatment within 62 days to include: maintaining mechanisms for patient tracking; breach analysis; and action planning and follow up with HSCB personnel In addition, Belfast Trust will progress developments to include: improved access to Brachytherapy; provision of	

enhanced thoracic surgical capacity and the centralisation of upper GI surgery in order to address pathway issues which contribute to delays.	
Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery. • Minimum of 30% of Breast Cancer Patients on self-directed aftercare pathway by Jan 2013- rising to 40% from Jan 2014; • All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services; • All Trusts should develop clear project plans and begin to introduce a risk stratified model of follow up across all other cancer groupings, which will clear and prevent review backlog; • Findings of external evaluation to be incorporated into Trust andTransforming Follow Up action plans.	The South Eastern Trust must work towards ensuring that 40% of Breast Cancer patients are on self-directed aftercare pathways from January 2014.
All Trusts should work with HSCB to implement the recommendations of the 2010 NI Chemotherapy Service Review. This should include: • Establishment of an Acute Oncology Service (activity to be monitored as agreed with the HSCB); • All Trusts to work with HSCB to	The South Eastern Trust must continue to ensure that all of the recommendations of the Chemotherapy Service Review are implemented.

agree regional model that provides appropriate oncology presence across centre and units; • All Trusts to monitor compliance with NICE guidance on neutropenic sepsis and to report to the HSCB on a monthly basis via the performance management information returns; • All Trusts to work closely with HSCB to modernise oncology services including staff levels and skills mix; All Trusts to implement C-PORT and; • All Trusts to continue to ensure involvement of relevant personnel / stakeholders in the development of RISOH	
Effective Multidisciplinary Teams All Trusts should ensure that cancer MDTs undertake the NICaN Peer Review process and develop action improvement plans which will be shared with HSCB. • All Trusts should participate in peer review of, Lung, Gynae, Colorectal, Urology and Haematology; • All Trusts will participate in peer review of Skin, Head and Neck, Upper GI/HPB and Breast ,MDTs; • BHSCT to participate in peer review of Sarcoma, Brain& CNS MDT; • All Trusts to participate in national Lung, e.g Bowel, UGI and Head and Neck audits; • All Trusts to share with HSCB on an	The South Eastern Trust must continue to ensure that cancer MDTs undertake the NICaN Peer Review process and that action improvement plans are shared with the HSCB on a regular basis

annual basis findings from national and other relevant audits (including M&M Meetings) and subsequent action plans and • All Trusts will audit the Protocol for Amending the Status of a Red Flag Referral including the implementation of the NICE Guidance for Suspected Cancer.	
All Trusts will work with the Regional NICaN TYA postholder to scope out current practice (including pathways and referral patterns) and will encourage staff involvement in education and training on the needs of this cohort of patients. • All Trusts to participate actively in the development of streamlined pathways for teenagers and young adults with cancer .Trusts to participate in multiprofessional multidisciplinary working e.g virtual MDMs.	The South Eastern Trust must continue to work collaboratively with the Regional NICaN TYA post holder.
Haematology Services • All Trusts should formally establish & implement virtual clinic; arrangements and support the agreed MDM configuration as determined by the HSCB regional working Group; • Trusts working with HSCB should ensure recommendations from NICR Haematological Malignancy Audits are implemented and All Trusts should ensure maximisation of skills mix initiatives as determined by the HSCB working group.	The South Eastern Trust must work towards full implementation of the regional commissioning recommendations for the local Haematology service.

Ovarian Cancer Trusts should link with Primary Care to raise awareness of the signs and symptoms of cancer, working with GPs within their area to provide Training and Awareness events. An initial focus will be on the introduction of specific referral and diagnostic pathways for suspected ovarian cancer in line with NICE Clinical Guidance.	The South Eastern Trust should link with Primary Care to raise awareness of the signs and symptoms of ovarian cancer, initially focusing on introducing referral and diagnostic pathways in line with NICE clinical guidance.

4.2 Children, Young People and Families

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

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

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

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

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

Regional Priority	Local Commissioning Intent
All Trusts should ensure that a child becomes looked after where that child's long term outcomes will be improved or there is a need for the child to be removed as a safety measure. Trusts should ensure that there is an adequate range of placements available to meet the assessed needs of Looked after Children / Care Leavers.	As outlined in the regional review of residential care overview report the Trust should develop, in cooperation with the Outcomes Group, edge of care services to provide the necessary support and family intervention programmes to prevent children, and in particular young people aged 14-16, from entering the care system. The Trust should also establish/reconfigure specialist foster care services to provide emergency placements and assessment and rehabilitation placements for children of all ages. The Trust should outline the actions necessary to reconfigure existing residential care provision including ISUs to meet the Board Service Specification and to address the issues outlined in the review overview report.
Working within the Children and Young Peoples Strategic Partnership the Trust led Outcomes Group should progress the development of local integrated delivery arrangements with the establishment of more Family Support Hubs. This should ensure that interventions are needs led and strive for the minimum intervention required. The HSCB / PHA will progress Family Support and Parenting Programmes to address TYC recommendation 46. It is assumed SureStart Projects,	The Trust should work with statutory, voluntary and community sector partners to further develop the Family Support hubs within the Trust geographical area to provide a comprehensive range of family support and earlier intervention services. In line with the TYC agenda this should be directed both at providing support at an earlier stage, and to provide a less intrusive, more flexible and cost effective alternative to Trust social work services where possible.

reporting to the Childcare Partnership will provide support in those localities and the focus for greater co-ordination and development will be in those areas which do not have Surestart provision.	
All Trusts should ensure that a robust needs assessment and a localised service is provided for children with complex healthcare needs and for children with a learning disability and challenging behaviour.	The Trust should follow departmental guidance on the resettlement of children from long stay hospital settings into community provision.
All Trusts to engage in the Review of AHP support for Children with Special Needs within Special Schools and Mainstream Education.	
All Trusts to increase the percentage of women who receive the recommended antenatal visit by a Health Visitor to reach 100% by March 2016.	The Trust will ensure that by March 2014, 50% of all women will receive the recommended antenatal visit by a Health Visitor.

4.3 Community Care and Older People

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

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

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

Regional Priority	Local Commissioning Intent
Trusts will review existing residential care provision and develop proposals for a phased reduction in capacity which is coordinated with the provision of alternative community based models of care.	The SELCG expects the SEHSCT to review statutory residential care as outlined in Transforming Your Care. SEHSCT should continue to promote and develop supported living opportunities and alternatives that will enable people to people to continue living in their own homes longer.
Trusts and HSCB will work with independent sector providers to identify practice, training and contractual implications of preventing unnecessary admissions to acute care from nursing homes.	The SELCG expects the SEHSCT to work with the independent sector to achieve this Regional objective through measures such as : -working through the liaison nurses - ICP for Frail Elderly

Trusts will review current respite care provision to identify the potential for increased support for carers through service remodelling/re-investment in the independent sector.	The SELCG will work SEHSCT to consider the findings of its review and the potential for increasing its support for carers, such as innovative and increased short breaks for carers.
Trusts will work collaboratively with HSCB/PHA/LCGs to scope and develop a regional network for Memory Services.	The SELCG expects the SEHSCT to participate fully in this regional initiative and following the scoping exercise produce proposals/plans to meet the needs of its local population accordingly.
Trusts will progress a comprehensive range of targeted health and wellbeing programmes in all localities to address the changing health and well- being needs of older people. They should ensure that arrangements are in place:- • To improve provision of advice information and signposting on all aspects of health and wellbeing improvement • Deliver a co-ordinated, multi-faceted falls prevention service • To fully implement the "Promoting Good Nutrition Guidelines for Older people across all settings • Develop and co-ordinate a shared service model to reduce the risk of social isolation and poor mental well-being amongst vulnerable older people • With relevant partners to reduce the risk of social isolation and poor mental well-being particularly	The SE Trust will ensure targeted services are in place by March 2014 across the area, delivered in conjunction with community, voluntary and statutory partners addressing the full range of regional priorities for older people's health and wellbeing.

amongst vulnerable older people. Deliver a co-ordinated range of Targeted Physical Activity and Health programmes to address the CMO Guidelines for Physical Activity.	
Trusts will implement eNISAT, the ICT for the Northern Ireland Single Assessment Tool within older people's services in line with agreed Project Structures, processes and deadlines.	The SELCG expects the SEHSCT to deliver on their allocated responsibilities as set out in the implementation plan for eNisat.
Trusts will establish single point of entry arrangements; enhance the role of the community and voluntary sector and develop a Re-ablement service which maximises the independence of the service user.	The SELCG will commission a Re-ablement Service from the SEHSCT in accordance with the regional model. During 2013/14 SEHSCT is expected to complete the roll-out of the Reablement Care Pathway and services across the Trust.
Trusts will develop a Gateway Model and single point of referral for the receipt and screening of all referrals to adult safeguarding.	The SELCG expects the SEHSCT to have adequate arrangements in place to respond to the increase in referrals to Adult Safeguarding services. The Trust should use the £93,000 recurrent investment received from the HSCB to recruit those additional staff specified in the relevant Investment Proposal Template.

4.4 Diagnostics

During 2013 the HSCB will establish a Radiology Clinical Network, which will be the vehicle to ensure the implementation of RQIA phase 1 and 2 recommendations for service improvement and planning from 2013.

The Trust must ensure, where appropriate, that services are available 7 days a week in order to optimise a patient's clinical pathway.

The Trust must evidence that they are complying with Royal College Guidelines, and National guidelines such as NICE guidance, to ensure the appropriateness of diagnostic tests and examinations.

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

- From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.

Regional Priority	Local Commissioning Intent
All Trusts should ensure that the RQIA radiology recommendations are fully implemented during 2013/14. As a minimum this requires all Trusts to: • Put in place written escalation procedures to reduce the risk of delays in plain X-ray reporting during 2013/14. • Ensure that all images are accounted for on the PACs system from March 2013 and they have processes in place to ensure that all images are reported on within the required target times from March 2014.	The SE Trust must ensure that there is full implementation of RQIA guidelines and advise on progress towards meeting priorities.
All Trusts should provide Ultrasound	The SE Trust should advise on how

as part of the neonatal hip screening programme from 2013/14.	this will be implemented.
All Trusts should ensure that the requirements for 7 day access to the MRI imaging requirements for Stroke and MSSC are delivered by March 2014. Going forward, all Trusts should ensure that, where additional imaging capacity is commissioned, that this will in the first instance be achieved through a longer working day to improve patient access.	The SE LCG has confirmed recurrent funding for a second MRI scanner in 2013/14. The Trust must confirm that 7 day access is provided within this additional capacity.
All Trusts should implement NICE CG on Management of Dyspepsia, supported by pre-referral testing as indicated by the Guidance.	The SE Trust must advise on action that will be undertaken during 2013/14 to implement NISC guidance.
All Trusts should have implemented a direct access pathway for ECHO for patients considered for left ventricular failure (LVF) *as defined by NICE Guidance CG for chronic heart failure,* by September 2013 with the aim to have reduced referrals to cardiology outpatients by 10 % by March 2014.	The SE Trust must establish a baseline referral rate and work with primary care to reduce outpatient referrals to cardiology.

4.5 Elective Care

The increase in referrals to secondary care has had a direct impact on elective admissions with the demand for inpatient and day surgery procedures increasing by 4% since 2009/10. In responding to the key messages within TYC elective services have a responsibility to ensure that significant and major changes happen regarding the future delivery of elective services.

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

- From April 2013 at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014 and no patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014.
- From April 2013, at least 70% of inpatients and day cases are treated within 13 weeks, increasing to 80% by March 2014, and no patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014.
- By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.
- From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Regional Priority	Local Commissioning Intent
All Trusts should ensure they have robust and effective booking, scheduling, POA processes to ensure the full utilisation of available elective capacity The HSCB will expect the following and will monitor these indicators to ensure this objective is achieved: • All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more that 8% by March 2014 Trusts should demonstrate a measurable improvement in shift of procedures from day surgery to outpatients with procedure (OPP) by April 2014. (this will be based on the day surgery rates at April 2012) • All Trusts should reduce Theatre DNA/Cancellation rates to 5% by	The SE Trust should continue to work through processes already in place to deliver reduced DNA rates in outpatients services and evidence an improved position on March 2013 by 30 September 2013 across all specialties. The Trust should forward a detailed action plan to the LCG by 30 May as to how it will achieve the DNA targets within 2013/14 through a variety of means such as virtual clinics, telephone reviews, text reminders, primary care initiatives etc. The SE Trust should provide an action plan to the LCG as to how it will reduce theatre cancellations in accordance with the priority. The SE Trust will improve endoscopy

31 March 2014.All Trusts should ensure theatre utilisation rates of 83% (as a minimum and in line with Audit Commission recommendations) from March 2014. • All Trusts should work to improve endoscopy throughput per session from an average of 6.2 patients per session in 2012/13 to 6.5 patients per session by December 2013, 6.7 by March 2014 and 7.1 by March 2015. • Trusts will ensure that they are delivering the recommended day surgery rates for the trolley of procedures identified by The British Association of Day Surgery from March 2015/16. • As a minimum Trusts should ensure that they are delivering the day surgery rate for the basket of 24 procedures identified by the Audit Commission (excluding Termination of Pregnancy). In addition, the Trusts should utilise the electronic referral system, to support effective patient pathways and triage processes from March 2013. For example in the use of photo images to support dermatology referrals and other means which will support the implementation of the EUR policy.	throughput during 2013/14 in accordance with the priority. The SE Trust must demonstrate an improved proportion of Day Case treatments across the Trust during 2013/14 using the BADS trolley of procedures. The SE Trust must also demonstrate an improved length of stay during 2013/14 based on the March 2013 baseline.
All Trusts should implement an enhanced recovery model across an agreed range of surgical specialties to improve outcomes, reduce lengths of	SE Trust must evidence the roll out of enhanced recovery models across the range of surgical specialties through a programme of improved productivity

stay and increase productivity by 2014/15.The initial focus should be on the best practice pathways. This may include the pathways associated with the following 8 procedures: colectomy; excision of rectum; prostectomy; cystectomy; hysterectomy (vaginal and abdominal); and hip and knee replacement.	and modernisation in the Trust.
Once established as a regional service, all Trusts will utilise the podiatric surgery service for foot and ankle surgery from 2014/15.	The SE Trust must work with the Commissioner and other trusts where required to deliver the agreed model.
In line with the NICE guidance for Glaucoma, Trusts will work with primary care in the referral refinement programme for glaucoma during 2013/14. This will reduce the false positives and ensure only those patients who require evaluation, monitoring and treatment are referred to secondary care.	The SE Trust must continue to work with other Trusts and primary care to implement the Glaucoma programme.
All Trusts should provide an ultrasound service for infants at risk of or with suspected developmental dysplasia of the hip in line with the standards and guidance of the UK National Screening Committee, the Royal College of Radiologists and the College of Radiographers	
All Trusts will work towards the development of pathways to support. • All Trusts will achieve 90% of vasectomy procedures provided within primary care or as a	The SE Trust must continue to work with Primary care to develop new pathways and primary care initiatives within its area and with other trusts as required.

minimum all moved off main acute hospital sites from April 2014. • All Trusts will move all low risk skin lesions off main acute sites from April 2013 and from April 2014 90% of low risk skin lesions are moved to a primary care setting. • All Trusts to work towards the introduction of a regional pathway for varicose veins which is in line with NICE guidance (CG the diagnosis and management of varicose veins) and includes the provision of minimally invasive surgery for 90% of varicose veins from April 2014. • All Trusts should support the implementation of an MSK / Pain pathway. This service will support the delivery of a primary/community care facing service, with MDT pathways developed to include lower back, knee, shoulder etc., by the end of March 2014. All service models should include self-management/education at the core of service design.	
All Trusts will support improved outcomes measurements to support service improvement and evidence based commissioning • All Trusts should participate in the national hip fracture database during 2013/14 and ensure 100% compliance from 2014/15.	The SE Trust must continue to support improved outcomes as relevant to its services and to work towards achieving the priorities identified locally and regionally.

• All Trusts providing elective orthopaedic procedures will participate and provide data into the National Joint register from 2013/14 and ensure 100% compliance from 2014/15. • All Trusts providing vascular services should ensure the full participation in the National Vascular Database from 2013/14. • Support the Patient reported outcome measures (PROMS) pilot for varicose veins.	
One Trust to work with the commissioner to undertake a pilot service of self-referral for Musculoskeletal Physiotherapy. Pilot to be evaluated for local learning moving towards implementation in 2014/15	

4.6 Health & Wellbeing Improvement

Health and Wellbeing Improvement is important in reducing health inequalities, morbidity levels and health service demand and improving quality of life. The primary focus is to reduce health inequalities with emphasis placed on services commissioned within health and social care, as well as the development of effective partnership with other sectors, including communities, in order to influence the wider determinants of health. Health and wellbeing improvement services are focussed at

(1) Giving every child the best start in life; (2) Working with others to ensure a descent standard of living; (3)Build sustainable communities and (4) Make healthier choices easier.

Specific Ministerial target to be achieved in 2013/14:

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

Regional Priority	Local Commissioning Intent
All Trusts are expected to deliver on the implementation of 'Fitter Futures for All' framework including: • Pilot pregnancy programmes; • Achieving UNICEF Baby Friendly Standards and peer support initiatives to support breast feeding; • Pilot weight loss programmes for adults and children; • Provision of healthy food choices in all HSC facilities.	The SE Trust will ensure the co-ordination and delivery of Health and Wellbeing Improvement services in line with the regional priorities and local commissioning intent.
All Trusts will ensure delivery of a range of evidence based early years intervention programmes including: • Roots of Empathy • Family Nurse Partnership • Infant Mental Health Training • Parenting support.	The SE Trust will ensure the effective co-ordination and delivery of Early years services and programmes across the area in line with the regional and local commissioning priorities.
All Trusts will ensure that they support the implementation of key public health strategies including: • tobacco cessation services and BIT in particular for pregnant women and other vulnerable groups; • work toward smoke free campuses; • services within hospital settings (including emergency departments) which can respond to alcohol and drug misuse, self-harm and associated mental	The SE Trust will ensure the effective co-ordination and delivery of Health and Wellbeing Improvement programmes and services to address the needs of local populations and in line with the regional and local commissioning priorities.

health issues and • continue to collect data for the roll out of Deliberate Self Harm Registry on attendances at ED that are related to self-harm, report on trends and delivery emerging issues and influence the maintenance and/or re-design of appropriate services.	
All Trusts will provide specialist sexual health services taking into account the findings of the RQIA Review.	The SE Trust will coordinate and develop sexual health services across the area to address agreed locality priorities.
Trusts will ensure that existing service provision is tailored to meet the needs of vulnerable groups including: Looked After Children; Homeless people; LGBT; Travellers; and Migrant groups.	The SE Trust will provided targeted health and wellbeing services to address the specific needs of vulnerable and marginalised populations and in line with the PHA Commissioning themes.
Trusts will support social economy businesses and community skills development using the power of the HSC sector through public procurement and expand capacity incrementally over the following 3 years.	The SE Trust will support the active development of social economy models to address disadvantage in local communities and build sustainable resource and capacity for health gain.

4.7 Health Protection

The PHA's Health Protection Service has a front line role in protecting the Northern Ireland population from infectious diseases and environmental hazards through a range of functions such as surveillance and monitoring, operational support and advice, response to health protection incidents,

education, training and research. Working closely with partner organisations in the UK and through international networks such as those of the Health Protection Agency (HPA), World Health Organisation (WHO) and the European Centre for Disease Prevention and Control (ECDC), the overall objective is to have the best quality health protection service possible for Northern Ireland.

Regional Priority	Local Commissioning Intent
All Trusts should test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption potentially associated with specific major events including the G8 Summit; the World Police & Fire Games 2013 and the All Ireland Fleadh in August as part of the City of Culture in Derry/Londonderry	
All Trusts will ensure that they support the implementation of key health protection initiatives including maintaining Northern Ireland's excellent vaccination rates in respect of influenza and childhood immunisations and the introduction of two new childhood vaccination programmes (Flu and Rotavirus)	
All Trusts will continue to monitor and review the occurrence of Health care Associated Infections (HCAI) and implement appropriate and agreed infection control measures with particular reference to Ministerial targets on Clostridium difficile and MRSA.	
The South Eastern Health and Social Care Trust will ensure that agreed	

procedures are in place in respect of infection control in the prison population including protocols for control of an outbreak of a communicable disease in a prison setting and access of prisoners to appropriate vaccinations.	

4.8 Learning Disability

In 2005, the Bamford Report estimated that about 9.7 per 1,000 people in Northern Ireland had a learning disability, with over 27% of these being severe/profound.

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

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

- From April 2013, ensure that 99% of all learning disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hour; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital taking place within 6 hours.
- By March 2014, 75 of the remaining long-stay patients in learning disability hospitals and 23 of the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.

Regional Priority	Local Commissioning Intent
Trusts should ensure the resettlement	In 2013/14 the South Eastern Trust

of the long stay population as identified over the next 3 years	will resettle 5 of their final long stay patients.
All Trusts should start to deliver Day Services in line with the Regional Model 2013 currently being developed.	SET will work with the developments relating to day services in line with the regional model.
All Trusts should develop their specialist community services to respond to the needs of people whose behaviours challenge services and those with offending behaviours including a 24 hour response 7 days per week and high support beds in the community.	Community infrastructure will continue to be developed to ensure the needs of people with offending behaviours and challenging behaviours are addressed to ensure inpatient treatment is kept to a minimum.
All Trusts should deliver additional support for Carers through enhanced short break and respite services.	
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.	SET will ensure each adult with learning disabilities is receiving a service. SET will develop Health Implementation plans for people with learning disabilities.
All trusts should develop action plans to promote the health of people with a learning disability, in line with the priorities identified in the Public Health Strategic Framework: Fit and Well Changing Lives 2012-22.	

4.9 Long Term Conditions

Long-term conditions (LTCs) refer to any condition that cannot, at present, be cured but can be controlled by medication and/or therapy. Care including clinical care, should be provided close to home with patients and their families being active participants in their care. Primary care needs to be supported by responsive secondary care services to deal with exacerbations or complications that cannot be managed at home.

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

- By March 2014, ensure that at least 10% of the proportion of patients with confirmed ischaemic stroke receive thrombolysis.
- By March 2014, deliver 500,000 telehealth monitored patient days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the telemonitoring NI Contract.
- By March 2014, develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively.
- By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.[1]

Regional Priority Areas	Local Commissioning Priorities
By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions through: • Community teams that are available to meet patient needs including provision of a named nurse for patients on disease registers (with clear arrangements for dealing with multi-morbidity and complex medication regimes)and access to specialist medical or nursing advice and • Development of admissions/escalation protocols	The South Eastern Trust work with the voluntary and community sector to provide self-management and patient education programmes aimed at enabling patients to manage their condition more successfully and avoid exacerbations of their condition.

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

between community teams and secondary care.	
Respiratory • All Trusts should have in place integrated paediatric respiratory and allergy and anaphylaxis teams, which can outreach to other parts of the hospital including A&E, outpatients and ambulatory care, and to the community, in cases of difficult asthma. • All Trusts should fully implement the COPD integrated Care Pathway. • All Trusts should fully develop Home Oxygen Services Assessment and Review. • All Trusts to participate in a six monthly audit of all COPD patient admissions.	
Stroke • Thrombolysis ➢ All Trusts to achieve a door to needle time of 60 minutes on a 24/7 basis. ➢ Trusts to achieve a minimum 10% thrombolysis rate for acute ischaemic strokes. • Urgent assessment of high risk TIAs ($ABCD^2$>4) must be available on a 7 day basis • All Trusts should support early supported discharge (ESD)	

following an acute stroke. This should support shorter LOS and "shift left" where resources will be freed from hospital beds to develop services in the community.	
Diabetes • All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes. • Subject to satisfactory pilot evaluation, all Trusts should mainstream the CAWT pre pregnancy care and structured patient education program (CHOICE) for children from January 2014 onwards. [2] All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14.	
Cardiac • Implement a Familial Hypercholesterolaemia cascade testing service in N. Ireland. • Commission a model for Emergency Life Support (ELS) training in the community together with an audit process to monitor agreed outcomes.[3]	
Prevention • All Trusts should ensure that smoking cessation services are	

[2] Requires further discussion between the Commissioner and provider(s) and /or DHSS&PS.
[3] Further discussion required between Commissioner and provider(s) and / or DHSS&PS.

available in all locations where patients with LTCs are seen including hospitals, primary care and community pharmacy. • All Trusts should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively.[4] • By March 2014, all Trusts should deliver 500,000 telehealth monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the telemonitoring NI contract.	The South Eastern Trust should ensure that information and support services are in place across secondary, primary and community settings for all patients newly diagnosed and living with a long term condition.

4.10 Maternity and Child Health Services

The last few years have seen a significant change in the model of maternity services within the South Eastern Trust. The Downe hospital opened with a new Midwife Led Unit (MLU) and the LVH changed from an obstetric unit to a Midwife Led Unit. During this time, the Ulster Hospital opened a new maternity unit which includes a midwife led unit and an obstetric service on the same site. Part of the increase in the number of births at the Ulster Hospital has been attributed to an increase in the birth rate as well as changes in the maternity services model in the South Eastern Trust and neighbouring Trusts.

Maternity

Regional Priority	Local Commissioning Intent

[4] Further discussion required between Commissioner and provider(s) and / or DHSS&PS.

All Trusts should ensure that the level of resident medical cover for consultant-led obstetric units meets the minimum standard recommended in the DHSSPS Maternity Strategy (ST3 or equivalent for obstetrics, paediatrics, anaesthetics). Those units that do not currently meet this standard must ensure in the interim that the risk profile of women booked to deliver in the unit is clinically appropriate to the level of staffing available.	The SE Trust will confirm with the LCG by 31 August 2013 that it meets resident medical cover at ST3 level or equivalent for obstetrics and anaesthetics and ST4 level in all relevant facilities.
All Trusts should ensure implementation of Normalising Birth Action Plans including: • Keeping first pregnancy and birth normal; • Increasing vaginal births after previous caesarean section (VBAC); • Benchmarking against comparable units in NI, rest of the UK and ROI and • Implementation of NICE CG 132	SE Trust must implement its Normalising Birth Action Plan during 2013/14 and reduce the level of caesarean sections.
All Trusts should ensure that where a consultant-led obstetric unit is provided a midwife-led unit will be available on the same site.	
All Trusts should ensure that all women are provided with balanced information on the available options for place of birth and benefits and risks, including midwife and consultant led units and home births.	The Trust shall advise the LCG by 31 August how it intends to implement this recommendation.
All Trusts should ensure that antenatal	SE Trust should confirm the location

booking clinics will be provided in the community by midwives which will offer: • Direct access for women to their community midwife • Confirmation of pregnancy scan; • Access to NIMATS and • Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.	of antenatal booking clinics and provide assurance that they comply with the standards set in the Maternity strategy and Maternity service specification.
All Trusts should ensure that for women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community and give greater continuity of care.	The SE Trust should bring forward plans by 30 May 2013 to increase the level of ante natal care provided in its locality.
All Trusts should bring forward 3 year plans to develop skill mix in the community midwifery service to include a phased increase in the number of maternity support workers in the community to assist with breastfeeding and early interventions commencing from 2013/14[5].	By the 30 September 2013, the SE Trust should submit a 3 year plan to the LCG for increasing MSWs in the community.
All Trusts should implement the Royal College of Obstetricians & Gynaecologists green top guideline No. 36 "The Prevention of Early-onset Neonatal Group B Streptococcal Disease".	The SE Trust should give written assurance to the commissioner in 2013/14 that this guideline has been implemented.

Child Health

[5] Further discussion required between Commissioner and provider(s) and / or DHSS&PS.

Regional Priority	Local Commissioning Intent
All Trusts to ensure that all children and young people admitted to an in-patient paediatric unit are seen by an appropriate level of medical staff within 4 hours and a consultant paediatrician within 24 hours of admission.	All children admitted to the Ulster Hospital should be seen by a doctor or suitably qualified advanced paediatric nurse practitioner on the middle grade rota within 4 hours of admission. All children admitted to the Ulster Hospital should be seen by a consultant paediatrician within 24 hours of admission.
All Trusts to achieve 16 years as the upper limit for acute paediatric and surgical care. Age appropriate care must be provided in all in-patient and out-patient settings.	
All units with in-patient paediatric services must have a short stay paediatric assessment unit SSPAU on site.	The Ulster Hospital will continue to develop its ambulatory care service. The operating hours of the service will be increased in line with the commissioning plan. Opportunities to further develop this service and enhance working arrangements with the ED that will ensure children are seen in a paediatric environment for as much of the hospital stay as possible will be explored.
All Trusts should ensure that all parents with a child with a Long Term Condition are given a named contact worker they can liaise with directly to discuss management of their child's condition and who will liaise with education services if required.	
All Trusts to ensure that all children	

receiving palliative care have an emergency plan agreed with their GP, care team and secondary care services	
All Trusts to ensure that diagnostic imaging services are available on a 7/7 basis to diagnose and manage the acutely ill child including the assessment of acute surgical conditions of childhood.	
All Trusts to implement the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units and NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection	

Sub-Fertility:

Regional Priority	
Belfast Trust should introduce oocyte cryopreservation (egg freezing and storage), and a blastocyst service[6].	

4.11 Medicines Management

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

Effectiveness is reduced by over or under prescribing, poor patient adherence, using treatments that are not effective, or using formulations that are not appropriate. Effectiveness is improved through adherence to NICE

[6] Requires further discussion between the Commissioner and the DHSS&PS with regard to funding.

recommendations and guidance on topics not covered by NICE, adherence to formularies like the proposed NI Formulary, electronic prescribing systems, education and systems to improve patient adherence, and peer review of prescribing practice, particularly if associated with opportunities to redirect a proportion of savings into local service priorities.

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

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

Regional Priority	Local Commissioning Intent
All Trusts to ensure the formulary is embedded within prescribing practice through active dissemination within electronic prescribing platforms.	The NI formulary is an invaluable tool to help promote the safe and cost-effective use of medicines which is consistent with the needs of the population. The formulary advises prescribers of the most cost-effective drug, which does not compromise efficacy, safety or quality of care. It is vitally important that all prescribers working in primary, secondary and community care settings have access to the most up-to-date formulary choices when making prescribing decisions. The development and use of electronic prescribing platforms which allows prescribers access to up-to-date accurate formulary information at the point of prescribing is an effective means of ensuring the NI formulary is delivering safe, evidence-based, cost effective use of medicines in the health service.
All Trusts will work with the Health & Social Care Board in 2013/2014 to	It is recognised that clinicians will at times prescribe drugs outside of the

establish the baseline position ensuring 70% compliance by end 13/14 and Trusts attaining target delivery in 2014/2015.	formulary for specific reasons and that the formulary should not constrain good practice. Hence a benchmark of 70% compliance with formulary choices has been applied to allow for such situations.
All Trusts should put in place arrangements to manage regional monthly managed entry recommendations including monitoring, reporting and disinvestment arrangements.	There are continued cost pressures in prescribing, for example the advent of newer and relatively expensive drug technologies. Managing the entry of new technologies into the health service will be a key element of ensuring the appropriate uptake of new medicines which are consistent with the needs of the population and which are affordable. This requires ongoing monitoring of the usage of such products in line with the managed entry recommendations e.g. ensuring a drug is only being prescribed for the indication/s for which it was recommended, monitoring the number of patients eligible for treatment with the drug and providing regular reports to the HSCB and others. Where a therapy is recommended as an alternative to existing therapies, consideration must be gave to the mechanism for stopping the use of the existing therapy and the financial impact of same to the SE Trust.
All Trusts to ensure 100% compliance with local delivery against the Regional Pharmaceutical Clinical Effectiveness Programmes such that all targets are met.	Both at a regional and local level primary care prescribing is of high priority. It has been recognised that NI spends significantly more on medicines in primary care and that despite higher

	levels of need, the difference between NI and other parts of the UK is not justified. The Pharmaceutical Clinical Effectiveness (PCE) Programme aims to reduce the prescribing costs in NI to those comparable with other parts of the UK. The programme consists of approximately 24 individual therapeutic projects which together aim to improve the consistency and quality of prescribing as well as support the delivery of financial efficiencies. Successful delivery is dependent on influencing prescriber behaviour and influencing demand through ICPs and Trusts.
All Trusts should support development of e-prescribing in hospitals through identification of clinical champions and leads and co-ordination of local Trust implementation teams.	Robust, efficient electronic prescribing systems are essential to reducing risk, reducing wastage of medicines and unnecessary spend on medicines. It is frequently the transfer of patients or care across the interface between organisations that can have most impact on the quality of patient care. Problems may occur for a variety of reasons such as a simple misunderstanding between departments, communication problems or different clinical guidelines or approaches. Such problems can be reduced by developing a joined up electronic solution to sharing information.
All Trusts should ensure that all	Adverse drug events may be a

patients with highest risks (complexity; high risk medicines) have their medicines reconciled on admission and at discharge in line with NICE guidance (http://guidance.nice.org.uk/PSG001) – baseline in 13/14; delivery 14/15	significant factor in 3 – 6% of hospital admissions. For some groups of patients, such as the elderly, the figure may be much higher. Reconciling medicines i.e. there is a review of what the patient was meant to have been taking and what was actually being taken, on admission and at discharge has been shown to be an effective way to optimize patients' therapy and reduce adverse drug events and hospital admissions. This has been highlighted by NICE Technical patient safety solutions for medicines reconciliation on admission of adults to hospital and at discharge (PSG001).

4.12 Mental Health

Mental illness is one of the major causes of ill health and disability in Northern Ireland. The Department of health estimates that one in six people of working age has a mental health problem and about a quarter of people visiting their doctor are there for a common mental health disorder such as anxiety or depression.

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.

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

- From April 2013, ensure that 99% of all learning disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hour; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital taking place within 6 hours.
- By March 2014, 75 of the remaining long-stay patients in learning disability hospitals and 23 of the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.
- From April 2013, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; and 13 weeks to access psychological therapies (any age).

Regional Priority	Local Commissioning Intent
All Trusts are required to fully implement the refreshed "Protect Life" strategy. This should include: • contributing to the development of an improved model of support for those who self-harm; • specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers and • supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed Memorandum of Understanding.	SET continue to work with the regional Bamford working group for "Protect Life" to implement local initiatives under the Protect Life Strategy. Ongoing initiatives in development are: • Support for bereaved families; • Self-harm support working group; • Develop model of support in line with IPT; • Local implementation group and action plans; Public information campaigns.
All Trusts should ensure the resettlement of the long stay	SE Trust to have resettled a total of 8 long stay patients by the end of

population.	2014/15.
All Trusts should establish integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of a Primary Care Psychological Therapy Service beginning with the appointment of Primary Care Coordinators and training in CBT and/or counselling for a minimum of 5 staff in each Trust.	SET will agree proposals in line with IPTs and develop this service.
All Trusts should begin to implement Recovery Approaches and related Integrated Care Pathways by December 2013.	SET has committed to arranging progress to implement Recovery approvals. SET will implement ICP as they are developed.
All Trusts should implement Crisis Response and Home treatment services for CAMHs with associated primary care teams/services including full implementation of the DHSSPSNI strategy for CAMHs.	SET will agree proposals in line with IPTs to develop this service.
All Trusts should further develop Specialist Community Services to include: • Autism Spectrum Disorder (ASD) services for Adult Services; • access to dedicated eating disorder beds in mental health and/or general hospitals (All Trusts should reduce eating disorder extra contractual referrals expenditure by 50% (based on the 01/04/2011 baseline);	SET will agree proposals in line with IPTs to develop these services. To work in line with regional requirements/target. To work in line with regional requirements/target.

• a range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual Referrals based on the 1/4/2012 baseline); • the implementation of the regional Tier 4 Substance Misuse Model including the development of agreed supporting community services and enhanced alcohol liaison services within Emergency Departments and • the implementation of services to identify, assess and treat first episode psychosis (age 16+).	To work in line with regional requirements.
Northern Trust to provide the regional Sexual Assault Referral Centre (SARC) at the Antrim Area Hospital site.	SET will support its victims of sexual assault through SARC.
All Trusts should achieve the targets of the Mental Health Bamford Action Plan 2012-2015 DHSSPS.	Ongoing.

4.13 Palliative Care & End of Life Care

Palliative care will enhance quality of life for those who are in the last year of life, although it is also applicable earlier in the course of an illness, in conjunction with other therapies which are intended to prolong life. Palliative care and acute care can both be provided together for those with cancer and non-cancer conditions. It provides relief from pain and other distressing symptoms as well as providing social, emotional and spiritual support.

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

Regional Priority	Local Commissioning Intent
All Trusts and ICPs should ensure that effective arrangements are in place to engage and promote awareness with the general population and professionals regarding issues around palliative care, dying and service delivery around death.	The Trust should work with the ICPs to ensure that awareness of issues around palliative care and dying is promoted.
All Trusts should provide evidence that they are working to increase the quality of life for people in the last year of life by ensuring that palliative care measures run alongside acute intervention for people with cancer, cardiovascular and respiratory disease, dementia, frail elderly and those with a physical disability who are at the end of life. This should include: • implementation of the end of life operational systems model; • identification, holistic assessment and referral for carers assessment; • offering people the opportunity to have an advance care plan; developed within 3 months of admission to a nursing home, in the last year of life and for those who have an anticipated deterioration in their condition (e.g. on diagnosis dementia); • people are supported to die in their preferred place of care and • use coordinated care planning in	The South Eastern Trust in 2013/14 is required to continue to develop palliative care services for individuals with cancer and non-cancer conditions that run alongside acute interventions, to ensure they are identified early and quality of life is enhanced in the last year of life. The LCG through the Palliative Care and End of Life Service Team will carry out regular monitoring of Trust progress in respect of these objectives.

the last few months, weeks and days of life.	
Trusts and ICPs should have processes in place to ensure that care for individuals identified as being on the possible last year of life is coordinated around the patient and across services and organisational boundaries. This should be supported through continuation of the palliative care coordination posts and should include: • Implementation of the regionally agreed key worker function; • The use of multidisciplinary records in the home and • Effective out of hours hand over arrangements.	The Trust should work with their ICPs to have processes in place to ensure that care for individuals identified as being on the possible last year of life is coordinated around the patient and across services and organisational boundaries.
Trusts and ICPs should provide evidence of how they are working with the independent and voluntary sector to ensure that there is an increased provision of general palliative care services in the community, supporting patients within their own home and nursing homes where that is their choice. This should include: • Access to 24 hour care and support; • Equipment; • Arrangements to support timely hospital discharge and • Support to nursing homes to meet the standards being developed in conjunction with RQIA.	The LCG will work with the Trust palliative care steering group to achieve 24 hour care support. The South Eastern Trust is required to work collaboratively with the voluntary, community and independent sectors (including GPs, nursing homes, Macmillan, Marie Curie and Hospice services) to support the delivery of palliative care services and ensure that more 24 hour care and support is provided. The Trust should have systems in place to ensure the timely discharge of patients, including provision of equipment where required.

Trusts and ICPs should provide evidence of how they are working with the voluntary sector to ensure that there is an increased provision of specialist palliative care services in the community, supporting patients dying within their own home and nursing homes where that is their choice. This should include: • Support to generalist palliative care services; • Education and training; • Development of community multidisciplinary palliative care teams; • Development of new models of palliative care day hospice and outpatient services; • Access to face to face specialist advice 7 days a week 9am to 5pm and • Trusts & ICPs to work with the commissioners to develop access to telephone advice to professionals 7 days per week until 11pm.	
All Trusts and ICPs should provide education and training in communication and end of life care for all staff (e.g. GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers etc.).	The SELCG and Palliative Care Service Team will work with the South Easter Trust to progress awareness and training of end of life care for all staff.

4.14 Physical Disability and Sensory Impairment

The DHSSPS Physical Disability & Sensory Impairment Strategy (2010) 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 changing expectations of people with Physical and Sensory Disabilities will require a fundamental review of traditional models of institutional and day care services and an increased emphasis on giving people more influence and control over their support needs through the promotion of personalised budgets and advocacy.

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

Regional Priority	Local Commissioning Intent
Trusts and HSCB will collaborate in producing a needs analysis of people who are Deafblind to improve assessment and access to services.	The SEHSCT is expected to participate fully in this regional exercise and fully implement the action points and learning gleaned from this exercise.
Trusts will participate in a Regional Review of Communication Services in order to improve service access and consistency.	The SEHSCT is expected to participate fully in this regional exercise and implement the learning achieved and fully consider the recommendations expected from this exercise.
Trusts will pilot at least one programme specific Self Directed Support scheme in order to develop a common approach to the use of personalised budgets and promote learning on a cross programme basis.	The SEHSCT is expected to contribute to the regional implementation of SDS, and initiate a pilot within one nominated Programme of Care.

Trusts will review their respite capacity by identifying opportunities to reduce reliance on current residential and domiciliary models and developing community-based services offering short break support.	The SELCG expects the SEHSCT to review its respite capacity by identifying opportunities to reduce reliance on current residential, domiciliary models and developing community-based services offering short break supports.
Trusts will work with the Carers Strategy Implementation Group to address the recommendations of the 2012 Self-Audit Update and RQIA Inspection of NISAT Carers Assessments.	The SELCG expects the SEHSCT to address the recommendations arising from both the 2012 Self-Audit and the RQIA Inspection of NISAT Carers Assessments.

4.15 Prisoner Health Services

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

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

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

Regional Priority	**Local** Commissioning **Intent**
SET to develop staff profiles for each of the main staffing groups including: • Primary Care; • Mental Health; • Addictions and • Women and Young Persons.	Regional Service taken forward by the Regional Service Team.
SET should further develop information systems to help facilitate a whole systems approach to prisoner healthcare to include full and appropriately use of EMIS by all healthcare staff, demonstrating that patient diagnoses are being appropriately coded.	Regional Service taken forward by the Regional Service Team.
SET should continue to progress the development of medical services and chronic disease management in line with the principle of equivalence. This should include: • Production of an annual profile of prisoners by chronic disease category as per Quality and Outcomes Framework (QOF). • Development of registers for individuals with: ➢ Cancer ➢ Obesity ➢ Smoking addiction ➢ Neuroses.	Regional Service taken forward by the Regional Service Team.
SET should develop care pathways in and out of prison, for prisoners with complex needs including: • Improved information at committal relating to: ➢ Medication needs	Regional Service taken forward by the Regional Service Team.

➢ Substance abuse ➢ Mental Health • Discharge plans are in place prior to prisoner release.	
SET should produce annual implementation plans directed toward the full implementation of the Health & Social Well-being Strategy. To include production of evidence based plans for: • Tobacco • Healthy eating and nutrition • Health lifestyles including sexual health • Active living • Drug and other substance misuse.	Regional Service taken forward by the Regional Service Team.
SET should ensure the recruitment of CAMHS and Psychological Therapies posts following additional investment from HSCB in line with IPTs.	Regional Service taken forward by the Regional Service Team.
SET should develop Mental Health services for the prison population in accordance with delivering the Bamford Vision for People with Mental Health and Learning Disability. This should include the introduction of a recovery approach for mental health service provision.	Regional Service taken forward by the Regional Service Team.
SET should ensure that prescribing and medicine administration processes comply with national and Local standards to include : • Monitoring and assurance that GP prescribing is in line with accepted regional standards in the	Regional Service taken forward by the Regional Service Team.

community and • A quarterly report of all instances (including reasons) when patients did not get their medications as prescribed and actions taken to improve administration.	
SET should ensure that people with a Learning Disability should be identified and their care managed in accordance with "Equal Lives" to include: • Introduction of CD Screening tool baseline audit. • Development of an appropriate care pathway.	Regional Service taken forward by the Regional Service Team.

4.16 Screening

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

Population screening allows certain diseases and conditions to be identified at an early stage when they are more amenable to treatment.

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

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

Regional Priority	Local Commissioning Intent
From April 2014, all Trusts should	Trust to put plans in place during

work with the PHA and the HSCB to increase screening colonoscopy capacity across the region by 25% to facilitate age extension of the bowel cancer screening programme up to 74 years. This should include the provision of at least one more endoscopy unit of JAG standard in Northern Ireland by the end of March 2015 and a further unit by 2015/16	2013/14 to increase its screening colonoscopy capacity, to enable it to achieve age extension of the bowel cancer screening programme to 74 from 1 April 2014. Trust to explore the potential to achieve a second JAG accredited endoscopy unit.
All Trusts should deliver a bowel screening service in 2014/15 for the eligible population aged from 60 to 74.	Delivery objective for 2014-15.
All Trusts should develop and implement action plans to enhance informed choice for the eligible population for bowel, breast and cervical screening. Work to focus particularly on hard to reach groups to reduce inequalities of access and uptake of cancer screening programmes.	Trust to develop an action plan to promote informed choice in cancer screening, focusing on hard to reach groups.
PHA, HSCB, Primary Care and BHSCT should work together to ensure robust processes are in place to maintain the screening interval for diabetic retinopathy and to ensure that ICT systems are in place so direct referral of appropriate patients from screening to ophthalmology occurs and the outcome of screening is shared with GPs and Diabetologists.	
Trusts who deliver the Breast Screening Programme to implement	Trust to implement local digital mammography action plan in within

local action plans, for the replacement of analogue breast imaging equipment with digital equipment to ensure the images taken are stored on NIPACS.	the context of the regional digital mammography action plan.
All Trusts to identify all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer. From April 2013, an identified Trust to provide an imaging service for ladies at high risk (x 8) of developing breast cancer in accordance with NHSBSP guidelines	Trust to identify and refer women at higher (x8+) risk of developing breast cancer to the new Higher Risk Surveillance Screening Programme managed by the Northern HSC Trust and provided at Antrim Hospital.

4.17 Specialist Services

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

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

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

longer than 9 months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013.

Regional Priority	Local Commissioning Intent
Belfast and Western Trusts (networking with NIAS and other Trusts as appropriate) should establish 24/7 primary Percutaneous Cardiac Intervention (pPCI) services at the RVH and Altnagelvin Hospitals and increase the scheduled cardiac catheterisation laboratory capacity in NI to circa 105 per week (to include extended day and weekend working) by September 2013 to improve access to diagnostic intervention and treatment as required.	
Belfast Trust should ensure that by March 2014, 30% of kidneys retrieved in all Trusts in Northern Ireland through Donation after Cardiac Death are transplanted in Northern Ireland; and, continue to ensure the delivery of a minimum of 50 live donor transplants.	
Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access specialist ophthalmology regimes, such as Wet AMD within a maximum of 9 weeks.	
All Trusts should pilot the regionally agreed patient journey for Duchenne Muscular Dystrophy.	
All Trusts should ensure that patients commence NICE approved specialist	

therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and multiple sclerosis in line with the Commissioning Plan Direction.	
Belfast Trust should: Progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast Hospital for Sick Children Network plan. Put in place additional capacity of 4 paediatric intensive care beds in line with projected demand expand specialist children's transport and retrieval services to support an increase in hours of cover.	
Belfast Trust will lead on the development and establishment of a specialist service model in line with the Strategic Framework for Intestinal Failure and Home Parenteral Nutritional Services for Adults.	
Belfast and Western Trusts (networking with NIAS and other Trusts as appropriate) should establish 24/7 primary Percutaneous Cardiac Intervention (pPCI) services at the RVH and Altnagelvin Hospitals and increase the scheduled cardiac catheterisation laboratory capacity in NI to circa 105 per week (to include extended day and weekend working) by September 2013 to improve access to diagnostic intervention and treatment as	

required.	
Belfast Trust should ensure that by March 2014, 30% of kidneys retrieved in all Trusts in Northern Ireland through Donation after Cardiac Death are transplanted in Northern Ireland; and, continue to ensure the delivery of a minimum of 50 live donor transplants.	
Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access current and new specialist ophthalmology regimes within a maximum of 9 weeks.	

4.18 Unscheduled Care

In the past three years, demand for unscheduled care in acute hospitals has grown. Good progress has been made to improve ED performance in terms of the number of 12-hour breaches. However significant challenges remain and in 2013/14 there will be a need for an increasing focus on 4-hour performance. The ED needs to be viewed as one component part of the unscheduled pathway with General Practitioners including Out of Hours, NIAS, Community Teams and Minor injury Units playing a more active role

Ambulance services have seen an overall rise in emergency calls with category A calls (for patients in greatest need) rising by 7.8% last year compared with 2009/10.

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

- From April 2013, 95% of patients attending any Type 1, 2 or 3 A&E Department are either treated and discharged home, or admitted,

within 4 hours of their arrival in the department, and no patients attending any emergency department should wait longer than 12 hours.

- By March 2014, secure a 10% reduction in the number of emergency readmissions within 30 days.[7]

Regional Priority	Local Commissioning Intent
By September 2013, the Ambulance Service will, in collaboration with primary and secondary care clinicians, develop and implement agreed protocols to enable paramedics to assess and treat patients at the scene (including home) without transporting them to hospital, where appropriate.	The Trust must continue to work with NIAS to further develop the "see and treat" model and put into operation locally the regional "treat and leave" and "assess and refer" protocols.
By December 2013, Trusts will agree clear protocols on the management of major trauma patients and further develop collaboratively these as necessary towards establishing a Trauma Managed Clinical Network[8].	The South Eastern Trust must actively work towards meeting this objective by December 2013.
By December 2013, Trusts and ICPs will ensure that effective arrangements are in place to prevent unnecessary attendances at Emergency Departments including: • Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage; • GP direct access to appropriate diagnostics to enhance management of conditions in Primary Care; and	The South Eastern Trust must actively work towards meeting this objective by December 2013.

[7] Achievement of this target will require input from a range of service areas and teams including Long term Conditions and Integrated Care.
[8] Further discussion required between Commissioner and provider(s) and / or DHSS&PS

• rapid outpatient assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion. between GP and senior hospital doctor and agreed decision on steps to take in patient management.	
During 2013/14, all Trusts to confirm that the necessary components are in place to deliver 7-day working on acute sites including access to radiology, pharmacy, and senior medical decision-makers with closer liaison with district/community nursing, AHPs and social care in order to prevent an unnecessary emergency admission through appropriate patient handover and earlier discharge.	In relation to 7 day working the Trust must continue to take forward key developments such as: - LEAN diagnostics; - Improved handover processes, specifically Friday PM handover to weekend teams; - Hand back processes on Monday AM; - Improved AHP cover at weekends, with links to appropriate community services to enable increased numbers of weekend discharges and - Improved medical cover at weekends.
By June 2013, all Trusts and LCGs will have jointly, identified, quantified and agreed the necessary community services required to ensure that Length of Stay (LOS) within hospitals, acute care at home and post-acute care are optimised. Integral to this will be the development, collaboratively among Trusts (including NIAS), by March 2014, of a directory of community services to support timely discharge of patients as well as prevent emergency	

attendances/admissions.	

5. Next Steps

The LCG recognises that 2013/14 will be a very challenging year as we move forward to implement the range of initiatives highlighted in this plan. The Ministerial statement on TYC in March 2013 focuses the Commissioner on the need to ensure that our local populations have timely access to safe, sustainable and high quality health and social care. The achievement of this requirement will mean potential significant service change in the context of limited new investment into the HSC system. The LCG has already identified to the South Eastern Trust how the provision of services might change in Lisburn as we move to ensuring the provision of improved quality services closer to home, in line with TYC. This may mean accessing services for the Lisburn population to a greater degree from Belfast hospitals for those patients who require more acute episodes of care.

The LCG intends to develop Strategic Commissioning Framework or statement for each of the localities across the south east which will set out our vision for future service models. The LCG will continue to engage with all its partner organisations in the coming year as we move through this period of significant change.

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Email southeastern. lcg@hscni.net

Internet: www.hscboard.hscni.net/LCG

APPENDIX 1: LCG Management Board Members

Ms Oriel Brown, Nursing Representative, PHA

Dr Nigel Campbell, General Practitioner (Chair)

Cllr Angus Carson, Elected Representative

Cllr Dermot Curran, Elected Representative

Dr Paul Darragh, Consultant in Public Health Medicine, PHA

Mr Donal Diffin, Social Work Representative, HSCB

Mr John Duffy, Social Work Representative, HSCB

Cllr Cadogan Enright, Elected Representative

Cllr Andrew Ewing, Elected Representative

Mr Brendan Forde, Allied Health Professional, PHA

Mr David Heron, Community & Voluntary Sector Representative

Dr Garth Logan, General Practitioner

Dr Paul Megarity, General Practitioner

Mrs Heather Monteverde, Community & Voluntary Sector Representative

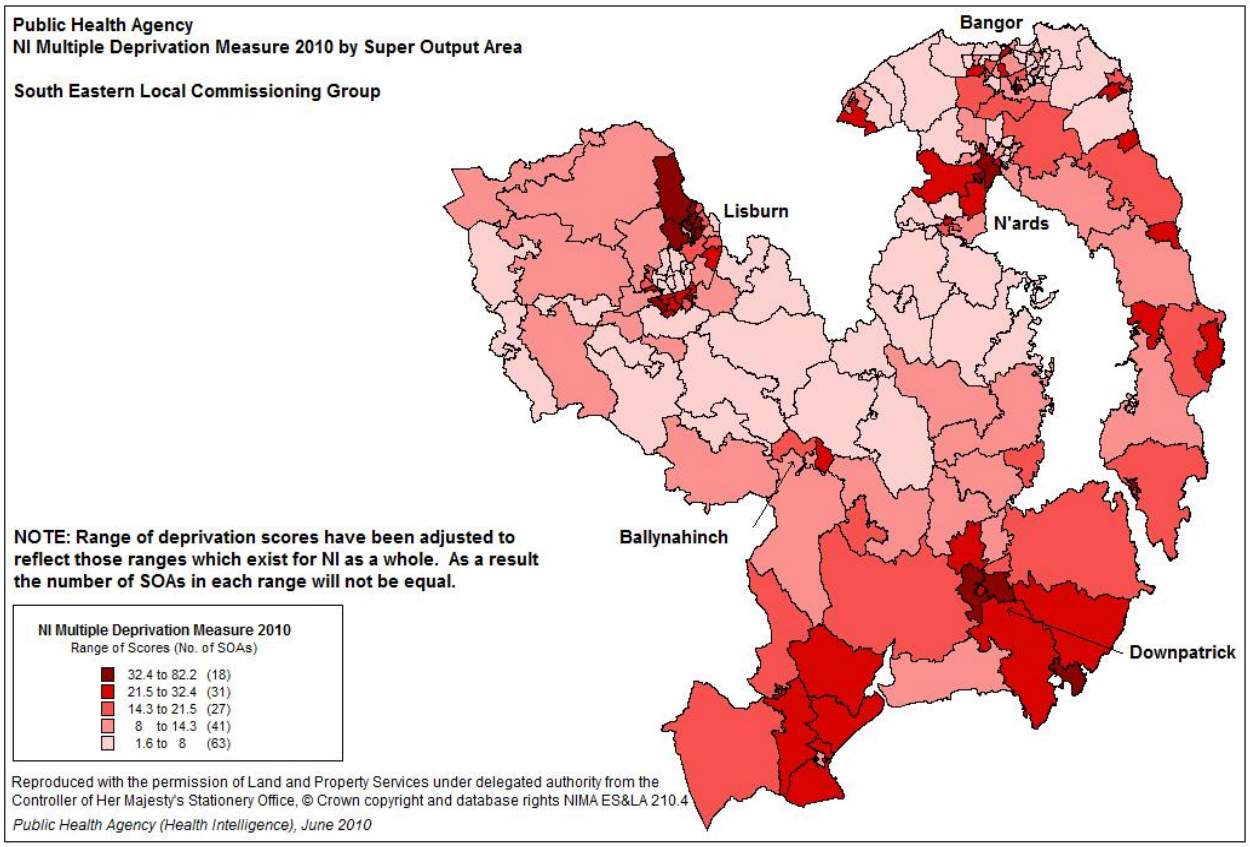
Mr Peter Mullan, Dental Practitioner

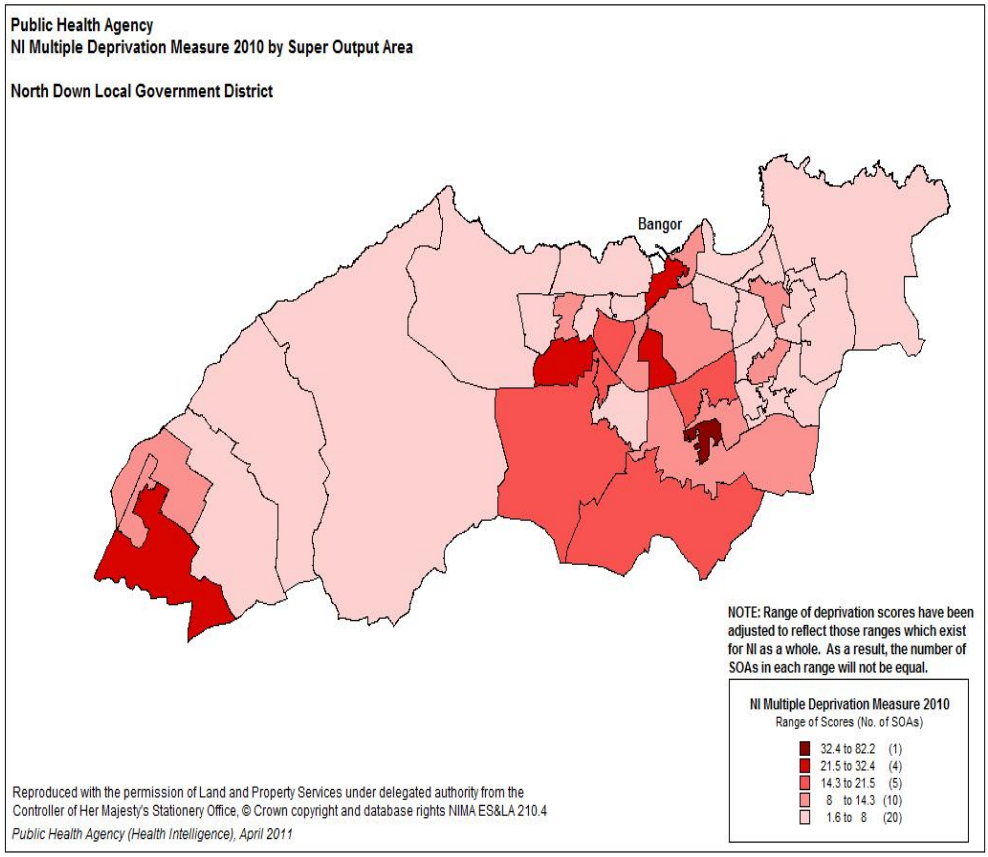
Dr Ultan McGill, General Practitioner

Mrs Louise Seymour, Community Pharmacist

Mr Paul Turley, Commissioning Lead

APPENDIX 2: MAP OF MULTIPLE DEPRIVATION AT SUPER OUTPUT AREA




Public Health Agency
NI Multiple Deprivation Measure 2010 by Super Output Area
North Down Local Government District
Bangor
NOTE: Range of deprivation scores have been adjusted to reflect those ranges which exist for NI as a whole. As a result, the number of SOAs in each range will not be equal.
NI Multiple Deprivation Measure 2010
Range of Scores (No. of SOAs)
32.4 to 82.2 (1)
21.5 to 32.4 (4)
14.3 to 21.5 (5)
8 to 14.3 (10)
1.6 to 8 (20)
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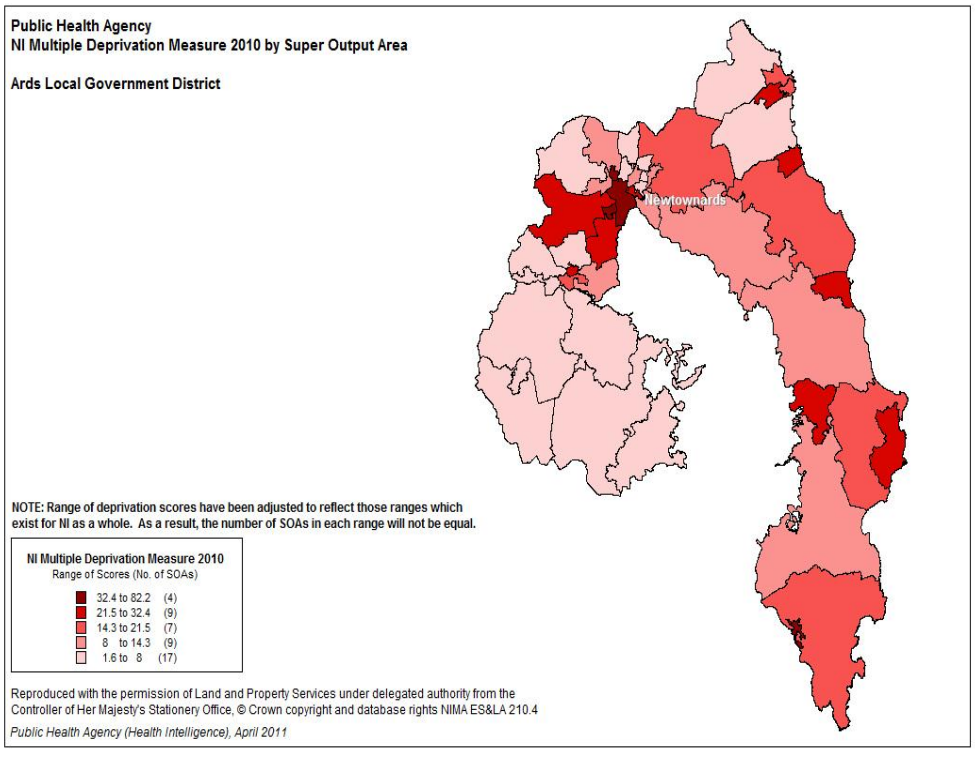
Public Health Agency (Health Intelligence), April 2011


Public Health Agency
NI Multiple Deprivation Measure 2010 by Super Output Area
Ards Local Government District
Newtownards
NOTE: Range of deprivation scores have been adjusted to reflect those ranges which exist for NI as a whole. As a result, the number of SOAs in each range will not be equal.
NI Multiple Deprivation Measure 2010
Range of Scores (No. of SOAs)
32.4 to 82.2 (4)
21.5 to 32.4 (9)
14.3 to 21.5 (7)
8 to 14.3 (9)
1.6 to 8 (17)
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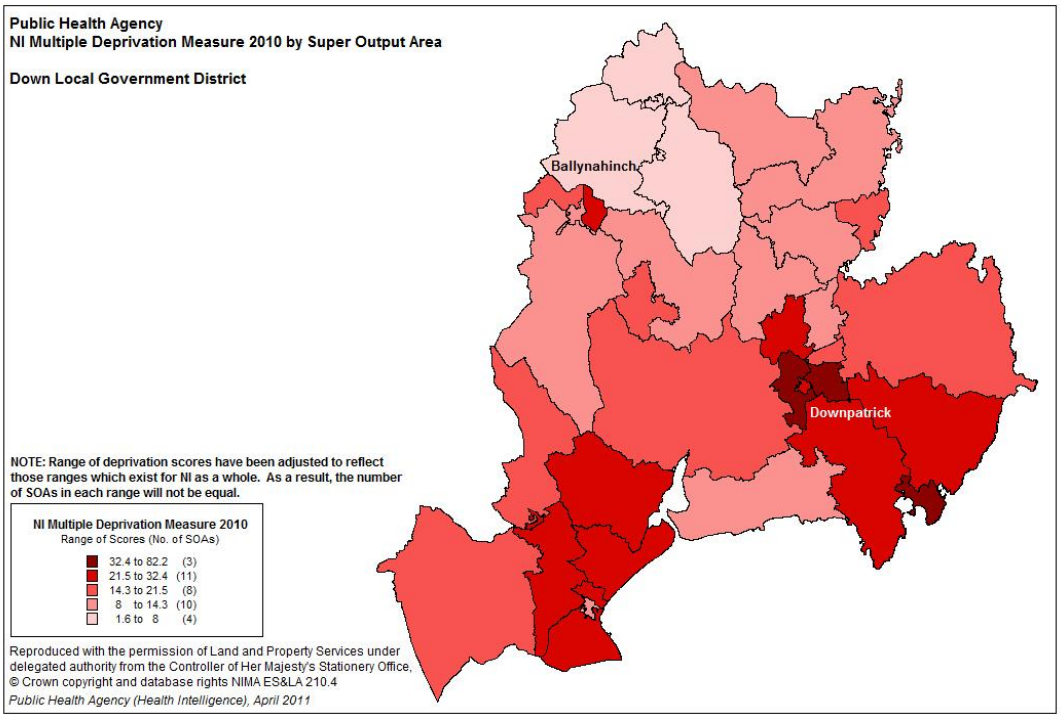
Public Health Agency (Health Intelligence), April 2011


Public Health Agency
NI Multiple Deprivation Measure 2010 by Super Output Area
Down Local Government District
Ballynahinch
Downpatrick
NOTE: Range of deprivation scores have been adjusted to reflect those ranges which exist for NI as a whole. As a result, the number of SOAs in each range will not be equal.
NI Multiple Deprivation Measure 2010
Range of Scores (No. of SOAs)
32.4 to 82.2 (3)
21.5 to 32.4 (11)
14.3 to 21.5 (8)
8 to 14.3 (10)
1.6 to 8 (4)
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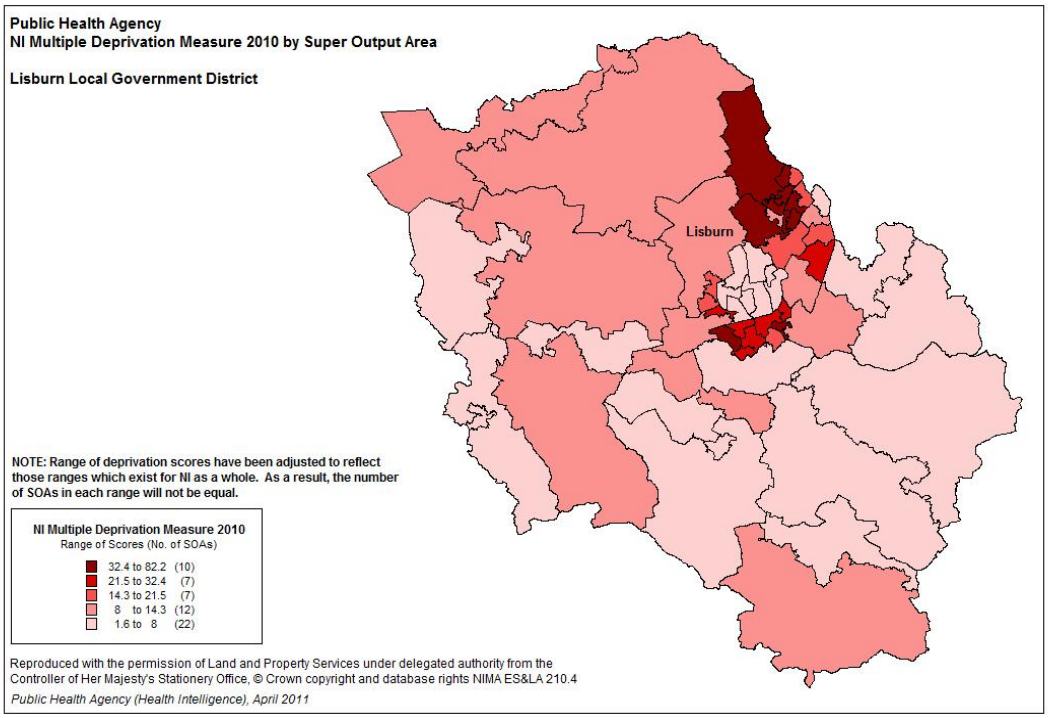
Public Health Agency (Health Intelligence), April 2011


Public Health Agency
NI Multiple Deprivation Measure 2010 by Super Output Area
Lisburn Local Government District
Lisburn
NOTE: Range of deprivation scores have been adjusted to reflect those ranges which exist for NI as a whole. As a result, the number of SOAs in each range will not be equal.
NI Multiple Deprivation Measure 2010
Range of Scores (No. of SOAs)
32.4 to 82.2 (10)
21.5 to 32.4 (7)
14.3 to 21.5 (7)
8 to 14.3 (12)
1.6 to 8 (22)
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Public Health Agency (Health Intelligence), April 2011