HSC Public Health Agency

AGENDA

76th Meeting of the Public Health Agency board to be held on Thursday 18 June 2015, at 1:30pm, Fifth Floor Meeting Room, 12/22 Linenhall Street Belfast, BT2 8BS

No	Time	Item	Paper	Sponsor
1.	1.30	Welcome and Apologies		Chair
2.	1.30	Declaration of Interests		Chair
3.	1.30	Minutes of the PHA board Meeting held on 21 May 2015		Chair
4.	1.35	Matters Arising		Chair
5.	1.35	Chair's Business		Chair
6.	1.40	Chief Executive's Business		Chief Executive
7.	1.45	Commissioning Plan 2015/16	**PHA/01/06/15 (for Approval)**	Mr Sullivan
8.	2.30	Draft PHA Budget 2015/16	**PHA/02/06/15 (for Approval)**	Mr Cummings / Mr McClean
9.	2.50	PEMS Report 2014/15	**PHA/03/06/15 (for Noting)**	Mr McClean
10.	2.55	Governance and Audit Committee Update • Minutes of 15 April 2015 meeting • Verbal briefing from Chair	**PHA/04/06/15 (for Noting)**	Mr Coulter
11.	3.05	Corporate Risk Register	**PHA/05/06/15 (for Noting)**	Mr McClean

12.	3.10	Data Protection/Confidentiality Policy	**PHA/06/06/15 (for Approval)**	Mr McClean
13.	3.15	Gifts and Hospitality Policy	**PHA/07/06/15 (for Approval)**	Mr McClean
14.	3.20	Annual Report 2014/15 to the Equality Commission	**PHA/08/06/15 (for Approval)**	Mr McClean
15.	3.35	Personal and Public Involvement Update	**PHA/09/06/15 (for Noting)**	Mrs Hinds
16.	3.50	Management Statement / Financial Memorandum	**PHA/10/06/15 (for Noting)**	Mr McClean
17.	3.55	Any Other Business		

18. **Date, Time and Venue of Next Meeting**
    Thursday 20 August 2015
    1:30pm
    Conference Rooms 3+4, 2nd Floor
    12/22 Linenhall Street
    Belfast
    BT2 8BS

HSC Public Health Agency

MINUTES

Minutes of the 75th Meeting of the Public Health Agency board held on Thursday 21 May at 1:30pm, in Fifth Floor Meeting Room, 12/22 Linenhall Street, Belfast, BT2 8BS

PRESENT:

Mrs Julie Erskine	-	Acting Chair
Dr Eddie Rooney	-	Chief Executive
Dr Carolyn Harper	-	Director of Public Health/Medical Director
Mrs Mary Hinds	-	Director of Nursing and Allied Health Professionals
Mr Edmond McClean	-	Director of Operations
Mr Brian Coulter	-	Non-Executive Director
Mrs Judena Leslie	-	Non-Executive Director
Mr Thomas Mahaffy	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director

IN ATTENDANCE:

Mr Robert Graham	-	Secretariat
Mr Paul Cummings	-	Director of Finance, HSCB
Mr Aidan Murray	-	Assistant Director (*on behalf of Mrs McAndrew*)
Mrs Joanne McKissick	-	External Relations Manager, Patient Client Council

APOLOGIES:

Councillor William Ashe	-	Non-Executive Director
Mrs Fionnuala McAndrew	-	Director of Social Services, HSCB

		Action
42/15	**Item 1 – Welcome and Apologies**	
42/15.1	The Chair welcomed everyone to the meeting and noted apologies from Councillor William Ashe and Mrs Fionnuala McAndrew.	
43/15	**Item 2 - Declaration of Interests**	
43/15.1	The Chair asked if anyone had interests to declare relevant to any items on the agenda. No interests were declared.	

44/15	**Item 3 – Minutes of the PHA Board Meeting held on 19 March 2015**
44/15.1	The minutes of the previous meeting, held on 19 March 2015, were approved as an accurate record of the meeting and were duly signed by the Chair.
45/15	**Item 4 – Matters Arising**
45/15.1	There were no matters arising.
46/15	**Item 5 – Chair's Business**
46/15.1	The Chair circulated to members an update on Chair's Business since the last meeting.
46/15.2	The Chair thanked all members for their support during her period as Acting Chair. She advised members that Mr Leslie Drew had been appointed as a non-executive member with effect from 1 July 2015.
47/15	**Item 6 – Chief Executive's Business**
47/15.1	The Chief Executive also expressed his thanks on behalf of the Board for all the work undertaken by the Acting Chair.
47/15.2	The Chief Executive said that since the last meeting he had met with the Older People's Commissioner as the OFMDFM Older People's Strategy is due to the published shortly.
47/15.3	The Chief Executive said that yesterday he had attended the most recent meeting of the All Departmental Officials' Group regarding the implementation of Making Life Better; he said that the meeting had been very positive.
48/15	**Item 7 – Commissioning Plan 2015/16 (PHA/01/05/15)**
	This item was not discussed.

49/15	**Item 8 – Finance Update** **PHA Financial Performance Report (PHA/02/05/15)**
49/15.1	Mr Cummings presented the final monthly Finance Report for 2014/15. He noted that there was not a spike of activity in the final month of the year, which had been a trend in previous years and he paid tribute to the work of Directors, Assistant Directors and other budget managers for achieving this. Other members echoed those views.
49/15.2	Mr Cummings sought members' approval for the PHA to use Bank of Ireland as its bank for the next seven years. This was approved by members.
50/15	**Item 9 – Governance and Audit Committee Update (PHA/03/05/15)**
50/15.1	Mr Coulter said that the approved minutes of the meeting of 19 February 2015 were available for members.
50/15.2	Mr Coulter gave an overview of the meeting of 15 April. He said that the revised Assurance Framework, updated Incident and Near Miss Reporting Policy and suite of health and safety policies had been considered. Mr Coulter said that the updated Business Continuity Policy and Plan had been considered and that there had been a presentation by Mrs Hinds on the complaints procedure. He added that the draft Annual Report, Governance Statement and Audit Committee Report were considered as well as an update on the Report to those Charged with Governance, BSTP and fraud.
32/15.3	Mr Coulter advised members that the Internal Audit update consisted of the Internal Audit plan for 2015/16, as well as the progress report on recommendations for 2014/15. He said that with regard to both Lifeline and the management of health and social wellbeing contracts, the Committee was satisfied with the progress being made. The Chair thanked everyone for their hard work in achieving this outcome.
51/15	**Item 10 – PHA Assurance Framework (PHA/04/05/15)**
51/15.1	Mr McClean said that the Assurance Framework had been brought up to date to reflect changes in terminology and

	approach in terms of reporting.
51/15.2	Members approved the PHA Assurance Framework.
52/15	**Item 11 – PHA Business Continuity Plan and Policy (PHA/05/05/15)**
52/15.1	Mr McClean advised that the updated Business Continuity Plan and Policy had been considered by the Governance and Audit Committee. He explained that there had been a full review to bring the Plan into line with international standards. He emphasised the important of the Plan and said that the Plan would be regularly tested, in conjunction with HSCB and BSO.
52/15.2	Members approved the Business Continuity Plan and Policy.
53/15	**Item 12 – Performance Management Report – Corporate Business Plan and Commissioning Plan Directions Targets for Period Ending 31 March 2015 (PHA/06/05/15)**
53/15.1	Mr McClean presented the end of year report. The Chair thanked staff for all their hard work in achieving the year-end outcomes, but she noted that many of the targets rated "amber" were rated as such due to issues beyond PHA's control.
53/15.2	Mrs Hinds said that the target relating to health visiting should improve as this has been identified as a priority in next year's Commissioning Plan, however, it would take time until all of the newly recruited health visitors were in post.
53/15.3	In response to a query from Alderman Porter regarding next year's plan, Mr McClean said that a draft set of targets would be prepared, but would not be approved until there was clarity on the breakdown of PHA's15% savings target.
53/13.4	Mr Coulter focused on the targets which were rated as "amber" throughout the entire year, and whether these should be rated "red", citing the example of the target around HCAIs. Dr Harper advised that the Trusts had continued to show improvement and were now facing more challenging targets, but that, for some, their performance was still among the top 25% of all Trusts across the UK. She said that it was important that these targets remained a priority so that Trusts keep a focus on this area.

53/13.5	Mr Coulter noted that attempts to reduce the amount of over-prescribing had not been successful. He added that smaller pharmaceutical companies may be more likely to respond to incentives to produce new antibiotics. Dr Harper said that appropriate use of antibiotics is an important element in tackling anti-microbial resistance. She said that more work needed to be done in this area.
53/13.6	Alderman Porter asked whether PHA should set more realistic targets. The Chief Executive said that PHA should set targets that are realistic, but more importantly would ensure that services are kept safe. He added that it was important not to pull back, but to maintain and keep up the good work in these areas. Dr Harper said that based on previous feedback, targets are set by taking into account previous performance and establishing where PHA would like to get to, and assessing how this can be achieved.
53/13.7	Mr Coulter asked for an update on Making Life Better. The Chief Executive said that although DHSSPS is leading this work, PHA will be responsible for its implementation. He advised that there is a workshop taking place on 26th May. Mr Mahaffy asked about DHSSPS role in pushing this work forward. The Chief Executive said that this strategy is seen as more than a health strategy and that there is great enthusiasm among all bodies to see the implementation take place.
53/13.8	Members noted the Corporate Performance Report.
54/15	**Item 13 – PHA Response to Donaldson Report (PHA/07/05/15)**
54/15.1	Dr Harper thanked those staff who had helped compile the PHA response to the Donaldson Report. She said that, in the main, PHA was supportive of most of the recommendations in the Report, but in some cases with caveats.
54/15.2	Mr Mahaffy queried why PHA had ticked the box to indicate that there would be no equality considerations to be taken into account in the event of any reconfiguration. It was agreed that a comment should be inserted to say that any final actions would have to be equality screened.

54/15.3	Mr Coulter suggested a reference to PPI should be inserted into the response for Question 1 under Recommendation 1. It was agreed that the insertion of the word "involve" would suffice.
54/15.4	Mr Coulter queried why PHA did not strongly agree with the response to Question 1 under Recommendation 5 regarding RQIA. The Chief Executive said that while PHA welcomed the role of the regulator in this area, it was not the only solution to the issue of improving the services delivered by acute hospitals. Alderman Porter sought clarity on the response to the following question regarding outsourcing and whether the issue in question was the concept, or what form this would take. Dr Harper said that it would not be reasonable for a non-healthcare organisation to take on a regulatory role. The Chief Executive suggested that if outsourcing is being given consideration, the first step should be to review the original issue.
54/15.5	Mr Coulter welcomed the change in the clarification of Serious Adverse Incidents whereby not all child deaths are required to be reported as SAIs. However, he was keen to ensure that the piece of work on "patient related incidents" is carried out. Dr Harper said that there are currently capacity issues in terms of dealing with the number of incidents and she said that before further work is carried out in the area of patient related incidents, caution was needed in terms of dealing with anonymous and non-anonymous issues as well as malicious and vexatious reporting.
54/15.6	Mrs Leslie noted that the Donaldson Report is part of a bigger agenda of reform and asked if the PHA response suggested introducing an operational model. Dr Harper explained that Transforming Your Care provides the high level strategic direction, but not the detail of what services should look like on the ground. There is therefore a need to develop an operational model that all stakeholders can sign up to.
54/15.7	Mrs Leslie queried the response of "neither" in relation to the question on alternative models of working for healthcare professionals. Dr Harper explained that the PHA response is recommending that future models should be based on analysis and on design principles to ensure lean, efficient services.
54/15.8	The Chair thanked staff for their input in pulling together the

response.

54/15.9 Subject to minor amendments, members approved the response.

55/15 Item 14 – DPH Annual Report (PHA/08/05/15)

55/15.1 Dr Harper presented the 2014 Director of Public Health Annual Report which she advised would be formally launched at the public health conference on 10 June 2015.

55/15.2 Mr Coulter said that the Report was very interesting and he suggested that in future years there could be a presentation to highlight the main findings. Dr Harper noted the suggestion.

55/15.3 Dr Harper advised that in addition to the main report, the core tables and other statistical information would be published on the PHA website. She added that next year's report would be a shorter one.

55/15.4 Members noted the DPH Annual Report.

56/15 Item 15 – Update on PHA Procurement Plan (PHA/09/05/15)

56/15.1 Mr McClean presented the update on the PHA procurement plan. He said that EU social procurement is quite a complex area with a lot of learning for PHA.

56/15.2 Mr McClean said that areas such as Lifeline, Early Years Interventions and Obesity will be the main focus over the next period. He advised that the new regulations do not apply to contracts under £625k in value. He added that a paper is currently being prepared detailing how HSCB and PHA can obtain support in dealing with these procurements.

56/15.3 Mr Coulter noted that procurement features on the PHA's Corporate Risk Register. He added that PHA was able to provide some additional capacity that the risk is in relation to this being short term and of a scale difficult to meet the demands presenting.

56/15.4 Alderman Porter noted the implications of funding being taken away from community projects. The Chief Executive noted the concerns and said that PHA has tried, where possible, to protect

groups that it funds, but organisations may turn to other funders.

56/15.5 Members noted the update on the Procurement Plan.

57/15 Item 16 – Child Development Programme Board Update (PHA/10/05/15)

57/15.1 Dr Harper said that the Child Development Programme Board continued to be a catalyst for change across a lot of organisations. Alderman Porter suggested that PHA should celebrate its achievements, and he made particular reference to the work in Early Interventions.

57/15.2 Members noted the update from the Child Development Programme Board.

58/15 Item 17 – Any Other Business

58/15.1 The Chief Executive expressed his thanks to all staff for their assistance in relation to the recent incident at Harland and Wolff.

58/15.2 The Chair thanked staff for their help and support during her period as Acting Chair.

59/15 Item 18 – Date and Time of Next Meeting

Date: Thursday 18 June 2015
Time: 1:30pm
Venue: Fifth Floor Meeting Room
12/22 Linenhall Street
Belfast
BT2 8BS

Signed by Chair: _____

Date: _____

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	18 June 2015
Title of Paper	Draft Commissioning Plan 2015/16
Agenda Item	7
Reference	PHA/01/06/15

Summary

Introduction
Members are asked to approve the attached draft Commissioning Plan 2015/16 for submission to the Department for consideration.

Summary
The Commissioning Plan describes the actions to be taken across Health and Social Care to ensure continued improvement in health and wellbeing of the people of Northern Ireland within the available resources. The plan responds to the Commissioning Plan Direction 2015, issued by the DHSSPS on 6 March 2015.

Should members approve the attached draft plan; it will be submitted to the Department no later than week commencing 22 June 2015.

Equality, Good Relations, Disability Duties and Human Rights
LCGs have undertaken a screening of local plans. These screening documents have been collated and combined with a screening of the regional component of the plan to form the overall screening report for the Commissioning Plan. The screening report outlines the cumulative impacts of the Plan on the population of N.Ireland.

The screening document specifies any mitigating actions that need to be taken to avoid any potential negative impact on the nine equality groups. It will also specify where a more in depth EQIA is likely to be required to be completed in advance of implementation.

Financial implications
The HSCB has a statutory duty to break even and operational responsibility for ensuring financial stability across the HSC. Following consultation on the draft budget for 2015/16, the DHSSP'S latest assessment of its financial position shows an unresolved gap of £31m.

In order to provide a balanced financial plan to the HSCB will delay a number of key projects, which will reviewed following the conclusion of the June Monitoring Round. As such, the commitments in the Plan should only be viewed as indicative at this time.

The plan also highlights areas of unmet need and service developments which cannot be progressed within currently available resources, or can only be

progressed at a significantly reduced scale and/or pace. Steps are being taken, where possible, to mitigate risk and HSCB will continuously review commitments to ensure best use of all available resources. In addition the HSCB have supported the DHSSPS in preparing bids for June Monitoring amounting to £89m – the bids remain subject to approval.

Recommendation
Members are asked to approve the draft Plan as a fit for purpose response to the Commissioning Plan Direction 2015/16, to be forwarded in due course to the Minister.

Attached:

(i) Draft Commissioning Plan 2015/16
(ii) Draft Equality, Human Rights & Good Relations Screening of Draft Commissioning Plan 2015/16
(iii) Commissioning Plan Direction and Indicators of Performance 2015 (DHSSPS, May 2015)

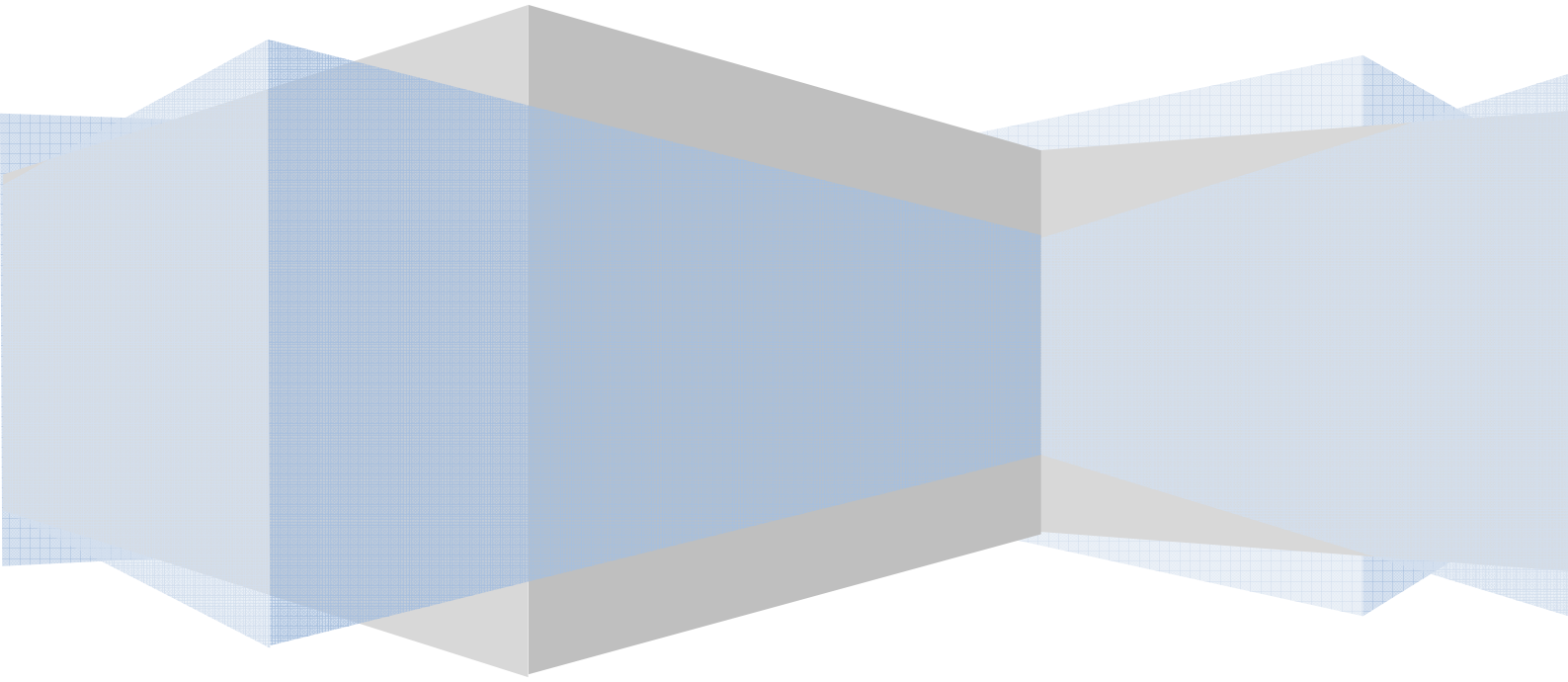
Equality Screening / Equality Impact Assessment	Attached
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Commissioning, HSCB
Date	18 June 2015

Health and Social Care Board

Public Health Agency

Commissioning Plan 2015/16 (DRAFT)

4 June 2015



Contents

Foreword

This Commissioning Plan describes the actions that will be taken across health and social care during 2015/16 to ensure continued improvement in the health and wellbeing of the people of Northern Ireland within the available resources. The Plan has been developed in partnership by the Health and Social Care Board and the Public Health Agency, and responds to the Commissioning Plan Direction published by the Minister for Health, Social Services and Public Safety on the 6 March 2015. In doing so, it includes the underpinning financial plan and outlines how the commissioning decisions planned in 2015/16 will deliver the planned transformation of services outlined in *Transforming Your Care*. It outlines a range of actions that have been developed in partnership with patients and the public which are driven by need, clear goals and financial transparency.

The plan also highlights areas of unmet need and service developments which cannot be progressed within currently available resources, or can only be progressed at a significantly reduced scale and/or pace. Steps are being taken, where possible, to mitigate risk and HSCB will continuously review commitments to ensure best use of all available resources. In addition the HSCB have supported the DHSSPS in preparing bids for June Monitoring amounting to £89m – the bids remain subject to approval.

Improvements in the quality of care for our population in recent years mean that people are living longer than ever before. With an increase in the age of the population comes an increasing burden of chronic disease, increased demand for health and care services and a greater reliance on hospital-based care. This increase in demand comes at a time when the Northern Ireland Executive budget has been reduced by 1.6% in real terms.

The only way to have sustainable, safe and high quality services is to transform how we plan and deliver our care. This plan focuses on the transformation agenda which is committed to improving patient experience and outcomes of care by placing the patient, carer and community at the heart of care and by thinking more innovatively about our ways of working. A consistent theme is the need to reduce our reliance on hospital and institutional care while focusing investment on the development of more responsive and individualised care closer

to home and the promotion of early intervention, prevention and greater choice and independence. This means that the way in which we deliver care will change; patients will be able to access new services in different places.

Both the Ministerial and TYC themes highlight the need to redesign and refocus services in order to:

- Enhance primary prevention to improve the way we live and look after our health;
- Supporting people to live independently for as long as possible;
- Providing more care closer to home – home as hub of care;
- Focussing on the provision of high quality, safe and effective care, which may require concentration of some services to ensure minimum clinical critical mass and maximum efficiency;
- Safeguarding the most vulnerable; and
- Ensuring efficiency and value for money.

The HSCB/PHA commits to supporting the delivery of the actions outlined in the Plan by:

- Listening to Patient and Client experience and learning from Personal and Public Involvement;
- Supporting our staff through training and development;
- Working with clinicians to ensure delivery of best practice;
- Working in partnership with providers, including the private and voluntary sector to support greater choice and innovation;
- Embracing innovation and technology;
- Use eHealth (technology) to improve citizens' experience of interacting with health and social care and to improve care by making it easier for staff to get the information they need to provide that care; and
- Through a continued focus on reducing health inequalities.

1.0 Introduction

1.1 The Purpose of the Plan

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

The commissioning priorities and decisions outlined within the Commissioning Plan have been identified through regional and local assessment of needs and inequalities and with reference to evidence-based or agreed best practice. In particular, they aim to respond to the three strategic themes and statutory obligations identified by the Minister in the Commissioning Plan Direction:

- To improve and protect population health and wellbeing and reduce inequalities.
- To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.
- To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

In line with established commissioning arrangements, the plan provides an overview of regional commissioning themes and priorities for 2015/16 (Sections 6 and 7) together with information on the priorities and decisions being taken forward at local level by the five Local Commissioning Groups (LCGs; Sections 9-14).

The regional themes and priorities outlined in Section 7 are closely aligned to the Ministerial priorities and the key themes within *Transforming Your Care*. The transformation agenda is therefore integrated throughout the plan. In addition to outlining how we intend to deliver on the transformation agenda, the document will also outline how commissioning will support the implementation of a range of Government and Departmental strategies, standards and initiatives including:

- Achievement of Ministerial standards / targets 2015/16 (see Section 8)
- The Executive's Programme for Government, Economic strategy and Investment Strategy (Section 3)
- Quality 2020 (Section 3.2)
- 10,000 Voices and Patient and Client Experience Standards (Section 5)
- Personal and Public Involvement (Section 5)
- Public Health Strategic Framework: Making Life Better 2013-23 (Section 6.1)
- Delivering Care: Nurse Staffing in N Ireland (Section 3.6)
- Other Departmental guidance and guidelines such as (e.g. Service Framework documents, NICE, Maternity Strategy). (Section 3)

Key actions in relation to a number of these strategies are addressed separately in Section 3, *Delivering on Key Strategies*. Others are embedded within the regional commissioning themes and priorities.

Finally, the Plan makes explicit those areas of service development and delivery that providers will be expected to respond to in their development plans for 2015/16 and against which they will be monitored.

It is important to note that the Plan does not attempt to encompass all of the many strands of work that HSCB and PHA will continue to progress with providers during 2015/16. Rather it provides focus on a discrete number of key strategic and service priorities which we feel will have the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level, and those which represent a step change in how we deliver our services.

1.2 Placing communities at the centre of commissioning

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

There are five Local Commissioning Groups (LCGs) and each is a committee of the HSCB: Belfast; Northern; South Eastern; Southern; and Western. LCGs are

responsible for assessing local health and social care needs; planning health and social care to meet current and emerging needs; and supporting the HSCB to secure the delivery of health and social care to meet assessed needs.

Local commissioning priorities, reflect the regional themes, but are presented by Programme of Care (PoC). PoCs are divisions of health care, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. In total, there are nine PoCs. Definitions of each PoC are provided in Appendix 1.

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

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

1.3 Monitoring Performance

The priorities and targets detailed in the *Commissioning Plan Direction* are complemented by a number of indicators of performance indicated in a separate *Indicators of Performance Direction* for 2014/15.

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

2.0 Summary of Key Demographic Changes

This section provides an overview of key demographic changes of the NI population and outlines information relating to lifestyle and health inequalities. Consideration has been given to these within the needs assessments outlined within sections 7 and 9-13 in order to inform the commissioning of services at both regional and local level.

N Ireland Resident Populations by Local Commissioning Group

Table 1

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	67,000	96,000	71,000	83,000	65,000	383,000
16-39	124,000	143,000	104,000	118,000	95,000	584,000
40-64	105,000	153,000	117,000	114,000	96,000	584,000
65+	53,000	75,000	59,000	50,000	42,000	279,000
All ages	350,000	467,000	366,000	366,000	297,000	1,830,000
%	19%	26%	19%	20%	16%	100%

Source: NISRA, 2013 MYEs

Some of the key demographic changes which will have an impact on the demand for health and care services in Northern Ireland are noted below:

- Recently published Mid-Year Estimates for 2013 indicate that there are approximately 1.83m people living in N Ireland (NI). Current population projections anticipate the population will rise to 1.927m by 2023.
- Belfast Trust has the lowest proportion of younger people aged 0-15 years, in comparison to other Trusts (19% or 67,000) and the Southern Trust has the highest percentage at (23% or 83,000).
- The Northern Trust however has the highest number of younger people within its population at 96,000 or 21% of its population.
- Persons of working age (persons aged 16-64) account for the highest proportions across all Trusts, ranging from 66% of the population in Belfast to 63% in the South Eastern Trust.
- There are a total of 279,000 older people (65+ years) in N Ireland, equating to 15% of the NI population.

- 19% of these or 53,000 persons are in Belfast Trust, 27% or 75,000 are in Northern Trust; 21% or 59,000 reside in South Eastern; 18% or 50,000 are in Southern Trust, and the remaining 15% or 42,000 live in Western Trust.
- The anticipated population increase is characterised by a marked rise in the proportion of older people. From 2015-2023 the number of people aged 65+ is estimated to increase by 74,000 to 353,000 – a rise of 26%. The number of older people will represent 18% of the total population compared with 15% currently.
- At sub-regional levels, the areas with the highest projected growth overall is the Southern Trust (+10%), for the aged 65+ and 75+ cohorts of the population is in the Western Trust at +32% and South Eastern Trust at +49%. For aged 85+ years, the highest projected growth is in the Southern Trust (+58%).
- Births in N Ireland have fallen from 25,300 in 2012 to 24,300 in 2013 – a decrease of 4%
- 14,968 deaths were registered in N Ireland during 2013, which is a slight increase of 212 or 1.4% since 2012.
- The main cause of death was cancer accounting for 28% of deaths in N Ireland (4,230).
- Life expectancy across the region has improved by 7 years for females and 9 years for males since 1980/82. In 2011/13 males could expect to live to the age of 78 years and females to the age of 82 years. Males living in the 10% least deprived areas in NI could expect to live on average approximately 9 years longer and females, approximately 6 years longer than their counterparts living in the 10% most deprived areas.
- The prevalence of long term conditions such as COPD, diabetes, stroke, asthma and hypertension is increasing. In conjunction the number of people coping with co-morbidities is increasing.
- Deprivation has an impact on health and wellbeing in many ways resulting in the lack of social support, low self-esteem unhealthy life style choices, risk taking behaviour and poor access to health information and quality services.

3.0 Delivering on Key Policies, Strategies and Initiatives

The Plan attempts to outline how Commissioning will deliver across a number of key Government and Departmental policies and strategies. As noted in the introduction, Transforming Your Care is integrated throughout the document and will therefore not be addressed separately within this section. Other policies and strategies are also encompassed within the regional themes and priorities (e.g. the Public Health Strategic Framework – 'Making Life Better', is addressed under the first of the regional themes). This section therefore outlines our commitments in relation to a small number of policies, strategies or initiatives which are not covered elsewhere in the plan. These include:

- Programme for Government
- Quality 2020
- Delivering Care: Nurse Staffing in Northern Ireland
- Service Frameworks
- Living Matters Dying Matters
- Maternity Strategy
- Physical and Sensory Disability Strategy
- Community planning

3.1 Programme for Government

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

3.2 Quality 2020

The DHSSPS Quality 2020 is the strategic framework that ensures patients and their experiences remain at the heart of service design and delivery.

During 2015/16 the HSC Quality 2020 Implementation Team will complete work to:

- Develop HSC Trust Annual Quality Reports

- Develop professional leadership via implementation of the Attributes Framework to develop HSC staff skills in Quality Improvement and Safety.
- Introduction of the WHO patient safety curriculum in undergraduate and post graduate training programmes.

In 2014 the DHSSPS, Patient Client Council and RQIA held a successful Stakeholder Forum and the findings from this event will inform the development of an annual Quality 2020 Stakeholder forum and will feed into the future work of Quality 2020.

3.3 Institute of Healthcare Improvement Liaison

The HSCB is working with the Institute of Healthcare Improvement (IHI) to build capacity and develop expertise, across the HSC, in quality improvement skills.

The focus of this work is on trialling and adopting the 'Triple Aim' framework - the term Triple Aim refers to the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health.

East Belfast Integrated Care Partnership and the South Eastern Trust have been selected to act as prototype sites for this approach. Both sites are working to develop and test new models of care at home for frail older people.

As part of the regional Outpatient and Care Pathway reform projects the HSCB are working in partnership with the NI Safety Forum to bring Institute of Healthcare Improvement science expertise to the identification of priority pathways for regional implementation and the design of same.

3.4 HSC Safety Forum

The role of the HSC Safety Forum is to provide leadership for Safety and Quality Improvement across Health and Social Care.

During 2015/2016 the key deliverables will include:

- Recruiting and funding key individuals to the role of Safety Forum Scottish Fellows, receiving high-level training on Improvement and Leadership.

- Linking with the Health Foundation to recruit HSC staff to the 1st Cohort of the *Q. Initiative*Develop a business case for further Quality Improvement training on an All-Ireland basis via Interregnum V funding via Co-operating and Working Together (CaWT).
- Create and deliver the first regional learning event to share and learn from Serious Adverse Events
- Continue the work to embed use of the Attributes Framework, developed under the leadership of the Safety Forum in staff development and appraisal.
- Follow-up the very successful Delivering Safer Care Conference in 2014 with a similar event in early 2016.
- Promote judge and award the first Safety Forum Awards to recognise and reward the efforts of staff to progress Quality Improvement and Safety.
- Complete the Lessons from Berwick series in partnership with the HSC Leadership centre
- Partner with RQIA to inform the development of its new programme of inspection Develop a regional bundle for the prevention and care of delirium as part of the Regional Dementia Strategy
- Support the development of a network of improvers across Health & Social Care – the Improvement Network- Northern Ireland (INNI)
- Develop and introduce a regional Early Warning Score for Paediatrics
- Continue to lead on the Quality Improvement Collaboratives and develop new areas of work as needed

3.5 Workforce Planning & Development

This Commissioning Plan and the reform agenda it sets out will reshape our service provision across health and social care over the coming years which will be underpinned by workforce planning and development. The movement towards model of care which deliver more services in primary or community care settings and the consequent re-allocation of resources and funds has significant implications for our workforce in terms of its roles, location and skills mix.

HSCB and PHA are taking forward a number of initiatives and strands of work with regard to workforce planning and development:

Integrated Service and Workforce Planning
The DHSSPS will soon publish the regional workforce planning framework, which will set out the relative roles of the HSC organisations, and this will drive the practical implementation and improvement of workforce planning at all levels across the HSC. The HSCB and PHA will led and participate in workforce reviews, as appropriate.

Profession specific workforce planning and development
There will continue to be consideration of workforce planning and development through profession specific activities, including the impact of the transformation agenda set out in the Commissioning Plan.

This includes:

- a comprehensive workforce planning review for Nursing and Midwifery services in Northern Ireland - *Delivering Care: Nurse Staffing in Northern Ireland* (see section 3.6)
- work with Trusts on increased introduction of working practices which support 7 day services, as reflected in this Commissioning Plan.
- a suite of workforce plans across different specialties have a been developed or are underway. It is anticipated that Trauma & Orthopaedics and Occupational Medicine will be complete early in 2015/16, and the next group of specialties to be reviewed in 2015/16 has been agreed with DHSSPS and Trusts.
- working with partners on the implementation of the Social Work Strategy, which includes workstreams focussed on First Line Managers, Workload Management in Adult Services, Job Rotation, Extended Hours & Flexible Working, and Promoting Leadership.

Capability Development Initiatives to support our reform agenda
The HSCB has invested in a range of development initiatives designed to increase the wider HSC's capacity and capability to deliver the transformation agenda.

These include:

- Change Management and core skills programme for those involved in TYC or transformation projects.
- Effective Partnership Working and bespoke skills programmes for those on Integrated Care Partnership Committees, or those supporting their successful operation.
- The establishment and on-going development of a HSC Knowledge Exchange open to all those involved in the design, commissioning or provision of health and social care services across N Ireland. During 2015/16, the HSCB will be investing in Organisation Workforce Development and Service Improvement skills to support staff in their roles, including promoting innovation, reform and change.

3.6 Delivering Care: Nurse Staffing in Northern Ireland

The aim of the *Delivering Care: Nurse Staffing in Northern Ireland* Project is to support the provision of quality care which is safe and effective in hospital and community settings through the development of a framework to determine staffing ranges for the nursing and midwifery workforce in a range of major specialities.

Phase one sets out the nursing workforce required for all general and specialist medical and surgical hospital services. The HSCB has agreed a detailed implementation plan to support the delivery of Phase One. Three further phases are at developmental stage. Phase two focuses on nurse staffing within Emergency Departments, Phase Three focuses on District Nursing and Phase Four is focused on Health Visiting. Once a regional approach for the implementation of these further phases has been agreed by DHSSPS, the HSCB, supported by the PHA, will agree implementation plans.

3.7 Service Frameworks

Service frameworks and strategies set clear quality requirements for care. These are based on the best available evidence of the treatments and services that work most effectively for patients.

Many of the standards contained in the Frameworks do not require additional resources as they are focused on quality improvement and are capable of delivery by optimising the use of existing funding. Where there are additional costs associated with specific standards, these will be sought through existing financial planning, service development and commissioning processes.

There are currently a total of six Service Frameworks (Respiratory, Cancer, Mental Health, Learning Disability, Cardiovascular and Older People) and a seventh for Children and Young People currently under development.
During 2015/2016 the key deliverables will include:

- Following formal publication of the Respiratory and Children and Young People Service Frameworks, the HSCB/PHA will develop implementation plans to take forward the standards and Key Performance Indicators (KPIs) set out in the frameworks.
- Fundamental reviews for Cancer and Mental Health Frameworks to be completed by HSCB/PHA by September 2015.
- Implementation of remaining three frameworks to be taken forward in line with implementation plans agreed with the DHSSPS.

3.8 Primary & Community Care Infrastructure

In 2011/12, the then Minister indicated that he wished to invest in the development of the primary and community care infrastructure as part of the strategy for improving the overall health and well-being of the community and for improving the delivery of integrated primary, community and secondary care services.

In 2014/15 a Strategic Implementation Plan was developed based on the hub and spoke model which sets out the regional plan for investment in primary care infrastructure. It includes an outline of the prioritised hub projects within the programme and proposed funding plan. Each hub will be a 'one stop shop' for a

wide range of services including GP and Trust led primary care services. This model will improve access to, and responsiveness of, primary and community care services, particularly making available more specialised services nearer to where people live and work. This includes provision of an enhanced diagnostic and treatment capability where appropriate.

The priority for 2015/16 is to continue to take forward the hub and spoke model. The key tasks will be to:

- Gain ministerial approval of the Strategic Implementation Plan;
- Complete construction of 3 Hubs in Banbridge, Ballymena and Omagh;
- Conclude on Value for Money of procurement approach for two 3PD pilot projects (Lisburn & Newry);
- Appoint the preferred bidder for the hubs in Lisburn and Newry;
- Commence detailed needs assessment of next tranche of hub projects including impact on commissioning and delivery model;
- Complete Tranche 1 of GP Loan Scheme and launch Tranche 2; and
- Continue detailed assessment of need for investment in spoke projects and prioritisation of investment in spoke practices.

3.9 Palliative and End of Life Care

The Transforming Your Palliative and End of Life Care Programme is supporting the redesign and delivery of coordinated services, in line with the *Living Matters: Dying Matters Strategy (2010),* to enable people across Northern Ireland with palliative and end of life care needs to have choice in their preferred place of care. The Programme is being delivered by the HSCB/PHA in partnership with Marie Curie, working with statutory, voluntary and independent sector providers.

During 2015/2016 the key deliverables will include:

- Agreement and implementation of regional advance care planning across the region for those with identified palliative and end of life care needs
- Implementation of the key worker function for those identified palliative and end of life care needs
- Development of a Transforming Your Palliative and End of Life Care business case to support the agreed regional palliative care model with implementation in 2016, subject to funding.

3.10 Maternity Strategy

The Maternity Strategy for Northern Ireland, published in July 2012, promotes improvements in care and outcomes for women and babies from before conception right through to the postnatal period. The Strategy focuses on the need to improve pre-conceptual health, promote antenatal care appropriate to the individual woman's needs, support midwife-led care for women with a straightforward pregnancy and ensure consultant-led care for women with a complex pregnancy. During 2015/2016 the key deliverables will include:

- Finalisation of a regional core pathway for antenatal care
- Development of a standard electronic referral letter for primary care referrals for maternity care
- Development of guidelines for admission to and transfer from midwife-led care in Northern Ireland
- Achieving an improvement in the uptake of Folic Acid by women pre-conceptually to reduce the incidence of Neural Tube Defects
- Continued improvement of the quality of clinical data collected
- The Maternity Quality Improvement Collaborative will continue to work to improve safety and quality of maternity care services
- Continued improvement of the quality of online information available about local care options for women and their partners
- Full implementation of the regional pathway for multiple pregnancy
- Developing services for women with epilepsy to help them have an optimum pregnancy outcome.

The funding position in 2015/16 will however impact on the ability of commissioners to take forward a range of maternity health service developments including:

- establishment of specialist midwifery service for the care of vulnerable groups of migrant and minority ethnic pregnant women
- establishment of specialist joint diabetic antenatal clinics for women with gestational diabetes mellitus, Type 1 and Type 2 diabetes to allow for the redesign of antenatal care for all diagnosed diabetes in the antenatal period

- ability to address additional pressures which may emerge from the current review of neonatology, for example, need to further expand medical capacity

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

3.11 Physical and Sensory Disability Strategy

The Physical and Sensory Disability Strategy 2012/15 has a number of overarching themes:

- Promoting Positive Health, Wellbeing and Early Intervention
- Providing better Services to Support Independent Lives
- Supporting Carers and Families

Significant effort has been expended over the past two years in the implementation of the Physical and Sensory Disability Action Plan which identifies 34 Actions to address the above themes. On-going improvements are required to ensure that people with physical and/or sensory disabilities are enabled to lead independent lives. By continuing to implement the Strategy, the HSCB will promote choice and independence as well as support carers. This will require further investment in:

- Wheelchair services
- Services to people with sensory loss (Deafblind, Visual, and Hearing loss)
- Community Access and Social Networking
- Implementation of neuro-rehabilitation pathways including people with neurological conditions.

The funding position in 2015/16 will impact on the ability of commissioners to maintain effective services for people with a physical or sensory disability. In particular, it is anticipated that complex care package and transitional care costs will exceed available resources.

3.12 Community planning

1 April 2015 heralds significant changes to Local Government with the number of councils reducing from 26 to 11 and a transfer of powers for central to local government. The new council boundaries are not co-terminus with the LCG/Trust areas but there will be enhanced opportunities for more effective working with local government under the auspices of Community Planning.
As a new statutory function, councils will be required to initiate, maintain and facilitate community planning. A corresponding duty will be placed on other statutory partners, including HSC, to participate in this process. Community planning will be a process, led by councils in collaboration with partners and communities, to develop and implement a shared vision for their area which will involve people working together to plan and deliver better services.

Building relationships across the sectors will be crucial to the success of community planning. Health and Social care has long worked in partnership with local government and other statutory and community partners. Learning from these partnerships will provide a solid foundation for HSC participation in the community planning processes. HSCB, PHA and LCG officers have already been involved in the exploratory community planning processes at local level and there will be further opportunities for engagement with local government in 2015/16 to build on progress and develop community plans.

3.13 E–Health

An eHealth & Care strategy has been developed by the HSCB, supported by the PHA and by other HSC organisations. Commissioning key priorities include;

- Working with NI Direct to further develop web portal access to support citizens for self-care; defining and building ways for citizens to access their health and care records to support independence; evaluating the NI investment in Remote Telemonitoring solutions to inform future design and deployment of remote health and care solutions to support citizens.
- Building on successes to date in sharing information to support improved care and wellbeing. This includes the implementation of care pathway support and the development of a shared key information summary for individuals with higher risk of health & wellbeing crises;

- Further developing risk management processes commenced in 2014/15 with General Practice to support improved care planning and intervention for individuals at risk of health and wellbeing deterioration; and agreeing an information development plan for HSCNI;
- Building on the development of electronic referrals by making available electronic triage of referral and electronic discharge support to Trusts to speed care decision making and reduce the delays and risks associated with paper based processes.
- Supporting re-design of processes for the provision of advice and guidance including outpatient consultation, to increase the timeliness of advice provision, and to reduce the cost of individual interventions.
- During 2015/16, the business case for e-prescribing and medicines administration will be finalized and the procurement process for medicines administration agreed. This will also support reducing the cost of these processes.

4.0 Ensuring Financial Stability & Effective Use of Resources

4.1 Introduction

The HSCB has a statutory duty to break even and operational responsibility for ensuring financial stability across the HSC. Following consultation on its draft budget for 2015-16 the DHSSPS latest assessment of its financial position shows an unresolved gap of £31m. This assessment takes account of significant opening pressures in all organisations which have occurred as a result of demand led expenditure levels in the HSC rising in prior years above funding allocations.

The 2014/15 initial Commissioning Plan identified a funding gap of £160m which was resolved through £80m non recurrent in-monitoring funding and one off savings opportunities within the HSC. The full year impact of these pressures is now carried forward into the 2015/16 plan.

The assessment of the financial gap has been arrived at following detailed engagement between the HSCB, PHA, Trusts and the DHSSPS to agree income sources, inescapable/discretionary cost pressures, savings opportunities and new funding requirements. During this engagement a significant range of service development and service pressure areas were identified, which given current assessment of the financial position, have not been included in this plan. These pressures, however, have been further prioritised and submitted to the DHSSPS for inclusion in the June Monitoring bids. The HSCB will also continuously review commitments to ensure best use of all available resources.

The HSCB and PHA are continuing to work closely with the DHSSPS in seeking urgent solutions to resolve the funding gap as early as possible. However, in the absence of any firm solutions the £31m gap will remain primarily the responsibility of the HSCB to address. In order not to breach the key financial target to break even the HSCB will be required to live within available resources. The DHSSPS will be submitting a range of bids in the forthcoming June monitoring round to address the funding gap and the need to fund service developments.

In the interim, following discussions with the DHSSPS, the HSCB will delay the implementation of a number of key projects and delay the investment in elective care at this stage. Whilst this will help manage the financial position in the short term, this decision will be revisited after the June monitoring round.

Table 2 summarises the current planning position in respect of HSCB and PHA.

Summary of 2015/16 Financial Plan

Table 2

2015/16		£m	£m	£m
PRESSURES	C/Fwd Service Commitments 14/15 HSCB		73	
	Trust CFwd Recurrent Pressures		131	
	Full Pay Award 2014/15	23		
	Less saving on implementation of pay award	(13)		
	Net Non-Recurrent cost of pay award		10	
	Non Pay		27	
	Demography		26	
	FHS		23	
	Primary Care		5	
	Inescapable service pressures		8	
				303
SOURCES				
	Addition allocation from DHSSPS		150	
	Trust Savings*		85	
	Regional Prescribing / FHS opportunities*		22	
	Regional Projects not being commenced		6	
	Reduction in baseline expenditure		9	
				272
	DHSSPS Unresolved Gap			**(31)**
	HSCB Options to resolve:			
	Slippage with in year consequences		9	
	Elective		22	
	Total Options			**31**

* includes savings from Pharmaceutical Price Regulation Scheme (PPRS)

4.2 Producing the Financial Plan

This section sets out an overview of key elements of the HSCB/PHA financial plan for 2015/16 covering:

- An assessment of opening positions across the HSC 2014/15;
- An overview of the additional inescapable pressures of HSCB and PHA in 2014/15 and indicative 2015/16;
- A summary of income sources available to HSC;
- Potential options to address funding shortfalls;
- An analysis of total planned investments by POC, LCG and Provider; and
- An equity analysis across Local Commissioning Group area.
- An update on progress in shifting resources through Transforming Your Care.

4.2.1 Assessment of opening financial positions across the HSC 2015/16

In recent years the HSC has experienced annual financial pressures significantly in excess of the annual recurrent funding allocations from the DHSSPS. This has meant substantial savings from within the system which, together with additional in year income sources such as the Executive in year monitoring monies, have been necessary to address service needs and deliver financial balance. Where these additional sources are not repeatable in the next year they result in opening shortfalls both within the HSCB itself and within local Trusts.

HSCB – Opening Position

The Commissioning Plan 2014/15 identified a range of inescapable service pressures for which there was no recurrent funding source available at that time. These service pressure areas have been carried forward into the 2015/16 Financial Plan and identified for priority funding as per Table 3.

These developments were commissioned in 2014/15 with only in-year funding.

2014/15 Carried Forward Service Commitments

Table 3

Carried Forward Service Developments	£m
Elective	15.80
Radiology Diagnostics	2.00
Implementation of Cancer Care Framework	0.80
Hospice funding	0.40
ED capacity planning	4.00
Haematology - 2 training posts	0.12
24/7 blood sciences	2.30
GMC recognition of trainers	1.13
24/7 acute & community working	4.00
Dementia strategy	0.25
CHOICE	0.18
Lakewood secure provision	0.42
Availability of personal advisers as required under the Leaving Care Act	0.30
Funding for Extended Fostercare Scheme	0.30
Supported accommodation (Young Homeless and Care Leavers).	0.55
Safeguarding child sexual exploitation	1.00
Assessment & approval support kinship foster carers	0.26
Health visiting	1.50
Expansion of FNP to SEHSCT & NHSCT	0.85
NHSCT LAC specialist nurse	0.05
Infrastructure for GP's(Hub/Spokes)	0.37
Alcohol/substance liason services	0.40
Supervised swallowing (Prisons)	0.08
Revalidation - Medical/GMS	0.16
10,000 voices	0.31
Review of AHP services in special needs schools	0.10
Normative Nursing	10.40
TYC	15.62
2014/15 Growth in existing NICE drug/therapies	9.00
TOTAL	**72.64**

Trust Opening Position - Carried Forward Pressures

The HSCB has worked closely with the Trusts in the identification and review of Trusts recurrent pressures brought forward from previous years. As a result the HSCB has recognised £131m in the 2015/16.

4.2.2 Planned additional investment 2015/16

Due to the overall constrained financial position only a limited number of inescapable pressures have been recognised in the 2015/16 financial plan to date which will need to be addressed. These are set out in Table 4 below. The financial plan has made provision for a limited number of inescapable service pressures.

Total new pressures 2015/16

Table 4

New Pressures	£m
Net Non Recurrent cost of pay award	10.0
Non Pay	27.0
Demography	25.6
FHS	22.8
Primary Care investment	5.1
Inescapable Service Pressures	7.7
TOTAL	**98.2**

Whilst there has been agreement in NHS England on the 2015/16 pay award, there is not yet an agreed position for the 2015/16 HSC pay award.

Therefore at this time, the financial plan has assumed that the 2015/16 pay award will cost the same as in 2014/15 and that it will be a non-recurrent award.

The 2014/15 pay award was projected to cost £23m on the basis of a 1% non-recurrent pay award for all staff but was implemented at a cost of £10m, hence the 2015/16 pay award has been projected to cost the same.

Non pay pressure of £27m will arise due to inflationary increases for goods and services and independent sector care. Non-pay expenditure has been modelled to increase by an average of 2%. This is to cover general inflationary uplifts and areas such as increased independent sector costs e.g. care homes.
The demography pressures identified in the plan take account of projected additional costs for each programme of care resulting from increases in population projections. The table below shows this by Programme of Care.

Demography by Programme of Care

Table 5

Programme of Care	£m
Acute Non Elective 1	8.91
Maternity 2	0.04
Family 3	0.35
Elderly 4	13.39
Mental 5	1.43
Learning Disability 6	0.47
Physical and Sensory Disability 7	0.48
Health Promotion and Disease Prevention 8	0.36
Primary Health and Adult Community 9	0.14
TOTAL CYE	**25.56**

The pressures identified for FHS are primarily to cover anticipated increased costs in Prescribing, Dental, General Medical and Ophthalmic Services including demography, residual demand, pay and non-pay inflation. See Table 6 below.

FHS Pressures

Table 6

FHS	£m
General Medical Services	1.0
General Pharmaceutical Services	18.0
General Opthalmic Services	0.5
General Dental Services	3.3
TOTAL	**22.8**

Table 7 below reflects revisions to the General Medical Services contract 2015/16 as agreed with the DHSSPS.

Primary care investment

Table 7

Primary Care	£m
Out of Hours	3.10
Diagnostic Work	1.20
GP development scheme	0.10
GP retention scheme	0.10
GP transfer	0.10
Sessional GP for apprasials	0.13
GP premises	0.35
TOTAL	**5.08**

There are a number of service developments that are a critical requirement in 2015/16 and must proceed because of statutory or other reasons. These are listed in Table 8 below.

Inescapable Service Pressures

Table 8

Inescapable Service Pressures	£m
Paediatric Congenital Cardiac Surgery Services	0.50
Virology	0.03
Paediatrics Transitional Care	0.08
Improving care for Multiple Preganacies	0.04
Neonatal Nursing (RJMS)	0.35
Looked After Children	0.25
High Cost cases	2.50
LD Community Forensic teams	0.28
LD Care Costs for adults living with older adults	1.00
LD Young people transitioning to adult services	2.50
Health Visiting	0.23
TOTAL	**7.73**

Pressures for which no funding is available

Over £100m of additional key service pressures were identified during the commissioning plan process. Only £8m of which have been included in the financial plan as these were deemed fully inescapable. The residual balances have been further reviewed and prioritised, and essential pressures will feed into the DHSSPS June monitoring bids. In the interim a comprehensive assessment has been undertaken by Local and Regional Commissioning Leads to identify any significant risk associated with these unfunded service pressures (see Appendix 3).

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

This section sets out the assumed additional income for 2015/16 (Table 9).

Income 2015/16

Table 9

	£m
HSCB Opening Allocation	4,114.8
PHA Opening Allocation	95.4
DHSSPS Additional funding to HSCB	148.3
DHSSPS Additional funding to PHA	1.4
TOTAL	**4,360.0**

The 2015/16 allocation letter from the DHSSPS also includes a number of other allocations/ retractions which are not included in the table above.
These are listed below:

- **15% reduction to HSCB admin budget** of £5.4m. The HSCB is currently developing plans to address this reduction.
- **15% reduction to PHA admin budget** of £2.771m. The PHA is currently developing plans to address this reduction.
- **Retraction of Conditions Management Programme** of £1m. This investment has historically been provided to help people get back to employment. Reduction in investment may affect funded posts in Trusts.
- **Clinical Negligence and other provisions settlements transfer** from DHSSPS of £39.5m. The devolvement of clinical negligence may come with associated risks to the HSCB given the difficulties in managing and predicting the resource and accounting implications.
- **Change Fund £1.46m.** The NI Executive final budget included a change fund which is for reform orientated projects that are innovative, involve collaboration between departments and agencies or focus on prevention. Funding of £4m has been identified to DHSSPS to take forward 5 projects 3 of which have been allocated to the HSCB for Extension for Community Healthcare Outcomes (ECHO), Rapid Assessment Interface Discharge

(RAID) and BHSCT outpatient modernisation. The DHSSPS has planned for a further £2.5m to be allocated later in the year to the HSCB for Congenital Cardiac Service model and NI Strategic Innovation in Medicines Management Programme.

It should be noted that in 2014/15 DSD provided £6.0m non recurrent funding to be used to help meet the care costs of people resettled from hospital to supported living schemes in the community. The £6.0m in 2014/15 was the third year of this funding (£2.0m was given non-recurrently in 2012/13 and £4.0m was given non-recurrently in 2013/14). It was understood that the £6.0m funding would be made recurrent in 2015/16, but this is now uncertain. The DHSSPS is endeavouring to secure confirmation from DSD for this funding. As this has not yet been agreed the £6.0m recurrent cost has been reflected in this plan as having to be met by the HSCB.

Efficiency Savings 2015/16

Since 2012/13 the HSC has delivered £550m as part of a comprehensive cash and productivity savings programme and in the context of annual targets by the HSCB to support financial breakeven.

Table 10 below shows additional income sources which will contribute towards the additional funding pressures identified for 2015/16. These comprise cash targets for Trusts and the HSCB totalling £122m.

There is a significant challenge for the HSC to breakeven in 2015/16 and the HSCB continues to work with Trusts and to review FHS services to identify all potential savings opportunities that could be achieved in 2015/16. To date the level of savings opportunities identified are £107m, which together with a further £15m of reduced expenditure identified from within existing baselines and from deferring investment in a number of regional projects, enables delivery of £122m.

Efficiency Savings 2015/16

Table 10

	Cash £m
Belfast HSC Trust	20.4
Northern HSC Trust	12.0
South Eastern HSC Trust	8.4
Southern HSC Trust	12.6
Western HSC Trust	11.4
NI Ambulance Service	1.2
Total Trusts	**66.0**
FHS	20.0
PPRS - Primary Care2	2.0
PPRS – Secondary Care	19.0
Sub Total	**107.0**
Regional projects not being commenced	6.0
Reductions in baseline expenditure	9.0
TOTAL	**122.0**

Trusts and Commissioners will work together to establish local plans to summarise how the cash release element will be achieved. They include a wide range of initiatives which include:

Staff Productivity

Within Trusts, savings opportunities for 2015/16 include vacancy control (scrutiny of permanent and temporary vacancies), absence management, reductions in agency costs and the management of skill mix, overtime and additional hours. There will also be a focus on securing savings from management and administration expenditure across the Trusts.

Non Pay Opportunities

Trusts are expected to target a range of areas to reduce expenditure on goods and services and discretionary spend as well as maximise the opportunities for procurement savings. This will include reviewing expenditure on items such as travel, courses and conferences, non-clinical equipment, management of minor work schemes and contract renegotiations.

Acute opportunities

Trust will continue to seek opportunities, including benchmarking with appropriate peers, to improve throughput and reduce the length of stay in order to reduce the number of beds required.

Social Care Opportunities

Trust opportunities within social care will focus on the review of the provision of domiciliary care, residential and day care and the continued implementation of reablement.

FHS Prescribing Efficiency and PPRS

The HSCB is committed to maximising efficiency across FHS services and significant savings in this area have been delivered in recent years.

Detailed project plans have been developed aimed at delivering £20m prescribing efficiency for Family Health Services in 2015-16. Achieving this scale of savings will depend upon a number of factors which may require policy and clinical support in the area of prescribing.

A further £21m savings target has been included in the plan to reflect savings from the national Pharmaceutical Price Regulation Scheme (PPRS) in both Primary Care and Secondary Care whereby a rebate is allocated to HSCNI by the pharmaceutical industry when spend on branded medicines goes above an agreed growth rate. However predicting accurately the scale of the rebate is complex and must also reflect any planned reduction in spend on branded drugs achieved as part of the general HSCNI prescribing efficiency highlighted above.

The £21m receipt is on top of a £15m estimated receipt from 2014/15, i.e. cumulative position of £36m.

4.2.4 Options to Ensure Financial Stability

The HSCB and PHA are continuing to work closely with the DHSSPS in seeking urgent solutions to resolve the funding gap which will have minimal impact on services.

However, in order to provide a balanced financial plan the HSCB has in addition identified a number of potential in year funding solutions these are listed below (Table 11). It is important to note that these will provide a temporary solution only.

Potential in year funding solutions

Table 11

		£m
RCCE	Royal Phase 2B	3.0
	Implementation of Regional Decontamination Strategy (BHSCT)	1.0
	Implementation of Regional Decontamination Strategy (NHSCT & SEHSCT)	0.9
	2nd MRI SHSCT	0.5
	Ballymena HCC	0.3
	RCCE other	1.4
Residual Demand	Residual Demand Other	1.1
	Community Resuscitation	0.1
	BHSCT Neonatal nursing	0.5
	Molecular Pathology	0.4
	Sub Total	**9**
	Elective	**22**
	TOTAL	**31**

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

The HSCB and PHA will receive some £4.4bn for commissioning health and social care on behalf of Northern Ireland 1.8m resident population for 2015/16.

Of the total received, over£3.2bn is spent in the six provider Trusts and other providers of care such as Family Health Services and voluntary organisations. Figure 1 illustrates this for both the HSCB and PHA.

Total Planned Spend by Organisation

Figure 1

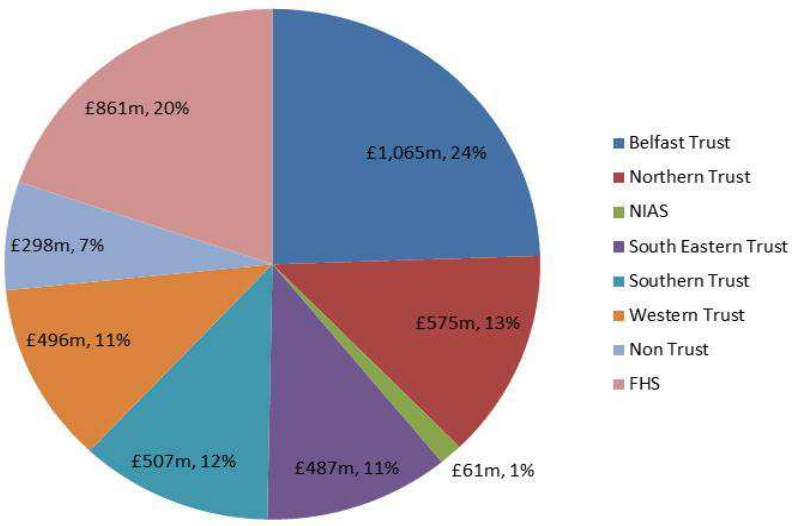


Table 12 sets out how the total resources are planned to be spent across the Programmes of Care and Family Health Services.

Planned Expenditure by Programme of Care

Table 12

Programme of Care	PHA		HSCB		TOTAL	
	£m	%	£m	%	£m	%
Acute Services	8	10.42%	1,419	42.62%	1,427	41.89%
Maternal & Child Health	0	0.06%	137	4.12%	137	4.03%
Family & Child care	1	1.02%	219	6.58%	220	6.45%
Older People	0	0.10%	681	20.47%	682	20.01%
Mental Health	13	16.28%	242	7.28%	255	7.48%
Learning Disability	0	0.00%	264	7.93%	264	7.75%
Physical & Sensory Disability	0	0.00%	108	3.23%	108	3.16%
Health Promotion	56	71.43%	47	1.42%	103	3.03%
Primary Health & Adult Community	1	0.70%	211	6.34%	212	6.21%
Sub Total	*78*		*3,328*		*3,406*	
FHS			861		861	
Not allocated to PoC*	16		68		84	
Total	**94**		**4,257**		**4,351**	
* BSO, DIS, Management &Admin						

Ensuring resources are fairly distributed across local populations is a core objective in the Commissioning process. The HSCB commissions by LCG population. Table 13 shows how the HSCB resources are planned to be spent across localities. This reflects the different population sizes and need profiles within each locality (e.g. the Northern LCG crude resident population is the largest with 25.50% and the Western LCG the smallest with 16.35%). Family Health Services (FHS) are not assigned to LCG as these are managed on a different population base. A&E, prisons and other regional services have not been assigned to LCG.

Resources by LCG

Table 13

Trust	Local Commissioning Group								
	A&E £m	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Regional £m	FHS £m	Total £m
BHSCT	21	531	125	117	49	26	196	0	1,065
NHSCT	17	2	539	0	0	1	15	0	575
NIAS	61	0	0	0	0	0	0	0	61
SEHSCT	28	39	3	372	5	0	40	0	487
SHSCT	16	1	5	6	463	2	15	0	507
WHSCT	13	0	6	0	4	450	23	0	496
Non Trust/Funds to be attributed**	0	47	50	36	41	39	1	861	1,075
Sub Total	**156**	**620**	**728**	**532**	**562**	**519**	**290**	**861**	**4,267**
Not Assigned to LCG*									84
TOTAL									**4,351**

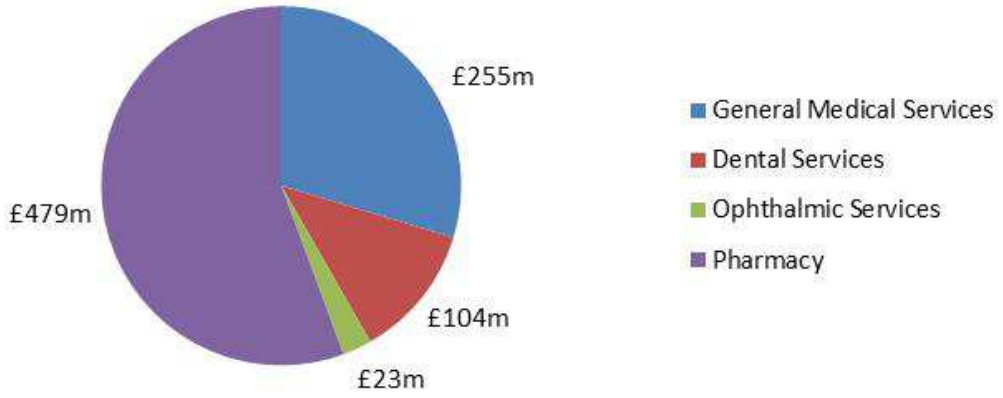
* Includes Mgmt & Admin, BSO, DIS
** Non Trust includes voluntaries and Extra Contractual Referrals

Total £4,351m reconciles to Table 9 total allocation £4,360m less HSCB admin reduction £5.4m, PHA admin reduction 2.8m and Condition Management Programme £1m.

The HSCB commissions services from a range of Family Health Services. Figure 2 below shows the breakdown of planned spend across these services.

Planned Spend for Family Health Services

Figure 2



4.2.6 Equity

Achieving equity in commissioning health and social care for its local population is a key objective of the HSCB. This involves comparing expenditure, access to services and quality of care received across local populations. The HSCB continuously reviews these as part of their on-going equity strategy. Part of this involves comparing at the start of each financial year the planned investment by

LCG with the capitation formula which provides a statistical assessment of the fair shares of total resources across population areas.

Capitation Formula

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

Expenditure

The expenditure analysis identifies planned investment on local populations. This is compared to the capitation fair shares. FHS (£856m), Management and admin (£84m) and PFI unitary payment (£11m) included in Table 13 above have been excluded from the equity LCG analysis Table 14 below.

Impact of 2015/16 Plan Compared to Capitation Share

Table 14

	Local Commissioning Group					
Year	Belfast £m	Northern £m	South Eastern £m	Southern £m	Western £m	Total £m
Capitation Shares 2015/16	20.947%	24.368%	17.910%	19.808%	16.967%	100.00%
Planned Spend - Adj for PFI	**711**	**836**	**610**	**650**	**587**	**3,395**
Capitation share	**711**	**827**	**608**	**672**	**576**	**3,395**
Equity gap (adj for PFI)	**0.22**	**8.59**	**2.41**	**(22.68)**	**11.47**	**0.00**
% from Capitation share	**0.0%**	**1.0%**	**0.4%**	**(3.4%)**	**2.0%**	**0.0%**

In percentage terms the variances are all relatively small. The largest relative underspend is in the Southern LCG. Residents in this area however benefit from the fact that their local Trust, SHSCT, is one of the most efficient Trusts in the region and therefore services will cost less than similar services in other Trusts.

The financial plan in recent years has been skewing additional resources with the specific aim of reducing capitation variances within a manageable process. In 2015/16 for example the Southern LCG will receive over £5m more than its capitation share of the additional 2015-16 funds. More material adjustments would potentially destabilise services, however it is recognised that the best strategy would therefore ensure increased access to local populations within the existing infrastructure.

4.3 Shifting Financial Resources through Transforming Your Care (Based on Gross Costs)

The Commissioning Plan Direction for 2015/16 contains a target by March 2016 to transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. An early indication for 2015/16 is that shift left delivered by the end of 2015/16 will cumulatively total a minimum of £45m.

4.3.1 Effecting the shift

The Commissioning Plan Direction for 2015/16 contains a target by March 2016 to transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. An early indication for 2015/16 is that shift left delivered by the end of 2015/16 will cumulatively total a minimum of at least £45m; however as the TYC programme and the projects therein are subject to continual change the value of shift left is likely to increase.

In order to affect this shift of care and funding, the HSCB will continue to commission services to be delivered in a different way. There will be a number of strands to this work including:

Integrated Care Partnerships (ICPs)

Integrated Care Partnerships are central to engaging clinicians and other health and social care professionals in leading reform and improve health outcomes. Each ICP has representation from general practice, pharmacy, acute medicine, nursing, allied health professions, social care and ambulance staff.

Built into the day to day work of ICPs, and to the supporting development initiatives put in place by the HSCB, is the development of new pathways and ways of working as well as opportunities for sharing across professional boundaries and across the clinical priorities of frail elderly, respiratory stroke, diabetes and end of life care. This is delivered through ICP working groups, committee meetings, and regular regional events including a regional workshop each year with all ICP committee members, and regular cross-ICP chairperson meetings, the majority of which are clinicians.
HSCB would envisage the development of clinical networking through ICPs as a real opportunity for these inspirational leaders to grow and support each other.

A variety of initiatives will either be introduced or expanded. These include:

- Acute/Enhanced Care at Home
- Falls Prevention
- Rapid Response Nursing
- Advanced Access to Diagnostic Tests
- Community & Hospital Pharmacy Lead Reviews
- Access to Community Specialist Respiratory Teams
- Home Oxygen Service
- Stroke Early Supported Discharge
- Diabetes management including comprehensive foot care

The HSCB does not anticipate that any of the above projects will achieve any material shift in funding before 2016/17.

Acute care
It is envisaged that a number of reform initiatives will be undertaken specifically within acute care, which ultimately will shift care out of hospital settings or reduce the hospital activity that would otherwise have occurred. Examples of potential initiatives where shift left from acute care could be delivered in 2015/16 and beyond are listed below. These will be confirmed via the Trusts response to this Commissioning Plan.

- Patients being admitted to an acute stroke unit as the ward of first admission

- Community Mental Health (Dementia) Teams
- Increased hyper acute care post thrombolysis treatment
- Increased Stroke Community Infrastructure to support Early Supported Discharges from hospital
- Increased use of Rapid Response Nursing Teams
- Increased use of Community Mental Health Teams
- Primary Percutaneous Coronary Intervention services
- Sepsis Screening, Early Detection and Intervention
- Virtual respiratory clinics
- Implementation of Day of Surgery Units
- New Ambulance Response Models
- Ambulatory Wards
- Increased Access to Renal Home Therapies
- Increased review by Community Pharmacists of Medicines Prescribed to Nursing Home Clients
- Home Based Diabetes Management Systems
- Outpatient Reform
- Reform of Hospital based Care Pathways.

Calculation of 'shift left' associated with hospital activity avoided is complex. At the time of writing it is expected that the above initiatives will contribute a value of £1m that can be delivered by the end of 2015/16.

Learning disability & mental health resettlement programmes

The resettlement programmes, which have are not yet complete, have contributed £28m to the £45m of shift left that can be delivered by the end of 2015/16.

Recurrent Investment in Reform

Since 2012/13, LCGs have been investing funds recurrently in a number of reform areas. These include Glaucoma Services in Primary Care, Community Nursing to Support Early Discharge, Telemedicine, Palliative Care Services in the Community and Reablement. By the end of 2015/16, it is estimated that £16m will have been invested by LCGs to commission new services from Primary Care,

Secondary Care and the Third Sector. This has formed a significant contribution to the achievement of the £45m of Shift Left. Further investment in 2015/16 is likely following finalisation of the financial plan.

A summary of the service changes that will contribute to £45m of Shift Left by the end of 2015/16 is outlined in the table below.

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

Table 15

	2012/13	2013/14	2014/15	2015/16	Total
	£m	£m	£m	£m	£m
	Actual	Actual	Actual	Estimated	Cumulative
ICPs	0	0	0	0	0
Acute Care	0	0	1	0	1
MH Resettlement	4	7	0	0	11
LD Resettlement	7	7	3	0	17
Recurrent Investment in Reform	6	8	2	0	16
Total	17	22	6	0	45

Further work is underway to provide a more robust assessment of the financial impact of all shift left initiatives and their associated timescales.

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

4.3.2 Monitoring the Delivery of Financial Shift Left

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

The funding position in 2015/16 will impact on the pace and scale of key regional reform initiatives. Particular service developments impacted include:

- Further expansion and roll out of reablement
- Acceleration and expansion of work in relation to redesign and implementation of care pathways
- Reform and modernisation of outpatient services
- Expansion of ICP initiatives in relation to frail elderly, diabetes, respiratory and end of life care
- GP Practices proactive management of the care of those at greatest risk of deterioration to reduce unplanned admissions
- Pilot of the Atrial Fibrillation Enhanced Service
- Elements of the Primary Care Infrastructure Development Strategic Implementation Plan.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow many of these priority reforms to be taken forward.

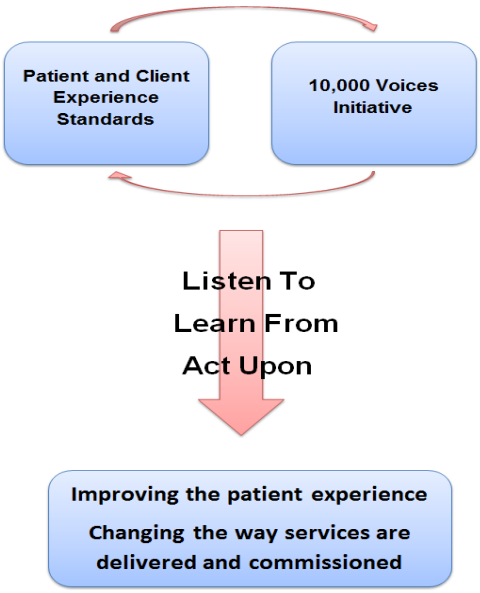
5.0 Listening to Patient and Client experience and learning from Personal and Public Involvement

The HSCB / PHA are focused on ensuring that our services are truly person centred; that they address need; that service users and carers have a voice in the commissioning, planning and delivery of services and that patient and client experience informs and shapes culture and practice. It does this in two key ways. Firstly through the implementation of DHSSPS Patient Client Experience Standards and the 10,000 Voices programme and secondly through compliance with the Statutory Duty to Involve and Consult, as set out in the HSCB and PHA's Personal and Public Involvement responsibilities.

5.1 Patient Client Experience Standards & 10,000 Voices

The PHA and HSCB lead on the monitoring and implementation of the DHSSPS Patient Client Experience Standards through a regional comprehensive work-programme with HSC Trusts. In 2014/15 the HSCB/PHA led the implementation of Experience Led Commissioning through 10,000 Voices and established a system which was responsive to 'real time improvements' ensuring that the 'patient/carer' voice was central to and informed local changes to practice. Throughout 2015/16 the HSCB/PHA will integrate the Patient Client Experience work programme and 10,000 Voices in order to further develop and improve systems to listen to, learn from and act upon patient and client experience.

Figure 3



Based on the outcomes from the audit of the five Standards of Patient Experience and 10,000 Voices the HSCB/PHA is committing to the following key priorities in 2015/16:

- Ensuring that patient experiences from patients on hospital wards is effectively communicated to all staff involved in the commissioning of services via the provision of updates and briefings to the Local Commissioning Groups (LCGs) and to the Boards of the HSCB and PHA.
- Undertaking a comprehensive work programme using 10,000 Voices surveys (patient and staff) in a range of other settings (e.g. Emergency Departments), with a particular focus on patients/carers and families in 'hard to reach groups' e.g. autism and CAMHS services
- Engaging other key stakeholders in 'listening to and learning from patients/carers/families' experience. For example, engaging with RQIA to undertake work to gain experience from residents in nursing and residential homes.
- Engaging with education providers to ensure that findings inform training for pre and post registration staff in medical, nursing, midwifery and Mental Health and Dementia teams.
- Raising the profile of "Hello my Name is…" in the primary care setting.
- Looking at ways of reducing 'Noise at Night' in hospital wards.

5.2 Patient Client Council (PCC) Peoples' Priorities 2014

Each year, the PCC ask the population of Northern Ireland to identify their top ten priorities for the coming year. The HSCB and PHA take account when deciding how to prioritise how they will invest available resources. The table below outlines the top 10 priorities and which section of the plan each priority is addressed.

Table 16

Priorities	Commissioner Response
1. Frontline health and social care staff	See section 3.5
2. Waiting times	See 6.3 & 8.0
3. Quality of care	See section 3.2, 3.4 & 6.3
4. Care of older people	See sections 6.2 through to 6.5 & POC 4 in LCG Plans
5. A&E services	See section 6.3.2

6. Funding, management, and cost-effectiveness	See section 6.6
7. GP services	See section 7.5.1
8. Access to a full range of health and social care services locally	See LCG Plans sections 9.0 through to 13.0
9. Cancer services	See section 6.3.6
10. Health and social care for children and young people	See sections 6.4.4 & 6.5

5.3 Personal and Public Involvement

The HSCB and PHA recognise that Personal and Public Involvement (PPI) is core to the effective and efficient design, delivery and evaluation of Health and Social Care (HSC) services. PPI is about the active and meaningful involvement of service users, carers and the public in those processesThe legislative requirements for HSC organisations in regard to PPI are outlined within the HSC (Reform) NI Act 2009. The concept of Involvement is also regarded as a Ministerial Priority.

Standards for PPI

A set of standards and Key Performance Indicators for PPI which were developed under the leadership of the PHA have been agreed with the DHSSPS, were endorsed by the Minister and launched in March 2015. The standards aim to embed PPI into HSC culture and practice, ensuring that the design, development and delivery of services is informed and influenced by the active involvement and input of those who are in receipt of them.

Involving Patients and Clients in the Commissioning of Services

All commissioning teams and Local Commissioning Groups actively consider PPI in all aspects of their work throughout the year, from ensuring that input and feedback from service users and carers underpins the identification of their commissioning priorities, to involving service users and carers in the development of service models and service planning, and in the evaluation and monitoring of service changes or improvements.

Each LCG has consulted on the local commissioning priorities contained within this document and has taken account of the feedback received. In addition, the HSCB / PHA have hosted a workshop of service users and carers to consult

on the regional themes and priorities included within the plan. The workshop, which was attended by 75 people, brought together individuals from across the nine equality groupings and generated useful feedback which has been incorporated within this document and helped to inform the accompanying screening document.

The PHA and HSCB have recently worked with staff, service users and carers, to take forward the development of PPI Action Plans for 2015-18. These plans outline our key commitments in relation to PPI and what we intend to do over the next three years in order to deliver on those commitments.

Increasing our capacity to engage with service users, carers and the public.
In its capacity as regional lead for PPI for the HSC, the PHA has led on the design and development of a PPI awareness raising and training programme for all HSC staff. This will provide a comprehensive PPI training programme for staff which is responsive to and accessible by the diverse range of staff across HSC organisations.

The HSCB has:

- Jointly funded a training programme specifically for service user's and carers in partnership with the Patient Client Council;
- Funded accredited training (ILM level 3) for service users and carers who work with the HSCB; and
- Invested in the Involving People Programme, an in-depth PPI and community development training programme for staff.

6.0 Regional Commissioning – Overarching Themes

6.1 Improving & Protecting Population Health & Reducing Inequalities

Improving health and reducing health inequalities requires coordinated action across health and social care, government departments and a range of delivery organisations in the statutory, community, voluntary and private sectors. DHSSPS published Making Life Better in 2014, a whole systematic strategic framework for public health which sets out key actions to address the determinants of health. Investment in prevention is a key contributor to reducing future demand for health and social care. A healthy population also contributes to economic prosperity, high educational attainment, and reduced reliance on welfare.

In Northern Ireland between 2002 and 2012 more than 41,000 people died prematurely of disease which was potentially avoidable or potentially treatable. Nearly 700,000 life years were lost. In 2012, 3,756 people died of illness which could either have been prevented in the first place (84%) or if detected early enough could have been treated successfully. Some, but not all, preventable deaths are directly related to healthcare and many reflect lifestyle and underlying social and environmental influences or what are referred to as the 'social determinants'.

Those most likely to die prematurely included men (61% for 2012), reflecting the four and a half year gap in life expectancy between men and women, and those living in our most deprived areas. Residents of most deprived areas are two and a half times as likely to die prematurely of preventable things as those in least deprived areas. This increases to a factor of four for drug and alcohol related deaths and three times for suicide, respiratory problems and lung cancer[1] .

The DHSSPS disaggregation of life expectancy differentials in Northern Ireland[2] highlighted the reducing impact of circulatory disease on premature mortality with the increased contribution of cancers and accidental injuries and suicide amongst

[1] http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-and-age-65-in-the-united-kingdom/2008-10/index.html
[2] http://www.dhsspsni.gov.uk/life-expectancy-decomposition

the younger age groups, particularly in more deprived areas. Known inequalities in health have been identified across a range of groups including:

- Travellers
- Young men
- Ethnic minorities
- Lesbian, Gay, Bisexual and Transgender (LGB&T)
- Migrants
- Carers
- Prisoners
- Homeless
- Disabled
- People living in more deprived areas

In producing local action plans, the LCGs have taken consideration of these groups and where appropriate how they may be targeted. Likewise any health improvement programmes, information and support services will assess any necessary additional requirements in order to enable full engagement or access for these groupings.

While the work programme for 2015/16 is likely to be impacted upon by the reduction in the administration budget within the PHA, improving and protecting population health and reducing health inequalities remain priorities across the HSC. The following paragraphs provide details of the specific commissioning intentions for 2015/16 to achieve these aims.

6.1.1 Giving every child the best start

The PHA will continue to prioritise investment in early years' interventions. Commissioning intentions during 2015/16 will include:

- Expansion of the Family Nurse Partnership Programme to the Northern and South Eastern Trusts, thereby providing N Ireland wide coverage, and developments in health visiting, early intervention services and family support hubs.

- Expansion of evidence based parenting support programmes which will support the development of the infant mental health action plan; the implementation of the Early Years Transformation Programme
- Implementation of the breast feeding strategy across all trust areas with specific attention to the training of staff, peer support and accreditation of facilities to meet the World Health Organisation UNICEF Baby Friendly standards.

6.1.2 Tackling poverty

Specific Commissioning Intentions for 2015/16 will include:

- Delivery of the MARA programme funded by the Department of Agriculture and Rural Development; this programme reduces rural isolation and poverty and achieves a 9-fold return on investment.
- Support through community networks for a range of local programmes
- Keep Warm initiatives with vulnerable populations

6.1.3 Sustainable communities

The PHA will continue work with a range of partners to use sports, arts and other leisure opportunities to improve the health and wellbeing of local populations. Specific Commissioning Intentions for 2015/16 include:

- Implementation of the Action Plan of the Regional Travellers Health Forum
- Expansion of the NI New Entrants service; and a support to a range of community development and health programmes.

6.1.4 Supporting healthier choices

The PHA will continue to implement a range of public health strategies to support people in making healthier choices. Specific Commissioning Intentions for 2015/16 include:

- Implementation of the obesity prevention strategy [*Obesity is one of the most important public health challenges in N Ireland today; the prevalence of obesity has been rising over the past number of decades. Projections suggest that half of the UK will be obese by 2030 – a rise of 73%. Research has shown that obesity can reduce life expectancy by up*

to 9 years, increasing the risk of coronary heart disease, cancer, type II diabetes and impacting mental health, self-esteem and quality of life (CMO, 2010)]

- Roll out of the 'Weigh to a Healthy Pregnancy'; (In accordance with Ministerial Target 2, appendix 2)
- Implementation of the tobacco control strategy including smoking cessation services [*First results published from the Health Survey, Northern Ireland (2013/14) reveal that around one-fifth of respondents (22%) were current smokers, a reduction in the proportion of overall smoking prevalence from 24% in 2012/13. There was no difference in smoking prevalence for males (23%) and females (21%) in 2013/14 and no change from 2012/13*];
- Promoting mental and emotional wellbeing and implementation of the suicide prevention strategy including procurement of new services and development of the Self-Harm Registry;
- Implementation of the sexual health strategy including improving access to public information and sexual health services –to include the development of a service specification which will enable closer integration of sexual and reproduction health services;
- Implementation of the New Strategic Direction for alcohol and drugs and the procurement of new services including the a priority to work toward a seven day integrated and coordinated substance misuse liaison service in acute hospital settings using agreed Structured Brief Advice or Intervention programmes. These services will be rolled out during 2015/16. (In accordance with Ministerial Target 3, appendix 2) [*Alcohol and drugs misuse have been a significant issue in N Ireland for many years. Alcohol related admission rates have also been on the increase in N Ireland over the past 5 years, see table below. In general admission rates have increased for all Trusts with the exception of Northern. Alcohol related standardised admission rates and death rates for Belfast Trust residents are significantly higher than all other Trusts*].

Certain population areas/groupings are also key priorities including disadvantaged areas, older people, homeless people, black minority ethnic groups, prisoners, Travellers, LGB&T, looked after children, and those with disability.

6.1.5 Screening & Health Protection

Screening

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

During 2015/2016 the key deliverables will include:

- The bowel cancer screening programme has been fully rolled out to include the population aged 60-74. Work will be ongoing to attain the 55% uptake and ensure that standards and relevant accreditation are attained and maintained. (In accordance with Ministerial Target 7, appendix 2)
- Develop a business case for an IT system to support the new-born hearing screening programme (NHSP) in N Ireland in order to eliminate many manual processes Increase the number of Joint Advisory Groups on GI Endoscopy accredited units within Northern Ireland by one in 2015/16 in order to ease the pressure on endoscopy services whilst also offering more choice for patients.

Health Protection

The Health Protection Service is a multidisciplinary service in the Public Health Directorate in the PHA. It comprises Consultants in health protection, nurses in health protection, epidemiology and surveillance staff, and emergency planning staff. The health protection service delivers on statutory responsibilities of the

Director of Public Health, with respect to protecting the health of the NI population from threats due to communicable diseases and environmental hazards. It provides the acute response function to major issues, such as outbreaks of infection and major incidents. The PHA Health Protection Duty room is the first point of call for all acute issues in relation to infectious disease incidents and for notifications of infectious diseases.

The funding position in 2015/16 will impact on the ability of commissioners to take forward the introduction of a surveillance system for antimicrobial resistant organisms and a region wide programme on antimicrobial stewardship.

Communicable diseases disproportionally affect certain groups in the population including those at social disadvantage, living in poor housing conditions, migrants from countries that have higher prevalence of infectious diseases, and those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities. Healthcare Associated Infections (HCAIs) are an important cause of morbidity and mortality. Levels of infections are increasing.

Commissioning priorities for 2015/16 include:

- *Healthcare Associated Infections (HCAIs)*
  - Trusts, supported by PHA will develop and deliver improvement plans to reduce infection rates. This will be monitored via PHA surveillance programmes for HCAIs. (In accordance with Ministerial Target 20, appendix 2)

- *Flu immunisation*
  - Trusts and Primary care to implement the flu immunisation programme for all pre-school children aged two and over, and all primary school children, increasing uptake to the required level (75%)
  - Trusts and Primary Care to increase uptake of flu immunisation among healthcare workers.

- *Meningitis B immunisation programme*
  - PHA will oversee the introduction of the programme, with the vaccine being offered from September 2015 onwards to infants at 2, 4 & 12 months of age. Primary care and Trusts should implement the programme ensuring that uptake is similar to that achieved for other vaccines given at these ages.

    The funding position in 2015/16 will impact on the ability of commissioners to take forward this programme. The PHA has supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow this and other public health priority service developments to be taken forward. The PHA will also continuously review commitments to ensure best use of all available resources.

- *Hazardous Area Response Team*
  - HART in NI is a well-established specialist response team in NIAS that provides essential paramedic level care to casualties within the hazardous area of a CBRN:HAZMAT incident. PHA works closely with HART in training for and responding to CBRN:HAZMAT incidents and as such will continue to work with HSCB colleagues to ensure that the present capability of this vital service is maintained

6.2 Providing care closer to home

Providing care closer to home, often in primary and community care settings means that people can access and receive services in the most appropriate place for them. By viewing home or the community as the 'hub of care', there is also potential to reduce the need for avoidable visits to hospital. The focus is on the patient and providing alternative options to admission to hospital, and creating the opportunity to prevent such occurrences whenever possible.

Multi-disciplinary teams provide the primary source of intervention, allowing quick response and effective treatment to be delivered locally. Community teams also help individuals to prevent their condition from worsening, with regular contact (particularly with those with long-term conditions) along with practical support and education.

Technology is also a key enabler to providing care closer to home. Greater support can be given to individuals and health care professionals through telehealth monitoring. Individuals can also have the ability to better manage their own condition through a combination of technology and access to information. The eHealth and Care Strategy implementation plan provides a framework for the introduction of technology enabled services.

The following service developments have been prioritised during 2015/16.

6.2.1 Commission acute care closer to home

During 2015/16, the HSCB will continue to implement their acute care at home commissioning framework. 'Acute care at home' is 'a service that provides active treatment by health care professionals in the persons own home for a condition that would otherwise require acute hospital in-patient care and always for a limited time'. The main components of the model moving forward in Northern Ireland are:

- Community Geriatrician led through a single point of referral with access to an ambulatory assessment facility, same day diagnostics, community Geriatrician-led inpatient beds and Speciality or Medical Admission Unit beds through direct discussion with the relevant Consultant. Other members include Medical Officers including those with General Practice skills, Nursing, Physiotherapy, Occupational Therapy, Social Work and Pharmacy.
- The team provides direct clinical care and will treat and manage the frail older person in the acute phase of illness i.e. 24 – 72 hours before formally returning the management of care to the GP and other community/ specialist teams.
- The team will cover 24/7 over 7 days although it is accepted that this will happen over a period of time.
- The team will be supported by 24/7 district nursing and GP in and out of hours service.

The HSCB, through the LCGs, will work with ICPs to implement the Framework as described.

6.2.2 Ensure effective community nursing and AHP interventions

The District Nursing service is the main provider of nursing care for patients in the community. The rising challenges and demands of an aging population with more complex and multiple health and social care needs, means that the need to prevent hospital admissions and reduce length of hospital stays is increasing and that the role of the District Nursing service is more highly valued than ever.

The District Nurse works autonomously and has a central and decisive role in the assessment, planning and delivery of care in the community. This includes the patient's home, or that of a family carer/informal carer, a residential/nursing home and a clinic/outpatient setting. Simultaneously the role also requires that the District Nurse works collaboratively and in partnership with statutory and non-statutory colleagues to coordinate care. This includes public health, self-management / teaching, provision of a range of treatments and interventions, palliative and end of life care.

Investment in District Nursing will be fundamental to the successful delivery of the integrated care pathways that are being implemented by ICPs across the clinical priority areas during 2015/16, such as long term conditions and frail elderly

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

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

Investment in community nursing and AHP provision will be fundamental to the successful delivery of the integrated care pathways and the new models of care (e.g. community wards, rapid response teams) that will be developed and implemented by ICPs across the clinical priority areas during 2015/16.

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

- Implement the DHSSPS District Nursing framework when approved
- Continued expansion of the district nursing service which includes a 24/7 service
- To commence the implementation of the community indicators for community nursing including District Nursing
- To ensure the electronic caseload analysis tool is functioning consistently in all HSC Trusts
- Increased roll out/implementation of radiography led plain film reporting
- Capacity building in ultrasound/sonography services for direct access from primary care, early detection and obstetrics
- Implementation of a Direct Access Physiotherapy pilot within South Eastern Trust, to commence May 2015 for a period of 9 months
- Continued delivery of the joint HSCB/PHA Regional Medicines Management Dietitian initiative to ensure the appropriate use of Oral Nutritional Supplements (ONS)
- Implementation of the AHP Strategy - Improving Health & Wellbeing through positive partnerships 2012/2017.

6.2.3 More appropriate targeting of domiciliary care services

The HSCB is committed to providing a range of health and social care services close to, or in, people's own homes and communities. Receiving services locally is typically people's first preference so wherever possible the HSCB will deliver care that is locally accessible and addresses individual need.

Domiciliary care is an important service that ensures people can remain in their own homes for as long as possible with the greatest possible level of independence. Regionally, approximately 24,000 people are supported by domiciliary care services; this equates to delivery of nearly 250,000 hours of care per week. Some of this support is provided directly by Trusts and some via a network of independent sector providers.

Domiciliary care is most effective when targeted at key client needs enabling it to respond quickly and flexibly to any changes in client circumstances. This means that the level of domiciliary care provided may increase or decrease over time.

Key actions during 2015/16 will include:

- Prioritising client need to allow domiciliary care to be targeted at those with higher level needs thus ensuring that flexibility and capacity are maintained within the service as a whole
- Ensuring care packages are kept under review and revised to meet changing client needs
- Implementation of the recommendations associated with the HSCB led Regional Review of Domiciliary Care.
- Improved interfaces with other services such as re-ablement to ensure that people receive focused and intensive packages of support when required
- Developing formal and informal arrangements with the community and voluntary sector to enable people to access a range of alternative community services such as befriending services or luncheon clubs
- Engagement with the independent sector to ensure providers are able to respond to the changing profile of user need (i.e. frail elderly, more highly complex needs).

The funding position in 2015/16 will impact on the ability of commissioners to maintain effective domiciliary services for older people with providers expressing concern regarding the increasing costs and their ability to provide these services within existing funding.

6.2.4 Statutory Residential Homes

The HSCB was asked by the former Minister, Edwin Poots, in 2013 to lead a consultation to determine criteria to assess the future role and function of statutory residential homes across the five Health and Social Care Trusts. A thorough and robust consultation was led by the HSCB in conjunction with the Trusts and a post consultation report on the agreed criteria for the evaluation of statutory residential homes was approved at its public HSCB meeting in June 2014.

The final criteria was used by Trusts to assist decision making about the role and function of statutory residential care homes in the context of planning suitable services for older people in the future. Trusts were then required to subsequently submit their proposals for change to statutory residential homes, following their evaluation of each home, to the five Local Commissioning Groups and the HSCB for consideration.

Following HSCB challenge and review of Trust proposals for change in late 2014, the HSCB project team summarised the regional proposals for change to statutory residential care for older people. Subject to DHSSPS approval the proposals contained in the report will be subject to consultations by individual Trusts in 2015/16.

The Department of Health, Social Services and Public Safety has now requested the HSCB to pause in considering the Trusts' proposals on the future of each home at this stage, whilst it considers the outcome of the Dalriada judicial review and the potential impact this may have on any future consultations. Having taking cognisance of public consultation on the proposed changes to residential homes, individual Trusts will commence their programme of change in 2015/16.

6.3 High quality, safe & effective care

The HSCB and PHA place the quality of patient care, in particular patient safety, above all other issues, and are continually working to monitor and review services. This is more important than ever in the context of the current unprecedented resource difficulties. While health and social care is both complex and pressurised, the HSCB and PHA are focused on ensuring that the experiences of patients, clients and carers are shared, understood and acted upon, appropriately influencing commissioning.

At the beginning of this year the Minister published for consultation the Donaldson Review (The Right Time, the Right Place). The majority of the findings and recommendations within the Review Report centre on the quality and safety of services and arrangements in place to learn from incidents and complaints.

While it is reassuring that the Review concluded that services in Northern Ireland are likely to be no more or less safe than those in any other part of the UK or comparable country globally, it did identify areas where improvements can be made. The HSCB and PHA will work with the Department, Trusts and other organisations to take these forward during the next year and beyond.

Key priorities for the HSCB and PHA in 2015/16 in relation to the safety and quality agenda are outlined below.

6.3.1 Quality Improvement Plans (QIPs)

The HSCB/PHA is required through the HSC framework (DHSSPS, 2011) to provide professional expertise to the commissioning of health and social care services that meet established safety and quality standards and support innovation.

The HSCB/PHA gain assurances on progress with regional safety and quality priorities through Quality Improvement Plans (QIPS). These consider the safety and quality indicators of performance which must be included in QIPS developed by Trusts. HSC Trusts are required to submit to PHA, an annual Quality Improvement Plan which includes the indicators identified in the HSCB/PHA Commissioning Plan. QIPs for 2015/16 include:

- Falls: - Trusts will continue to improve compliance with Part B of the 'Fallsafe' Bundle. Trusts will spread Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented.
- Pressure Ulcers: 'From April 2015 establish a baseline for the Incidents of pressure ulcers (grade 3 & 4) occurring in all adult inpatient wards & the number of those which were unavoidable.'
- Venous Thrombosis Embolism: Trusts will sustain 95% compliance with VTE risk assessment across all inpatient hospital wards throughout 2015/2016.
- Sepsis6: The HSC Safety Forum will monitor the Sepsis6 bundle compliance in the pilot areas and establish a spread plan.

- The 'Malnutrition Universal Screening Tool' (MUST) tool: % compliance of the completed MUST tool within 24 hours admission to hospital in all Adult Inpatient Wards by March 2016.
- Early Warning Scores (EWS): % compliance with accurately completed EWS charts.

6.3.2 Unscheduled Care Services

The ensuring of safe and effective unscheduled care services continues to present a particular challenge for both commissioners and providers. This matter has been given the very highest priority, including the establishment by the Department of a regional Unscheduled Care Task Group chaired by the Chief Medical and Nursing officers. However patients at a number of larger hospital sites continue routinely to have to endure long waiting times in Emergency Departments for assessment, treatment and, where appropriate, admission to hospital.

Regionally the Unscheduled Care Task Group identified five priorities to be addressed to improve patient flow, with a focus on seven day working. Three of these priorities will be progressed in year; however the priorities relating to medical workforce (to ensure twice – daily decision making) is likely to have significant resource implications which cannot be fully addressed within available funding for 2015/16. However, work will continue to be taken forward with Trusts to review and address outstanding medical workforce issues with a view to delivering twice-daily Senior Decision making for inpatients and more generally improving the effectiveness of ward rounds.

A further issue is that, when patients are admitted to hospital, it is often by necessity to a bed in a ward area other than that which would be most appropriate for their healthcare needs. This is very challenging for both patients and staff and compromises the patient experience, quality of care and presenting risks in terms of patient safety. It has also impacted materially on the provision of key regional services such as cardiac surgery, due to specialist beds being occupied by general unscheduled care patients necessitating the frequent cancellation of planned surgical procedures.

Levels of demand for unscheduled care services have continued to increase with sustained pressures on services throughout the winter and into the springtime.

Against this exceptionally challenging background, the key objectives and actions to be progressed by the HSCB and PHA in 2015/16 include the following:

- The continued roll out of a range of measures to identify earlier and better meet patients' needs in community settings and to avoid the need for patients to attend hospital. These measures include:
  - The establishment of Acute Care at Home models and other rapid response arrangements.
  - The establishment of a range of alternative care pathways, linked to the NI Ambulance Service, to provide alternatives for both patients and staff to hospital attendance.
  - The establishment on a pilot basis of an alcohol recovery centre in Belfast.
  - The reform of palliative care services, facilitating people to die in their place of choice – typically their own home - rather than a hospital bed. During 2015/16 this will include:
    - The implementation of advance care planning arrangements across Northern Ireland to allow the needs and wishes of palliative care patients to be identified and planned for.
    - The implementation of a key worker function – typically the District Nurse to oversee care planning arrangements.

The above measures will take time to embed, and the pace and scale of service change will be impacted upon by the availability of resources. In parallel with the above "out of hospital" initiatives, arrangements will be taken forward to further improve the flow of patients through hospital and back into community settings, with a particular focus on moving towards seven-day working. Key initiatives in this regard to be taken forward in 2015/16 at the five larger hospital sites include:

- Establishment of radiology services seven days a week to support same day/next morning investigation and reporting (to include CT, MRI and non-obstetric ultrasound scans).

- Establishment of dedicated minor injury stream in EDs (9am to 9pm, 7 days a week).
- Embedding of physiotherapy, occupational therapy, pharmacy and social work support within EDs and short-stay wards (9am to 5pm, 7 days a week).

During 2015/16 the HSCB will continue to progress with Trusts and primary care directly (including through the newly established GP Federations) and through ICPs a range of other initiatives to improve hospital flows and the patient experience:

- The roll out of same day/next day ambulatory care models, providing an appropriate alternative for many patients to admission to hospital (as well as providing a key vehicle to transform outpatient services more generally).
- The roll out of alternative care pathways for frail elderly patients, avoiding as far as possible the need for them to wait in Emergency Departments.
- Appropriate and early planning for winter 2015/16 informed by the findings and recommendations of the recent external stock-take commissioned by the HSCB in relation to planning arrangements for the winter of 2014/15.

More generally, local discussions between LCGs and Trusts have highlighted particular ED and acute care pressures that are currently impacting on performance against the 12 hour and 4 hour standard. A number of these will require additional investment which is unlikely to be available in 2015/16. The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS to make a bid through June monitoring for additional in-year resources to enhance unscheduled care services and improve patient flow, and will consider any other opportunities to provide additional funding in-year.

6.3.3 Acute reform

Transforming Your Care set out the strategic direction of travel for acute services to be based around 5-7 hospital networks within which services would be configured to secure the sustainability of services and care pathways to ensure patients have the best possible outcomes by being able to access the right service from the right clinical team as rapidly as possible. The function of each hospital within a network is becoming more specialised with some offering mainly acute

emergency treatment and others focusing on care for the frail elderly and those with long term conditions.

The RQIA highlighted the importance of care pathways for acute care within each hospital network as well as between local networks and regional specialties. The review supported the development of direct admission arrangements, with patients avoiding Emergency Departments where appropriate, and recommended a collaborative approach to the development of care pathways across the health and social care system both within each hospital network and at regional level.

The HSCB will establish a regional workstream to further develop care pathways. Developments currently underway will be extended. GPs will increasingly able to contact specialists directly, for example through a single phone number in Belfast, to discuss the most appropriate care plan for their patient which may mean receiving acute care at home delivered by specialist community teams or being transported directly to hospital-based assessment and admission if required. As referred to above, protocols are being introduced for the NI Ambulance Service to enable paramedics to make decisions in the patient's home about their care pathway with specialist advice.

Care pathways are being agreed jointly between regional specialists, local networks and primary care. Regional specialties such as Neurology will continue to extend their support to local networks and groups of GP through tele-medical links, referral for advice and peer education sessions.

Key initiatives to be taken forward in 2015/16 include:

- The completion, by September 2015, of a public consultation on the delivery of vascular services on a regional, networked basis
- The development, by December 2015, of a networked urology services on a safe, sustainable basis
- The development of a long term plan for the delivery of networked neurology services on a safe, sustainable basis.

6.3.4 Delivering Care

As referred to in Section 3 of this Plan, *Delivering Care: Nurse Staffing in Northern Ireland* is a key quality initiative in terms of identifying minimum nurse staffing requirements in a range of hospital and community settings, and ensuring these requirements are met.

To date the key focus of the HSCB and PHA working with the Department, Trusts and RCN, has been in relation to nurse staffing levels in medical and surgical hospital wards. During 2014/15 required nurse staffing levels for each medical and surgical ward across Northern Ireland have been developed and agreed with Trusts, and implementation plans are now being finalised. In total some £12m will be invested in additional permanent nursing staff during 2015/16. The HSCB and PHA will continue to work closely with Trusts to ensure timely and effective implementation and ongoing monitoring (in order to support the delivery of Ministerial Target 26, appendix 2)

During 2015/16 the HSCB and PHA will continue to support the regional work being taken forward in relation to the other areas of the nursing workforce that have been identified, specifically emergency department district nursing and health visiting.

6.3.5 Managing Long-Term Conditions

The prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation. Across N Ireland the most prevalent LTCs are hypertension (131 per 1000 patients; 250,000 people), asthma (60 per 1000 patients) and diabetes (54 per 1000 patients; 82,000 people).

Emergency Admissions to hospital for Long Term Conditions

In each of the years from 2010/11 to 2014/15 (Full Year Effect projected based on activity between April and September) the number of emergency admissions to hospital ranged from approximately 11,500 to 12,900 for those aged 18 years and over (see Table 17). COPD accounts for the majority of these admissions at

approximately 40% of the total, with Asthma having the lowest percentage of admissions at approximately 8%.

Number of Emergency Admissions by condition (relevant ICD-10 codes were coded as primary diagnosis or main condition treated on the admission episode)
Table 17

Emergency Admissions	Asthma		Diabetes		Heart Failure		COPD		Stroke	
	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000
2010 11	986	64	1017	74	2341	173	4716	343	2537	195
2011 12	934	60	1013	73	2373	172	4730	343	2848	206
2012 13	995	71	1098	78	2503	197	5434	389	2820	203
2013 14	960	69	1078	77	2693	198	5355	383	2833	203
2014 15 FYE	969	62	1038	74	2652	193	4756	343	2632	191

Source: PAS Data Warehouse

During 2014/15, there has been a 10% increase in the number of self-management programmes for people with long term conditions. The funding position in 2015/16 will impact on the ability of commissioners to maintain and deliver additional accessible self-management programmes.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow priority service developments to be taken forward.

6.3.6 Addressing known shortfalls in capacity/quality concerns

Improving Cancer Services

According to NISRA, cancer now accounts for the largest number of deaths attributable to a single cause. The proportion of deaths due to cancer in N Ireland has increased from 20% in 1983 to 28% of all deaths in 2013. By way of contrast, deaths in 2013 due to ischemic heart disease decreased by 60% since 1983 from 4,786 to 1,916.

The HSCB will continue to monitor Trust progress against best practice and suspect cancer/red flag pathways.

More people are living with cancer as a chronic illness. New models of follow up have been introduced to address the needs of cancer survivors. The learning from the 3 year transforming cancer follow-up (TCFU) programme evaluation will help shape the future of patient follow up. The HSCB and PHA will progress a number of key areas, including building on the successes of the TCFU programme, specifically;

- Commitment to continuation of the TCFU approach, which now has a sound evidence base.
- Consolidation of the approach and the learning such that it becomes best practice for all eligible patients with cancer, while recognising that each site specific tumour area may have differing requirements.
- Extension of the TCFU approach to all other cancer service areas where it is potentially applicable and continue to demonstrate the clinical and cost effectiveness of the TCFU approach.

The introduction of Acute Oncology teams at the Cancer Centre and Cancer Units during 2015 will enhance the quality of services for patients with complications of cancer or cancer treatment, advanced cancer or those admitted to hospital with a newly diagnosed cancer. National evidence has shown that these teams can aid in admission avoidance, reducing unnecessary diagnostic investigations, reduce length of stay and aid in the co-ordination of care and end of life support. The teams and the supporting infrastructure will be instrumental in implementing NICE guidance on Neutropenic Sepsis (CG 151) and management of Metastatic Malignant Disease of Unknown Primary Origin (CG 104). Neither set of guidance can be implemented without the establishment of a multidisciplinary acute oncology team.

The expansion of the National Peer Review Programme to cancer Multidisciplinary Teams (MDTs) in Northern Ireland is being utilised as a mechanism to ensure services are as safe as possible, that quality and effective care is provided and that the experience of the patient and carer is positive. Over the three year cycle all MDTs will be assessed against national measures and benchmarked against equivalent MDTs in Northern Ireland and at a nation level. A robust mechanism has been put in place to ensure the production of appropriate Trust action plans and for HSCB monitoring of required service improvements.

The findings of the first rollout of National Cancer Patient Experience Survey (CPES) in Northern Ireland will provide a patient assessment of the quality of care and support provided by Cancer Services across Northern Ireland. Over 2,800 submissions will be analysed by HSCB and Trusts and appropriate actions plans will be produced in order to continuously improve the quality of patient care and experience.

Current consideration of chemotherapy services for oncology and haematology patients indicates an opportunity to improve skills mix by which chemotherapy is delivered. Recommendations expected from the regional chemotherapy review will create an opportunity to improve skills mix and consequently improve quality and timeliness of treatment. Subject to consultation HSCB anticipate introduction of skills mix in late 2015.

Implementation of the recommendations from the 2014/15 Teenage and Young Adult Cancer Scoping Exercise of Service Provision will lead to streamlining of pathways and increased access to support for this cohort of patients who have complex care and pyscho-social needs.

Work is currently underway to develop a robust and sustainable plan for specialising nursing expertise to support people with cancer. This work is in direct response to peer review findings, CPES findings and feedback from patients, members of the public and cancer organisations.

Standardised clinical management guidelines and regimen prescribing will be facilitated by the introduction of the Regional Information System for Oncology and Haematology (RISOH) during 2015/16.

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of service developments for patients with cancer including:

- centralisation of Upper GI Cancer Surgery in BHSCT and associated pre and post-operative care by a specialist multidisciplinary team (MDT)

- development of skills mix approach to prescribing and delivering of chemotherapy services across NI
- access to cancer clinical nurse specialists throughout patient pathway for cancer patients across NI
- access to fully constituted MDT for discussion on diagnosis and treatment options for all patients with a suspected and/or confirmed cancer
- ability to provide timely access to molecular pathology tests that inform most appropriate treatment choices
- ability to ensure a resilient and sustainable radiotherapy medical physics service is restricted by limited resourcing for workforce planning
- ability to respond to cancer MDT peer review findings.

Improving Fracture Services

The changing demographic profile of the population, coupled with changes to clinical practice and training has put an increasing demand on the fracture service. Patients who previously would have had their fracture managed within the Emergency Department are increasing being referred to a fracture clinic. This has had a direct impact on the number of patients seen in fracture clinic, increasing the waiting times at those clinics and generating unnecessary clinic visits for patients.

A redesign of the non-operative fracture pathway, modelled on the work previously undertaken in the Glasgow Royal Infirmary, has resulted in a standardised treatment pathway for a range of stable fractures, supported by patient discharge leaflets. Patients with minor, stable fractures are now being discharged with no further follow-up arranged.

This new pathway has already been piloted across a number of Trusts with significant quality benefits including better clinical decision making via the use of agreed ED fracture pathways, addressed the issue of over booked clinics and helped reduce the waiting times for patients attending fracture clinic. The new pathways have also reduced unnecessary attendances for patients at fracture clinics and allowed consultants to spend more clinical time on those patients with moderate to severe fractures

Improving Imaging Services

Diagnostic imaging is an integral part of modern healthcare. It plays a role in diagnosing and screening for virtually all major illnesses and contributes to the planning of treatment. There is increasing recognition of the need to place imaging early in care pathways to reduce the time to diagnosis and treatment and to improve efficiency and effectiveness.

Traditionally, each hospital has its own imaging service employing its own radiologists to support its own service, providing a variable level of local primary care imaging access. In the current NI radiology service model, the overall activity within the services is limited by reporting capacity rather than the capacity for image acquisition.

The accurate and timely interpretation and reporting of all radiological images is fundamental for patient care. Mostly, image reporting is done by radiologists, although some images are viewed by other medical practitioners by formal local arrangements. Although, some images are reported by advanced practitioner radiographers e.g. ultrasound, breast screening and some plain film examinations, radiologists are required for more complex and time consuming examination e.g. CT and MRI scans.

Each HSC Trust manages the reporting of the scans undertaken for their patients. In addition, work may be either outsourced to the Independent Sector or undertaken as in-house additionality. There are number of hidden drawbacks to the outsourcing model which are increasingly apparent with greater use. Most work is reported in-hours, but the level of reporting undertaken out of hours has increased significantly, not least because there are approximately 21 vacant radiologist posts across the region.

Following discussion of a reporting-related SAI, and through discussion at the Radiology Network, the concept of combining the resources of radiologists and reporting radiographers across the region has emerged. In the first instance, it is proposed that a regional reporting network will serve to bring back plain film reporting from the Independent Sector through formation of networks staffed by

HSC staff. This could further develop to support specialist networks to better utilise scare, valuable resources.

6.4 Promoting independence and choice

Personalisation, independence and choice are at the heart of a more person-centred model in which statutory health and social care acts as an enabler, working in partnership with each individual, their carers and organisations outside the statutory sector, to help people access the support that meets their individual needs. This signals a move from a "service led" system to one which promotes peoples' autonomy and independence. .

Voluntary and community sector organisations play a vital role in providing this much wider range of support and promoting individual control and independence. The priorities referred to under this theme are key to enabling independence and choice.

6.4.1 Reablement

Reablement is a short term service to help people perform their necessary daily living skills such as personal care, walking and preparing meals so that they can regain their confidence and independence within their own home and avoid remaining in hospital, as well as reduce further hospital admissions. Reablement helps people to do things for themselves rather than having to rely on others.

The Regional Reablement Model was originally issued in 2012/13 as a guide for Trusts in their work to establish the Reablement service model, with the intention to review in the light of Trusts' experiences of embedding the key components of the model. To determine the progress and effectiveness of the Reablement service across the Health and Social Care Trusts, the Reablement Project Board approved a Regional Audit in 2014 which was conducted by the HSCB. This Audit demonstrated that there was a divergence in how the Trusts interpreted the model and its roll-out. However, it also clearly highlighted the essential components which should be considered for adoption within a Northern Ireland model. Therefore, to ensure a convergence across the region the HSCB has revised the model to reflect key essential elements which will underpin a

consistent and effective model which will allow more effective measurement of outcomes, planning investment and will set out a "road map" for further improvement.

During 2015/16, the HSCB will seek to implement the revised regional model for reablement. This will be aided through a number of key actions:

- Finalise the standardisation of the access criteria for the service across Trusts and further reductions in the number of access points so that there is greater consistency and fairness.
- Continuing development of partnership arrangements with non-statutory services. The range of services will be increased and additional IT solutions explored to improve accessibility to existing directories.
- Investment in additional Reablement Occupational Therapists and the establishment of a Clinical Forum for these specialists to standardise best practice including the development of standards for governance and practice, and production of regional practice tools to assist in assessment and independence planning.
- Enhancing the role of Reablement Support Workers (RSW) through the development of a regional framework to support learning and development in conjunction with NISCC. The framework should become the benchmark for all aligning all RSW training and mentoring needs.
- Review and develop the existing Key Performance Indicator (KPI) - number of service users discharged with no statutory service needed – as it is now largely being met. Other indicators of effectiveness (such as longer term impact of the service) should be developed.

6.4.2 Promotion of direct payments / self-directed support

This Self Directed Support initiative is in response to what people have overwhelmingly requested. Third sector groups representing those who use the service and their Carers have raised the importance of having greater choice and control for a long time. In response to this, and in reviewing the development of Self Directed Support in England and Scotland, social care in Northern Ireland has begun to work towards the implementation of our own Self Directed Support.

Self-Directed support allows people to choose how their care is provided, and gives them as much control as they want over their personal budget. Self-Directed Support includes a number or combination of options for getting support, namely:

- Direct Payment (a cash payment); (to support the delivery of Ministerial Target 8, appendix 2)
- Managed budgets (where the Trust holds the budget, but the person is in control of how it is spent);
- Trust co-ordination of services on behalf of the client.

The Self Directed Support initiative is a key element of the Transforming Your Care reform agenda and is fundamental to social care services moving forward to that extent it is important that Trusts maintain an active commitment to the implementation of SDS.

A regional and local project has been established over the past months with a three-year plan (2015-18) to mainstream Self Directed Support within social care. Implementation plans have been developed and agreed with all the Trusts and the HSCB is currently undertaking a region-wide Equality Impact Assessment with a range of key stakeholders prior to implementation (end of May).

6.4.3 Carer support

Approximately one in eight adults is a carer; a person who, without payment, provides support to a family member or neighbour who is older, infirm or disabled, so that they can remain at home. Many will be able to do this without assistance, but many make a substantial weekly commitment, and may be lone carers and have been doing this for some time. HSC has been prioritising support to this group.

Key priorities for 2015/16 include:

- *Increasing uptake of carer's assessments* - In any quarter, trusts identify approximately 2500 "new" carers and offered them their legal entitlement of a carers assessment. (In accordance with Ministerial Target 7, appendix 2) But there are numbers who are not recognised and we need to improve performance here. This will include better information directly available to

all who might be carers; and working with GP Practices who increase numbers referred at the point of GP consultation.

- *Improving the carer experience of the carer assessment* - Carer feedback has sometimes been that carers assessments experienced as a test of their eligibility rather than an opportunity to acknowledge their contribution and the emotional pressures on them. As part of the updating of NISAT carers assessment, Trusts should participate in the HSCB service improvement focus on carer experience. Trusts should also adhere to the carer support parts of the Service Framework for Older People.
- *Creating more community-based short break options* - Trust provision of short break support is now more than one million hours in each quarter; but more than half of this is in an institutional setting and we need to offer carers home-based alternatives where that is feasible or by offering more carers some form of self-directed support so that they can arrange their own support. HSCB also expects trusts to respond to the findings of the TYC report on short break pilot projects and cooperate with the HSCB review of home-based short break support currently underway and implement service improvement measures which emerge.

6.4.4 Implementation of Learning Disabilities Day Opportunities Model

Following the endorsement of the Learning Disability Day Opportunities Model in 2014, implementation has now begun. The number of young people leaving school with a learning disability who require either a buildings-based or community based day support service has been identified. The appropriate additional services required to meet these needs will be delivered by HSC alongside other statutory providers with responsibility for further education, vocational training, supported employment, travel and leisure.

The HSC services to meet the young peoples' needs who are leaving school in 2015/16 are divided approximately 50/50 between day care and community activities. The range of services to be provided must support young people with complex physical and behavioural needs. These services will also play a vital role in supporting families and carers with whom the vast majority of these young people live.

6.5 *Safeguarding the most vulnerable*

There is a clear requirement to ensure that robust arrangement are in place to protect the most vulnerable in Northern Ireland; specifically those living with dementia, people with learning disability or mental health illness, children and adults in need of protection.

6.5.1 *Dementia strategy*

It is estimated that at present in Northern Ireland there are 19,000 people living with dementia; fewer than 1000 of these people are under 65. As the population of Northern Ireland ages, dementia will increasingly be a major public health and societal issue, with numbers of people with dementia rising to 23,000 by 2017 and around 60,000 by 2051. The cost to society is also likely to increase dramatically.

During 2015/16 the focus in commissioning care for people with dementia is designed to drive up the quality of care for those with dementia and delirium and their carers which will include the following:

- Implementation of a Public Awareness campaign to improve early diagnosis and information support
- Work with training and care providers and informal carers to complete a training needs analysis and knowledge skills framework in order to drive up workforce skills base and support carers to continue to care.
- Implement a delirium pathway to optimise patient experience
- Development of short breaks offered to people with dementia and their carers.
- A review of outpatient memory services to analyse the barriers to practice, functional and structural integration, identify and reduce all unwarranted service and practice variations.
- Profiling service demand, including an analysis of existing follow up / review models. This will include exploring the opportunities to develop a new risk / need stratified care model for follow on care.

- Benchmark current service capacity including an analysis of how current clinics operate, their respective capacity, the workforce, resources and skills.
- An audit of dementia care in acute hospitals has just finished across NI and recommendations from this audit will be factored into commissioning decisions during 15/16.

6.5.2 Investing in mental health/learning disability community infrastructure

The shift in focus from hospital based services to community services for both Mental Health and for Learning Disability needs to continue. During 2015/16 services which provide community based assessment and treatment 7 days per week should be enhanced. Such services are crucial to preventing inappropriate admissions to hospital, and to facilitating timely discharges in line with discharge targets; including complex discharges.

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of mental health service developments including the delivery of:

- accessible services for patients requiring Tier 2 and 3 addiction service support
- accessible psychiatry services for people presenting at Emergency Departments with self-harm and/or suicidal intentions
- accessible physical health services for people with mental illness
- additional psychological therapy services to meet demand and to address current breaches in access targets.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow many of these priority service developments to be taken forward.

Similarly, the funding position in 2015/16 will impact on the ability of commissioners to take forward a range of learning disability service developments including the delivery of:

- accessible day care/day opportunities for young adults with learning disability who are leaving school
- accessible services for the assessment and treatment of Autism Spectrum Disorder and Attention Deficit Hyperactivity
- short-break/ respite for families caring for adults with a learning disability.

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

6.5.3 Safeguarding services

Safeguarding children

There remains a clear requirement to ensure that robust safeguarding arrangements are in place to protect all children. In providing safeguarding services there needs to be a recognition that children who have been exposed to adverse life experiences may be more vulnerable to abuse and exploitation.

There have been a number of high profile Inquiries into Child Sexual Abuse at both a local and national level across the UK. Following a review undertaken by the PSNI the DHSSPS set up a local Inquiry into CSE. The Marshall Inquiry reported its findings in November 2014 and the DHSSPS established a HSC Response Team. The Response Team will oversee progress against the action plan to address the various recommendations.

The PSNI have recently restructured the Public Protection Units which are aligned with Trust boundaries to enhance closer working relationships between HSC and the PSNI. Issues around abuse of alcohol use of legal highs and illegal drugs continue to present as difficulties. The HSCB identified additional investment to help address issues around CSE and other concerns within both the statutory and voluntary sectors.

A further pressure identified by Trusts relates to children with complex healthcare needs and those children with additional needs and challenging behaviours, some

of these children will be in the looked after system. The HSCB is leading on a reform agenda within LAC service provision and Trusts submitted plans to address the commissioning proposals. During 2015/16:

- The HSCB will complete the implementation of the Residential Care review recommendations including a reduction in the size of homes, reviewing statements of Purpose and Function to meet a range of needs and address therapeutic intervention.

  This integrated approach will also address edge of care reduce the need for the placement of children in care by addressing complex need within the community, specialist fostering placements and joint commissioning with NIHE to ensure there is adequate range of placements

There has been a significant rise in the numbers of looked after children over the past number of years. This is consistent with the national picture and has resulted in particular challenges as regards the availability of appropriate care placements to meet the assessed needs of children. During 2015/16:

- The HSCB will continue to recruit additional professional foster carers who will, with the necessary supports, be able to care for some of the young people who present with complex issues – this in line with TYC recommendations.
- The HSCB will commission a range of placements to meet the identified need and have also expanded the number of kinship placements a part of the strategic direction.

As referenced above, there is a cohort of young people who are in contact with a range of services, including the regional acute CAMHS facility, Secure Care which are supported by other statutory services such as Youth Justice. On occasion the demand for secure care will exceed supply for short durations and Trusts put in place suitable alternative arrangements to manage the presenting risks. Work is progressing on a regional basis to consider the interdependencies across the LAC continuum and with other services to determine how the service can best respond to these complex situations.

The Marshall Inquiry Report made a recommendation that further consideration is given to the concept of "Safe Spaces" and an engagement with young people to ensure their views are factored into any future services. During 2015/16:

- Work will be progressed on the reconfiguration of the regional secure care unit, alongside developments within the residential sector and foster care to provide a more responsive service that provides greater stability and meets the assessed need the young people involved.

Adult Safeguarding

Adult Safeguarding is a developing area of concern and activity continues to increase sharply. The total investment of £1.5m recurrent has been made in adult safeguarding services to date. This investment has provided dedicated specialist staff to improve the prevention, detection and investigation of allegations of abuse. The DHSSPS and Department of Justice will be launching a new Adult Safeguarding Policy in 2015. This will have a significant impact on activity across all sectors and providers and is likely to lead to a further increase in referrals.

Quality of Care is a central theme in adult safeguarding, particularly where the adult in need of protection is in receipt of care services. During 2015/16 HSCB will commission a range of safeguarding activities designed to drive up the quality of care and so prevent / reduce the likelihood of abuse occurring. This will include the following:

- Work with providers to develop innovative ways to prevent abuse and promote a safe environment for the delivery of care. This will include consideration of the use of new or alternative technologies (PoC 4-7)
- Complete move to Gateway approach to respond to all adult safeguarding referrals across all Programmes of Care. This will improve the quality of decision-making, ensure a standard response to all referrals and improve working arrangements with other partner agencies (PoC 4-7)
- Implement generic and specialist safeguarding standards contained in all Service frameworks, with specific reference to the Older Person's Health and Wellbeing Service Framework (PoC 4- 7)
- Work with providers to drive up the quality of services to support people living in residential, nursing or supported living environments (PoC 5)

The majority of referrals to adult safeguarding are made by or on behalf of older people. It is therefore important that adult safeguarding commissioning priorities reflect the particular needs of older people. In 2015/16 the HSCB will:

- Ensure early detection of abuse through full implementation of the NISAT
- Deliver local prevention plans to prevent abuse with particular reference to Community Safety Strategy priorities in relation to Fear of Crime in Older People and the role of the Police and Community Safety Partnerships
- Roll out Peer Educator Programmes to increase the capacity of older people, local and community groups to keep themselves safe from all types of harm.

6.6 Efficiency & Value for Money

In the context of the financial challenges facing the health and social care system in 2015/16 and beyond it is essential that all appropriate opportunities to improve productivity and cost effectiveness are identified and taken.

For several years the HSCB has produced a range of indicative measures to support Trusts in identifying the partial areas to target further efficiency and productivity gains. This work has included benchmarking Trust to Trust performance locally, and comparing Trust performance against equivalent healthcare providers in GB. During 2015/16, the methodology used to benchmark Trust performance will be reviewed and refined, taking account of input from Trusts and the Department and changes to service models. In addition, it is planned to broaden the scope of the benchmarking indicators to include a wider range of performance measures for community-based services.

These indicators will be used to support ongoing work with HSC Trusts to improve the efficiency and effectiveness of service delivery; as appropriate they will also be used to support the case for commissioning from alternative providers.

Key productivity and cost effectiveness initiatives underway or to be progressed in 2015/16 include the following:

- *Pathology services* – the HSCB will complete by December 2015 a public consultation process on the future delivery arrangements for blood sciences, microbiology and cellular pathology
- *Effective use of resources* – the HSCB will complete by September 2015 a public consultation process in relation to the range of elective surgery procedures which are routinely available to patients in Northern Ireland, to ensure that scarce services are targeted towards those procedures with greatest patient benefit
- *Patient transport services* – the HSCB will, in partnership with the Department and NIAS, complete by December 2015 a public consultation on the future provision in non-urgent patient transport services
- *Pharmacy expenditure* – the HSCB will work to secure further reductions in pharmacy expenditure with a target saving of [£30m] to be delivered during 2014/15
- *Hospital bed days* – the HSCB will support the delivery of further reduction in hospital length of stay and associated bed requirements through improved arrangements for managing patient flow
- *Outpatient reform* – as one of four agreed regional workstreams, the HSCB will lead a process to implement outpatient reform. A key element of this process will be the development and implementation of a 21st century care model for patients requiring specialist assessment – whether following a GP consultation or an ED attendance – with patients being seen same day/next day in an ambulatory care model rather than being added to a more traditional waiting list.
- *Regional service delivery opportunities* – in the context of both financial pressures and issues of sustainability and resilience, there are opportunities to deliver particular services in a more consolidated fashion, potentially with a single provider for the whole of NI. In this regard, the HSCB will during 2015/16 establish regional arrangements for the delivery of out of hours radiology reporting and stroke lysis advice. Opportunities for regionalisation will also be explored through the outpatient reform

initiative referred to above with proposals already being worked up in relation to neurology and urology.

- *Interpreting services* – the HSC's expenditure on interpreting services is increasing annually with an annual spend of over £3m. Following a public consultation in 2014/15 the HSCB is working with BSO to support the provision of telephone interpreting services where appropriate, as a more cost effective alternative to face to face interpreting.

6.6.1 Procurement from Alternative Providers

The majority of health and social care services for the NI population are purchased by LCGs from their 'local' Trust. The size of NI, the limited number of statutory providers and the need to maintain financial stability both at individual provider and system level means that, in practice, the opportunities to establish a truly competitive provider market locally are limited. Nonetheless the HSCB will in 2015/16 continue to pursue opportunities in this regard in the context of the need to secure improved value for money.

Specifically, the HSCB will seek to respond to existing and new patient demands by commissioning services where appropriate from a provider other than the local HSC Trust to include:

- Commissioning from another HSC Trust in NI
- Commissioning from the community/voluntary sector
- Commissioning from partnership of providers e.g.GP Federations
- Community from the Independent Sector or the Statutory Sector in GB or RoI.

This approach will be adopted across a range of service areas. In each case the over-riding priority will be to identify opportunities for more patient-focused, sustainable and cost effective delivery while at the same time seeking to maintain the integrity of other related services commissioned from existing providers.

GP Federations

All GP practices in Northern Ireland are set to form not-for-profit provider companies by September 2015. The practices will form federations covering 100,000 patients, each including around 20 practices, which together will own and manage a not-for-profit social enterprise.

Under the plans, practices will maintain their current GMS work and the social enterprises will be able to employ staff to carry out the extra work that will result from the shift of care from secondary to primary care, as detailed in Transforming Your Care. Federations will also co-ordinate and empower the work of practices enabling them to work in a more effective and integrated manner and enable GPs to provide a better service for their patients.

It is hoped that the development of Federations can contribute to the delivery of the objectives of TYC working alongside Trusts and integrated-care partnerships.

6.6.2 Delivery of Contracted Volumes

During 2014/15 there have been instances where the volume of services delivered by providers has fallen considerably short of the level of service commissioned – impacting directly on patient care. In some instances performance difficulties have arisen as a result of ongoing operational difficulties, in others they may have arisen directly as a result of vacancy controls.

While the HSCB will continue to work with Trusts and other providers to support improved performance, during 2015/16 the HSCB will in addition, remove funding in full in targeted service areas where there have been performance difficulties with the funds being used to secure services from another provider.

It is recognised by the HSCB that this intervention will present challenges for Trusts and other provider organisations, particularly in the current financial context. However at the same time it is essential that the scarce commissioning resources which are available in 2015/16 are used to best effect to deliver commissioned services for patients.

7.0 Regional Commissioning

There are a small number of services which are commissioned at regional level. These include:

- Family & childcare services
- Regional specialist services
- Prisoner health
- NI Ambulance Service
- Family Practitioner Services

Commissioning priorities for 2015/16 for these areas are outlined below.

7.1 Family & Childcare Services

It is acknowledged that the Children and Families programme is heavily prescribed within legislation and thus there is an imperative for Trusts in their role as Corporate Parent to assist children and young people who are looked after to realise their aspirations and ambitions to their maximum potential.
Current strategic drivers within Children and Families Services include:

- Responding to the Marshall Inquiry on Child Sexual Exploitation, whilst also remaining cognisant of the wider safeguarding agenda
- Continuation of the Transforming Your Care (TYC) plans relating to the reviews of Residential Child Care and Fostercare
- Progression of the various proposals within the Early Intervention Transformation Programme (EITP) and development of Family Nurse Partnerships in the NHSCT and SEHSCT (The latter is in accordance with Ministerial Target 4 , appendix 2)
- Pursuance of key actions emanating from the Acute CAMHS Review
- To continue to take forward the Review of AHP support for children with statements of special educational needs in special and mainstream schools
- There are increasing demands arising from the growing number of children with complex healthcare needs and those with challenging behaviours. The HSCB and PHA are reviewing the position to inform future actions.

Family and Childcare– Key Commissioning Priorities 2015/16

Needs and Assessment

1. The Marshall Inquiry identified that Child Sexual Exploitation (CSE) is a growing threat in Northern Ireland
2. There is an increasing number of LAC coming into the system.
3. There is an increase in demand for CAMHs service and a recognised need to improve the interface between acute and community CAMHs teams as well as working arrangements with secure care and the regional Youth Justice Centre.
4. There are an increasing number of children with complex health care needs and challenging behaviour.
5. Inequity of access to AHP provision for children with statements of educational needs (SEN)

Services to be commissioned

1. HSCB will commission specialist teams within Trusts to co-ordinate responses to CSE and Alcohol and Drug Support Workers to work with LAC across Trusts
2. HSCB will commission:
   - a range of appropriate LAC/16+ placements to meet the projected demand detailed in the Residential and Fostercare Reviews
   - additional early intervention programmes to include and extension of the Family Nurse Partnership to South Eastern and Northern Trusts.
3. HSCB to progress the recommendations of the Regional Acute CAMHS Review.
4. HSCB will commission required care packages to enable these children to be looked after at home where appropriate
5. HSCB/PHA to progress review of AHP provision within mainstream and special schools for children with statements of SEN

Securing Service Delivery

1. Regional action plan to be monitored by DHSSPS led HSC Response Team with mechanisms in place for Trusts to provide regular updates to HSCB
2. Trusts will provide placements in line with agreed investments. The availability of placements will be monitored through DHSSPS Strategic Framework reporting arrangements and meetings with Commissioning Leads.

   FNP monitoring arrangements are in place.
3. Local Implementation Teams will progress the Acute CAMHs Review Action Plan and report into the regional HSCB steering group.
4. LCGs will monitor number of care packages made available in each locality

Regional Priorities (see appendix A): Allied Health (MT9), Mental Health Services (MT22), Family Nurse Partnership (MT4)
Key Strategies: Marshall Enquiry recommendations, Regional Acute CAMHS Review, Residential Child Care Review, Fostercare Review

Family and Childcare– Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 18

Programme of Care	Service Description	Currency (no. of children)	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Family and Childcare	**Looked After Children**	Residential Care	194	0	194
		Foster Care	2,189	0	2,189
		Other (placed at home, specialist facility etc.)	493	0	493
		Planned investment in 2015-16		£0.48m	

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of services relating to the need for assessment of children for Autism Spectrum Disorders/ Attention Deficit Hyperactivity Disorder and treatment/support services for children and their families.

In addition, the overall pressures within Children's Services indicate a likely rise in unallocated cases. The securing of appropriate placements for the increased number of looked after children will present particular challenges and will take longer to achieve.

7.2 Specialist Services

Specialist acute services include specialist tertiary or quarternary level services delivered through a single provider in Northern Ireland or designated centres in Great Britain / ROI. High cost specialist drugs also fall within the remit of this branch of commissioning.

Due to our small population the more specialist services are proving increasingly difficult to sustain through the traditional service models. Services which fall within this branch of commissioning include rare diseases, renal services, genetics, specialised services for children, specialist ophthalmology services; specialist neurology services and cardiac surgery. There are some 30-40 sub-specialist or small specialist areas within specialist services.

The 2015/16 priorities set out on the next page are subject to available funding.

Specialist Services – Key Commissioning Priorities 2015/16

Needs and Assessment

1. Transforming Your Care established the commitment of the HSC in supporting the delivery of more specialist care in the local setting where it is safe and effective to do so. In 2015/16 services will be configured to support improvements in local access across the region to highly specialist drugs and diagnostics.

2. A number of specialist services are delivered by one or two person teams in Northern Ireland. This can create difficulties in consistently delivering access times and securing resilience in the provision of the service locally.

3. The availability of specialist drug therapies for a range of conditions has improved the care available for a significant number of patients. Each year there is an increase in the number of patients accessing existing therapies and an increase in the number of new NICE approved therapies available.

Services to be Commissioned

1. SSCT will commission:
   - Increased local access to Tysabri for MS patients
   - Increased local access in the community setting to general support services such as phlebotomy to reduce the need for hospital attendances to support the ongoing clinical management of patients undergoing specialist treatment
   - The roll out of diagnostic capacity for imaging associated with ophthalmology macular services.

2. SSCT will commission:
   - A programme of in-reach and networked services through formal alliances with tertiary and quarternary providers outside NI
   - Models to further support the work of small specialist teams to cascade learning and expertise through local acute and community services
   - The implementation of the NI Rare Disease Plan

3. SSCT will work with Trusts to increase the number o patients on existing treatments and introduce NICE approved therapies approved in 2015/16 in NI.

Securing Service Delivery

1. The SSCT will work with the relevant Trusts and/or primary care colleagues to identify the requirements associated with the provision of these developments in each Trust area.

2. SSCT will continue to progress the establishment of both local and national clinical networks to enhance resilience and sustainability across a range of specialities. Work will initially focus on those services provided in Belfast Trust but will be set within a framework which identifies opportunities for linkages and integration with local services.

3. SSCT will progress through existing forums, including the Regional Biologics Forum, Regional MS Group and Cancer Commissioning Team, the arrangements for ensuring timely provision of existing and newly approved drug therapies throughout 2015/16 within available resources.

Needs and Assessment

4. A Ministerial decision has been made on the future model for Paediatric Congenital Cardiac Services which will in the future see surgical services for children from NI in the main provided in Dublin

5. There is a need to ensure delivery of additional infrastructure and activity in a number of specialist areas including cardiology and cardiac surgery.

6. Due to the complex and lengthy treatment undertaken for patients with severe intestinal failure, every effort has been made to provide as much of this care as possible in NI.

Services to be Commissioned

4. HSCB will put in place arrangements with relevant specialist surgical centres to ensure the provision of safe and robust services for children from NI during the implementation of the Ministerial decision on the future model of care.

5. SSCT will agree gaps in current capacity which are impacting on the ability of Trusts to deliver on waiting time targets and negotiate with Trusts on the level of resource required to meet the demand for services.

6. To meet national service framework standards for this highly specialist service, investment in excess of £0.5m has been made available to improve support for high dependency patients in the Belfast Trust.

Securing Service Delivery

4. HSCB will secure Service Level Agreement with the relevant surgical centres in GB and ROI for the provision of Paediatric Congenital Cardiac Services in 2015/16. HSCB will also be represented on the all-island network board which will be responsible for taking forward the timely implementation of the proposed model of care.

5. SSCT will work with relevant Trusts to secure additional capacity in areas with agreed gaps with a view to improving the waiting time position for patients in these specialist areas.

6. Belfast Trust will increase their high dependency capacity from 4 to 10 beds with additional nursing, medical pharmacy, AHP and support staff.

Needs and Assessment

7. Adult Critical Care capacity across NI operates as a network to ensure access to critical care beds as required. HSCB has a clear understanding of commissioned capacity for this high cost specialist service. In recent years there appear to have been difficulties and staffing challenges in maintaining the consistent availability of all beds in the network. Issues have also been highlighted for the review of the model for adult critical care transport service (NiCCaTs)

8. The CPD for 2015/16 includes the target that by March 2016, ensure the delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.
   - There is a need to increase the numbe of kidneys retrieved and transplanted in NI that are kidneys donated after circulatory death (DCD)
   - There is a need to increase the use of peritoneal dialysis and home haemodialysis

Services to be Commissioned

7. SSCT will, through the Critical Care Network,
   - confirm the bed stock and staffing levels across the region, review the number and frequency of bed non availability and reasons for same for the last 12 months.
   - Introduce a 12 hourly monitoring report from each ICU to be collected from April 2015. This will be reviewed by PMSI to identify daily capacity issues. SSCT will, through the Critical Care network
   - Review the proposal for the transfer of ICU capacity to Phase 2b in RVH
   - Bring forward proposals for a future model for the adult critical care transport service

8. The HSCB and PHA will continue to work closely with the service towards ensuring the delivery of a minimum of 80 kidney transplants in total to include live, DCD and DBD donors by March 2016. This will include optimising the potential for organ donation to include:
   - Continuing to provide at least 50 live donor transplants per annum
   - Maintain and if possible increase the number of kidneys transplanted in NI that are kidneys donated after circulatory death (DCD) (subject to the donation of kidneys) and increasing consent rates for deceased organ donation
   - Maximise the use of peritoneal dialysis / home haemodialysis

Securing Service Delivery

7. Each Trust will
   - undertake to provide the twice daily reporting through PMSI from April 2015. Belfast Trust will work with SSCT and the Network to agree the way forward for the future configuration of ICU capacity across the region as appropriate.
   - provide the information requested on bed stock, staffing and bed availability over the past 12 months for comparison against the 2009 baseline

8. The HSCB and PHA will:
   - Work with Belfast Trust to ensure that the appropriate infrastructure is in place to ensure that the required level of kidney transplants are undertaken during 2015/16

   - Work with all stakeholders to:
     - Ensure that the potential for organ donation in NI is maximised in 2015/16
     - Maximise the use of peritoneal dialysis / home haemodialysis during 2015/16 and beyond

Regional Priorities (see appendix A): Organ Transplants (MT18), Patient Safety (MT25), Delivering Transformation (MT29)
Key Strategies: National Intestinal Failure Service Framework Standards, DHSSPS PCCS Review, Transforming Your Care

Specialist Services – Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 19

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Specialist	**Specialist**	Emergency FCEs Cardiology switch to procedural contract	6,950	162	7,112
		Elective Contract	7,291	41	7,332
		Daycase	9,727	300	10,027
		New OP	45,208	3,593	48,801
		Review OP	97,765	8,986	106,751
		Other (Changes to SBA including cardiology procedural contract and specialist drugs and inject SBA volumes inc Cardiology)	16,202	4,343	20,545
		Beddays	20,094	3,650	23,744
		Planned investment in 2015-16		£1.5m	

NB: Cardiology other - include 11,000 procedures which were excluded from 2014/15 volumes

The funding position in 2015/16 will impact on the ability of commissioners to take forward a range of specialist acute service developments including the delivery of:

- increase in availability of endovascular stents associated with the impact of AAA screening
- availability of a range of specialist "sendaway" diagnostic tests for a range of genetic disorders
- required expansion in critical care capacity required in acute hospitals
- an accessible resilient specialist immunology service
- an accessible apheresis service for patients requiring bone marrow and stem cell transplantation associated with oncological/ haematological disorders
- a local, accessible cranial stereotactic service for all appropriate patients with cerebral brain metastases
- an accessible service for adults with Cystic Fibrosis.
- delivery of accessible paediatric asthma and anaphylaxis services
- availability of insulin pumps and associated services for children with diabetes

The HSCB has supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

Access to NICE Treatments

NICE provides guidance on current best practice in health and social care, including public health, health technologies and clinical practice. The DHSSPS has a formal link with the Institute under which NICE Technology Appraisals, Clinical Guidelines and other types of guidance are reviewed locally for their applicability to Northern Ireland and, where found to be applicable, are endorsed by the DHSSPS for implementation within Health and Social Care (HSC).

The funding position in 2015/16 means that it may not be possible to fund all new NICE-approved treatments; however each Technology Appraisal will be assessed to arrive at decision on timeframe for implementation which takes account of costs and benefits. The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to enable access to these treatments.

7.3 Prisoner Health

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

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

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

Within N Ireland there are just over 5,000 committals annually and approximately 1,800 – 1,900 prisoners throughout the prison estate at any time. NI has an imprisonment rate of 99/100,000 of the population. In line with prisons elsewhere in the UK the prison population has continued to increase over the last ten years and there is a growing population of older prisoners. Routine figures from Northern Ireland Prison Service show that the average prison population has increased by 73% between 2002 and 2012.

These figures report that the proportion of the average population sentenced to immediate custody over age 60, has increased from 1.5% to 2.8% between 2002 and 2012. This is a small proportion of the overall population but the relative increase is almost double. Male prisoners and young offenders predominate, with females constituting approximately 3% of the prison population. Prisoners in 2012 were over two thirds immediate custody, 31% remand and 2% fine defaulters. Prisoners in NI are on more prescription items per person than the general population of the same age.

The 2013/14 Health Needs Assessment (HNA) highlighted that mental health needs are very important to identify and address for prisoners. Mental health needs of a diverse population whilst can be difficult to describe, prisoners can be separated into two categories for the purpose of considering need; those with a mental health diagnosis, and those with mental health symptoms who may require support from mental health services but who may not otherwise be identified as having a mental health condition. The 2014/15 HNAs will provide a detailed mental health and addictions prisoner health needs assessment.

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

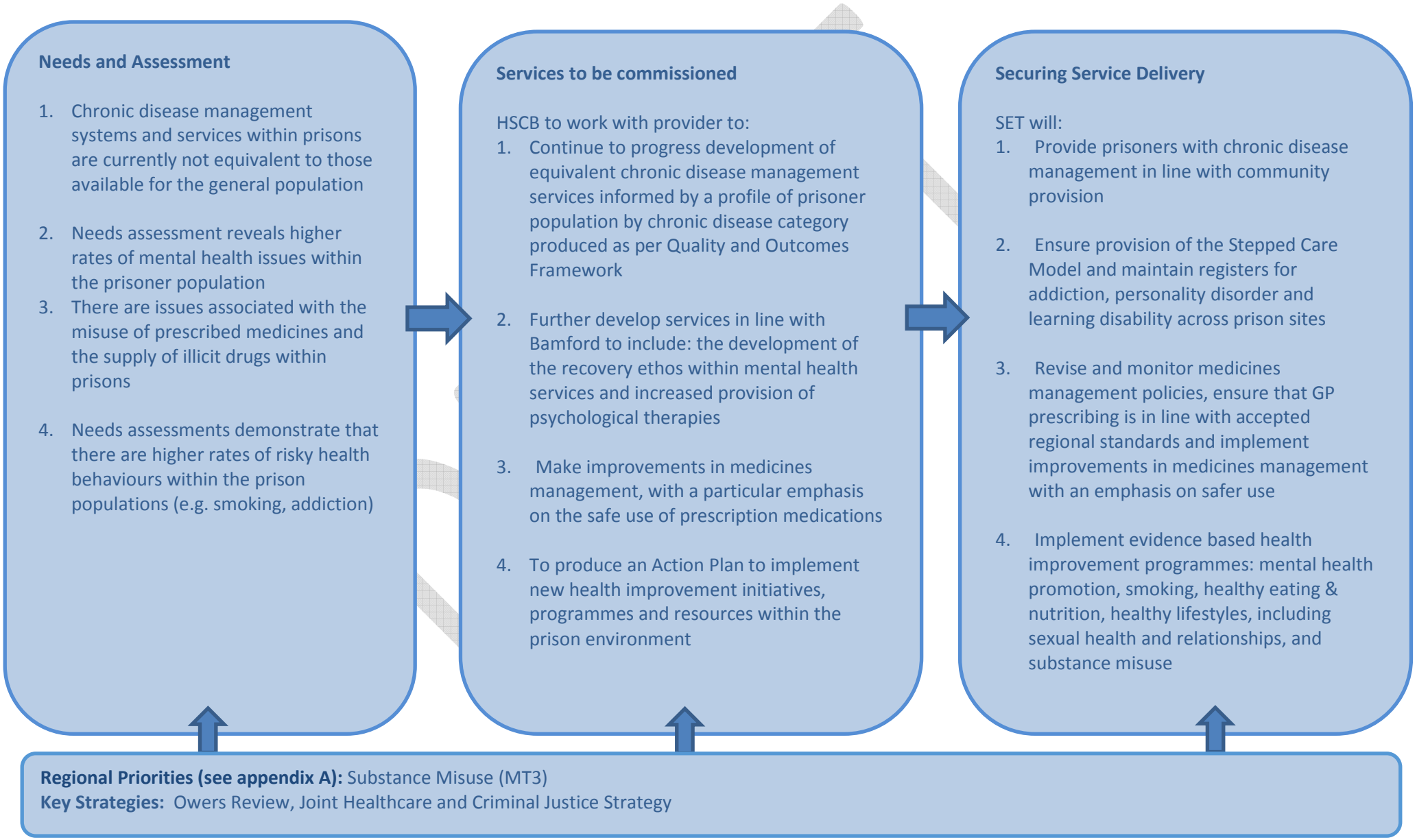
- Prison populations have risen since the transfer of healthcare in 2008 from Department of Justice to Department of Health placing increased pressure on available resources.
- There is a particular need to address the healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities.
- Rates of mental ill health for those in prison are higher than the general population, with the prison population having a much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses.
- Work continues on developing better integration with community and secondary care services on committal and discharge.
- There is a need to ensure that, following the identification of prisoners' healthcare needs at committal, these are followed up with appropriate action.
- There are issues associated with the misuse of prescribed medicines and the supply of illicit drugs.
- There is a need to forge improve relationships and cooperation between the Criminal Justice System and Health and Social Care.

Following the 2010 Owers Review, the Department of Justice and the Department of Health continue to work together to develop a joint Healthcare and Criminal Justice Strategy. The joint strategy seeks to address 5 key areas in the offender journey:

- Police response and prosecution
- The Courts Process
- Custody
- Supervision in the Community
- Resettlement

The HSCB and the PHA will work with the Department of Justice, the Department of Health and Health and Social Care Trusts in taking forward the Joint Healthcare and Criminal Justice Strategy.

Prisoner Health – Key Commissioning Priorities 2015/16



Prisoner Health – Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 20

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Prison Healthcare	**Primary Care**	Face to face contacts	20,488	0	20,488
	Secondary Care – in-reach clinics	Face to face contacts	1,970	0	1,970
	Allied Health Professionals	Face to face contacts	11,336	0	11,336
	Mental Health	Face to face contacts	46,800	0	46,800
	Substance misuse (inc supervised swallow)	Face to face contacts	295,147	0	295,147
	Dental Health	Face to face contacts	7,652	0	7,652
		Planned investment in 2015-16		Nil	

7.4 Northern Ireland Ambulance Service

Meeting emergency ambulance response times, regionally and at LCG level, is challenging in the face of increasing demand and a constrained financial environment. The number of emergency calls received by NIAS in 2013/14 was 154,755, a rise of 3.1% on the previous year. Category A response (within 8 minutes) also fell from 68.3% in 12/13 to 67.6% in 13/14. Particular challenges were evident in meeting the Category A target in Northern, Southern and South-Eastern areas.

The HSCB is supporting NIAS to respond to this demand by delivering alternative care pathways, which avoid transporting patients to hospital, where appropriate. These pathways provide NIAS with options to 'hear and advise', thereby avoiding a response to a 999 call which is not an emergency or urgent; to 'see and treat or refer', where a paramedic can provide the appropriate medical response without requiring transport of the patient to hospital; and to transport to an appropriate facility other than an Emergency Department, such as a Minor Injury Unit. (Which after a period of improvement, turnaround times at some major acute hospitals have begun to lengthen with loss of ambulance response capacity due to crews waiting long rot handover patients to Emergency Departments).

The HSCB has supported a pilot of Hospital Ambulance Liaison Officers which it intends to mainstream in 2015/16 in a drive to reduce handover times to no more than 30 minutes. The pilot will address:

- Development of eligibility criteria for non-emergency transport. NIAS provided over 205,000 non-emergency patient journeys in 2013/14. 55.4% of journeys (i.e. 113,623 journeys) were provided by NIAS Patient Care Service (PCS) which is a direct service provided by NIAS staff. 44.6% of journeys (i.e. 91,489 journeys) were provided by the Voluntary Care Services (VCS), which is a NIAS coordinated service delivered by volunteer drivers. Eligibility criteria, based on patient mobility, would serve to limit non-emergency transport to those in greatest need and release capacity to support intermediate care, such as inter-hospital transport and timely hospital discharge.

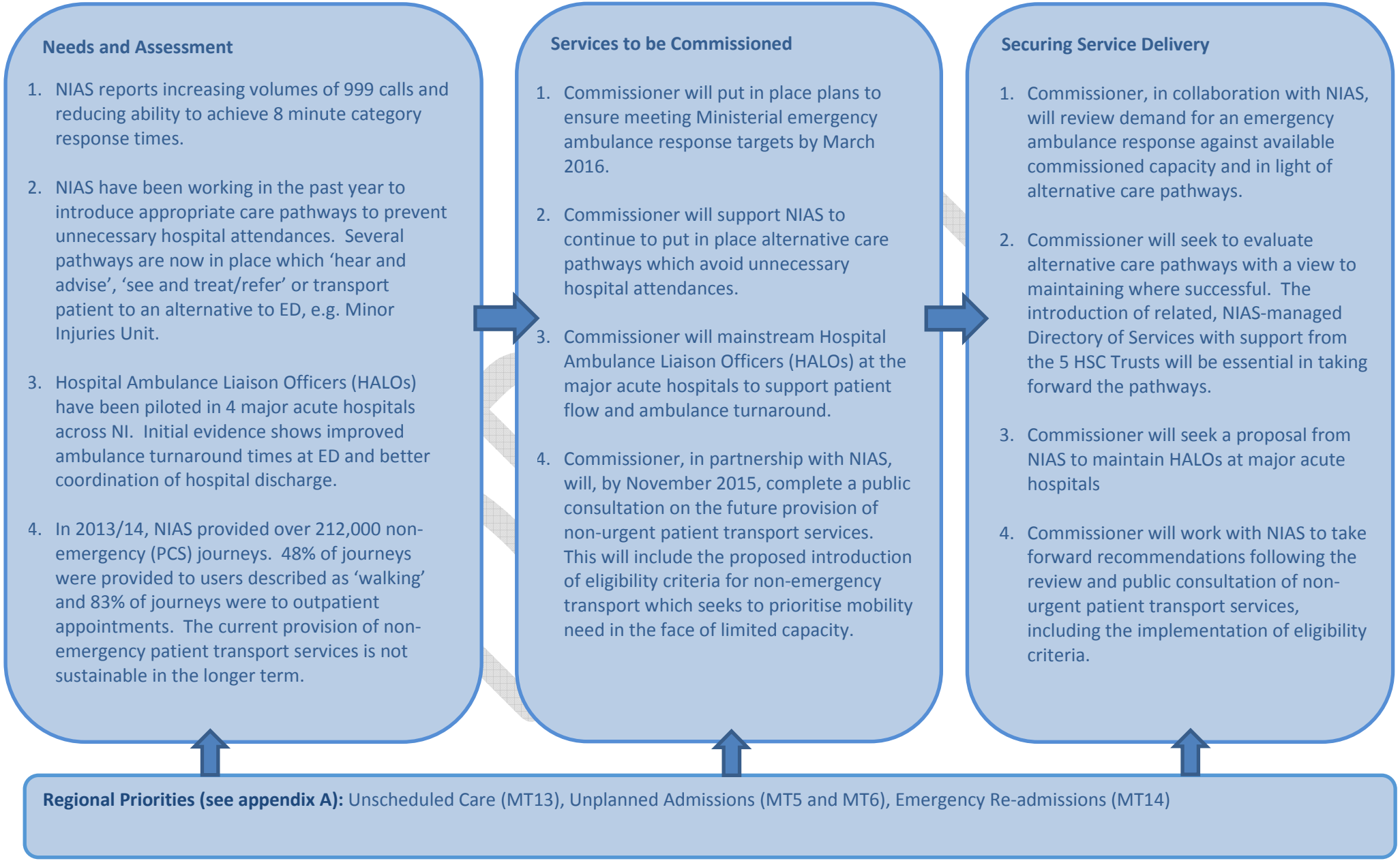
Nevertheless, despite the planned additional investment and service reform, it is unlikely that the 8 minute target response time for 999 calls will be delivered throughout the year. HSCB will work with DHSSPS to consider opportunities for further reform, service improvement or funding opportunities to address this challenge.

The funding position in 2015/16 will also impact upon the required expansion of community resuscitation including:

- Recruitment of permanent Community Resuscitation Development Officers (CRDOs) to deliver training in Emergency Life Support (ELS) and in the use of Automatic External Defibrillators.
- Development of information infrastructure to assist in the measurement of outcomes of Out of Hospital Cardiac Arrests (OHCA).

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to allow these priority service developments to be taken forward.

NIAS– Key Commissioning Priorities 2015/16



NIAS – Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted throughout 2015/16 to address identified needs. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 21

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
NIAS	**Calls**	Emergency	181,577	338	181,915
		Emergency Cat C HCP	28,188	0	28,188
		Urgent	7,525	600	8,125
		Non-Urgent	27,433	0	27,433
		Planned investment in 2015-16		£1.07m	

7.5 Family Practitioner Services

Family practitioner Services comprise the following four key areas:

1. General Medical Practitioners Services
2. General Ophthalmology Services
3. General Dental Services
4. Community pharmacy provision

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

7.5.1 General Medical Practitioners Services

General Medical Services are delivered by 350 General Medical Practices, through a contract between the HSCB and each individual practice (contractor).
The GMS Contract covers three main areas:

- The Global Sum covering Essential and Additional Services to treat patients who are sick
- The Quality and Outcomes Framework (QOF) which aims to promote the use of evidence based practice and a systematic approach to long term care, thereby reducing inequalities and improving health outcomes. Practices can choose whether to deliver these standards.
- Enhanced Services which practices can choose to provide. They can be commissioned regionally or locally to meet the populations healthcare needs.

The HSCB remains responsible for 24 hour high quality care being available to all patients. The Out of Hours service is commissioned from three Trusts and two individual organisations to provide urgent care for patients when their normal GP surgery is closed. Recognising the current pressure on the Out of Hours Service, the Health Minister is investing up to £3.1 million.

This is part of a £15 million package which includes:

- Up to £1.2 million helping GPs meet demand for blood tests and other diagnostic work in the community delivered through GP Federations.
- Up to £300,000 to recruit and retain GPs
- Releasing up to £10 million of funding for GP practices to borrow to upgrade and expand their premises and £350,000 to meet the on-going costs of these new premises.

However, the funding position in 2015/16 together with associated workforce issues will impact on the ability of commissioners to ensure effective primary care services. A particular issue is the ability to maintain accessible GP services in-hours and out of hours. The HSCB will continuously review commitments to ensure best use of all available resources and has also supported the DHSSPS in making a bid through June monitoring for additional in-year resources to enhance unscheduled care services; this bid includes elements to increase GP sessions and practice nurse sessions, and to enhance out of hours capacity. Furthermore the HSCB has secured funding in order to encourage those GPs who are close to retirement to continue working and to encourage GPs who have trained elsewhere to move to N Ireland.

The HSCB currently encourages practices through comprehensive demand management enhanced services to further improve the management of workload, demand, capacity and responsiveness within primary care. This work needs to be built on during 2015/16.

In response to the issues identified above the HSCB will prioritise the following during 2015/16:

- The HSCB commissions a range of Enhanced Services to meet the clinical needs of patients. The focus in 2015/16 will be on service delivery that will enable a structured annual review of patients with chronic conditions in order to improve their management and avoid unnecessary hospital admissions.
- The HSCB will revise NILES Demand Management to further improve the management of workload, demand, capacity and responsiveness within primary care. The HSCB will also continue to promote and encourage increased self-care among patients.

Enhanced Services uptake by general practice will continue to be challenged to ensure equity of provision to patients. The GP annual reporting requirements enable the HSCB to evaluate and review all Enhanced Services. This information will be used to improve future services and patient care.

7.5.2 General Ophthalmology Services

The main priority for general ophthalmic services during 2015/16 is to enhance community provision for glaucoma. Glaucoma as a long term ophthalmic condition which requires lifetime monitoring and patients once diagnosed, are subject to treatment and ongoing review. Following introduction of NICE Clinical Guideline 85[3] the demand on ophthalmology services in Northern Ireland increased exponentially with increasing numbers of referrals to secondary care resulting in patient access problems with subsequent threats to patient experience and outcomes.

During 2013/14 the HSCB introduced a local enhanced service (LES) within primary care which utilises a first-stage refinement of referrals (based on one clinical indicator). This LES have demonstrated a reduction of 65% in referral rates. Evidence[4] [5]exists that further enhancements/refinement strategies for primary care optometry could assist in further reducing the referrals to secondary care thus reducing the demand capacity gap for the glaucoma service. The adoption of strategies to stratify risk and deliver enhanced services to patients in primary care aligns to the theme of ensuring that services are resilient and provide value for money in terms of outcomes achieved and costs.

Commissioning Priorities 2015/16

During 2015/16 the HSCB will seek to further enhance skillsets in primary care, and use of eHealth technology to ensure glaucoma patients are treated to high quality safe and effective care closer to home.

[3] Glaucoma: Diagnosis and Management of Chronic Open-Angle Glaucoma and Ocular Hypertension, 2009, NICE
[4] Hall, D., Elliman,D. 2003 Health For All Children Revised Fourth Edition. Oxford University Press
[5] Das et al. Evidence that children with special needs all require visual assessment. Arch Dis Child 2010

- LCGs will commission training and accreditation of community optometrists in line with NICE and Joint College Guidelines to make full use of the available skillset across primary and secondary care.
- LCGs will ensure there is adequate access to Level 2 LES practitioners (in terms of both geography and timeliness)

Regional glaucoma hubs will continue to quality assure service provision, providing clinical leadership and governance. HSCB will monitor qualitative and quantitative data inputs to ensure timely access, clinical and patient experience outcomes and value for money.

7.5.3 General Dental Services

Responsibility for managing the General Dental Services (GDS) budget moved from DHSSPS to HSCB in July 2010. The population's utilisation of dental services has never been as high as it is now. In the last twenty years the proportion of patients who attend the dentist regularly has increased from 42% to 60%. Over the last five years GDS expenditure has increased by more than 50%.

The most recent Children's Dental Health Survey undertaken in Northern Ireland showed that Northern Ireland's children have, across all age groups, the poorest oral health in the UK. Among five year olds, for example, 60% had experienced dental decay while the UK average is 43%. In contrast, adult oral health in Northern Ireland is comparable with other parts of the UK and has shown a marked improvement over the last thirty years.

The current GDS contract is demand led – the more health service treatments that are provided the greater the cost to the GDS budget. At this time it is not possible to limit the number of dental practices in Northern Ireland or the number of dentists who may work in General Dental Practice.

HSCB and DHSSPS agree that a new contract is required if the GDS is to maintain access levels and continue to improve population oral health within an affordable funding envelope. The HSCB will pilot this new contract in 2015-16 and 2016-18.

HSCB will commission 18 dental practices to provide primary dental care for 50,000 patients for a 12 month period in order to test the new contracting arrangements. Practices will be selected so that they represent, as far as is possible, the main types of dental practice found in Northern Ireland.

Each practice will have their income fixed at the 2014 level but rather than remuneration being linked to treatment activity as it is under the current GDS contract, for this level of funding dentists will be required to maintain and secure the oral health of the patients registered with their practice.

It is hoped that moving away from the item of service elements of the current contract will incentivise practitioners to adopt a more patient centred and preventive approach to care, which will lead to improved outcomes for children over time.

HSCB will monitor the quality of care received by patients during the pilot. Patients' access to dental services (both routine and emergency) will also be checked. In addition, HSCB is collaborating with the University of Manchester to evaluate the pilot. A £500k research grant has been secured from the National Institute of Health Research. The evaluation will focus on changes in dentists' treatment patterns, the costs and value for money of the contract under test and patients' and dentists' views of the new arrangements.

7.5.4 Community Pharmacy and Medicines Management

There are three key areas of focus that HSCB will take forward strategically in 2015/16:

General Pharmaceutical Services

Incremental development of community pharmacy services has occurred over the past ten years. The Terms of Service for community pharmacy provision are dated compared to other parts of the UK. The HSCB is seeking to modernise the Terms of Service upon which community pharmacy services can be safely and effectively developed to encompass quality improvement, service review and specification, health improvement and modernisation of service provision.

Negotiations on the development of revised community pharmacy contractual arrangements have been challenging in 2014/15 not least with the initiation of Judicial Review proceedings by the community pharmacy contractor representative body, Community Pharmacy NI.

Looking forward into 2015/16, it is anticipated that the HSCB will lead on a series of actions set out in the DHSSPS *Making it Better Strategy Implementation Plan* which seeks to extend community pharmacy involvement in the delivery of services to address public health challenges and improve medicines use (e.g. minor ailments, repeat dispensing; medicines use review and smoking cessation services).

Medicines Management

Integrated Care has specific budgetary responsibility for prescribing in primary care and as the use of medicines spans all care settings with the majority of use and spend in primary care. NI Audit Office and the Public Accounts Committee have specifically highlighted the need for improved efficiency with respect to prescribing in primary care.

During 2015/16, HSCB will seek to both manage and influence the use of medicines throughout the HSC system:

- Deliver the Pharmaceutical Clinical Effectiveness programme in order to improve the quality and safety of medicines use and also realise £20m of efficiencies
- Further refinement and implementation of the NI Formulary
- Further refinement of Managed Entry (and exit) of medicines.

This work will be supported through the commissioning of practice based pharmacists' provision through an Enhanced Service to all GP practices in Northern Ireland.

Medicines Safety

Medicines are the most commonly utilised intervention in the HSC and the HSCB has a key leadership role in supporting the delivery of safer medicines systems.

Electronic Prescribing has been identified as a key issue to be addressed in secondary care.

During 2015/2016 the key deliverables will include:

- Performance measurement of medicines reconciliation processes to with the aim of increasing the percentage of patients having their medicines reconciled on admission and at discharge;
- Implementation of a number of medicines safety initiatives; and
- Support for the Electronic Prescribing and Medicines Administration project within secondary care.

8.0 Achievement of Ministerial Targets

The Commissioning Plan Direction sets out the Minister's targets and standards for the HSC for 2015/16, in many cases building on the targets and standards in 2014/15.

The HSCB is committed to working with Trusts to deliver these targets and standards, and to improve services for patients and clients. The constrained financial environment will however present significant challenges to improving or maintaining performance across a number of service areas. Notwithstanding this, it is important that the best possible outcomes are secured through the implementation of best practice and the full delivery of commissioned activity.

In 2015/16, the HSCB's performance management function will continue to enable and support a formal, regular, rigorous process to measure, evaluate, compare and improve performance across the HSC, identifying trends and performance issues, assessing performance risk, agreeing corrective actions, setting improvement goals and taking appropriate escalation measures in relation to the achievement of those improvement goals.

This section provides a brief overview of performance against the Ministerial standards and targets set for 2014/15. It also outlines the proposed approach to the delivery of the Ministerial targets set out in the Commissioning Plan Direction 2015/16. It does not seek to address every target; rather it seeks to outline how we intend to:

1. Support the continued achievement of targets of the required levels of performance in areas where the standards have been retained in 2015/16.
2. Address underperformance against existing targets and standards through the commissioning of additional capacity or other actions during 2015/16.
3. Support the achievement of new targets introduced for 2015/16.

In addition to the content within this section reference has been made in the preceding sections as to those commissioning intentions which are in line with or support delivery of Ministerial Targets.

1. *Support the continued achievement of targets of the required levels of performance in areas where the standards have been retained in 2015/16*.

During 2014/15, the HSCB continued to closely monitor Trusts' progress against the standards and targets set out in the Minister's Commissioning Plan Direction 2014/15 and take action as necessary.

Progress was made in a number of areas including:

- the target to deliver a minimum of 80 kidney transplants by March 2015 has been exceeded.
- significant improvement in performance against the 14-day breast cancer standard during the second half of 2014/15 – regionally during quarter three, 98% of urgent referrals were seen within 14 days and this improving trend is expected to continue.
- regionally, performance is on track to secure a 5% increase in the number of direct payments by March 2015
- the standard to ensure that no patient waits longer than 3 months to commence specified NICE approved specialist therapies has been substantially achieved.

2. *Address underperformance against existing targets and standards through the commissioning of additional capacity or other actions during 2015/16.*

There have also been a number of performance challenges on which the HSCB will continue to work with Trusts during 2015/16 to secure improvements, including:

- Cancer Care Services (62 day)
- Unscheduled Care (4 hour and 12 hour)
- Elective Care waiting times
- Mental health services
- Children's services
- Access to AHP services

The HSCB and PHA will work with Trusts during 2015/16 to maximise performance against all of the standards and targets set out in the Commissioning Plan Direction.

Cancer Care Services: From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Significant improvement has been made against the 14-day breast cancer standard during the latter half of 2014/15 compared to 2013/14. While performance has deteriorated slightly in the latter part of 2014/15 this is primarily in one HSC Trust. Actions to address this have been agreed and performance is expected to improve during quarter one of 2015/16 and be sustained thereafter. Performance against the 31-day standard has been consistently strong regionally, ranging from 95.1% - 97.4% for the period April December 2014 and it is the expectation this too will continue. However for the same period Trust level performance has ranged from 90.6% - 100%.

In relation to the 62-day standard, good progress has been made by the HSC during 2014/15 to reduce the number of cancer patients actively waiting longer than 62 days and the length of time they were waiting. It will take further time until this improvement is evident in the completed waits 62-day performance. In delivering this improved position, the HSCB has introduced enhanced monitoring arrangements with Trusts specifically around improving cancer performance. Further focussed efforts will be required in 2015/16 to improve the percentage of patients with a diagnosis of cancer who commence definitive treatment within 62 days of urgent referral, in particular in relation to the continued modernisation of the urological pathway. There will continue to be a particular focus on the longest waiting patients to reduce both the number of patients waiting longer than 62 days to commence cancer treatment and the length of time they wait.

To support the delivery of the cancer standards, the HSCB will continue during 2015/16, to seek to commission sufficient capacity across all relevant specialties as required to ensure that all patients have timely access to assessment, diagnosis and treatment. During early 2015/16 the HSCB will agree with Trusts the key messages and actions following analysis of 'red flag referral' information.

Another area for focused attention during 2015/16 will be a review of the Upper and Lower GI pathways in line with best practice, and to ensure more patients go straight to the appropriate diagnostic test, so avoiding any unnecessary delay in their diagnosis and treatment.

Unscheduled Care: From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.

The number of patients who have waited longer than 12 hours in Emergency Departments has been reducing steadily over the past number of years – from over 10,000 in 2011/12 to 3,100 in 2013/14. Unvalidated figures for 2014/15 indicate a slight increase to 3,175. Eliminating breaches of the 12-hour standard and significantly improving the percentage of patients attending an Emergency Department who are treated and discharged, or admitted within four hours of arrival will continue to be a top priority for the HSC in 2015/16.

During 2015/16 the HSCB will provide additional recurrent funding to enable Trusts to implement plans to ensure that key services (diagnostics, AHPs, social care, pharmacy etc.), at the five main hospital sites in the first instance, are delivered on a seven-day basis thereby improving patient flow at weekends.

The HSCB Unscheduled Care Team and LCGs will also work with Trusts during 2015/16 to develop plans to support twice daily senior decision making for all inpatients, and to ensure patients with the highest clinical priority are seen first during hospital ward rounds followed by patients potentially fit for discharge to facilitate early discharge and improve patient flow.

The HSCB also intends to take forward a programme of work to improve the efficiency of the utilisation of non-acute beds, building on the findings of audits undertaken during 2014/15.

The HSCB will also continue to support Trusts to improve the unscheduled care pathway through enhanced implementation of the 18 key actions.

Elective Care: From April 2015 at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks; no patient waits longer than nine weeks for a diagnostic test, and at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.

Regionally performance against the elective access standards deteriorated during 2014/15. The increase in waiting times in the first half of 2014/15 was due to a combination of increased referrals and an underdelivery of commissioned volumes of core activity by Trusts across a range of specialties. The delivery of core position improved in quarters three and four however, the inability to fund additional activity in the second half of the year led to a continued increase in waiting times for assessment and/or treatment.

At the end of March 2015, 44% of patients waiting for a first outpatient appointment were waiting less than nine weeks, and almost 70,000 were waiting longer than 18 weeks. In relation to inpatient / daycase treatment, 52% were waiting less than 13 weeks and 13,600 were waiting longer than 26 weeks.

The level of funding available to invest in elective care services in 2015/16 is likely to result in a significant and rapid increase in the number of patients waiting and in the length of time they wait for a first outpatient appointment, and for inpatient or daycase treatment.

To mitigate some of implications of the increase in waiting times, the HSCB will continue to work with Trusts to maximise the delivery of funded capacity and ensure the application of good waiting list management practice, including assessing and treating urgent cases first, and thereafter seeing and treating patients in chronological order.

In addition, the HSCB has prioritised the use of available funding in additional diagnostic capacity to ensure that serious conditions are diagnosed, and can then be prioritised appropriately.

Finally, the HSCB and DHSSPS will work together to consider opportunities to secure additional funding throughout the year. The HSCB will continuously review commitments to ensure best use of all available resources and have also supported DHSSPS to bid for additional in-year resources for elective care services as part of the June monitoring process.

Mental Health Services: From April 2015, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; 9 weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Regionally performance against the Mental Health and Psychological Therapy access standards deteriorated during 2014/15. The increase in waiting times in the first half of 2014/15 was due to a combination of increased referrals and capacity shortfalls within Trusts. There have also been difficulties within some Trusts in recruiting and retaining staff in Child and Adolescent Mental Health Services.

During 2014/15, the HSCB worked with the Trusts to review demand and capacity across a number of Mental Health services, including Child and Adolescent Mental Health Services (CAMHS) and Dementia Services, and to agree the service improvement steps to be taken to address the waiting time position. As a result numbers waiting in excess of 9 weeks at the end of March 2015 had fallen to 96 in CAMHS and 43 in Dementia Services and the HSCB is continuing to work with Trusts to reduce these numbers further during 2015/16.

The HSCB has also reviewed demand and capacity across all Psychological Therapy Services and agreed a range of service improvement actions across all Trusts to ensure that Trusts are delivering within their agreed activity framework. During 2014/15 the HSCB has worked with Trusts to expand capacity in Psychological Therapy Services with a recurrent capacity gap, subject to available funding and available funding will be prioritized during 2015/16 towards undertaking additional activity. This will not be sufficient to achieve the 13 week standard in 2015/16 but it will secure an improved position during 2015/16. The HSCB will continue to monitor Trusts' performance to ensure full delivery of capacity in all specialties, the

improvement of capacity through service improvement and the implementation of good waiting list management practice.

Children's Services: From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%.
By March 2015, ensure a three year time frame for 90% of children who are to be adopted from care.
During 2014/15, the HSCB has put in place arrangements to monitor trends for these children in care, acknowledging the time gap in performance reporting, with the most recent information for the year 2014/15 showing an improvement from 2013/14, whilst still not meeting the targets. The HSCB will be working with Trusts to agree the steps to be taken to improve performance in these areas during 2015/16.

AHPS: From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.
During 2014/15, revised AHP waiting time definitions were developed and arrangements put in place to consistently report performance in line with these definitions. An AHP demand and capacity exercise was undertaken by PHA during 2014/15 and the HSCB and PHA will be working with Trusts to agree the steps to be taken to address the waiting time position during 2015/16.

Ambulance Response Times: By March 2016, 72.5% of Category A (Life Threatening) calls responded to within eight minutes, 67.5% in each LCG area.
There was a deterioration in ambulance response times during 2014/15 compared with the previous year.

NIAS has advised that challenges remain in securing adequate levels of staffing to cover evening and weekend rotas due to sickness absence (long and short term) and staff cancelling planned overtime and the HSCB will work with the Trust in this regard.

NIAS has also experienced an unexpected increase in demand for Category A calls following the introduction of the Card 35 scheme. A software upgrade to the

booking system associated with this scheme is expected to resolve the current difficulties, resulting in improved response times for Category A calls in 2015/16.

The HSCB is working with NIAS to finalise a demand-capacity modelling exercise during 2015/16, and ongoing work to introduce alternative care pathways and to prioritise non-emergency transport are all expected to support improved Category A response times.

3. Support the achievement of new targets introduced for 2015/16

The Commissioning Plan Direction includes four new targets to be met during 2015/16:

Unplanned admissions (acute setting): During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.
The HSCB is working with Trusts, Community and Primary Care Providers to address this target. Information from the monthly download of the Hospital Inpatient System will be analysed so that emerging patterns can be reviewed against relevant care pathways and the capability of primary care services to see, treat and support patients in a primary / community setting.

Public Health lifestyle messages including the 'Choose Well' campaign will continue to be promoted. It is anticipated that the introduction of Acute Oncology Services at the Cancer Units / Cancer Centre will reduce unplanned admissions of acutely ill oncological patients - as has been the experience nationally.

Patient safety: From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.
Day of the week should not be a discriminator in the delivery of timely, resilient safe and sustainable services for patients. Just as people become unwell seven days a week, they get better seven days a week and there is a challenge to respond effectively and in a timely manner across 7 days to deliver care as required.

During 2015/16 commissioning will focus on improving 7 day working to improve the flow of patients through hospital systems, and ultimately improve both the patients' outcomes and experiences. PHA/HSCB have a process for managing RQIA reports through the Safety & Quality Alerts Team meetings and monitoring of implementation. The above target will be monitored and included monthly in the HSCB Report for 2015/16.

Cancelled Appointments: By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment.
Following the work undertaken by the Short Life Working Group, timely and accurate information on the number of hospital cancelled consultant-led outpatient appointments that had an actual impact on patients is now available. During 2015/16, the HSCB will continue to monitor Trusts' performance in this area and will work with Trusts to identify opportunities to reduce the number of hospital cancellations.

Pharmaceutical Clinical Effectiveness Programme: By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.
The programme focuses on key therapeutic areas where by application of clinical evidence (e.g. NICE) and promotion of formulary choices as per NI formulary can result in improvements in quality and safety whilst producing efficiency and gains.

The HSCB have developed a detailed action plan outlining the efficiencies and actions to be taken in 2015/16 and the programme is overseen by a Prescribing Efficiency Review team. This team will review efficiencies and actions on a monthly basis to ensure delivery of the PCE target and to consider remedial action where required.

Delivery of the targets will be achieved through engagement with GPs, LCGs and Trusts. The HSCB will continue to work with GPs to further develop commissioning arrangements for provision of prescribing support for all GP practices in NI. The

HSCB will also identify opportunities to collaborate more effectively with Trusts to ensure delivery targets through joint HSCB/LCG/Trust meetings focusing on particular therapeutic topics where key clinicians will be attendance.

9.0 Belfast Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure delivery either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

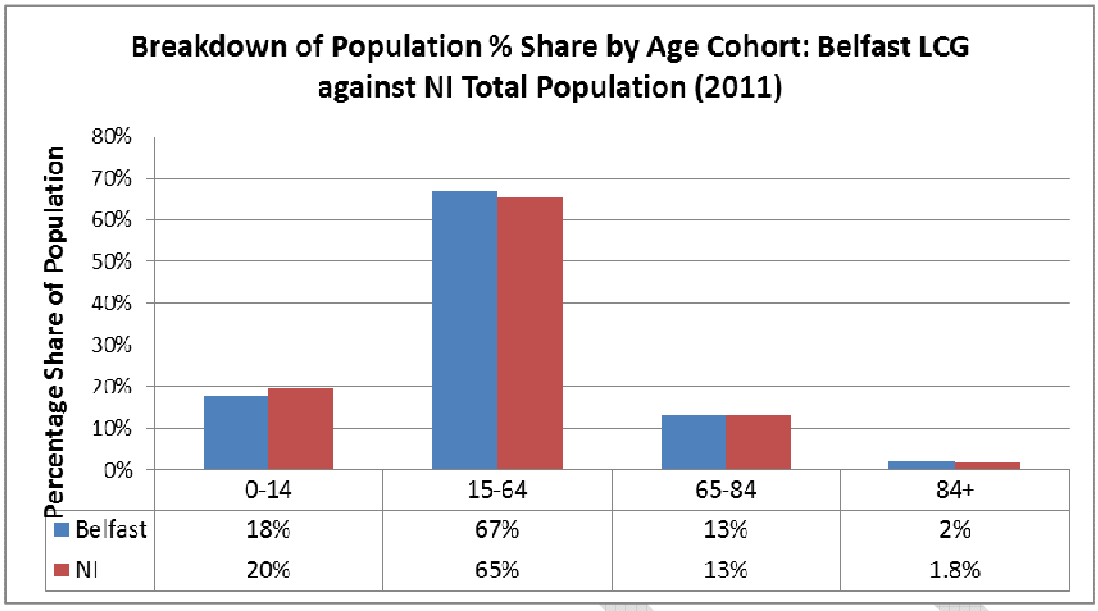
9.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Belfast LCG. A range of info and analyses has been used to identify the challenges facing the LCG in 2015/16 and beyond.

9.1.1 Demographic changes / pressures

This section gives a general overview of the population Belfast LCG serves, describing the age structure, general health and income of the resident population.

Figure 4



Source: NISRA 2012

Demography

Figure 4 above shows that the Belfast LCG area has a relatively older population profile than other areas of Northern Ireland. The breakdown of the Belfast LCG population change at five year intervals from 2012 – 2027 below indicates that the largest increases will be in the numbers of children and older people which are groups with greater needs than other age groups. The increase in people aged 85 and over is also significant as this group tends to have the greatest need for health and social care.

Belfast LCG population changes

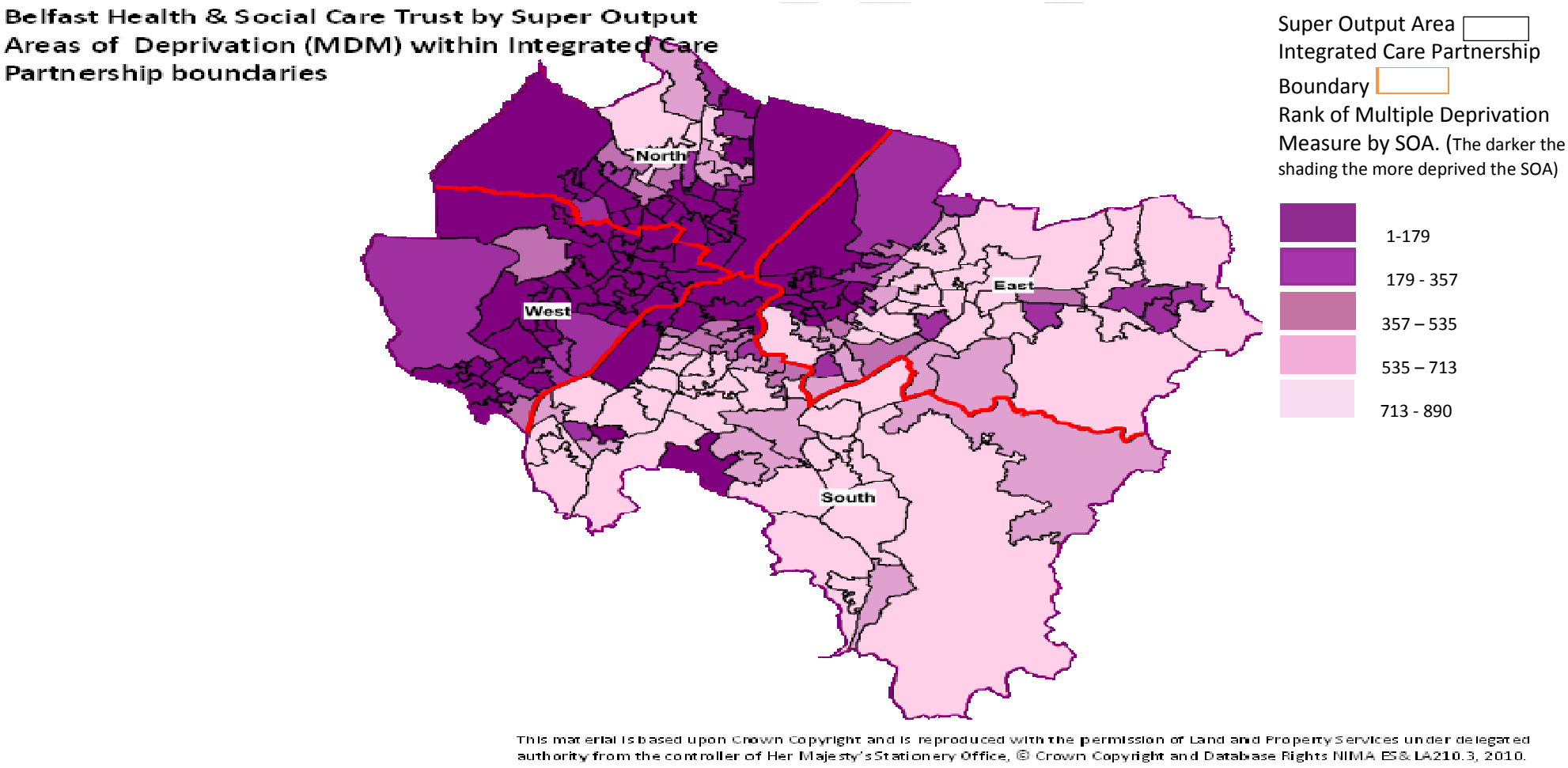
Table 22

AGE / YEAR	2012	2017	2022	2027	Total Change 2012-2027
0-14	61912	66179	69305	66885	4973
15-64	233354	234627	231392	228663	-4691
65-84	45732	46847	50332	56838	11106
84+	7255	8346	9418	10575	3320
TOTAL	**348253**	**355999**	**360447**	**362961**	**14708**

Deprivation

The extent of deprivation in Belfast Council area is greater than in any other Local Government District in Northern Ireland, with 46% of the population estimated to be living in multiple deprivation (NINIS 2010). The map below shows the areas of deprivation across the 4 ICP localities within the Belfast area. The population in multiple deprivation tends to be concentrated in north and west Belfast but there are also significant areas of deprivation in south and east Belfast. Figure 5 shows that people living in more deprived areas tend to have greater health needs than those in less deprived areas.

Figure 5



Health Summary

The table below shows the health of the Belfast LCG population in comparison to Northern Ireland as a whole which indicates that for most of the key health indicators the population of the Belfast LCG area is in poorer health and have greater need.

Table 23

Domain	Indicator	Descriptor	BELFAST	NI Average	Most Deprived in BLCG	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.33	19.12		
	COPD	Prevalance per 1000	21.8	18.56		
	Stroke	Prevalance per 1000	18.61	17.94		
	Diabetes	Prevalance per 1000	42.49	42.61		
	Dementia	Prevalance per 1000	6.91	6.67		
Disability	Pain or Discomfort	% of population (2012-13)	36	35	43	
	Learning Disability	Prevalance per 1000	4.56	5.33		
Emotional Health and Wellbeing	Mental Health	Prevalance per 1000	10.38	8.54		
	Crude Suicide Rates	All Persons	21.5	15.8		
Risk Factors	Smoking- current smoker	% of population (2012-13)	26	24	37	
	Obese or overweight	% of population (2012-13)	62	62	66	
	Meeting Physical activity levels	% of population (2012-13)	51	53	45	
	Anxious or Depressed	% of population (2012-13)	33	26	37	
Maternal and Child Health	Children in Need	Rate per 100,000	85.67	60.18		
	Diabetes in Pregnancy	Belfast Mothers (12/13)	3.19	3.6		
	Obesity in Pregnancy	BMI >30	18.7	19.3		
	Births to Teenage Mothers	Percentage 2013	5.39	3.86		
Life Expectancy	Male	Age (2009-11)	75.1	77.5	73	
	Female	Age (2009-11)	80.18	82	79.4	
	Cancer (All ages)	Standardised Death Rate	333.7	291.6		
	Circulatory Diseases	Standardised Death Rate	118	93		
	Respiratory Diseases	Standardised Death Rate	125	113		
Carers	Unpaid Care	50+ Hours provided (2011)	3.4	3.1		

Higher than NI Average

Lower than NI Average

9.1.2 Personal and Public Involvement

Belfast LCG continually engages with key stakeholder including service users, carers, community and voluntary sectors, political representatives, HSC organisations and health and social care professionals.

In developing the specific proposals in the Commissioning Plan, the Belfast LCG has involved service users, advocacy groups and community groups, particularly members of the Long Term Conditions Alliance such as Diabetes UK and Arthritis Care; Carers groups such as Carers NI; mental health such as NIAMH and local community groups providing counselling and other services; groups representing Older People such as the Greater Belfast Seniors' Forum, local lifestyle forums in Belfast and Castlereagh and Age Partnership Belfast; groups representing people with Disabilities such as the Prosthetic Users' Forum and the Stroke Survivors and Carers Forum; and members of the five Area Partnerships in Belfast.

The Draft Commissioning Plan was thoroughly discussed at a plenary workshop of interest groups hosted by the LCG. Issues raised were considered by the LCG and amendments were made to the plan. This will be followed up by regular workshops to ensure that implementation of the plan reflects the agreed plan.

9.1.3 Summary of key challenges

- Higher standardised mortality ratios for cancer, heart disease and respiratory diseases;
- A growing population of elderly people with increased care needs and increasing prevalence of disease;
- Higher proportion of people living with long term illness;
- Highest proportion of individuals using prescribed medication for mood and anxiety disorders
- An over-reliance on hospital care, with activity exceeding current funds;
- Services which are fragmented and lack integration;
- Health and quality of life generally worse than the rest of NI

9.2 LCG Finance

Use of Resources

The Belfast LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £619.7m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 24

Programme of Care	£	%
Acute Services	208.6	33.59%
Maternity & Child Health	23.5	3.79%
Family & Child Care	44.9	7.24%
Older People	144.7	23.31%
Mental Health	60.3	9.71%
Learning Disability	56.9	9.17%
Physical and Sensory Disability	25.8	4.16%
Health Promotion	27.3	4.41%
Primary Health & Adult Community	27.7	4.63%
POC Total	**619.7**	**100%**

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

Table 25

Provider	£	%
BHSCT	530.8	85.51%
NHSCT	2.0	0.32%
SEHSCT	39.0	6.27%
SHSCT	0.8	0.13%
WHSCT	0.3	0.05%
Non-Trust	46.8	7.71%
Provider Total	**619.7**	**100%**

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

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Belfast Trust is

in the region of £20.6m. The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Belfast area and additional investment in the therapeutic growth of services.

9.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Belfast Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

9.3.1 POC 1: Acute – Elective Care

Strategic Context: The LCG will address the demand on elective services to ensure standards and response times are improved. The LCG will work with primary care to support GPs and others in developing innovative approaches to managing the care of patients as far within their locality, without the need for referral to a Consultant-provided service. The role of other healthcare professionals will also be extended to reserve Consultant appointments for those patients who require it.

Local Needs and Assessment

1. Demand for imaging exceeds capacity as follows: 8150 MRI Scans, 7160 CTs, 6000 Non-Obstetric Ultrasounds and 250 Fluoroscopies.
2. Demand for Endoscopies exceeds commissioned capacity by 660 per year.
3. Demand exceeds service capacity by 5900 outpatient consultations, 700 inpatient and 2650 day case treatments, across 12 local specialties.
4. 2700 patients per year presenting with musculoskeletal conditions and pain require a coordinated pathway to ensure they get the right care from the right clinician in the right setting as quickly as possible.

Services to be commissioned

1. The LCG will commission an additional 3455 MRI, 7244 CT, 6520 NOUS and nearly 6000 other tests to achieve a maximum wait of 14 weeks in 15/16; however this excludes existing waiters of nearly 4000.
2. Referrals for endoscopy will be scored on a JAG accredited points system to ensure more effective use of clinical capacity.
3. Primary care will be supported in managing demand for Neurology, Dermatology, ENT, Rheumatology, Respiratory, Urology and Gynaecology.
4. The LCG will also take forward an integrated Musculoskeletal pathway across Orthopaedics, Rheumatology

Securing Service Delivery

1. The Belfast Trust should bring forward proposals to fully utilise its in-house imaging capacity, including the new MRI scanner at RBHSC.
2. The Trust should fully develop the potential for Nurse-led Endoscopy and introduce an agreed points system to maximise utilisation of endoscopy services.
3. Demand management will be sought from primary care contractors where these can be shown to reduce the need to refer to Trust Consultant-led services.
4. ICPs should bring forward proposals in response to the LCG specification for integrated musculoskeletal services.

Regional Priorities (see appendix A): Cancer services (MT11), Unscheduled Care (MT12), Elective Care (MT15, 16, 17), Patient Safety (MT25),

9.3.2 POC 1: Acute – Unscheduled Care

Strategic Direction: The LCG will aim to commission an urgent care pathway which reduces reliance on hospital services, achieving a transfer of resources from hospital to community services through investment in alternatives to hospital and more effective decision-making when people attend an Emergency Department.

Local Needs and Assessment

1. The number of patients admitted as emergencies for less than 48 hours is increasing, in line with national trends.

2. Variation in demand for urgent care by hour of day and day of week is not matched by appropriate service responses in hospital or in the community, leading to delays in the delivery of care and requiring expansion of capacity in specific areas.

3. Around 46,000 people attend Emergency Departments for minor illnesses or injuries which could be addressed more appropriately within primary care or by self-care.

Services to be commissioned

1. The LCG will commission 7-day Acute Care at Home and Community Respiratory services to avoid unnecessary short stay admissions of the frail elderly and COPD patients to hospital.

2. The LCG will commission a new Emergency Department and supporting services at the RVH which match the pattern of attendances at this hospital. The LCG will commission 7 day services which support the Emergency Department and avoid unnecessary short stay admissions and delays.

3. The LCG will commission integrated Minor Injury, Minor Illness, Out of Hours and Primary Care services, supported by community and voluntary resources.

Securing Service Delivery

1. The Belfast ICPs should continue to implement the ICP Respiratory team and bring forward proposals to extend Acute Care at Home to 7 days.

2. The Belfast Trust should ensure that: the new RVH ED has sufficient support from hospital services to meet Ministerial targets for waiting times; senior decision-makers are able to assess and discharge rather than admit, where this is clinically appropriate, and the frequency of ward rounds is increased to ensure no unnecessary delays in discharging patients. Excess days in hospital should be reduced in line with best practice in the NHS.

3. The ICPs should bring forward proposals for minor illness/injury services based on the LCG specification.

Regional Priorities (see appendix A): Patient Safety (MT25), Unplanned Admissions (MT5/6)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 26

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	19,715		19,715
		Daycases	49,717		49,717
		New Outpatients	129,259		129,259
		Review Outpatients	284,278		284,278
	Unscheduled	Non Elective admissions - all	46,037	2,061	48,098
		ED Attendances	211,667	7,800	219,467
		Planned investment in 2015-16		£3.4m	

9.3.3 POC 2: Maternity and Child Health Services

Strategic Priorities: The LCG will commission implementation of the objectives of the Maternity Strategy and Healthy Child, Healthy Futures: including a strategic shift towards providing more maternity care in the community, more midwife-led care and tackling inequalities. The paediatric inpatient review led by the DHSSPS will set a framework for the future development of inpatient services which are safe and sustainable. The LCG will continue to work closely with ICPs in ensuring that children receive the best possible care in the most appropriate settings.

Local Needs and Assessment

1. Births at the RJMH are projected to decrease by a further 2% by the end of 2014/15. However, the RJMH also provides a range of regional services which deal with complex deliveries and peri-natal care. A regional review of neo-natal services identified a requirement to incrementally increase the number of intensive care costs from 27 to 31.

2. Higher levels of deprivation increase demands on the service. 1 in 5 Belfast mothers has a BMI over 30 with a growth of 37% in diabetes in pregnancy over past 2 years. 64 per 1000 babies have Low Birth Weight in Belfast (NI rate is 59). The needs of ethnic minorities must also be taken into account.

3. Emergency Department attendances at RBHSC are increasing each year.

Services to be commissioned

1. Investment to be reviewed in line with the Maternity Strategy, taking account of birth numbers, full utilisation of Midwife led Units and complexity of births.

2. Increasing complexity will require a gestational diabetes service, a multiple pregnancy ante-natal service and joint obstetric-specialist physician antenatal clinics to address increasing complexity.

3. The LCG will commission alternatives to ED attendance for minor illnesses. The LCG will ensure that a sustainable medical rota at the RBHSC ED. The age limit for admission to children's wards will be raised to 16.

Securing Service Delivery

1. The SBA with Belfast Trust will be adjusted to reflect changing needs and demands. The Trust should ensure that midwifery-led care is extended and work with GPs, midwives and the local community to ensure that capacity within the Mater Midwifery Led Unit is fully utilised.

2. The Trust should provide a gestational diabetes service, a multiple pregnancy ante-natal service and joint obstetric-specialist physician antenatal clinics. From April 2015, all eligible pregnant woman aged 18 years & over with a BMI of >40 at booking should be offered the weigh to a healthy pregnancy programme.

3. The ICPs should propose alternatives to ED for minor illness from ICPs. The Trust should secure a 5th ED consultant in RBHSC and

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 27

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	6,931		6,200
	Health Visiting	Contacts	20,702		20,702
		Planned investment in 2015-16		£0.06m	

9.3.4 POC 4: Older People

Strategic Priorities: additional community nursing support, acute care at home and direct access to specialist assessment will be commissioned to reduce the risk of hospitalisation and avoid Emergency Department attendance wherever appropriate. Early supported discharge with enhanced therapeutic interventions will reduce unnecessary days in hospital and improve long term outcomes. Early diagnosis and support for carers should improve outcomes for people with dementia.

Local Needs and Assessment

1. Older patients, especially those with multiple chronic conditions, are more likely to need to attend an ED and, once there, are far more likely to be admitted, often for assessment and short term nursing and medical care. (Audit Commission 2013).
2. Around 1000 people with Dementia in Belfast are undiagnosed and will therefore not benefit from early support and intervention.
3. 180 of the Belfast residents who suffer a Stroke and are admitted to the RVH Stroke Unit could have their outcomes improved by receiving Early Supported Discharge.

Services to be commissioned

1. The Acute Care at Home scheme will commence on 1 April 2015 to treat 3302 patients in their own homes per year. Admission to this "virtual ward" will be an alternative to admission to a hospital ward.
2. An enhanced Dementia Memory Service will be commissioned this will improve early diagnosis rates, support care planning and support for carers.
3. An Early Supported Discharge programme will be commissioned with a capacity of 180. The shorter length of stay will also ensure Stroke beds are available for those who need them.

Securing Service Delivery

1. ICPs should bring forward proposals to extend the Acute Care at Home scheme to receive admissions on a 7 day basis.
2. The Trust should provide an additional 1560 appointments for clients across 10 local Dementia Memory Clinics. This will reduce waiting times and increase early diagnosis.
3. ICPs should finalise proposals for Early Supported Discharge. The LCG will commission supported self-management programmes for those living with Stroke from Active Belfast and the voluntary sector.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency readmissions (MT14), Patient Discharge (MT21)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 28

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,029,469	25,600	2,055,069
	Residential and Nursing Home Care	Occupied bed days	924,874	10,600	935,474
	Community Nursing	Contacts	256,905		256,905
		Planned investment in 2015-16		£2.1m	

9.3.5 POC 5: Mental Health

Strategic Priorities: The LCG will work closely with the Regional Bamford Team to develop services for the severely mentally ill and for those with mild or moderate mental illness, emphasising recovery through the Stepped Care model which supports people to live independently with or without on-going mental illness. The LCG, Trust, ICPs and Belfast Strategic Partnership in developing a Primary Care Talking Therapies Service enabling GPs to help patients access appropriate C&V support, or specialist support when required. This approach also aims to reduce the relatively high dependency on prescription drugs for depression, anxiety and pain within Belfast.

Local Needs and Assessment

1. Belfast has the highest proportion of individuals of any constituency in NI (160 vs. 147 per 1000) using prescribed medication for mood and anxiety disorders; estimated demand of 4000 patients per year requiring treatment for mild to moderate mental health problems.
2. Evidence indicates that intensive early intervention when symptoms of psychosis first emerge can significantly improve life chances and health outcomes. Similarly early intervention in respect of eating disorders can reduce the severity and longevity of harmful behaviours and associated physical health problems.
3. Evidence indicates that Recovery approaches in mental health improves outcomes by supporting people with long term mental health conditions to take more responsibility for self-care, supporting them to become economically active, and to sustain family and social relationships.

Services to be commissioned

1. 32,000 sessions of NICE recommended evidence-based interventions (talking therapies) will be commissioned to meet the estimated demand for treatment.
2. The multi-disciplinary early intervention psychosis service will be expanded to enhance peer support; primary care based early intervention provision will be commissioned from the specialist eating disorder service.
3. HSCB will support the Trust in reshaping practice and services initiatives to ensure a Recovery Focus, develop a Recovery College and to continue to enhance the provision of peer support. A Substance Misuse Liaison Service (SMLS) will be commissioned in appropriate acute hospital settings, delivering regionally agreed Brief Intervention Programmes.

Securing service delivery

1. The Trust and ICPs should develop the Primary Care Talking Therapies Service with a Hub in each ICP area. The Trust should commission the range and volumes of therapies from community-based organisations to meet the estimated demand and offer a training programme to organisations to support the delivery of the evidence-based interventions.
2. The Trust should bring forward plans for the further development of the early intervention psychosis and eating disorder services in response to a commissioner specification.
3. The Trust should bring forward plans for the development of a Recovery College in response to a commissioner specification. The Trust should respond to a commissioner specification for an SMLS.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 29

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	90,683		90,683
	Residential and Nursing Home Care	Occupied Bed days	57,461	150	57,611
	Domiciliary Care	Hours	96,242	350	96,592
		Planned investment in 2015-16		£0.2m	

9.3.6 POC 6: Learning Disability

Strategic Priorities: The Bamford principles of promoting independence and reducing social isolation for people with learning disabilities continues to underpin the commissioning objective for Belfast LCG. With a focus on supporting family carers; and working with other statutory, voluntary and community partners to deliver services that enable people with a learning disability to maximise their potential and enjoy health, wellbeing and quality of life.

Local Needs and Assessment

1. Better health care has resulted in an increase in the number of young people with complex learning disability and physical health needs surviving into adulthood.
2. The resettlement of people from long stay hospital to community settings is reaching completion. There is a need to further develop community based services to support people with complex needs to sustain their community placements.
3. As the life expectancy of people with a learning disability increases there is an increase in the number and age of family carers. Also as people live longer they develop health needs associated with old age. This is increasing the complexity of needs that family carers are coping with. The Trust has identified 82 clients with a risk of family care breakdown because of caring pressures.

Services to be commissioned

1. Day opportunities will be commissioned for up to an additional 20 young people with complex needs transitioning to Adult Services.
2. An enhanced range and availability of intensive community support services will be commissioned to prevent placement breakdown, avoid the need for hospital admission and facilitate timely discharge from hospital.
3. Innovative forms of support will be commissioned for parents and other family carers living with adults with learning disabilities at home.

Securing Service Delivery

1. Belfast Trust should commission a number of day opportunities packages, to be specified by the LCG, in line with the Regional Day Opportunities Model and criteria, for young people transitioning to adult services, to be specified and funded by the LCG.
2. The Trust should develop intensive support services to reduce the risk of hospital admission and extend availability out of hours.
3. The Trust should make proposals in response to a commissioner specification for the extension of the parenting support services, and implement other carer support initiatives identified in the "Short Break" review.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Patient Discharge (MT21), Unplanned Admissions (MT5)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 30

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	251,247	310	251,557
	Residential & Nursing Home Care	Occupied bed days	111,071		111,071
		Planned investment in 2015-16		£0.1m	

9.3.7 POC 7: Physical Disability and Sensory Impairment

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

Local Needs and Assessment

1. Prevalence of hearing impairment (5.6%), visual impairment (2.0%) is higher for Belfast LCG than for Northern Ireland as a whole (5.1% and 1.7% respectively);
2. 11,700 people in the Belfast LCG population each provide more than 50 hours of care per week (585,000 hrs.)
3. The rate of major amputations per 1000 on the diabetes register was 3 for NI in 2013/14 compared to 1 per 1000 in England.

Services to be commissioned

1. Subject to the outcome of recent pilot schemes, the LCG plans to increase investment in sensory impairment services including deaf/blind training and audiology support services for hearing aid users and people with tinnitus;
2. Following a regional review, investment will be made in innovative Short Breaks for carers as an alternative to traditional forms of respite care;
3. The LCG will commission a Foot Protection Team model of service to reduce the risk of foot disease and ulceration, so reducing the need for amputation. Outcomes for amputees through investment in rehabilitation and modernisation of the service through E-Health and technology development.

Securing Service Delivery

1. Services for people who are deaf/blind use hearing aids or have tinnitus will be procured from the community and voluntary sector.
2. The Trust should bring forward proposals for additional investment in short breaks for carers which balance the need for intervention and responding to crisis situations; the LCG will expect innovative proposals which make greater use of Direct Payments and which are underpinned by improved identification of carers
3. The Belfast ICPs will be commissioned to provide a Foot Protection Service. The Trust should also bring forward proposals for additional investment in AHPs to support the regional Amputee Service and should develop proposals for modernisation using technology.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Allied Health (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC 7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 31

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	339,886	2500	342,386
	Residential & Nursing Home Care	Occupied bed days	39,649	180	39,829
		Planned investment in 2015-16		£0.16m	

9.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better was launched by DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. Belfast Strategic Partnership Framework for Action sets out a range of priorities to address life inequalities in the BLCG area. In 2015/16 Community Planning will be introduced. BLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs Assessment

1. Higher standardised mortality of Cardiovascular, Cancer and Respiratory disease, especially in more deprived areas leading to lower life expectancy.
2. Risk factors and evidence of parental stress include relatively high rates of teenage pregnancy, lower breastfeeding rates, prevalence of self-harm and alcohol intake during pregnancy.
3. Between 32% and 4% of households in the LCG are Fuel poor which can lead to poor health and even death.

Services to be commissioned

1. Chronic Disease Prevention Hubs will be commissioned in each locality to enable GPs, Pharmacists and others to refer patients with known health risks, including stress, smoking and obesity to accredited, community based risk-reduction programmes. Community-based organisations will support health promotion by targeting workplaces and schools using community development approaches.
2. Evidenced based parenting programmes will be promoted and supported by an Early Interventions Officer.
3. NICE guidance on Excess Winter Deaths will be implemented through the Belfast Strategic Partnership

Securing Service Delivery

1. ICPs should bring forward proposals to provide Chronic Disease Prevention Hubs which develop, coordinate and deliver programmed risk reduction plans for individuals. These should be closely linked to Primary Care Talking Therapy Hubs to support emotional health and well-being. The Hubs should also work with GPs and the Trust Reablement Team and Falls Prevention Team to provide practical and emotional support to older people to support independent living.
2. Belfast Trust should ensure that appropriate staff are released to take Brief Intervention Training.
3. The LCG and PHA will work through the Belfast Strategic Partnership and Community Planning to secure implementation of agreed objectives to address life inequalities.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1), Patient Safety (MT25), Mental Health (MT22)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

9.3.9 POC 9: Primary Health and Adult Community

Strategic Context: The LCG will continue to support the modernisation of primary care services. A programme of co-location of primary and community care services is being taken forward involving local communities and the new Councils. The NIAO has drawn attention to higher spending on prescription drugs in NI than in the rest of the UK and the LCG has developed a joint action plan with the four ICPs in its area to reduce this by funding practice-based pharmacists, encouraging adherence to guidelines and offering alternative therapies. The LCG will also work with practices to reduce variation in services.

Local Needs and Assessment

1. Referral rates of patients with Type 2 Diabetes to hospital vary significantly between GP practices in Belfast. There are also patients with Diabetes who are house-bound and require domiciliary visits.

2. Spending on the drug Pregabalin in Belfast is higher than the NI average and its abuse is a public health hazard. There is a 13 week wait for psychological therapies by people with long term health conditions, such as chronic pain, who have associated mental health conditions.

Commissioning Requirements

1. The LCG will commission a 'Shared Care' service for Diabetes which will provide specialist support to GP practices to ensure consistency of care management and prescribing, reduce referral variation and carry out domiciliary care visits per year.

2. The LCG will commission a Pain Management Programme with sufficient capacity to provide an alternative or complement to prescription of Pregabalin for pain relief.

Securing Service Delivery

1. The ICPs should bring forward proposals for a Diabetes 'Shared care' service which builds on the South Belfast Care Pathway and reduces variation in service provision.

2. The LCG will commission a Pilot Pain Management Programme (PMP) from Arthritis Care and, if positively evaluated, will procure a PMP through a tendering process.

Regional Priorities (see appendix A): Unplanned Admissions (MT5,6), Emergency Readmissions (MT14), Pharmaceutical Clinical Effectiveness Programme (MT30)

10.0 Northern Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure deliver either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

10.1 Overarching assessment of need and inequalities for LCG population

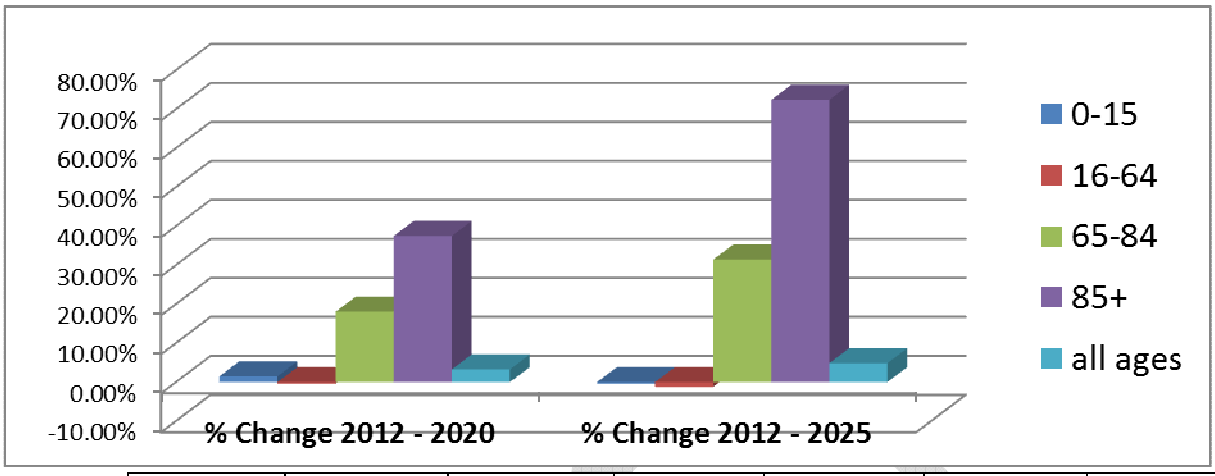
This section provides an overview of the assessed needs of the populations of the Northern Local Commissioning Group (NLCG). A range of information and analyses have been used to identify the challenges facing the NLCG in 2015/16 and beyond.

10.1.1 Demographic changes / pressures

This section provides a general overview of the population the NLCG serves, describing the age structure and general health of the resident population. The NLCG covers an area of 1,670 square miles with a total population of 466,724 (49% or 228,731 are male and 51% or 237,933 are female). The NLCG has the highest share (26%) of the Northern Ireland population.

NLCG Population Forecast Change: 2012-2020 vs. 2012 - 2025

Figure 6



	Year: 2012	Year: 2020	Year: 2025	Variance from 2012 - 2020	Variance from 2012 - 2025	% Change 2012 - 2020	% Change 2012 - 2025
0-15	96,199	97,628	95,828	1,429	-371	1.49%	-0.39%
16-64	296,079	294,900	292,513	-1,179	-3,566	-0.40%	-1.20%
65-84	64,710	76,379	85,044	11,669	20,334	18.03%	31.42%
85+	8,541	11,743	14,724	3,202	6,183	37.49%	72.39%
all ages	**465,529**	**480,650**	**488,109**	15,121	22,580	3.25%	4.85%

Source: NISRA, 2012

The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five to ten years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group.

Current Population for NLCG Residents Aged 65+ by Age Band and Local Government District

Table 32

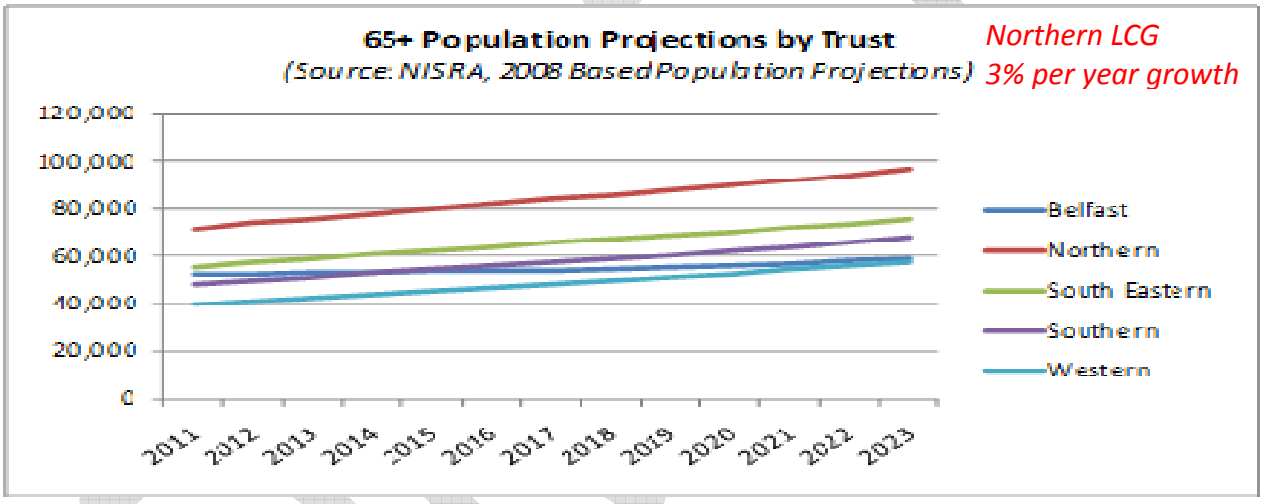
LGD	65-74	75-84	85+	Total 65+
Antrim	4,549	2,347	798	7,694
Ballymena	6,117	3,707	1,393	11,217
Ballymoney	2,751	1,570	570	4,891

Carrickfergus	3,783	2,174	747	6,704
Coleraine	5,887	3,495	1,192	10,574
Cookstown	2,950	1,577	613	5,140
Larne	3,350	1,862	661	5,873
Magherafelt	3,445	1,928	711	6,084
Moyle	1,756	934	339	3,029
Newtownabbey	7,488	4,551	1,701	13,740
NLCG Total	**42,076**	**24,145**	**8,725**	**74,946**
NI Total	**155,300**	**90,550**	**33,284**	**279,134**

Source: NISRA, Mid-Year Estimates 2013

Current >65 Population

Figure 7

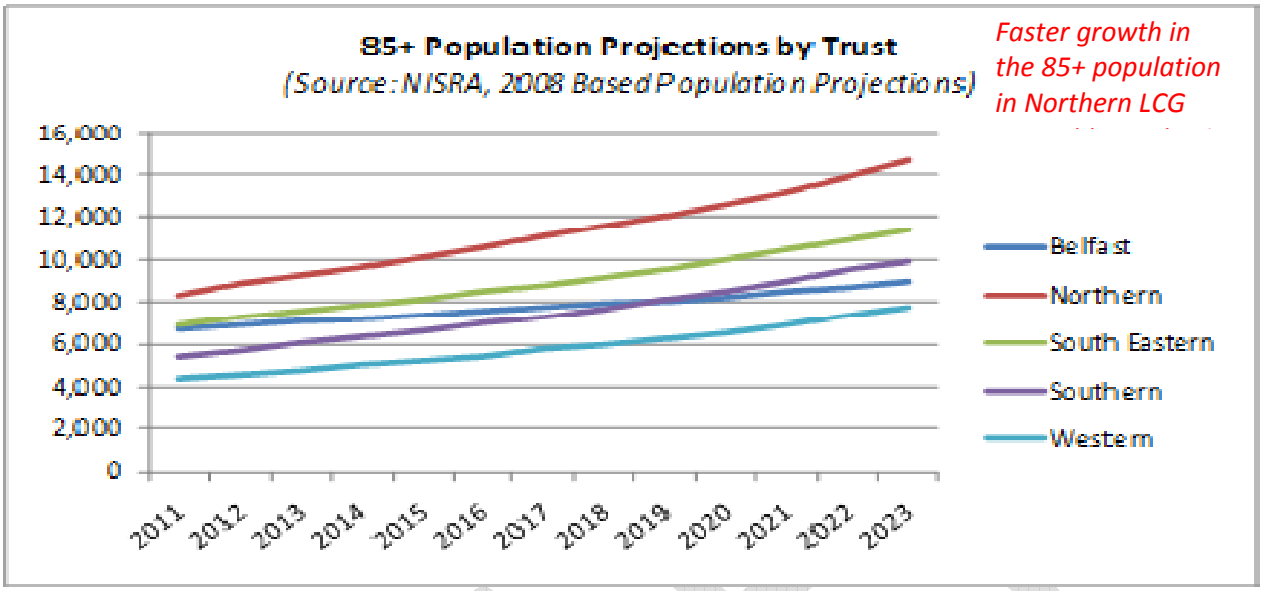


Year:	2011	2012	2013	2014	2015	2016	2017
65+ Pop	71,527	73,876	75,912	77,834	79,785	81,725	83,706
	2018	**2019**	**2020**	**2021**	**2022**	**2023**	
65+ Pop	85,693	87,661	89,630	91,777	94,024	96,386	

Source: NISRA, 2008 Population Projections

Current Over 85 Population

Figure 8



Year:	2011	2012	2013	2014	2015	2016	2017
85+ Pop	8,340	8,882	9,232	9,584	10,065	10,590	11,064
	2018	2019	2020	2021	2022	2023	
85+ Pop	11,538	12,073	12,608	13,185	13,935	14,660	

Source: NISRA, 2008 Population Projections

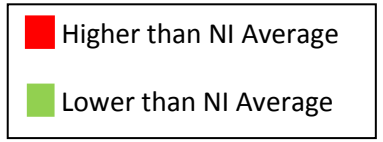
The table below highlights the greater prevalence of certain conditions in the Northern LCG area namely: cancer, stroke, atrial fibrillation, coronary heart disease, hypertension and diabetes.

Health Summary

The table below shows the health of the Northern LCG population in comparison to Northern Ireland as a whole.

Table 33

Domain	Indicator	Descriptor	NLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	19.49	19.12	
	COPD	Prevalance per 1000	18.43	18.56	
	Stroke	Prevalance per 1000	18.44	17.94	
	Atrial Fibrillation	Prevalance per 1000	15.99	15.12	
	Coronary Heart Disease	Prevalance per 1000	41.34	38.81	
	Hypertension	Prevalance per 1000	137.67	130.5	
	Diabetes	Prevalance per 1000	45.93	42.61	
	Asthma	Prevalance per 1000	61.8	60.48	
	Dementia	Prevalance per 1000	6.46	6.67	
	Learning Disability	Prevalance per 1000	5.19	5.33	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.86	8.54	
	Anxious Depressed	% of population (2012-2013)	24	26	
	Crude Suicide Rates	All Persons	13.1	15.8	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	61	62	
	Meeting Physical activity levels	% of population (2012-2013)	54	53	
	Pain or Discomfort	% of population (2012-2013)	36	35	
	Bowel Cancer Screening	Programme Uptake	53.39	49.8	
Child Health	Children in Need	Rate per 100,000	47.19	60.18	
	Births to Teenage Mothers	Perecentage 2013	4.04	3.86	
Life Expectancy	Male	Age (2009-11)	77.95	77.5	
	Female	Age (2009-11)	82.45	82	
	Neonatal	Death Rate (2013)	0.3	0.3	
	Infant Mortality	Death Rate (2013)	3.9	4.6	
	Lung Cancer	STD Death Rate (2008-2012)	58.3	66.5	
	Female Breast Cancer	STD Death Rate (2008-2012)	35	38.1	
Carers	Unpaid Care	50+ Hours provided (2011)	2.9	3.1	



10.1.2 Personal and Public Involvement

The Northern LCG had a successful joint working forum with representatives from the 10 district councils and the Northern Trust. This group has been reconstituted to take account of the new Council structures. The group will continue to meet quarterly and more often when appropriate to discuss matters relating to health and social care locally and in particular progress the agenda relating to transformation. The group is chaired by the Chair of the Northern LCG and the Vice Chair is a local elected representative. The group also shares information relating to developments in local government such as community planning which is relevant to the work of local commissioning.

The Northern LCG has also established links with Causeway Older Active Strategic Team (COAST), Mid and East Antrim Agewell Partnership (MEAAP) and Age Well Mid Ulster in order to ensure that there is on-going dialogue in respect of issues of common interest relating to older people.

More recently the Northern LCG has also engaged with the local community networks of South Antrim, Causeway Rural and Urban Network, Cookstown Western Shores and North Antrim Community Network.
Service Users and Carers are involved in specific initiatives undertaken by the Northern LCG. These include work that is on-going to develop specific pathways such as the MSK pathway and the preparatory work on pathways undertaken to inform the work of the Integrated Care Partnerships for example in dementia.

Representatives from the Northern LCG also participate in the Carers Steering Group locally and in the Northern Area Promoting Mental Health and Suicide Prevention Group.

It is recognised that the Northern LCG will need to continue to extend opportunities for engagement and user involvement in the coming year as significant reforms will continue to be progressed as part of improving efficiency and rolling out the transformational agenda.

10.1.3 Summary of Key Challenges

A summary of the key challenges in 2015/16 are as follows:

- A growing older population with increasing prevalence of long term conditions;
- An over reliance on hospital care with capacity issues in some service areas;
- Growing demand for elective specialties and the need to reshape and redesign services to better meet demand;
- Meeting the needs of older people for domiciliary care and support in the context of a therapy led reablement service;
- Delivering on the potential of ICPs to implement agreed care pathways to reduce reliance on hospital care and effect a shift of resources;
- With the NLCG having a large rural hinterland, access to services can be problematic – e.g. access to emergency ambulances.
- Maximising the role of the voluntary and community sector in the delivery of health and social care.
- Working with Partners in local government and other statutory services to deliver on the Community Planning functions.

10.2 LCG Finance

Use of Resources

The NLCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £728.4m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 34

Programme of Care	£	%
Acute Services	281.2	38.54%
Maternity & Child Health	33.0	4.53%
Family & Child Care	46.5	6.37%
Older People	166.2	22.78%
Mental Health	59.3	8.12%
Learning Disability	61.0	8.37%
Physical and Sensory Disability	21.6	2.96%
Health Promotion	24.0	3.29%
Primary Health & Adult Community	35.6	5.05%
POC Total	**728.4**	**100%**

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

Table 35

Provider	£	%
BHSCT	125.1	17.15%
NHSCT	539.2	73.89%
SEHSCT	3.0	0.41%
SHSCT	5.0	0.68%
WHSCT	6.5	0.88%
Non-Trust	49.6	6.98%
Provider Total	**728.4**	**100%**

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

Whilst Emergency Department (ED) services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Northern Health and Social Care Trust (NHSCT) is in the region of £17m.

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

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Northern area and additional investment in the therapeutic growth of services.

10.3 Commissioning Priorities 2015/16 by Programme Of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Northern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

10.3.1 POC 1: Acute – Elective Care

Strategic Context: The NLCG will continue to meet demand shortfalls across both elective and non-elective services to achieve ministerial waiting times. The NLCG will seek commissioning opportunities with emerging GP Federations, in addressing Acute demand shortfalls.

Local Needs and Assessment

1. NLCG patients require a diagnostic test within the Ministerial waiting time of 9 weeks. There are currently (February 2015) 7,900 patients waiting more than 9 weeks across priority tests.
2. Elective capacity across a number of local specialties such as Dermatology, ENT, Rheumatology, Neurology, Respiratory, Urology and Gynaecology remains insufficient to meet current demand. The number of patients waiting over 18 weeks for assessment and 26 weeks for treatment is increasing.
3. Local Cancer pathways continue to evidence capacity challenges to meet expected
31 days and 62 days Ministerial objectives.

Commissioning Requirements

1. Local demand levels for diagnostic services mean that additional capacity is required. NLCG will commission this capacity to address elective demand and deliver 7 Day working across the main modalities to support unscheduled pathways.
2. Commission additional Elective capacity across Inpatient and Daycase treatments, and New and Review Outpatient Appointments. NLCG will explore options to deliver this outside secondary care settings, where appropriate, together with securing optimum Trust performance across existing elective outpatient, in-patient, day case, capacity including reducing cancellations.
3. Develop local pathways to improve access times and promote direct to test for patients, to reduce un-necessary delays in cancer pathways.

Securing Service Delivery

1. Subject to available funding, additional diagnostic capacity will be commissioned from the NHSCT. Additional capacity will be secured from existing equipment with the existing MRI scanner being replaced in 2015, alongside a 2nd MRI scanner in 2016.
2. NLCG will work on a regional basis to take forward primary care alternatives to secondary care referral. Specialties include Dermatology, ENT, Rheumatology, Neurology, Respiratory, Urology and Gynaecology and MSK/Pain. Develop E-Health opportunities across the Tele Dermatology, Neurology Triage and Pain Management pathways.
3. NLCG will secure additional Nurse Specialist and Cancer Nurse Specialist capacity to meet elective demand.

Regional Priorities (see appendix A): Cancer services (MT11), Unscheduled Care (MT12), Elective Care (MT15, 16, 17), Patient Safety (MT25), Excess Bed Days (MT27),

10.3.2 POC 1: Acute – Unscheduled Care

Acute POC: Unscheduled Care: The NLCG will aim to develop and commission services in the community which will provide an urgent care pathway for patients and reduce reliance on hospital services. This will be achieved by transferring appropriate resources from hospital to community services.

Local Needs and Assessment

1. Unplanned admissions to hospital resulting in stays of <48 hours are increasing.
2. Variation in demand for urgent care by hour of day and day of week is not matched by service capacity, leading to delays in the delivery of care. Patient flow remains challenging especially in Antrim with a significant number of 12 hour breaches and unsatisfactory 4 hour performance, leading to bed capacity issues.
3. Of the 133,000 people who attend ED every year, around 46,000 attend for minor illnesses or injuries.
4. Approximately two thirds of paediatric admissions stay <48 hours
5. Ambulance response times for Cat A calls are below the required target

Commissioning Requirements

1. NLCG will commission 7-day Acute Care at Home to avoid unnecessary short stay admissions of frail elderly patients to hospital. NLCG will commission an Elderly Assessment Service to be based in Antrim, which will prevent admission when appropriate.
2. In line with the recommendations of the Regional Co-ordinating Group for Unscheduled Care, the NLCG will commission an enhanced 7 day service in Antrim ED.
3. NLCG will procure a GP Out of Hours service that is aligned to the wider Unscheduled Care Pathway.
4. NLCG will commission a Paediatric Ambulatory service in Antrim and then Causeway to better match the demand with capacity.
5. The LCG will work with the HSCB and NIAS to improve Ambulance response times and to commission additional capacity.

Securing Service Delivery

1. Northern Integrated Care Partnerships (ICPs) should bring forward proposals to develop Acute Care at Home in this area. NLCG will work with the Trust and other stakeholders to develop an Elderly Assessment Service in Antrim.
2. NLCG should ensure that the Antrim ED has sufficient support within the ED to avoid delays and that senior decision-makers are able to assess and discharge rather than admit, where this is clinically appropriate, by implementing a 7 day model. The Trust will take forward the 5 key commissioning priorities.
3. Out of Hours provider to deliver required service changes.
4. Within identified resources, the LCG and Trust will develop required capacity in Antrim; this capacity may be helped by service improvement and redesign.
5. Ongoing engagement with HSCB and NIAS to secure additional capacity and sustained improvement in response times.

Regional Priorities (see appendix A): Unscheduled Care (MT12), Patient Safety (MT25),

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 36

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	8,127	260	8,387
		Daycases	23,552	2450	26,002
		New Outpatients	109,881	6100	115,981
		Review Outpatients	110,769		110,769
	Unscheduled	Non Elective admissions - all	36,904	2000	38,904
		ED Attendances	132,222	250	132,472
		Planned investment in 2015-16		£1.5m	

10.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The NLCG is committed to commissioning high quality, safe and sustainable maternity services for women and babies in line with the Strategy for Maternity Care in NI 2012-18. The forthcoming Departmental Paediatric Review, NICE guidance and the recommendations from the regional Review of Neonatal Services will focus the NLCG in its commissioning of efficient and value for money networked neonatal and paediatric acute services at both acute sites and the supporting primary and community services give the best outcomes for all involved.

Local Needs and Assessment

Despite a modest fall in births, there is a growing number of complex pregnancies with older mothers, multiple births and women with a BMI >40. Around 6% of mothers have diabetes requiring more frequent care during and after pregnancy.

There have been challenges in maintaining safe and sustainable consultant led obstetric and paediatric services at Causeway.

Services to be commissioned

NLCG will work with the PHA and the Trust to bring forward a robust plan to ensure safe and sustainable consultant led obstetric and paediatric services at Causeway in the medium term (not less than 5 years).

In paediatrics, a training programme for Advanced Paediatric Nurse Practitioners will commence to support the delivery of paediatric services in Causeway and other units.

NLCG will commission an alongside midwife led unit/midwife led pathways at **both** Antrim and Causeway, within the existing footprint on both sites. NLCG will review neonatal service at Antrim following publication of the Neonatal Review.

Securing Service Delivery

Monitoring of consultant and midwife births will continue, with emphasis on normalisation of birth. An action plan will be developed to ensure that the plans to maintain services at Causeway are robust, deliverable to meet relevant standards.

Progress of the APNP will be monitored.

From April 2015, all eligible pregnant woman aged 18 years & over with a BMI of >40 at booking are offered the weigh to a healthy pregnancy programme with an uptake of at least 65% of those invited.

The development of alongside midwife led units will be monitored through regular meetings with the Trust.

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 37

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,941		4,941
	Health Visiting	Contacts	14,723		14,723
		Planned investment in 2015-16		Nil	

10.3.4 POC 4: Older People

Strategic Context: The LCG will continue support people to live in their own home and maintain their independence with the appropriate provision of domiciliary care and reablement. However there remains a proportion of older people who will require nursing home care. The provision of a number of intermediate care beds providing step up and step down care will help to provide support and rehabilitation when necessary in community settings. The ongoing implementation of key actions of the Dementia Strategy will remain a priority in the area in light of the growing demand and the need to address this issue by introducing innovative ways of working.

Local Needs and Assessment

1. Each year the 65+ population increases by approximately 2,000 people with the over 85s increasing by approximately 500 people. This places increased demand on a range of services including: domiciliary care; Reablement; intermediate care and dementia services.

2. The number of nursing home placements has increased by 80 from March 2013 to March 2014.Trends would indicate that Nursing home placements are projected to rise by the end of 2015/16.

Services to be Commissioned

1. The LCG will:
   - commission additional domiciliary care hours to meet the estimated rise in the older population.
   - continue to commission OT Led Reablement service which is effective in supporting older people to maximise their independence and remain at home.
   - continue to commission Inter-mediate Care beds in the local community to avoid admissions to hospital and to enable timely discharge for older patients requiring support to recover from an acute episode. This will form an element of the pathway associated with Acute Care at Home model.

2. The LCG will commission additional Nursing Home placements to meet projected demand.

Securing Service Delivery

1. NHSCT will:
   - Ensure the provision of additional domiciliary care hours
   - Ensure the provision of the regional reablement model throughout the NHSCT's area.
   - Ensure that the optimum number of Intermediate Care beds is provided in order to enable rehabilitation in the most appropriate setting.
   - Ensure that the diagnosis rate for dementia is increased and that reviews are handled in line with the integrated service model which will be developed on a regional basis.

2. NLCG will invest in order to enable the NHSCT to purchase additional nursing home placements.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency readmissions (MT14), allied Health (MT9)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 38

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,190,035	40,500	2,230,535
	Residential and Nursing Home Care	Occupied bed days	870,518	18,980	889,498
	Community Nursing	Contacts	265,198		265,198
		Planned investment in 2015-16		£5.5m	

10.3.5 POC 5: Mental Health Services

Strategic Context: The LCG will work with the Regional Bamford Team to develop services for the severely mentally ill and for those with mild or moderate mental illness, placing an emphasis on recovery through the Stepped Care model which supports people to live as independently as possible with or without on-going mental illness. The LCG is taking a lead role, in conjunction with the Trust, ICPs and Northern Strategic Partnership in developing a Primary Care Emotional Wellbeing Service enabling GPs to help access appropriate community and voluntary support, or specialist support when required. This approach aims to reduce the high dependency on prescription drugs for depression, anxiety and pain within NLCG.

Local Needs and assessment

1. 25% of patients admitted to acute care have an underlying psychiatric problem. A Rapid Assessment, Interface and Discharge (RAID) service was commissioned last year to provide a specialist multidisciplinary mental health team to work within both acute hospitals.
2. High demand for support services for patients with mild to moderate mental health conditions; this is associated with higher usage of prescription drugs for mood disorder. Evidence shows service users benefit from support provided by peers who also benefit in turn.
3. The number of long-stay patients in hospital must be reduced by 5 by 31st March 2016.

Services to be Commissioned

1. NLCG will commission an expanded RAID model to include linkages with substance misuse, older people, younger people and people with learning disability in acute care.
2. NLCG will commission Emotional Wellbeing Hub pilots in the Coleraine and Larne areas at Level 1 and Level 2 of the Stepped Care Model.

   NLCG will commission Peer Support workers to be appointed in every community mental health team (9) in the Northern area over the next three years.
3. The HSCB will commission resettlement packages of care for 5 long stay patients. NLCG will commission additional domiciliary care to support people with mental health

Securing Service Delivery

1. One year change funding from Directorate of Finance & Personnel (DFP) has been secured to develop this model.
2. Funding has been secured for Co-ordinator posts and voluntary services and the NHSCT should commence the pilots in September 2015.

   NHSCT should commence appointment and training of peer support workers.
3. NHSCT will provide resettlement packages for 5 long stay patients by 31st March 2016, reducing the total number of their long stay patients to 0.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22), Allied Health (MT9), Excess Bed days (MT27)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 39

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	22,772	0	22,772
	Residential and Nursing Home Care	Occupied Bed days	50,100	0	50,100
	Domiciliary Care	Hours	108,150	2000	110,150
		Planned investment in 2015-16		£0.4m	

10.3.6 POC 6: Learning Disability Services

Strategic Context: The LCG will continue to work with the Regional Bamford Team to develop services for people with a learning disability. The focus is on promoting independence through use of day opportunities and supported living models. The NLCG is working closely with the Trust in securing places in day care for young people transitioning to adulthood who require intensive support packages. In addition, support for ageing carers is a key regional priority which will require enhanced access to short breaks in the next year.

Local Needs and Assessment

1. People with a learning disability who experience crisis out of hours are more likely to be admitted to hospital.
2. Service users with learning disabilities are now living longer thanks to the medical advancements in their care. There is therefore an increase in numbers and complexity.
3. Carers provide a valuable service in the day to day care of people with a learning disability. Support needs to be provided to these carers in the form of breaks from the caring responsibility.
4. The number of long-stay patients in hospital must be reduced by 8 by 31st March 2016.

Services to be Commissioned

1. NLCG will commission an Out of Hours (OoH) crisis response service for service users with a learning disability.
2. In light of the increasing complexity and numbers of young people with a learning disability, the NLCG will commission additional day care places.
3. NLCG will commission additional packages of care for carers of people with a learning disability in the Northern area.
4. NLCG will support the HSCB to commission resettlement packages of care for 8 long stay patients. NLCG will commission additional domiciliary care to support service users with Learning Disabilities to live in the community.

Securing Service Delivery

1. NHSCT should commence development of a similar service as to that provided for mental health.
2. NHSCT will provide an additional 15 daycare places for school leavers.
3. NHSCT will provide an additional 20 short breaks including overnight stays.
4. NHSCT will provide resettlement packages for 8 long stay patients by 31st March 2016, reducing the total number of their long stay patients to 0.

Regional Priorities (see appendix A): Unplanned Admissions (MT5), Carers' Assessments (MT7), Patient Discharge (MT21), Excess bed days (MT27), Delivering Transformation (MT29)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 40

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	81,112	1,500	82,612
	Residential & Nursing Home Care	Occupied bed days	111,688		111,688
		Planned investment in 2015-16		£0.08m	

10.3.7 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: The LCG will continue to promote the main aim of the Physical and Sensory Disability Strategy and Action Plan which is to improve the lives of those with a disability by promoting independence and supporting a more personalised approach to the provision of services in terms of choice, control and self-directed support.

Local Needs and Assessment

1. In December 2014, 28% of those with a physical disability/sensory impairment in the NHSCT were in receipt of direct payments which is lower that the regional average of 31.6%.
2. 65% of people needing a wheelchair wait less than 13 weeks. Of the 106 waiting more than 13 weeks across the region, 50% were in the Northern area.
3. Provision of care for patients with ME – Chronic Fatigue Syndrome is variable, with no agreed care pathways.
4. NLCG has a small number of complex, high cost cases each year. These patients require to be to be supported in the community.

Services to be Commissioned

1. NLCG will support the roll out of Self Directed Support and as part of this initiative will expect a 10% increase in the number of direct payments. NLCG will commission additional domiciliary care to support those with a Physical Disability or Sensory Impairment to live in the community.
2. NLCG will continue to commission the provision of wheelchairs and will work with the Trust to examine models of service delivery to improve the waiting times.
3. Following a pilot of an ME service during 14/15 in the NLCG area, the LCG will invest recurrently in the service
4. NLCG will commission additional community nursing inputs to enable patients with complex needs to be discharged from hospital to a community environment.

Securing Service Delivery

1. NHSCT will appoint a Practice Development Officer for Self Directed Support and will implement the model in accordance with the regional guidance.
2. NHSCT will improve the waiting time for wheelchairs and identify new ways of working which will achieve long term benefits for the service.
3. NHSCT will appoint a ME / Chronic Fatigue Syndrome lead to work with the Condition Management Programme team to assess and treat 100 new referrals per annum.
4. NHSCT to bring proposals for community nursing input to address ongoing care of people with complex needs.

Regional Priorities (see appendix A): Direct Payments (MT8), Patient Discharge (MT21)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 41

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	324,450	6,000	330,450
	Residential & Nursing Home Care	Occupied bed days	30,603		30,603
		Planned investment in 2015-16		£0.14m	

10.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better (MLB) was launched by the DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. In 2015/16 Community Planning will be introduced and the NLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs and Assessment

1. The prevalence of cardiovascular disease and cancer is high in the NLCG area compared to other areas in the region. 21% of the population in the NLCG area smoke cigarettes and there are 62% adults and 29.4% Year 8 children overweight or obese. Up to 30% of all hospital admissions (adults) potentially demonstrate some degree of alcohol/substance misuse. This, however, is often not detected: local hospital admissions statistics bear out a detection level of around 3%.
2. At present in N Ireland there are 19,000 people living with dementia. As the population ages, dementia will become be a major public health and societal issue, with numbers of people with dementia rising to 23,000 by 2017 and around 60,000 by 2051.
3. Births to Teenage mothers in the NLCG area are above average for the region.

Services to be commissioned

1. NLCG will:
   - Commission stop smoking support targeting those with long term conditions and mental health issues
   - Ensure delivery of "Fitter Future for All" Strategy & facilitation of multi-agency obesity partnership. NLCG will explore options for commercial weight management programmes following the positive regional pilot programme.
2. NLCG will commission a part-time Community Dementia Co-ordinator to increase awareness of dementia within the community in order to support early detection and intervention.
3. NLCG will commission Family Nurse Partnership (FNP) and Roots of Empathy (RoE). A suite of evidenced based parenting programmes will be promoted /supported by a newly appointed Early Years/Early Interventions Officer.

Securing Service Delivery

1. NHSCT should ensure that commissioned services meet specified quality standards which are monitored, i.e. Stop Smoking Services.

   NHSCT should be smoke free by No Smoking Day 2016.

   By March 2017, screen 90% of all (adult) non elective acute admissions per year and 25% of ED attenders per year; provide structured brief advice and interventions; and direct care of more complex patients.
2. Key Performance Indicators are being developed and will be used to monitor progress and performance locally.
3. NHSCT will meet the required performance standards which will be monitored quarterly by the LCG.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1), Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

10.3.9 POC 9: Primary Health and Adult Community

Strategic Context: The LCG will continue to work with the ICPs to implement the Transforming Your Care ethos for the provision of care to service users. The LCG will also endeavour to address the recommendations from RQIA and the Sexual Health Promotion Strategy regarding Genito-Urinary Medicine. The LCG recognises the importance of eHealth and the electronic care record being accessible to all staff involved in a patient's care.

Local Needs and Assessment

1. A growing older population has led to an increase in the number of people with chronic diseases. In particular, NLCG has a higher prevalence of stroke. Sentinel Stroke National Audit Programme, RQIA and NICE have all made recommendations in respect of Stroke.
2. There is an increase in the numbers of young people contracting sexually transmitted diseases.
3. eHealth solutions have a role to play in managing patient health by enhancing decision-making and improving communication.
4. Prescribing Data highlights high usage of Benzodiazepines and "Z" drugs

Services to be Commissioned

1. NLCG will work with ICPs to develop and monitor chronic disease management programmes in the ICP clinical priority areas to prevent unplanned admissions or emergency readmissions.
2. NLCG will support the development of an additional sexual health hub and will work to progress this initiative with the NHSCT.
3. NLCG will continue to support the regional roll out of the Electronic Care Record will be progressed on a regional basis.
4. NLCG will work with the NHSCT and primary care colleagues to develop a programme to improve the quality of patient care in respect of Benzodiazepines.

Securing Service Delivery

1. ICPs will implement and evaluate services commissioned in 2014/15 and respond to commissioner priorities for 2015/16.
2. NHSCT should assess the feasibility of an additional sexual health hub and submit proposals to the NLCG.
3. NHSCT should increase access to the Electronic Care Record.
4. NLCG will achieve a reduction in use of Benzodiazepines.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency Readmissions (MT14), Pharmaceutical Clinical Effectiveness Programme (MT30)

11.0 South Eastern Local Commissioning Plan

This plan sets out what the South Eastern Local Commissioning Group (SELCG) will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population. This response takes account of feedback from patients, clients and carers and community and voluntary organisations who the LCG have engaged with during 2014/15, through our Personal and Public Involvement (PPI) process and other commissioning processes which the LCG have in place.

The Plan outlines, on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to those needs and how we intend to ensure deliver either through a Health and Social Care Trust, Integrated Care Partnership (ICP) or other provider. The Plan reflects the themes identified at regional level, with a focus on how we can transform services while delivering efficiency and value for money.

The SELCG will work closely with its community partners in the delivery of the Plan, in particular seeking to take advantage of the opportunities that partnerships with the new local Councils presents through improved community planning.

The SELCG is one of five LCGs across Northern Ireland and is a committee of the Health and Social Care Board (HSCB). The SELCG Management Board is made up of 17 members including 4 General Practitioners (GPs), 4 Local Government Councillors, 5 Health and Social Care Board and Public Health Agency (PHA) officers, 2 community and voluntary representatives, a general dental practitioner and a community pharmacy representative.

The SELCG rotates its monthly public board meetings around various communities across the locality as part of its engagement process.

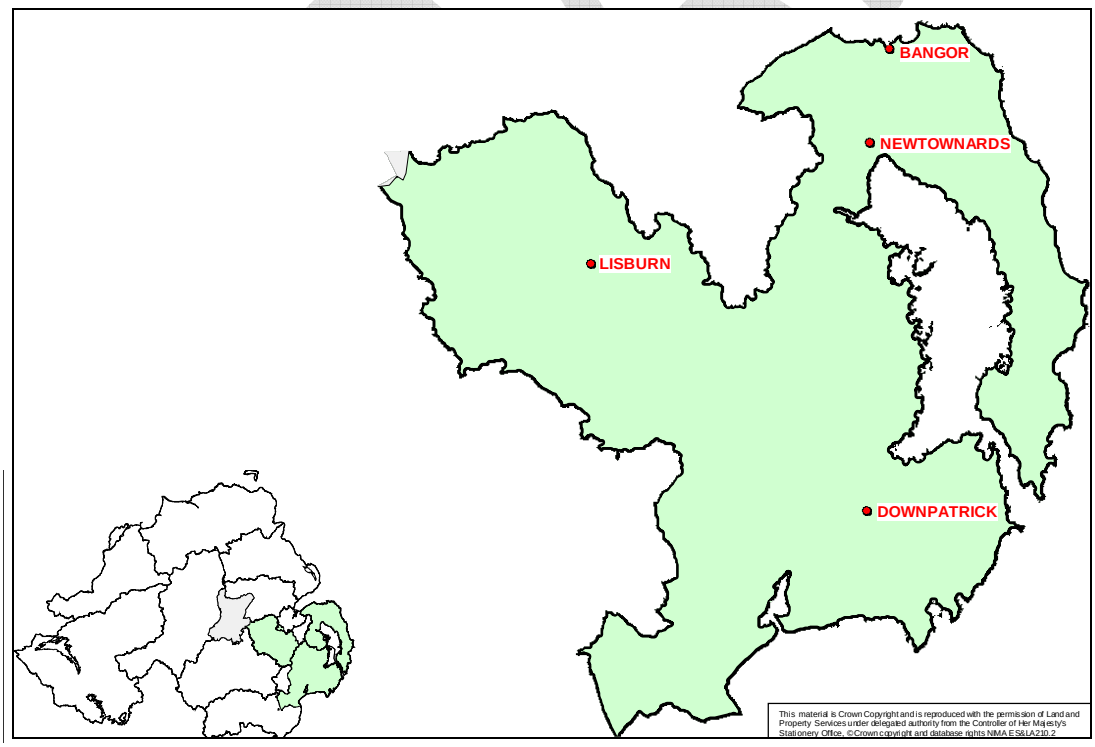
11.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the SELCG. A range of information and analyses has been used to identify the challenges facing the LCG in 2015/16 and beyond.

Geography and Communities

The SELCG covers an area which can be characterised as a mix of urban and rural settlements. The main population centres are Lisburn City, Downpatrick, Bangor and Newtownards. The LCG area is co-terminus with the boundaries of the South Eastern HSC Trust, but not co-terminus with the new Council boundaries which came into effect on 1 April 2015. While Ards/North Down Council will be within the SELCG area, only the Down sector of the Newry Mourne and Down Council will be within the LCG area, while the Lisburn sector of the new Lisburn and Castlereagh City Council will be within our geography. Figure 9 sets out the LCG area and the main centres.

Figure 9: Population Centres in SELCG area



11.1.1 Demographic changes / pressures

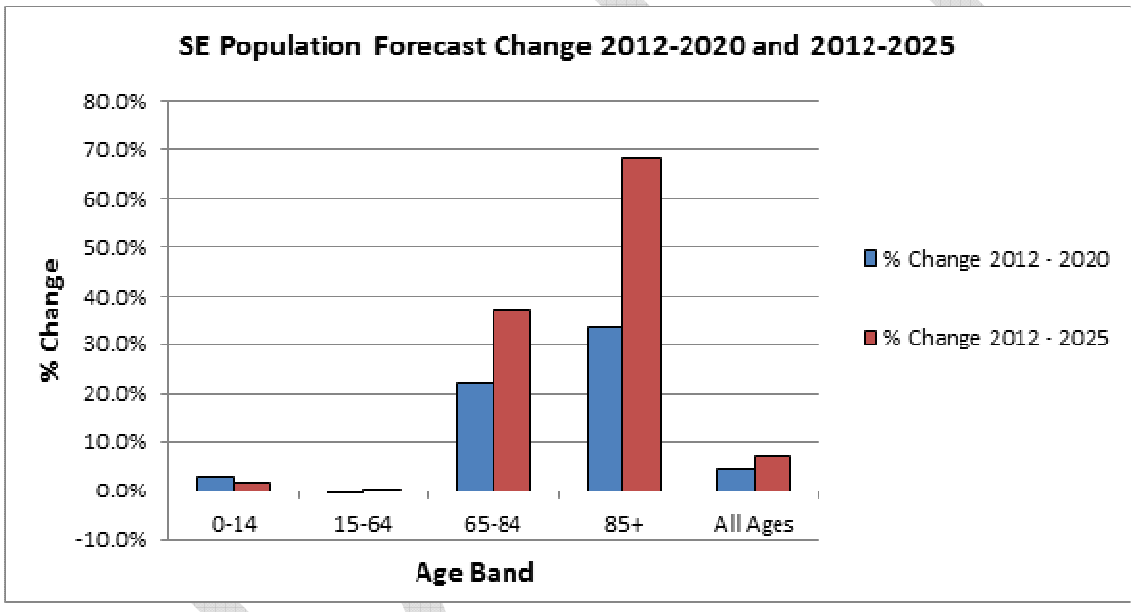
This section gives a general overview of the population within the LCG area, describing the age structure, general health and income of the resident population.

Demography

The population of the SELCG is circa 347,000 (NISRA: 2011 Census). 20.5% of that population are between the 0-15 years age group, 30.3% 16-39 years, 33.32% 40-64 years, 13.88% 65-84 years and 1.92% 85 plus.

Population Forecast Change

Figure 10



Regionally since 2001 the total population in N. Ireland has increased by circa 8.3% with the largest percentage increase (41.9%) from the ages shown in the 85+ age band.

The population in the south east has similarly increased by 8.5% in total however, the percentage increase in the 85+age band is significantly lower in the south east (38.4%) compared to N. Ireland (41.9%)

Population Projections

Table 42

	Age / Year	2012	2017	2022	2027	% Change 2012 - 2027
Down	0-14	14030	14246	14692	14470	3%
	15-64	45570	45663	45547	45337	-1%
	65-84	9474	10963	12287	13922	47%
	85+	1366	1682	2157	2697	97%
	ALL AGES	**70440**	**72554**	**74683**	**76426**	**8%**
Lisburn	0-14	24925	25515	26516	26272	5%
	15-64	79326	81212	83065	84709	7%
	65-84	15486	17683	20001	23109	49%
	85+	1950	2364	3082	3935	102%
	ALL AGES	**121687**	**126774**	**132664**	**138025**	**13%**
Ards / North Down	0-14	27931	27934	27706	26602	-5%
	15-64	101015	98513	97418	95758	-5%
	65-84	25401	29094	32088	35309	39%
	85+	3623	4094	4956	6238	72%
	ALL AGES	**157970**	**159635**	**162168**	**163907**	**4%**
SE LCG Area	0-14	66886	67695	68914	67344	**1%**
	15-64	225911	225388	226030	225804	**-0.05%**
	65-84	50361	57740	64376	72340	**44%**
	85+	6939	8140	10195	12870	**85%**
	ALL AGES	**350097**	**358963**	**369515**	**378358**	**8%**

As can be seen by the above table, we predict significant increases in our elderly population, particularly in the 85 plus grouping. While this highlights the success of past and current health, social care and wellbeing initiatives and advances in medical and drug technologies, it also points to the need for an incremental reshape of HSC services to ensure that community services are responsive to the future needs of an older population profile.

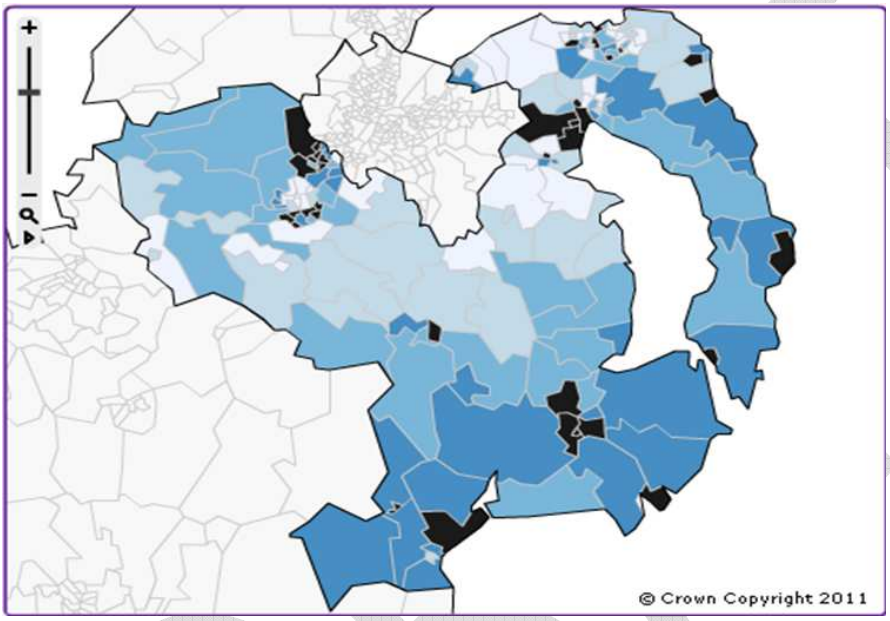
Deprivation

The map below shows the differences in deprivation within the SELCG area based on deprivation quintiles at Super Output Area. Those shaded black represent the 20% most deprived areas in the LCG area; those shaded light the least deprived 20%.

Life expectancy for males within the most deprived areas of the south east at 2010-12 was 3.4 years lower than the overall figure for the area, and 2.5 years lower than N. Ireland as a whole. Female life expectancy within the most deprived areas over the same period was 1.6 years lower, and 1.2 years lower than N.I Ireland as a whole.

Deprivation Mapping

Figure 11



One in ten people residing within the SELCG area in 2013 were living within the most deprived of the N. Ireland deprivation quintiles. Across N. Ireland 18.8% of the population live in the most deprived quintile. This is represented in the figure below.

Percentage of Population in NI Deprivation Quintiles
Figure 12

Source: PMSI South East Local Area Health Profile

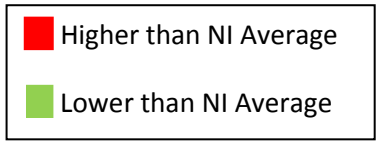
Work produced by the N. Ireland Health and Social Care Inequalities Monitoring System (HSCIMS) sub regional inequalities (2015) has been helpful in identifying, across a range of domains, inequalities across the south east in comparison to the N. Ireland average. The general picture shows that within the LCG area there is an overall trend of reducing deprivation, however the reduction in gap between the deprived and most deprived is variable. In comparison to the N. Ireland averages the LCG population is under these figures with the following exceptions; drug related mental health disorders, admissions due to self-harm and ambulance response times.

Health Summary

The table below shows the health of the SELCG population in comparison to N. Ireland as a whole.

Table 43

Domain	Indicator	Descriptor	SELCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	20.96	19.12	
	COPD	Prevalance per 1000	15.94	18.56	
	Stroke	Prevalance per 1000	19.55	17.94	
	Atrial Fibrillation	Prevalance per 1000	16.36	15.12	
	Coronary Heart Disease	Prevalance per 1000	41.48	38.81	
	Hypertension	Prevalance per 1000	136.76	130.5	
	Diabetes	Prevalance per 1000	44.4	42.61	
	Diabetes Prescriptions	Stdised Prescription Rate	37	39	
	Asthma	Prevalance per 1000	63.95	60.48	
	Dementia	Prevalance per 1000	8.39	6.67	
	Learning Disability	Prevalance per 1000	5.48	5.33	
	Bowel Cancer Screening	Programme Uptake	55.19	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.49	8.54	
	Crude Suicide Rates	All Persons	13.5	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score 2013	45.75	46.23	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	67	62	
	Meeting Physical activity levels	% of population (2012 -2013)	56	53	
	Pain or Discomfort	% of population (2012-2013)	35	35	
	Anxious Depressed	% of population (2012 -2013)	26	26	
Maternal and Child Health	Children in Need	Rate per 100,000	47.52	60.18	
	Births to Teenage Mothers	Percentage 2013	4.04	3.86	
	Births to unmarried mothers	Percentage 2013	41.13	42.46	
	Births to Mothers from outside NI	Percentage 2013	16.12	17.88	
Life Expectancy	Male	Age (2009-11)	78.36	77.5	
	Female	Age (2009-11)	82.4	82	
	Neonatal	Death Rate (2013)	0.4	0.3	
	Infant Mortality	Death Rate (2013)	5.3	4.6	
	Lung Cancer	STD Death Rate(2008-2012)	54.7	66.5	
	Female Breast Cancer	STD Death Rate (2008-2012)	38.8	38.1	
Carers	Unpaid Care	50+ Hours provided (2011)	3.2	3.1	



11.1.2 Personal and Public Involvement

Across the south eastern locality there is a strong and vibrant community development culture and infrastructure in the form of many voluntary and community networks.

The SELCG has been proactive in engaging with communities to ensure that local patients and carers have an opportunity to influence and shape what services might be commissioned in the future.

The SELCG has maintained its policy of initiating engagement with political representatives at local Council level and through locality meetings with MLAs and MPs. LCG Board Meetings are in public and time within these meetings is set aside for discussion with the public. The LCG also participates in workshops undertaken by voluntary organisations. A full list of LCG Personal and Public Involvement (PPI) activity can be viewed on the LCG web page www.hscboard.hscni.net

11.1.3 Summary of Key Challenges

From the needs assessment analysis undertaken, our engagement with communities and our ongoing work with providers the LCG has identified the following summary of key challenges for 2015/16:

- The increasing levels of overweight and obese adults, with few people meeting the recommended national guidelines in physical activity. There are higher prevalence of heart disease, stroke, hypertension, asthma and diabetes in the south east compared to the N.Ireland average.
- With a significant rural geography, access to services has been identified as a concern for those communities highlighted in the *Regional Health Inequalities Report (March 2015)* e.g., emergency care requiring a 999 ambulance or specialist/urgent services located in Belfast.
- An over-relevance on hospital services with current demand causing pressure on the system and the need to address improving patient flow at the Ulster Hospital.

- A growing older population with increasing health and social care needs.
- The increasingly complex health needs of some children and adults with disabilities living longer.
- Promoting the Transformation agenda in working with ICPs in the designated Clinical Priority Areas.
- Ensuring close working with Primary Care specifically in regard to the quality of referrals to secondary care and opportunities to improve prescribing in General Practice.
- Continuing to push to address inequality gaps within our population.
- Supporting the capital infrastructure programme in the south east to ensure the modernisation of services in respect of the Ulster Hospital (Phase B), the Primary and Community Care Centre planned for at the Lagan Valley Hospital site.

Equality and Human Rights

The SELCG is mindful that the changing make-up of the south eastern population brings challenges in ensuring that identified groups within communities have equity of access to services and that individuals' human rights are upheld. In this regard the LCG has carried out an equality screening of the proposals set out in the section below and the findings and the mitigating actions are available for review.

11.2 LCG Finance

Use of Resources

The SELCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £531.6m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 44

Programme of Care	£	%
Acute Services	192.9	36.25%
Maternity & Child Health	28.2	5.30%
Family & Child Care	39.4	7.39%
Older People	127.0	23.85%
Mental Health	39.4	7.39%
Learning Disability	52.2	9.80%
Physical and Sensory Disability	17.1	3.21%
Health Promotion	15.2	2.86%
Primary Health & Adult Community	20.2	3.96%
POC Total	**531.6**	**100%**

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

Table 45

Provider	£	%
BHSCT	116.8	21.97%
NHSCT	0.4	0.07%
SEHSCT	371.9	69.78%
SHSCT	5.9	1.12%
WHSCT	0.2	0.05%
Non-Trust	36.4	7.02%
Provider Total	**531.6**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the Family Health Services (FHS).

Whilst Emergency Department (ED) services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of emergency care by the South Eastern Trust is in the region of £27.8m.

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

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the South Eastern area and additional investment in the therapeutic growth of services.

11.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the South Eastern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key Health and Social Care priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

11.3.1 POC 1: Acute (Elective)

Strategic Context: The LCG, with stakeholders, will consider the demand on elective services to ensure standards and response times are further improved. Key to this approach will be to explore optimising the opportunities through GP Federations and community service for safe and viable services to closer to home.

Local Needs and Assessment

1. Demand for diagnostic services across a range of modalities has increased.
2. Elective capacity for outpatients and treatments across many specialties remains insufficient to meet demand. The number of patients waiting up to and over a year to be seen is increasing.
3. SET has the lowest number of surgical patients in NI admitted for treatment on the day of surgery which impacts length of stay.
4. The Cardiology model in the SE area needs reformed to address increasing demand and advances in treatment.
5. The number of referrals for suspected cancer in the SE area continues to increase.

Commissioning Requirements

1. LCG will commission additional capacity to meet projected increases in demand in MRI, CT, Non-Obstetric Ultrasounds and Plain film X-rays.
2. The LCG will invest in a number of specialties to increase capacity through provision of new outpatient clinics, as well as inpatient and day case treatments are required.
3. The LCG will seek a proposal from SET to pilot a surgical admissions Unit at Ulster Hospital to provide dedicated beds
4. The LCG will reshape the cardiology service in SET by putting in place a rapid assessment and diagnostic model to support elective and non–elective care and enhance communication with primary care.
5. The LCG will work with the Trust to identify improvements in cancer care within the SE area.

Securing Service Delivery

1. SET will deliver additional diagnostic capacity and reporting as commissioned
2. To ensure demand is met, the LCG will work with the Trust/ICP/GP Federations to ensure there is sufficient capacity and to provide care out of hospital and closer to home.
3. LCG will support agreed plans to establish a surgical admissions unit to increase capacity by reducing patient lengths of stay.
4. SET will implement the new cardiology model in line with the commissioner specification.
5. SET to implement approved service developments.

Regional Priorities (see appendix A): Cancer services (MT11), Elective Care (MT15, 16, 17), Patient Safety (MT25), Excess Bed Days (MT27)

11.3.2 POC 1: Acute (Non-Elective)

Strategic Context: The SELCG, with stakeholders, will address the demand non-elective services to ensure standards and response times are further improved. Key to this approach will be to explore commissioning opportunities from GP Federations/ICPs, to provide safe and effective services to complement secondary care and to community services to provide more complex care at home.

Local Needs and Assessment

1. Attendances at the Ulster Hospital have increased by 8,272 since 2011/12 to a projected 86,000 for 2014/15. The demand for unscheduled admissions to the Ulster Hospital since 2011/12 has increased by 3,500 to 30,000.
2. SET is not consistently delivering on unscheduled care targets.
3. The current model of emergency care in SE area remains vulnerable due to pressures in the medical workforce. The local community acknowledges the need for changes in emergency/urgent care services and seek to have in place an appropriate and sustainable model of care which ensures access to emergency /urgent care, particularly for rural communities.
4. The local community has voiced its concern on ambulance response times.

Commissioning Requirements

1. The LCG will commission a Care at Home model to improve care between the acute and community interface.
2. The LCG will commission an increasing range of 7-day services to improve patient flow at the Ulster Hospital.
3. The model of acute care in the SE area needs to further evolve to ensure that communities can access appropriate care in the right place when required. A new urgent care model will require changes to the provision of acute medical care on some sites.
4. The LCG will work with the HSCB to look at opportunities to improve Ambulance response times specifically in the Down and Ards localities.

Securing Service Delivery

1. ICPs to deliver a comprehensive range of care closer to home and specifically to ensure that patients with more complex needs who are currently admitted to hospital can be supported and cared for at home.
2. SET will deliver 7 day working in a range of service areas at the Ulster Hospital
3. The LCG has requested that the SET submits a proposal supporting the continued modernisation of acute and urgent care provision and associated acute medical services in relevant hospitals.
4. SET will work with HSCB/NIAS to support the improvement of response times in the SE area.

Regional Priorities (see appendix A): Unscheduled Care (MT12), Patient Safety (MT25), Excess Bed Days (MT27), Patient Discharge (MT21)

POC 1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 46

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	5,849		5,849
		Daycases	22,071		22,071
		New Outpatients	77,570		77,570
		Review Outpatients	128,511		128,511
	Unscheduled	Non Elective admissions	34,655	400	35,055
		ED Attendances	147,053	2,200	149,253
		Planned investment in 2015-16		£1.5m	

11.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The LCG will continue to work with the Regional Maternity and Pregnancy Related Gynae, Fertility, Paediatric and Child Health Commissioning Service Team, the SET and other key stakeholders (including the ICP) to develop services that are in line with the DHSSPS Strategy for Maternity Care in N.Ireland 2012 -2018, relevant NICE Guidelines, the regional Neonatal Network Review and the DHSSPS Paediatric Strategy for N.Ireland (anticipated to be published during 2015).

Local Needs and Assessment

1. There has been an increase in births above the commissioned capacity (4,356 in 13/14). In particular, there has been an increase in births at the Ulster Hospital (UH). This has put pressure on both inpatient and outpatient provision.

   The prevalence of mothers with higher BMIs and births where diabetes was identified as a maternal risk factor is increasing.

2. The incidence of asthma and allergies among children has increased in recent years and there is currently no paediatric consultant in place in the SE with an interest in Epilepsy.

   Medical cover in paediatrics – there are fewer consultant paediatricians serving the locality than in other LCG areas despite having the second largest childhood population.

3. There are a small number of children with complex needs require specialised, high cost care.

Services to be Commissioned

1. Core baseline funding will be reviewed due to sustained increase in births above commissioned capacity. The LCG will commission additional resource to make labour rooms 6 and 7 operational at the UH.

   The LCG will also seek to address capacity issues within the UH's maternity outpatient area to deal with the volume of Gynae, fertility and other maternity clinics, to include diabetes clinics. The LCG will also review neonatal services at the Ulster Hospital following the publication of the Neonatal Review

2. The LCG will explore with the SET, a new paediatric model, to include a consultant with an interest in epilepsy and will work with the SET to support improved access to paediatric services at the Ulster Hospital

3. The LCG will continue to work with SET to address pressures associated with complex care packages at home.

Securing Service Delivery

1. The LCG will seek to commission an evaluation of Downe and Lagan Valley Midwifery Led Units in conjunction with the Leadership Centre.

   SET should continue to ensure that the model of care in place is line with the Maternity Strategy and participate in projects led by the HSCB/PHA to implement other key priorities.

   SET should relocate gynae and speciality outpatient clinics from the UH maternity unit to community hubs (or other appropriate sites) where it is safe to do so.

   SET should ensure that all eligible pregnant women, aged 18 years or over, with a BMI of 40 or more at booking are offered the 'Weigh t to a Healthy Pregnancy Programme', with an uptake of at least 65% of those invited.

2. SET to provide a paediatric epilepsy service subject to funding.

3. SET to increase access to paediatric services by extending the opening hours of the paediatric short stay assessment unit at the UH.

Regional Priorities (see appendix A): Tackling Obesity (MT2), Patient Safety (MT25)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC 2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 47:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,941		4,941
	Health Visiting	Contacts	24,430		24,430
		Planned investment in demographic growth		Nil	

11.3.5 POC 4: Older People

Strategic Context: The elderly population (65+) of the south eastern locality is growing faster than any other age group. With an ageing population, gains in life expectancy often present challenges in the context of higher prevalence rates of long term conditions such as COPD, diabetes, heart failure and stroke. Population aging means that overall health and social care need has risen. This holds new responsibilities and challenges for us to commission services that help older people to stay healthy, independent and active for as long as possible

Local Needs and Assessment

1. SE LCG locality has, and into the future is projected to have, the highest number of 65+ older people in NI as a % of its population (18.3% of SELCG population by 2017). By 2023, 11,418 people will be 85+, a rise of 57.8%.

   This is leading to increased demand on both acute and community services including, unscheduled care, domiciliary care, dementia care, psychiatry of old age, safeguarding and provision of end of life care.
2. SE LCG the highest prevalence of Stroke and TIA in Northern Ireland and it continues to rise. (Source GP QoF)
3. As the population ages, the LCG area has an increased number of people providing unpaid care. Evidence shows that caring impacts negatively on both the mental and physical wellbeing of the carer.

Services to be Commissioned

1. To meet the increasing demands the LCG will commission:
   - additional domiciliary care hours
   - additional community equipment
   - appropriate care at home as an alternative to ED and acute hospital admission where clinically appropriate for elderly patients.
   - a 'Safe and Well 'model of community support.

   The SELCG will also work with PHA to develop and commission preventive services to include falls prevention, social inclusion and the promotion of active and healthy lifestyles
2. A new stroke model for the SE will be designed.
3. The LCG will commission additional short break provision for carers of older people.

Securing Service Delivery

1. SET will provide additional hours of domiciliary care for older people through a mix of statutory and independent domiciliary care provision and implement a 'Safe and Well' model.

   The ICP will:
   - implement an Enhanced Care at Home initiative in North Down in 15/16.
   - develop initiatives to support older people to remain at home e.g. Falls programme.
   - progress actions coming from the Transforming Your Palliative and End of Life Care initiative to support people to die in their preferred place of death.
2. A new stroke model will be delivered by the ICP.
3. SET will provide additional short break provision for carers of older people.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC 4 Values & Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 48

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,048	58,700	2,316,748
	Residential and Nursing Home Care	Occupied bed days	730,804		730,804
	Community Nursing	Contacts	206,704	6,400	213,104
		Planned investment in 2015-16		£4.2m	

11.3.6 POC 5: Mental Health Services

Strategic Context: The LCG will continue to work with the Regional Bamford Team to develop services for those with mild, moderate or severe mental illness, placing an emphasis on recovery through the Stepped Care Model which supports people to live as independently as possible. Focus should also be on people who have significant life events and/or stressors that increase the threshold of harm. The LCG will also work to develop access as appropriate to community voluntary or specialist support by targeting clients at an earlier stage to prevent crisis intervention.

Local Needs and Assessment

1. Clients are waiting longer than 13 weeks for psychological therapy within the secondary care service.

   There is an over dependency in the SE area on prescription drugs for those with mental health issues.
2. Current hospital admissions and length of stay for acute patients are currently higher in NI compared to England and could be further reduced with greater use of Crisis Response/Home Treatment and a new acute MH in-patient model.
3. Carers continue to provide vital support to family members with mental health issues. Carers have reported to the LCG poorer mental and physical health as a consequence of their caring role.

Services to be Commissioned

1. The LCG will commission additional psychological therapies within primary care at levels 1 and 2 of the Stepped Care Model; and within secondary care at Level 3.
2. The LCG will commission a reprofiling of Crisis Response Home Treatment with the inclusion of a skill mix based staffing complement and the opportunity to develop a new MH centre of excellence.
3. The LCG will commission additional carers assessments and support to include short breaks in addition to uplifting nursing and residential home places.

Securing Service Delivery

1. SET will establish a Primary Care Mental Health and Well-Being Hub pilot site in Dunmurry. The evaluation of this pilot will influence further commissioning intent in other sectors.

   SET will also deliver the additional commissioned capacity within secondary care for psychological therapies.
2. SET will further develop and extend access to the Crisis Response Home Treatment service in accordance with the commissioner specification.
3. LCG will monitor provision of short breaks.

Regional Priorities (see appendix A): Unplanned Admissions (MT6), Carers' Assessments (MT7), Mental Health Services (MT22), Excess Bed days (MT27)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC 5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 49:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	7,446	0	7,446
	Residential and Nursing Home Care	Occupied Bed days	41,808	720	42,528
	Domiciliary Care	Hours	13,042	2,612	15,654
		Planned investment in 2015-16		£0.43m	

11.3.7 POC 6: Learning Disability Services

Strategic Context: The key aims of Learning Disability services are to promote independence for people with a learning disability in inclusive community environments which promote their health and wellbeing and provide appropriate support for their families who care for children and adults with learning disabilities.

Local Needs and Assessment

1. A small number of LD clients remain to be resettled from Muckamore Abbey Hospital.
2. There is a need to reduce the number of LD clients presenting at EDs.
3. There is also a need to extend supported living schemes for LD clients.
4. A number of children with learning disability and complex health needs are transitioning to adult services in 2015/16
5. There is a need to continue the delivery of Day Services in line with the Regional Day Opportunities model.

Services to be Commissioned

1. The LCG will respond to plans for resettlement to finalise the arrangements for the remaining LD clients in Muckamore Abbey
2. The LCG will commission a pilot Crisis Response Home Treatment service for people with LD.
3. The LCG will continue to develop supported living schemes under South Eastern Area Supporting People Partnership.
4. The LCG will commission services for those young people with LD and complex health needs who are transitioning to adult services.
5. The LCG will commission the delivery of additional Day Services subject to budgetary constraints

Securing Service Delivery

1. SET will be required to report on the progress of the remaining LD clients. If needed, appropriate funding will be made available to facilitate this process.
2. SET will pilot the Crisis Response Home Treatment service.
3. LCG will monitor provision of supported living places in line with need.
4. SET will be commissioned to provide a number of services for those young people with LD and complex health needs who are transitioning to adult services.
5. SET will provide additional Day Services for LD clients

Regional Priorities (see appendix A): Delivering Transformation (MT29)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 - Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 50

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	108,582	4,000	112,582
	Residential & Nursing Home Care	Occupied bed days	116,456		116,456
		Planned investment in 2015-16		£0.13m	

11.3.8 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: SELCG will continue to the implementation of the Physical and Sensory Disability (P&SD) Action Plan and Transforming Your Care (TYC) recommendations to support people to live independently in their own homes as long as possible. We will continue to invest in additional neuro-rehabilitation services to support the increasing number of people being discharged from hospital with complex care needs.

Local Needs and Assessment

1. As of September 2014 there were 489 physical and sensory disabled clients in receipt of a domiciliary care package. Of these, 193 are receiving intensive domiciliary care. The number of people with complex needs is increasing and these people require significant packages of care.
2. Wait times for access to audiology services do not meet with regional guidelines
2. Over 5% of the SELCG population provide 20 hours or more of unpaid care per week.
3. It is anticipated that there will be increased pressure to discharge from secondary care those patients who suffer from brain injury and who are clinically appropriate for discharge to an alternative facility best placed to meet their longer term needs.

Services to be Commissioned

1. The LCG will commission an appropriate mix of domiciliary care and direct payments via a mix of statutory and Independent providers and additional Nursing Homes for P&SD clients.
2. The LCG will commission additional audiology capacity for those with a hearing impairment
3. The LCG will commission short break provision for Carers of People with Physical and Sensory Disabilities.
4. The HSCB will commission additional bed days in Thompson House to support the brain injury pathway;

Securing Service Delivery

1. SET will ensure delivery of additional domiciliary hours and nursing home beds
2. SET to appoint an additional audiologist and ensure improvements in audiology access.
3. SET will provide the required number of short breaks.
4. SET will ensure provision of the neuro-rehabilitation additional bed days and consultant sessions.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Direct Payments (MT8), Allied Health (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC 7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 51

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	342,870	500	343,370
	Residential & Nursing Home Care	Occupied bed days	27,192	80	27,272
		Planned investment in 2015-16		£0.08m	

11.3.9 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing health inequalities are key priorities for the SELCG and the PHA. In line with the new public health strategy ' Making Life Better' and the Marmot Review 2010 and 2012, action will focus on strengthening coordination and collaboration across organisations and communities, and with the community planning function of the new councils, to ensure children and young people get the best start in life, people are supported to make healthy choices and together with partners we seek to ensure structural, economic, environmental and social conditions are conducive to health.

Local Needs and Assessment

1. In the SE area 20% of the population continue to smoke (NI 22%), 37% of adults are overweight (NI 37%), 26% are obese (NI 25%) and 18% of adults drink above recommended weekly limits (NI 16%).
2. Communities experiencing higher levels of deprivation continue to experience lower levels of life expectancy and higher levels of disability and poor health.
3. There is a high rate of suicides and self-harm among the south eastern population
4. Local Councils now have a lead role in developing Community Plans which include Health and Wellbeing.

Services to be Commissioned

1. The LCG/PHA will commission programmes to encourage changes in behaviour related to physical activity, healthy eating, alcohol and drug use, cancer prevention, sexual health and smoking
2. The LCG/PHA will commission evidence based parenting programmes to ensure accessible and equitable family support services & programmes across the area
3. The LCG/PHA will commission programmes to promote mental and emotional wellbeing and prevent suicides and self-harm
4. The LCG/PHA will engage with the new Councils in the development of Community Plans.

Securing Service Delivery

1. The LCG with PHA will continue to invest in the work of the SET Health Improvement Service to provide effective operational leadership, coordination and support across all communities and organisations contributing to health and wellbeing improvement
2. Early Years Intervention Communities to deliver programmes in Colin, Lisburn, Downpatrick, Ards/North Down
3. ICPs, Primary Care Teams & SET to deliver commissioned mental health support programmes.
4. New Partnerships through Local Councils should deliver and support improved health outcomes.

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

12.3.10 POC 9: Primary Health and Adult Community

Strategic Context: This programme of care includes all work, except screening, carried out by General Medical Practitioners, Out of Hours, General Ophthalmic, Dental, and Pharmacists as well as community based AHPs and nursing services. The GP practice population for the SELCG is 315,664 (overall population is circa 350,000). The SELCG will continue to commission primary care led services for the frail elderly and people with long term conditions, such as coronary heart disease, diabetes, respiratory conditions and TIAs/strokes.

Local Needs and Assessment

1. There are increasing numbers of adults being referred to ED and admitted to hospital. Many of these people could be alternatively treated at home or in the community.
2. SELCG population has higher than average prevalence of cancer, stroke, coronary heart disease, hypertension, asthma, diabetes and chronic pain
3. Along with the rest of N.Ireland, reliance on prescription medication remains high within the population.
4. Prevalence rates of sexually transmitted infections are higher than the NI average.

Services to be Commissioned

1. LCG will continue to commission services in relation to the 'Care at Home' model of care and Frail Elderly LES.
2. LCG will invest in ICP developed care pathways. Subject to funding, Arthritis Care NI will be commissioned to provide a Peer Education Pain Management Programme for patients with chronic pain.
3. LCG will continue to invest in Practice Based Pharmacists to facilitate efficient medicines management and further reduction of prescribed medication costs
4. LCG will commission the roll out of Asymptomatic STI testing in Primary Care to the Down and Ards localities with a view to developing a fully integrated sexual and reproductive (family planning) service.

Securing Service Delivery

1. SE ICP will implement the Care at Home initiative in the North Down locality in 2015/16
2. ICPs will implement new care pathways for respiratory disease and diabetes.
3. The SELCG will continue to monitor prescribing practice and costs within south east locality.
4. SET Sexual Health service will build the Primary Care Asymptomatic STI testing service LCG wide and will seek to redesign and integrate the FP service.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Pharmaceutical Clinical Effectiveness Programme (MT30)

12.0 Southern Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure deliver either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

12.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Southern LCG. A range of information and analyses have been used to identify the challenges facing the LCG in 2015/16 and beyond.

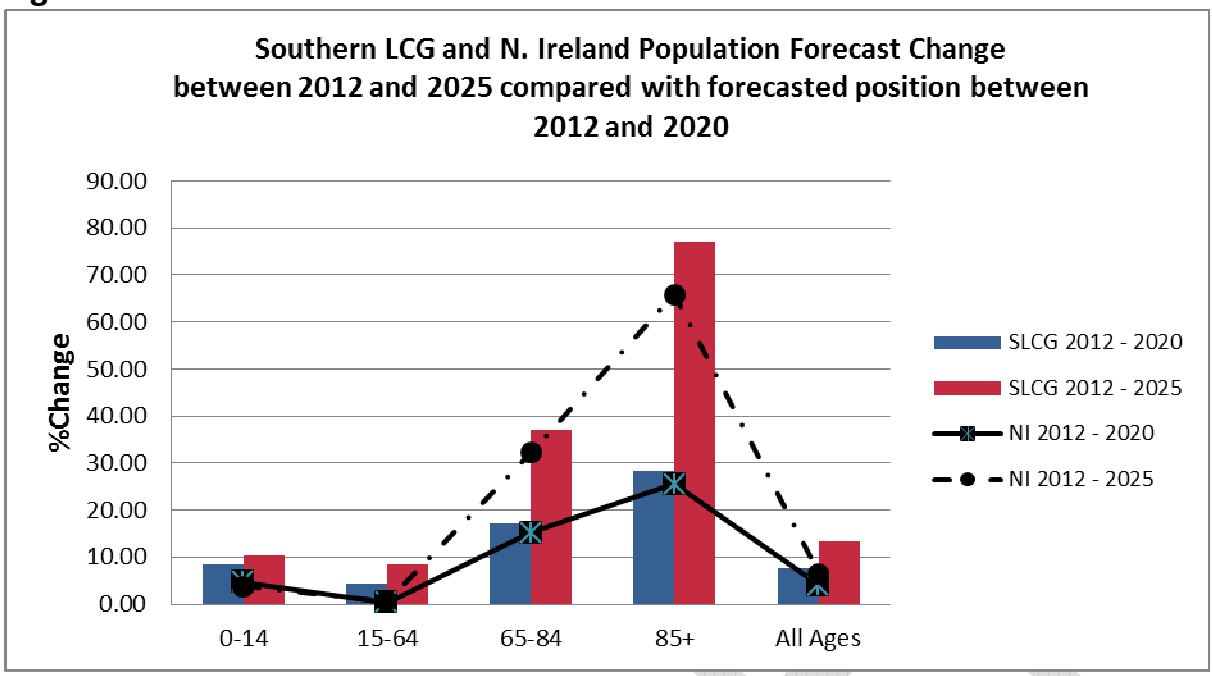
12.1.1 Demographic changes / pressures

This section gives a general overview of the population which the Southern LCG serves, describing the age structure, general health and income of the resident population.

Demography

The Southern LCG currently has a population of 365,712, representing 20.0% of the overall N. Ireland population. 93,595 SLCG residents aged 0-17 years account for 25.5% of the total SLCG population. 60.5% are aged 18-64 years, and 14% make up 65 years and over SLCG population.

Figure 13



The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five to ten years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group. Investment in the "Acute Care at Home" model and District Nursing will be pivotal in meeting this need.

Migration

The Southern LCG area has experienced a high influx of foreign nationals, between July 2004 and June 2013 the 5 Local Government Districts within the Southern LCG area experienced a net international migration population of 20,233 which accounts for 68% of the overall N. Ireland total. In addition, 4 of the 5 SLCG LGDs fell within the highest net figures across N. Ireland, with Dungannon LGD accounting for 22% of the NI total.[6]

[6] NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 52

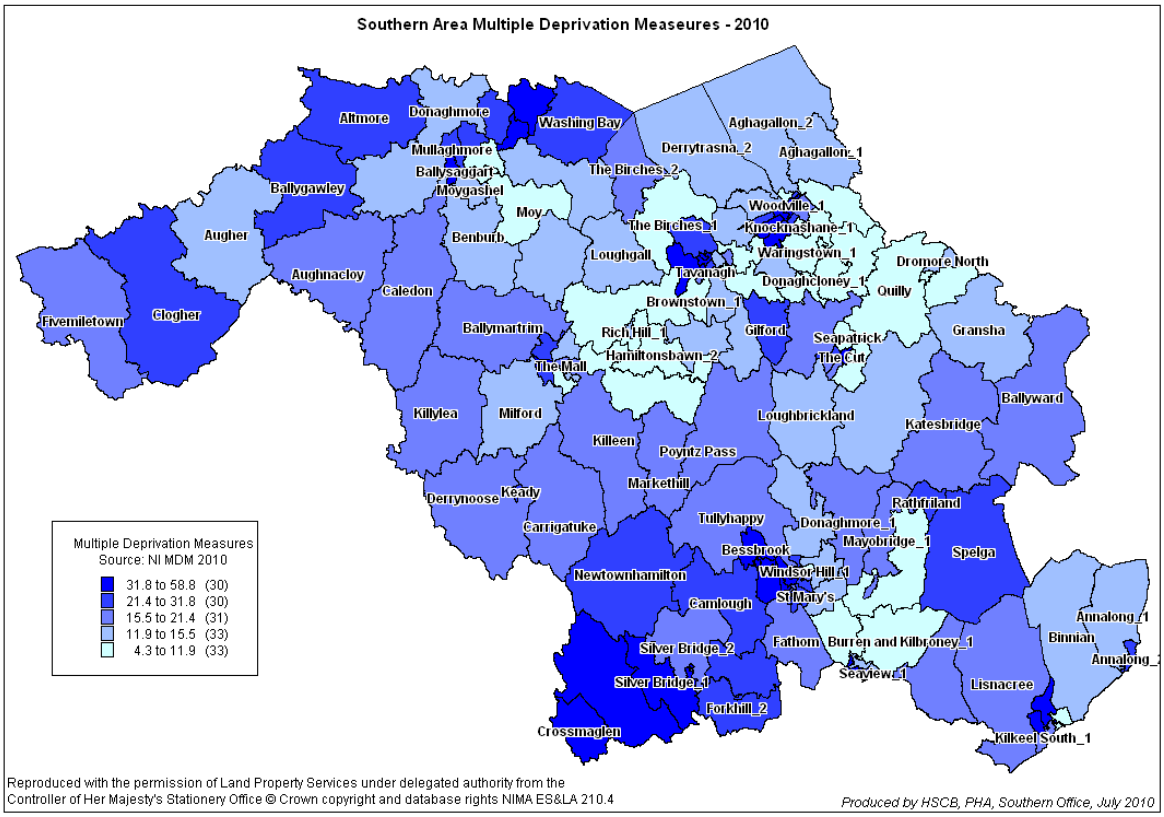
NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 4.3: Estimated Net International Migration, by Age and Gender (July 2012 - June 2013) - N. Ireland, Trust and SLCG LGD											
Gender / Age	Estimated Net International Migration	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Armagh	Banbridge	Craigavon	Dungannon	Newry and Mourne
Male	**-547**	**-756**	**-89**	**-124**	**527**	**-105**	**86**	**-9**	**207**	**156**	**87**
Less than 18 years	263	52	49	-20	158	24	27	0	44	60	27
18-24	216	-168	51	28	314	-9	28	-2	113	109	66
25-34	-529	-386	-125	-17	23	-24	21	-5	40	-19	-14
35-44	-331	-182	-61	-59	34	-63	12	1	6	0	15
45-54	-32	-12	8	-33	15	-10	6	-2	10	-3	4
55-64	-69	-29	-10	-10	-9	-11	-2	3	-3	1	-8
65 years and over	-65	-31	-1	-13	-8	-12	-6	-4	-3	8	-3
Female	**-340**	**-367**	**-202**	**-56**	**493**	**-208**	**55**	**7**	**205**	**126**	**100**
Less than 18 years	421	132	42	27	178	42	18	8	42	58	52
18-24	225	-22	-19	32	236	-2	19	9	77	73	58
25-34	-652	-322	-173	-54	25	-128	6	1	33	-3	-12
35-44	-254	-125	-44	-39	-6	-40	-1	-14	24	0	-15
45-54	-44	-24	-15	-17	35	-23	6	2	20	-2	9
55-64	-1	15	-1	0	9	-24	-1	-1	1	1	9
65 years and over	-35	-21	8	-5	16	-33	8	2	8	-1	-1
Total	**-887**	**-1,123**	**-291**	**-180**	**1,020**	**-313**	**141**	**-2**	**412**	**282**	**187**
Source: NISRA (June 2014)											

Deprivation

- Using the Multiple Deprivation Measure, the most deprived Super Output Area across the Southern area is Drumnamoe_1 (Craigavon LGD) whilst the least deprived is Waringstown_2, (Craigavon LGD).
- Using Multiple Deprivation, Drumnamoe_1 is ranked 16 out of 890 and Waringstown_2 is ranked 830 out of 890 across Northern Ireland.
- *Summary Measures* - using the Extent score (% of an area's population living in the most deprived SOAs in NI); the highest % in the Southern area is within Craigavon LGD, 21%. This LGD ranks 4th across NI using this score.
- The summary measures also indicate that almost 30,000 people or 29% of the total population in Newry/Mourne LGD are considered income deprived (ranked 3rd in NI).

Southern Area Multiple Deprivation Measures (2010)
Figure 14

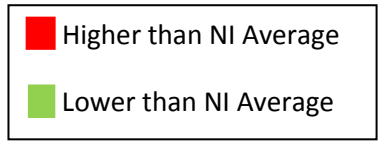


Health Summary

The table below shows the health of the Southern LCG population in comparison to Northern Ireland as a whole.

Table 53

Domain	Indicator	Descriptor	SLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.61	19.12	
	COPD	Prevalance per 1000	15.82	18.56	
	Stroke	Prevalance per 1000	15.86	17.94	
	Atrial Fibrillation	Prevalance per 1000	13.45	15.12	
	Coronary Heart Disease	Prevalance per 1000	35.59	38.81	
	Hypertension	Prevalance per 1000	124.32	130.5	
	Diabetes	Prevalance per 1000	38.47	42.61	
	Asthma	Prevalance per 1000	55.35	60.48	
	Dementia	Prevalance per 1000	5.8	6.67	
	Learning Disability	Prevalance per 1000	5.35	5.33	
	Bowel Cancer Screening	Programme Uptake	47.76	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.66	8.54	
	Crude Suicide Rates	All Persons	15.2	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	61	62	
	Meeting Physical activity levels	% of population (2012-2013)	51	53	
	Pain or Discomfort	% of population (2012-2013)	34	35	
	Anxious Depressed	% of population (2012-2013)	23	26	
Maternal and Child Health	Children in Need	Rate per 100,000	45.64	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	2.57	3.86	
	Births to unmarried mothers	Percentage 2013	53.44	42.46	
	Births to Mothers from outside NI	Percentage 2013	20.98	17.88	
Life Expectancy	Male	Age (2009-11)	77.5	77.5	
	Female	Age (2009-11)	82.11	82	
	Neonatal	Death Rate (2013)	0.2	0.3	
	Infant Mortality	Death Rate (2013)	3.5	4.6	
	Lung Cancer	STD Death Rate	58.8	66.5	
	Female Breast Cancer	STD Death Rate	42.2	38.1	
Carers	Unpaid Care (2011)	50+ Hours provided	3	3.1	



12.1.2 Personal and Public Involvement

The Southern LCG has over the past year initiated, faciliated and supported a range of opportunities to engage directly with patients, service users and the public on both their experiences of using health and social care services in the southern area and their views on how these could be commissioned and provided in the future to improve outcomes for patients. Specific engagement events[7] have been held on:

- Integrated Care Partnerships and their role in the delivery of health and social care at a local level
- The views of carers and carers representatives on the provision of short breaks
- Urgent Care, as provided by emergency departments, minor injuries units and the GP Out of Hours services

In addition and as a consequence of the second event above, the LCG has established a carers group of 10 local carers who will work directly with the LCG to contribute to and support its commission decisions. Already and in response to carers input, the LCG has invested in support for carers in a number of programmes of care and intends to continue this support in year.

The LCG has also recognised that the voice of adults with a physical disability and /or sensory impairment is often not heard and so has set up a User Panel to seek the views of individuals who have experienced these services to improve the outcomes for service users.

The LCG has also extensively engaged with public representatives on a range of issues and has and will continue to offer community and voluntary groups the opportunity to come to meet LCG members. Groups have used these opportunities to share what they are doing to improve outcomes for individuals, families and communities at both a service and / or geographical level.

[7] Full reports on the events can be found at www.hscboard.hscni.net in the Southern LCG section

Following all these events and processes, a number of key themes have emerged which the SLCG is committed to taking forward, namely:

- **Improved communication with service users**: The SLCG will continue to hold 3-4 engagement events annually.
- **Continued support for carers**: The SLCG has identified this as a commissioning priority in Programmes 4, 6 and 7.
- **Need for more flexible services which respond to real life situations, especially at weekends**: The SLCG is committed to working toward extended day and /or 7 day services where possible

12.1.3 Summary of key challenges:

- A growing population of elderly people with increased care needs and increasing prevalence of disease;
- Higher proportion of people living with long term illness;
- Highest proportion of individuals using prescribed medication for mood and anxiety disorders
- An over-reliance on hospital care, with activity exceeding current funds;
- Services which are fragmented and lack integration;
- Health and quality of life generally worse than the rest of NI

12.2 LCG Finance

Use of Resources

The Southern LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £562m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 54

Programme of Care	£m	%
Acute Services	205.6	36.50%
Maternity & Child Health	27.3	4.85%
Family & Child Care	38.8	6.89%
Older People	128.2	22.79%
Mental Health	48.4	8.60%
Learning Disability	54.3	9.65%
Physical and Sensory Disability	18.8	3.34%
Health Promotion	19.5	3.46%
Primary Health & Adult Community	21.1	3.93%
POC Total	**562.0**	**100%**

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

Table 55

Provider	£m	%
BHSCT	49.1	8.69%
NHSCT	0.1	0.02%
SEHSCT	5.3	0.93%
SHSCT	463.1	82.32%
WHSCT	3.7	0.65%
Non-Trust	40.7	7.39%
Provider Total	**562.0**	**100.00%**

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

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Southern Trust is in the region of £15.7m.

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

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Southern area and additional investment in the therapeutic growth of services.

12.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Southern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

12.3.1 POC 1: Non Specialist Acute – Elective Care

Strategic Context: The LCG, working with key providers, will address the demand on elective and non-elective services to ensure Ministerial targets, extant standards and response times are improved, as per priorities below. Key to this approach will, in 15/16, be exploring opportunities to commission from Integrated Care Partnership, GP Federations and other new providers, for safe and viable services to complement secondary care.

Local Needs and Assessment

1. Demand for imaging exceeds capacity and it is recognised that this needs to be addressed.
2. Demand for Endoscopies exceeds commissioned capacity by 3352 per year.
3. Demand exceeds service capacity by 11,820 outpatient consultations, 972 inpatient and 1,046 day case treatments
4. There is no longer a local Consultant Ophthalmology service in the Southern area and this gap needs to be addressed.

Services to be Commissioned

1. The LCG will commission an additional 1324 MRI Scans, 7364 CTs, 10,545 Non-Obstetric Ultrasounds and 37,675 plain film
2. Referrals for endoscopy will be scored on a JAG accredited points system to ensure more effective use of clinical capacity.
3. The LCG will support initiatives in Primary care to manage demand for Neurology, Dermatology, ENT, General Surgery, Urology and Gynaecology.
4. The LCG will work with the Trust to agree the future configuration of BHSCT Ophthalmology outreach clinics and the possible provision of clinics in the WHSCT in order to meet demand

Securing Service Delivery

1. The Trust should fully develop the potential for Nurse-led Endoscopy and introduce an agreed points system to increase capacity.
2. Demand management will be sought from primary care contractors where these can be shown to reduce the need to refer to Trust Consultant-led services.
3. The Trust should seek to recruit to funded capacity particularly where recent investments have been made to further enhance the service. This is particularly relevant to T&O, Rheumatology, Obs & Gynae and to ENT
4. BHSCT and WHSCT to deliver the agreed service model.

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Cancer services (MT11), Elective Care (MT15, 16, 17),

12.3.2 POC 1: Non Specialist Acute – Unscheduled Care

Strategic Context: The SLCG aim is to ensure that there is a fully integrated care system in place in the Southern area where patients know who to contact in an urgent care situation, receive appropriate care and treatment as close to home as possible, move through the patient pathway in a seamless manner and where outcomes, as per the regional priorities identified below.

Local Needs and Assessment

1. The number of new and unplanned ED attendances at all SHSCT emergency departments is expected to increase by 8% this year compared to last

   Performance against the 4 hour target has reduced in recent years, currently averaging 85%

   Conversion from attendance to admission is low, (24%) with discharges spread evenly Monday to Friday but less at weekends

2. Baseline position for the Regional Unscheduled Care Task Force's 5 identified key tasks has identified gaps in AHP, Social Care, Nursing and Pharmacy input to EDs and wards

Services to be Commissioned

1. Subject to a satisfactory evaluation of the current Phase 1 of the Acute Care at Home model, the LCG will consider further roll out of this to support and manage patient flow within the Trust.

   The LCG will commission integrated Minor Injury, Minor Illness, Out of Hours and Primary Care services, supported by community and voluntary resources.

2. The LCG will take forward the implementation of the recommendations in the unscheduled care plan to address 5 identified key tasks including additional capacity for CAH ED

Securing Service Delivery

1. The Trust should provide evidence of improved discharges at weekend, reducing transfers after 7pm and increased use of minor injury streams at CAH

2. The Trust will implement the agreed recommendations of the Unscheduled Care Plan with defined activity agreed in SBA

Regional Priorities (see appendix A): Unscheduled Care (MT12), Excess Bed Days (MT27)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 56

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	6,947		6,947
		Daycases	23,573		23,573
		New Outpatients	78,976		78,976
		Review Outpatients	132,485		132,485
	Unscheduled	Non Elective admissions	33,108	1,236	34,653
		ED Attendances	129,961	4,548	134,509
		Planned investment in 2015-16		£1.9m	

12.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The SLCG is committed to commissioning high quality, safe, effective and sustainable maternity services for women and babies in line with the objectives of the "Strategy for Maternity Care in Northern Ireland 2012 -2018". The forthcoming Departmental Paediatric Review, NICE guidance and the recommendations arising from the regional Review of Neonatal Services will focus the SLCG in its commissioning of efficient and value for money networked neonatal and paediatric acute services at both CAH and DHH and the supporting primary and community services to give the best outcomes for mothers, babies and children.

Local Needs and Assessment

1. Projected number of increased births until 2017 /2018 (circa total 6000 births per annum)

   Increased number of complex pregnancies are circa 105 multiple births annually, 20% mothers present with a BMI over 30 and 4% of mothers present with Diabetes, all of whom require more frequent clinic visits in an ambulatory care setting

   Caesarean sections rates are significantly higher than NI average (34%v28%)

2. A 29% increase in birth rate in the decade from 2002, has resulted in a growing child population in SLCG with associated rising demand for child health services, including universal services provided by Health Visitors i.e. Healthy Child Healthy Futures.

Services to be commissioned

1. The LCG will work with the Trust to achieve an increase in midwife led births and promoting midwife as first point of contact, particularly in DHH. Commissioning requirements for the neonatal services at both CAH and DHH will be clarified following the publication of the Neonatal Review recommendations

   The Treating Obesity in Pregnancy programme will be commissioned by the PHA

2. The LCG will issue a commissioner specification for paediatric ambulatory care will be issued in 2015/2016 outlining required performance and monitoring standards to be delivered.

   In paediatric care, a planned programme of investments will continue in 2015 / 2016 to ensure that appropriate paediatric medical and nursing capacity is provided and that ambulatory paediatric care is available to the standard outlined in the commissioner specification

Securing Service Delivery

1. Monitoring of consultant and midwife births along with intervention rates will continue, including full implementation of the Trust's normalisation of birth action plan on both sites

   The Trust should put in place additional consultant obstetric capacity to monitor and support mothers with identified risk factors, including multiple pregnancies and complex risk factors in line with NICE and other relevant guidance

   Midwifery and Health Visiting capacity will continue to be monitored.

   The Trust will implement the Treating Obesity in Pregnancy Programme. At least 139 women per year will receive this additional support.

2. Universal child health programmes will provide data on the state of health of children in the SLCG area informing targeting of initiatives, such as FNP, at those sub-populations with poorer health outcomes

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 57

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	5995		5995
	Health Visiting	Contacts	116,073		116,073
		Planned investment in 2015-16		Nil	

12.3.4 POC 4: Older People

Strategic Context: The SLCG is committed to promoting independence and choice and securing care closer to home, with an appropriate range of inpatient services for those who require it. We will work with providers including Integrated Care Partnerships to commission a range of services to meet the needs of our frail elderly population. Our commissioning intent will underpin the principles of TYC, the Regional Dementia Strategy and the Older People's Service Framework.

Local Needs and Assessment

1. 2012 Population Estimates would suggest that there are 48,922 people aged 65 and over living in the Southern LCG area, over 5,500 of these are aged 85 and over. Every year our older population increases by 3% (almost 1,500 persons).

2. Alzheimer's Society suggests that 1 in 14 people over the age of 65 have dementia. This number rises to 1 in 6 over the age of 80. Currently 2,234 patients are registered with the Southern Trust as living with dementia. Application of prevalence rates would indicate that there could up to 3,490 people in the SLCG area currently living with dementia, rising to as many as 4,435 people by 2020.

3. Demand for nursing home beds has increased Currently 1,360 beds are used by older people in the SLCG area.

Services to be Commissioned

1. The LCG will continue to commission phase 1 of the Acute Care at Home model and will conduct a detailed evaluation of the service during 2015/16, the outcome of which will inform its further development. The LCG will continue to support the ICP through commissioning extended hours and pharmacy input to this service.

   The SLCG will explore the potential to implement a crisis response model to address the urgent needs of people with dementia and their carers. An OT-led cognitive model will also be considered.

2. The LCG will commission additional care packages in line with assessed need and demographic growth. The reablement model will be extended to the full LCG area during 2015/16.

3. The LCG will work with the Southern Trust to assess the demand and capacity within district nursing services. This may require additional investment to ensure a 24/7 DN service which is GP aligned

Securing Service Delivery

1. The SHSCT should report against agreed KPIs to demonstrate the activity of the Acute Care at Home team, taking account of patient outcomes impact on unscheduled/urgent care services and stakeholder feedback.
   Investments in dementia should be implemented and the SHSCT should report on demand/capacity of the memory service which commenced in 2014/15.

2. The LCG will continue monitoring of domiciliary care provision against SBA volumes. This will include assessment of the impact of extended reablement services.

3. The SHSCT will comply with data requests on community nursing activity through community indicators, ensuring consistent ECAT's implementation across the Trust.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7), Emergency readmissions (MT14)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 58:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,781	35,000	2,322,781
	Residential and Nursing Home Care	Occupied bed days	662,160	17,549	679,709
	Community Nursing	Contacts	207,073	6,187	213,260
		Planned investment in 2015-16		£4m	

12.3.5 POC 5: Mental Health Services

Strategic Context: Bamford Strategy, Regional Psychological Therapies Strategy, Mental Health Services Framework and NICE guidance, all outline the need for a focus on improving access to psychological therapies. The SLCG is committed to securing local services which focus on prevention and early intervention to improve and protect the mental health and wellbeing of our population. We believe that through this we can reduce unnecessary demand for secondary care services, protecting access to more specialist services for those most in need.

Local Needs and Assessment

1. During 2012/13, within the SLCG there were 308 mental health compulsory admissions which represented the highest number across NI accounting for 28.7% of the NI total for 2012/13
2. SLCG GP registers indicate that 3,040 patients are registered as having schizophrenia, bipolar affective disorder and other psychoses or are on lithium therapy
3. During 2009/10, the Southern Trust received 2,460 referrals to the community addictions service (686 per 100,000 people against the NI average of 665 per 100,000 people). There has been a significant increase in the gap between the least and most deprived areas in the SLCG in terms of the standardised death rate relating to, alcohol and standardised admission rates relating to drugs, alcohol and self-harm (DHSSPSNI Sub Regional Health Inequalities).

Services to be Commissioned

1. The SLCG will seek assurance that there are adequate levels of staff to support complex patients in local inpatient units. The SLCG will monitor use of the regional addiction beds by Southern residents during 2015/16 to ensure fair access.

   The LCG will commission the first talking therapies hub in the Southern area to support people with low level mental health needs resident in the Armagh and Dungannon locality.
2. The LCG will seek to invest in additional staff to support community addictions services during 2015/16.
3. The SLCG will consider local capacity to support the diagnosis of adults with ASD.

Securing Service Delivery

1. SHSCT should ensure that local addictions staffing is in line with regionally recommended levels.
2. The Trust should progress against the action plan for implementation of psychological therapies primary care hubs.
3. The Trust will closely monitor short breaks and day opportunities investment in 2014/15 will be measured during 2015/16.

   SHSCT to implement the alcohol liaison 7 day service during 2015/16.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22),
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 59

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	34,230		34,230
	Residential and Nursing Home Care	Occupied Bed days	64,119		64,119
	Domiciliary Care	Hours	120,505	2000	122,505
		Planned investment in 2015-16		£0.66m	

12.3.6 POC 6: Learning Disability Services

Strategic Context: People with learning disabilities have a variable range of health and social care needs and often experience greater health and wellbeing inequalities than the general population and can experience difficulty in accessing services. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. Both TYC and the DHSSPS Learning Disability Service Framework highlight the needs of the increasing numbers of young people with complex needs surviving into adulthood and the importance of the right support at transition stage.

Local Needs and Assessment

1. In 2013/14 there were 2,123 people identified on Southern LCG GP Practice registers for learning disability. Uptake of day opportunities has increased in line with the regional direction - an increase from 274 persons in 2012 to 359 by 2014.
2. It is expected that there will be at least 50 young people who will transition into adult learning disability services during 2015/16.
3. The regional caseload review audit as part of the learning disability service framework suggests a need for an increased focus on carer's assessments, recording of service user satisfaction levels and the documentation of person centred plans.
4. There are 585 adult carers known to the learning disability programme in the Southern area, representing 23% of the NI total for this programme.

Services to be Commissioned

1. The SLCG will commission the development of additional day opportunities for people with learning disabilities.
2. The SLCG will invest further to support the additional needs of young people transitioning into adult services, including enhancement of the transitions team.
3. Following on from investment in 2014/15, the LCG will provide further support to carers, particularly older carers
4. The SHSCT will be required to produce health action plans for people with learning disabilities.

Securing Service Delivery

1. The Trust should develop a menu of day opportunities across a range of sectors, continuing to engage with service users/carers and monitor uptake and change in demand patterns for day care.

2. The LCG will develop and implement a monitoring proforma for high cost packages in transition to adult services.

3. The Trust should continue to deliver the required complex caseloads and conduct ensure following on from the caseload review audit improved outcomes

4. The LCG will monitor the use of health action plans to ensure equity of outcomes for people with a learning disability.

Regional Priorities (see appendix A): Carers' Assessments (MT7),
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 60:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	276,991	2100	279,091
	Residential & Nursing Home Care	Occupied bed days	113,740	800	114,540
		Planned investment in 2015-16		£0.36m	

12.3.7 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: In support of the strategic direction to provide as much support and care close to home as possible, the SLCG are aware of a sharp increase in the number of people with complex disabilities being cared for in hospital settings who require discharge. In addition, demand for services to support people with a brain injury is increasing. The LCG will work within the Physical and Sensory Disability Strategy to ensure the provision of safe, high quality and effective services which are person-centred, promoting independence, choice and control.

Local Needs and Assessment

1. The Physical Disability Strategy estimates that 21% of adults in Northern Ireland live with a physical or sensory disability. In terms of the adult population of the Southern area, this would equate to around 54,781 people (based on an adult population of 260,860 people - 2011 Census persons aged 19+).
2. The SHSCT provided details on 25 complex hospital discharges requiring significant care packages.
3. Population growth in the Southern LCG area, including a significant growth in the child population, has resulted in increased demand for hearing aids.
4. Headway UK state that 661 persons per 100,000 sustained an acquired brain injury in 2011-12 in NI, the highest rate in the UK. Pro rata to the Southern area, this would equate to 2,379 persons. There were 6,943 finished episodes in NI hospitals relating to head

Services to be Commissioned

1. The SLCG will commission an appropriate mix of care to meet the needs of persons with complex disability upon discharge from hospital. This will require investment across a range of community service such as domiciliary care, short breaks and care homes.
2. A monitoring template will be developed to enable to LCG to capture information on the ongoing care needs of complex hospital discharges.
3. The LCG will invest further in equipment to support both children and adults with sensory disabilities, including audiology services and hearing aids.
4. The existing service agreements with community and voluntary sector organisations should be reviewed to ensure that people with a brain injury across the southern area are able to avail of a range of supports to meet their needs.

Securing Service Delivery

1. The Trust should continue to move towards increased uptake of direct payments and self-directed support.
2. Trust to put in place arrangements to address the outcomes of the LCG monitoring process
3. The Trust should ensure that there is appropriate access to audiology services including hearing aids.
4. The SHSCT should report to the LCG on plans to re-procure community and voluntary sector supports for people with a brain injury.

Regional Priorities (see appendix A): Direct Payments (MT8)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 61

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	365,130	5200	370,330
	Residential & Nursing Home Care	Occupied bed days	20,805	259	21,064
		Planned investment in 2015-16		£0.22m	

12.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better was launched by the DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. In 2015/16 Community Planning will be introduced and the SLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs and Assessment - SLCG

1. 17% of babies born are to mothers who themselves were born outside of the UK or ROI. Approximately one fifth of the population live in relative poverty, including 22% of children.
2. 20% of adults smoke cigarettes and 13% drink in excess of weekly recommended alcohol limits. 57% of adults and 17% of boys and 24% of girls in P1 are overweight or obese. In 2012 an estimated 656 people died prematurely of potentially avoidable causes
3. Uptake for screening programmes in 13/14 was 78% cervical; 76% breast; 49% bowel; 82% AAA and 79% diabetic retinopathy.

Services to be Commissioned

1. Family Nurse Partnership, Roots of Empathy and a suite of evidenced based parenting programmes will be made available.
2. The LCG will commission a range of health promotion services will be available on smoking; healthy eating; physical activity; alcohol; drugs; mental health and suicide prevention.
3. The LCG will commission a range of screening programmes including the Be Cancer Aware Programme

Securing Service Delivery

1. The Early Years/Early Interventions Officer will support this work. These services will link with the existing Family Support Hubs and the EITP.
2. Trusts should ensure that services commissioned meet specified quality standards which are monitored i.e. Stop Smoking Services; Drugs and Alcohol; Mental Health and Emotional Wellbeing
3. Performance targets for all programmes commissioned are specified and monitored quarterly.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

12.3.9 *POC 9: Primary Health and Adult Community*

Strategic Context: Enabling people to maintain their independence, live at home and receive care at or as close to home as possible remains a key strategic and local commissioning priority. Ensuring effective community nursing and therapeutic interventions, 7 day working and developing work with Integrated Care Partnerships and the emerging GP Federations will assist in addressing known shortfalls in capacity and quality concern of service users.

Local Needs and Assessment

1. NI Quality and Outcomes Framework (QOF) 2013 registers indicate that there are 6,012 patients registered in Southern LCG GP practices as having Chronic Obstructive Pulmonary Disease (COPD) and 6,068 registered as having survived a stroke. During 2012/13, there were 528 people admitted to hospital in the Southern area following a stroke.

2. In the NI Diabetes Inpatient Audit (2013 Draft Report), the Southern Trust performance was below that of other NI hospitals and also suggested there were lower levels of specialist nursing investment in NI compared to the rest of UK.

3. The LCG has seen a higher increase than the NI average in both cost 2.5% compared to 1.9%) and volume of prescribed drugs (1.7% to 1.5%).

Services to be Commissioned

1. The LCG will work with the SHSCT to assess the demand and capacity within district nursing services which may require additional investment to ensure a 24/7 DN service which is GP aligned

The LCG will consider enhanced specialist nursing input to diabetes services to improve patient care, specifically inpatients.

2. Through the Southern ICPs, the LCG will continue to develop pathways and commission services to deliver on ICP specifications

3. The LCG will work closely with primary and secondary care to ensure efficient and effective prescribing in line with the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Proposals for the allocation of the SLCG prescribing budget will be brought forward in early 2015/16.

Securing Service Delivery

1. The Southern Trust should contribute to community indicators data to monitor activities of community nurses. The Trust should also ensure eCAT is implemented consistently throughout the Trust.

2. The SLCG will continue to monitor the progress of the Southern ICPs in delivering on the agreed specifications for priority groups – frail elderly, diabetes, respiratory and stroke.

3. Primary and Secondary Care should ensure that the prescribing budget is brought into line with the requirements of the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Regional Priorities (see appendix A): Pharmaceutical Clinical Effectiveness Programme (MT30)

13.0 Western Local Commissioning Plan

This plan sets out what Western LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines, on a Programme of Care (PoC) basis, what our local needs are, what we will commission in-year in response to that need and how we intend to ensure delivery either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

13.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Western LCG, covering the council areas of Derry and Strabane District; Fermanagh and Omagh District; and the former Limavady Borough now within Causeway Coast and Glens.

13.1.1 Demographic changes / pressures

On Census Day (27 March 2011), the resident population of the Western LCG area was 294,417 persons accounting for 16.26% of the NI total. Mid-Year Estimates (2013) show projected increase in population to 296,883 persons.

The age profile on Census Day includes:

- 22.1% were aged under 16 years and 13.1% were aged 65 and over;
- 49.6% of the usually resident population were male and 50.4% were female; and

- 36 years was the average (median) age of the population

The older people population is lower proportionately than the NI average (13.1% and 14.6% respectively) although the Western area is projected to see the greatest increase in 65+ persons in the next ten years, i.e. 40.1% increase compared to 29.7% for NI as a whole. There were 3,951 births to Western families during 2013/14.

Deprivation

One in four people (25.3%) residing within the Western area in 2013 were living within the most deprived of the Northern Ireland deprivation quintiles. Across Northern Ireland, 18.8% of the population live in the most deprived quintile.

Key Indicators of Health and Wellbeing

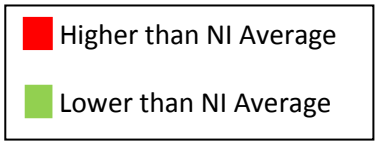
Table 74 below provides an overview of key indicators of health and wellbeing. Despite high levels of deprivation, Western population shows better health outcomes than the NI average, apart from for respiratory conditions, i.e. asthma and chronic obstructive pulmonary disease (COPD). Mental health however is considerable worse, particularly due to anxiety and depression. There is higher rate of children in need.

Health Summary

The table below shows the health of the Western LCG population in comparison to Northern Ireland as a whole.

Table 62

Domain	Indicator	Descriptor	WLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.49	19.12	
	COPD	Prevalance per 1000	20.36	18.56	
	Stroke	Prevalance per 1000	17.33	17.94	
	Atrial Fibrillation	Prevalance per 1000	15.11	15.12	
	Coronary Heart Disease	Prevalance per 1000	36.08	38.81	
	Hypertension	Prevalance per 1000	128.91	130.5	
	Diabetes	Prevalance per 1000	41.45	42.61	
	Asthma	Prevalance per 1000	61.62	60.48	
	Dementia	Prevalance per 1000	6.02	6.67	
	Learning Disability	Prevalance per 1000	6.34	5.33	
	Bowel Cancer Screening	Prevalance per 1000	50.22	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	9.12	8.54	
	Crude Suicide Rates	All Persons	16.7	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012 - 13)	28	24	
	Obese or overweight	% of population (2012-13)	60	62	
	Meeting Physical activity levels	% of population (2012-13)	51	53	
	Pain or discomfort	% of population (2012-13)	39	35	
	Anxious Depressed	% of population (2012-13)	28	26	
Maternal and Child Health	Children in Need	Rate per 100,000	85.51	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	3.34	3.86	
	Births to unmarried mothers	Percentage 2013	43.79	42.46	
	Births to Mothers from outside NI	Percentage 2013	15.58	17.88	
Life Expectancy	Male	Age (2009-11)	77.23	77.5	
	Female	Age (2009-11)	81.84	82	
	Neonatal	Death Rate (2013)	0.4	0.3	
	Infant Mortality	Death Rate (2013)	4.9	4.6	
	Lung Cancer	STD Death Rate	67.9	66.5	
	Female Breast Cancer	STD Death Rate	37.4	38.1	
Carers	Unpaid Care	% of population 50+ Hours provided	3.1	3.1	



13.1.2 Personal and Public Involvement

In 2014, Western LCG undertook a flagship engagement programme, *Voice of Older People*, which engaged with 1,050 older people between January and March. The LCG worked with a range of Community Networks who undertook semi-structured interviews in line with an LCG brief to ascertain the views of older people from across the West on using Primary Care, Secondary Care and Community Care; on Transforming Your Care; and their expectations of future services.

The Networks engaged with older people in places which they routinely used, such as Luncheon clubs, Community Centres, Healthy Living Centres Community Theatre, Art Groups, Drop in Clubs, Exercise Classes, Singing Groups, Smoking Cessation Groups, Diabetes and Podiatry clinics in Healthy Living Centres to ascertain their views on the services they receive and use through the health service. The views of older people who did not attend community activities/centres or did not access local Voluntary and Community groups, and who are harder to reach were also sought through the Networks contacts and member organisations. Participants ranged from 65 to 90 years. Each participant completed.

Providers nominated one "Champion", an older person who had participated in the exercise, from each area who attended the Local Commissioning Group meeting in May 2014. There was an opportunity for LCG members to hear initial findings and to engage directly with the Champions on issues of interest and concern. The LCG gave an undertaking to convene feedback sessions to inform and discuss with participants the outcomes and findings of the engagement process. The undertaking to feedback to stakeholders is a crucial element in getting the Networks to agree to accept the commission as it showed the HSCB's commitment.

Key issues from the engagement initiatives:

- Need for more joined up approach in tackling health inequalities;

- Need for greater communication with older people regarding the services available;
- Need to tackle anxiety experienced by older people when attending the Emergency Department;
- Importance of transport in accessing health and social care services and alignment of appointments to transport schedules;
- Need for more support to carers; and
- More services delivered in local health centres, such as Physiotherapy, Minor injuries

LCG has committed to feedback sessions in response to issues raised and has published a report on the engagement programme.

The LCG also held a conference on health and social care in rural communities, in partnership with five local Community Networks, in Enniskillen on 3rd April 2014. The conference focused on:

- Rural issues of poverty, isolation, transport and access to services;
- Mental Health Services, promoting positive mental health; and
- Community planning, access and influencing key agencies

82 participants attended this event, largely comprising service users and carers living in rural areas across the Western area. Representatives from Rural Community Network, community and voluntary sector organisations, local Government, HSCB, WHSCT, NIAS and PHA also attended to hear participant views on services and related issues.

13.1.3 Summary of Key Challenges

Key challenges for the LCG in 2015/16 include:

- Fulfilling the potential of Western Integrated Care Partnerships in driving the *Transforming Your Care* agenda through integrated care pathways;
- Extending Pain Management programmes;

- Delivering the proposed Primary Care Infrastructure programme for the Western area, in line with agreed priorities;
- Further enhancing carers support and short breaks opportunities;
- Progressing plans towards having in place appropriate 24-hour community nursing services, including Acute Care at Home;
- Meeting domiciliary long-term care demand supported by the roll-out of reablement model;
- Tackling impact of alcohol on HSC services, particularly Emergency Services;
- Ensuring provision of Older People's Mental Health Services;
- Putting in place across key acute specialties processes to allow GPs to gain consultant and specialist professional advice which might prevent the need for referrals and improve management of patients in primary care;
- Maximising utilisation of hospital theatres and in-patient beds; and
- Identification of opportunities to consolidate the provision of intermediate and acute beds and/or sites.

13.2 LCG Finance

Use of Resources

The WLCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £519.1m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Table 63

Programme of Care	£m	%
Acute Services	196.8	37.85%
Maternity & Child Health	25.2	4.84%
Family & Child Care	42.1	8.09%
Older People	114.9	22.10%
Mental Health	47.3	9.10%
Learning Disability	39.2	7.53%
Physical and Sensory Disability	15.5	2.98%
Health Promotion	17.0	3.28%
Primary Health & Adult Community	21.1	4.22%
POC Total	**519.1**	**100%**

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

Table 64

Provider	£m	%
BHSCT	26.2	5.05%
NHSCT	1.1	0.21%
SEHSCT	0.2	0.03%
SHSCT	1.9	0.38%
WHSCT	450.4	86.60%
Non-Trust	39.3	7.73%
Provider Total	**519.1**	**100%**

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

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Western Trust is in the region of £12.7m.

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

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Western area and additional investment in the therapeutic growth of services.

13.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Western Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

13.3.1 POC 1: Non-Specialist Acute Services

Strategic Context: Growing demand for hospital care, coupled with challenges recruiting and retaining medical and other staff, remain a key feature for Western services. Alternative pathways, designed to reduce demand, have been championed by LCG and ICPs and further opportunities exist in light of emerging GP Federations. The prerogative to extend Acute Care at Home, building on enhanced community nursing services adds an important dimension to transformation of care.

Local Needs and Assessment

1. Demand for OP assessment in the West currently outstrips capacity by around 6,000 patients per year, with referral rates continuing to rise annually.
2. Unscheduled care patient flow at Altnagelvin Hospital remains challenging. In 14/15, there were 25 12-hours breaches of Emergency Dept standards across WHSCT; 4-hour performance fell below 95%; and delayed discharges were a feature of pressures through the winter months.
3. Older Persons Assessment and Liaison Services in Altnagelvin demonstrated that through comprehensive geriatric assessment that a 4-day reduction in length of stay was achievable
4. Demand for neurology services exceeds commissioned capacity by 750 outpatients per year and demand for Orthopaedics exceeds commissioned capacity by 1,100 outpatients and resulting conversions.

Services to be Commissioned

1. The LCG, working with ICPs, will seek the introduction of GP request for advice across acute specialities, including extension of virtual clinics and direct GP access to hospital diagnostics
2. The HSCB approved 5 key commissioning priorities to improve patient flow. The LCG, supported by the Unscheduled Care Team, will prepare costed proposals for Altnagelvin Hospital for implementation.
3. The LCG will ensure the introduction of the commissioned Older People's Assessment and Liaison Services at South-West Acute Hospital with the provision of a multi-disciplinary assessment for all patients admitted to hospital, leading to reduced length of stay of 4 days for over 75 year olds
4. LCG will commission additional capacity in neurology and orthopaedics services to meet demand

Securing Service Delivery

1. Demand management initiatives will be sought from Integrated Care Partnerships where these can be shown to reduce the need to refer to Trust Consultant-led services.

2. The Trust will take forward the 5 key commissioning priorities, including delivering additional multi-disciplinary access and activity 7 / 7; extended senior clinical decision making; and a seven day dedicated minor injury stream in ED.

3. The Trust should implement Older Persons Assessment and Liaison Services in the South West Acute Hospital.

4. The Trust should bring forward proposals to close the elective gaps for neurology and orthopaedics.

14.3.1 POC 1: Non-Specialist Acute Services (continued)

Local Needs and Assessment

5. Increased annual demand on elective surgery, unscheduled admissions and GP surgical assessments.
6. Acute Care at Home (POC 1&4) can provide active treatment by health care professionals in the patients home avoiding unnecessary inpatient care.
7. The Western area has the largest increase in prevalence rates for stroke between 2007 (13.8/1000 population) and 2014 (17.3/1000 population) at 25%. RQIA recommends clear definition of a stroke unit, accessible thrombolysis service and TIA assessment and treatment at weekends for high risk cases.
8. In Western hospitals, there were 24,689 hospital cancelled outpatient appointments in 2014/15

Services to be Commissioned

5. The LCG will review the Elective Day of Surgery Unit and Surgical Assessment Area pilot with a view to mainstreaming if successful in reducing length of stay and admissions.
6. The LCG will commission a proportionate 24-hour community nursing service, building on district nursing, Rapid Response nursing and Treatment Room services which prevents unnecessary hospital admissions and supports the introduction of Acute Care at Home.
7. The LCG will consider the redesign of stroke services in line with regional model of care, including creation of a specialist acute unit and appropriate rehabilitation in hospital and at home.
8. The LCG will seek assurances that hospital cancelled appointments are minimised and appropriate and in line with Departmental requirements, i.e. reduced by 20% by March 2016.

Securing Service Delivery

5. The Trust should complete an evaluation of the Elective Day of Surgery Unit and Surgical Assessment Area.
6. The Trust should implement a phased Acute Care at Home model, building on commissioned expansion within Community nursing with Demographics investment in 15/16 focused to enhance the delivery of the 24/7 Community Nursing Model aligned to GPs, pathway development for >65years frail elderly Disease Specialist Nursing and an Acute Care at Home Team.
7. The LCG will work with the Trust to review existing medical, nursing and AHP capacity with a view to agreeing a new stroke service model later 2015.
8. By June 2015, the Trust will provide a plan to reduce cancelled consultant-led hospital appointments by March 2016

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Unscheduled Care (MT12), Elective Care (MT15, 16, 17) Stroke (MT19)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 65

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	11,302		11,302
		Daycases	31,915		31,915
		New Outpatients	115,379		115,379
		Review Outpatients	150,756		150,756
	Unscheduled	Non Elective admissions	37,053		37,053
		ED Attendances	103,173	3,109	106,282
		Planned investment in 2015-16		£1.4m	

13.3.2 POC 2: Maternity and Child Health Services

Strategic Context: Normalisation of birth remains the imperative in line with the Maternity Strategy. There have been fewer births in Western hospitals in recent years although there is some evidence of increased complexity, particularly a marked increase of mothers with a diabetes risk. Medical staffing challenges continue and are exacerbated by moves to extend cover of middle and senior obstetrician and paediatricians at South West Acute Hospital in the face of safety concerns regionally.

Local Needs and Assessment

1. WHSCT SBA outturn in 2013/14 outstripped the legacy SBA volume across a number of POCs with an increase in demand for health visiting 1,446 contacts within maternity & child health.
2. There are typically 3,600 medical admissions to paediatric wards in Altnagelvin, with requirement for escalation beds every year over the winter period.
3. While 27% of births were by caesarean section (elective & non elective, 2,1% below the NI average, caesarean section rates at SWAH have increased steadily and 0.7% higher than the NI average in 2013/14
4. The pilot weight management programme for pregnancy women, "Weigh to a Healthy Pregnancy" is underway offering a lifestyle intervention to all pregnant women with a

Services to be Commissioned

1. In the context of on-going regional review, LCG will review capacity and demand for health visiting services (across PoCs) with a view to closing any gap and in line with normative nursing levels.
2. The LCG will review the pilot of the Paediatric Assessment Unit (PAU). If successfully evaluated, the LCG will consider commissioning recurrently, leading to reduction of admissions by 20%.
3. The LCG will work with Western Trust to promote normalisation of births in line with Maternity Strategy 2012-18.
4. The LCG, working with PHA, will seek to mainstream "Weigh to a Healthy Pregnancy", drawing on the learning of the pilot programme.

Securing Service Delivery

1. The LCG in collaboration with PHA will realign the WHSCT Health Visiting SBA 15/16 to reflect current service and modernisation reform that has been undertaken in line with normative nursing.
2. The Trust will carry out an evaluation of the PAU by July 2015 and LCG will consider the findings in due course.
3. The Trust will take steps to reduce Caesarean section rates to NI average within 12 months.
4. The Trust will bring forward proposals to continue "Weigh to a Healthy Pregnancy" programme.

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC 2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 66:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,009		4,009
	Health Visiting	Contacts	67,633		67,633
		Planned investment in 2015-16		Nil	

13.3.3 POC 4: Older People's Services

Strategic Context: In the face of rapid growth of the older population and in light of *Transforming Your Care*, it is imperative that services for older people change and grow. The priority will be to provide support to enable all older people to remain independent and living in their own home for as long as possible.

Local Needs and Assessment

1. The number of over 65 years continues to grow in the LCG area; increasing demand on domiciliary care and among people with mental health difficulties and those with disabilities.
2. The demand for domiciliary care service has increased by 23% (2010-2014 estimated contact hours). Reablement services provide considerable benefit to patients with reduction in care requirements following period of intervention.
3. Older people with mental health challenges, particularly dementia continue to increase.
4. From April to September 2014, 1,168 people over 65 years attended Altnagelvin ED due to a fall. 82% of these falls were at the home.

Services to be Commissioned

1. The LCG will seek to increase the number of Domiciliary Care hours although this may be reduced by initiatives, such as the roll-out of Reablement.
2. The LCG will commission the further roll-out of Reablement across the Western area with a view to realising 45% reduction in referral rates to long term caseloads during 2015/16.
3. The LCG will review older people's mental health services, including dementia care, to ensure recent investments have proven successful and need is appropriately met.
4. The LCG will support ICP initiative to coordinate falls prevention through integrated care pathways supported by GPs, Western Trust, NIAS and voluntary sector agencies.

Securing Service Delivery

1. The Trust will deliver the required domiciliary care hours and other initiatives as specified by the commissioner.
2. The Trust should complete the roll-out of Reablement to the Southern sector to include an OT led Reablement Team and Contact and Information Centre covering the whole Western area, leading to 45% of discharges requiring no on-going care.
3. In collaboration with the Trust, LCG will produce a needs assessment of older people's mental health by October 2015, taking into account ICP plans to develop an integrated dementia care pathway.
4. ICPs will lead in building on GP pathway to Stepping On programmes and developing a Western wide falls prevention service.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 67

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	1,606,351	38,624	1,644,975
	Residential and Nursing Home Care	Occupied bed days	511,947		511,947
	Community Nursing	Contacts	162,488	7,000	169,488
		Planned investment in 2015-16		£2.8m	

13.3.4 POC 5: Mental Health Services

Strategic Context: In line with *Transforming Your Care* and taking forward the *Bamford Review*, the importance of maintaining mental health and intervening early in Primary Care remains the priority. A focus on Recovery Approaches in line with *Transforming Your Care* which states that "At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives."

Local Needs and Assessment

1. Mental health in NI is poor compared to GB. 25% of those surveyed in the West for NI Health Survey in 13/14 reported being anxious or depressed; higher than the NI average.
2. Patients on the Mental Health Register have risen by almost 10% in the 5 years to 2012.
3. HSCB has reviewed in-patient addiction services which recommends a regional model for detoxification and stabilisation care and rehabilitation.
4. The number of patients waiting longer than 13 weeks for a first appointment with psychological therapies service has increased through 2014.

Services to be Commissioned

1. The LCG will commission the introduction of Primary Care Talking Therapies, with support from ICPs to put in place clear GP referral pathway and appropriate access protocols.
2. The LCG will seek a consistent model of Primary Care Liaison and Crisis Response Home Treatment services across the Western area.
3. The LCG will support regional plans to have in place a 7-day in-patient addiction treatment service, including 8-beds in the Western area.
4. The LCG will review demand and capacity in psychological therapies required to deliver 13 weeks waiting times for first appointment.

Securing Service Delivery

1. The Trust will provide 400 talking therapy sessions through community and voluntary sector providers in 2015/16. The LCG will work with the Trust to ensure roll-out across the entire Western area during 2016.
2. The Trust will ensure consistent access to these services, particularly in the Southern Sector, leading to further reductions of acute mental health beds.
3. The Trust will ensure appropriate staffing levels are in place in line with investment.
4. The Trust will ensure that additional capacity is made available, in line with the commissioner requirements.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22),
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 68

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	38,759		38,759
	Residential and Nursing Home Care	Occupied Bed days	30,086	210	30,296
	Domiciliary Care	Hours	29,294	250	29,544
		Planned investment in 2015-16		£0.26m	

13.3.5 POC 6: Learning Disability Services

Strategic Context: The population of people with a learning disability is continuing to rise in line with the very welcome increase in the average lifespan. Consequently, there are greater numbers of people with a learning disability reaching adulthood and requiring day opportunities and appropriate community support. As adults reach old age in greater numbers, planning is required for their future long term care and housing and support for carers, in particular older carers, is crucial.

Local Needs and Assessment

1. The LCG area has the highest prevalence in NI of people with learning disabilities (6.17 per 1,000 people) and the number of people with a severe learning disability has increased by 30% since 2000.

2. For adult carers of LD clients, availability of alternatives to traditional forms of respite (day and residential care) is very limited.

3. Transition from children's to adult services is a challenging time for young adults with a learning disability and their families. Collaborative work between Education and Health sectors seeks to manage smooth transition and ensure individual needs are addressed through a coherent transition plan.

Services to be Commissioned

1. The LCG will seek to keep pace with growing demand for day opportunities to adults with learning disabilities, including providing support to up to 50 school leavers and meeting the needs of older adults.

2. The LCG will extend innovation fund for Adult carer recipients of short break hours in line with SDS approaches. Further short break options will be tested to extend the range of choice and flexibility for carers.

3. Given anticipated transition of up to 50 school leavers in 15/16; continued pressures on adult services and the emphasis on day opportunities, the LCG will seek assurance that the current transition process is effective in supporting individuals.

Securing Service Delivery

1. The LCG will continue to work with Western Trust to extend day opportunities and meet the needs of school leavers in 2015 as a priority, in line with emerging self-directed support model.

2. The Trust will provide additional innovative short breaks hours based on the outcomes of an LCG workshop in April 2015

3. The LCG and Trust will review the transition process and identified needs leading to any gaps in service.

Regional Priorities (see appendix A): Carers' Assessments (MT7)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 69

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	92,760		92,670
	Residential & Nursing Home Care	Occupied bed days	135,520		135,520
		Planned investment in 2015-16		Nil	

13.3.6 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: Developments in services for people with Physical and Sensory Disabilities have received a renewed impetus with the recent publication of Departmental and OFMDFM strategies. Implementation has benefited from the involvement of voluntary sector partners and emphasis on the participation of service users.

Local Needs and Assessment

1. In September 2014, 70 adults were awaiting a multi-disciplinary assessment for autistic spectrum disorder, most in excess of 13 weeks. 85 adults with a learning disability also required ASD assessment and support.
2. Western Trust figures show there are 279 deaf service users in the Western area, 127 of whom have no speech. Some have significant mental health and developmental difficulties and at risk behaviours in later life.
3. There is an increasing number of people with physical disabilities which are more complex including service users requiring high cost care packages and young people transitioning to adult services.

Services to be Commissioned

1. The LCG is investing in development of assessment and support service for adults with autism spectrum disorder leading to no one waiting longer than 13 weeks for an assessment by March 2016.
2. The LCG will commission community-based flexible service model of enablement, communication and skills development, providing 7 places in 15/16.
3. The LCG, working with regional colleagues, will consider a review of physical disability services, taking account of Trust reported pressures; the move to self-directed support; and population needs.

Securing Service Delivery

1. The multi-disciplinary Adult ASD service will provide integrated care plans for all young people transitioning to adult services; 30 adults supported by dedicated psychologist; 40 adults supported by dedicated Speech & Language Therapist and 40 adults supported by a dedicated Occupational Therapist.
2. The Trust will provide the commissioned service through Action for Hearing Loss.
3. The LCG will seek the input of Western Trust and relevant voluntary organisations in reviewing current services and evident gaps against regional standards.

Regional Priorities (see appendix A): Allied Health Professionals (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 70

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	298,781	1,200	299,981
	Residential & Nursing Home Care	Occupied bed days	24,283		24,283
		Planned investment in 2015-16		£0.06m	

13.3.7 POC 8: Health Promotion

Strategic Context: NI Executive published Making Life Better in 2014, a whole systematic strategic framework for public health which sets out clearly the action required to address the determinants of health alongside a life course approach. The health and social care system will play a full part through embedding health improvement and health inequalities in planning, commissioning and delivery processes.

Local Needs and Assessment

1. Hospital attendances and admissions continue to disproportionately relate to substance misuse and in particular alcohol.

2. 11% of Travellers live in Derry City Council area. The 2009 All Ireland Travellers Health Study has highlighted the huge disparities in life expectancy and other health outcomes for Travellers.

3. The number of older people who rely on HSC services is increasing. Initiatives to build or restore self-confidence and self-reliance among older people, providing practical support to help them achieve their aspirations and reduce dependency are required

Services to be Commissioned

1. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days

2. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days

3. The LCG, in collaboration with ICPs, will pilot the Social Prescribing scheme which seeks to offer alternatives to medicine prescription and overcome social isolation and loss.

Securing Service Delivery

1. The LCG, PHA and Trust will review the progress in the brief intervention and alcohol liaison service relating to both acute hospitals with a view to having in place a development plan by October 2015.

2. The LCG is co-funding support workers who will scope needs and services leading to an Action Plan, including health improvement programmes and improve access to HSC services.

3. ICPs have appointed a voluntary organisation to pilot the Social Prescribing Scheme with a number of GP Practices. Review will be undertaken in Autumn 2015 to inform decisions on mainstreaming in 2016/17.

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

13.3.8 POC 9: Primary Health and Adult Community Services

Strategic Context: Integrating primary and secondary care is central in the drive for Health and Social Care reform. Integrated Care Partnerships are established to be a key driver in this with their emphasis on integrated care pathways focused developing the role of primary care. Challenges in developing the necessary physical infrastructure in terms of primary care hubs and spokes; appropriate hospital accommodation; and IT systems are of critical importance. Engagement with service users and staff to ensure services meet their needs remain the strategic priority.

Local Needs and Assessment

1. An innovative partnership with community networks across the West elicited the views of over 1,000 older people, with older person champions raising their concerns directly with the LCG.

2. Chronic pain is estimated to affect approximately 20% of people in Northern Ireland. 35% of people in the West, surveyed as part of the NI Health Survey 2012/13, reported having pain or discomfort. Demand for pain management service outstrips commissioned capacity.
3. Clinical Interventions centres (CICs) reducing avoidable hospital admissions, facilitates early hospital discharge, reduces ALOS

Services to be Commissioned

1. During 2015, LCG will provide feedback on the issues raised during engagement projects in 2014, highlighting progress in addressing issues raised and will engage with community networks to elicit the views of HSC services from 1,000 adults in the Western area.

2. The LCG will commission a Pain Management Programme in the Northern sector of the Trust to reduce demand on assessment and treatments.

3. The LCG will commission Clinical Intervention Centres at Enniskillen Health Centre and Strabane Health Centre

Securing Service Delivery

1. LCG will engage with 5 local community networks who will each undertake at least 200 semi-structured interviews in a council area, including the involvement of Section 75 groups. LCG will engage with older person champions and network representatives to provide feedback on issues raised during engagement projects in 2014.

2. The Trust should bring forward proposals to expand the Pain Management Programme Trust wide

3. The Trust will provide an ambulatory service for patients in the community in Enniskillen and Strabane CICs in an ambulatory setting when it is safe and effective to do so

POC 9: Primary Health and Adult Community Services (continued)

Local Needs and Assessment

4. There is a need to put in place Primary Care Infrastructure (PCI) capital projects within primary care to support wider system change and the implementation of the recommendations of Transforming Your Care (TYC)

5. Altnagelvin's Emergency Department is not fit for purpose to meet the needs of its annual 60,000 patients. Outpatient demand also continues to rise placing considerable pressure on existing clinic space. There is also anticipated pressure on ICU/HDU.

6. The Transforming Your Palliative and End of Life Care Programme is supporting the redesign and delivery of coordinated services to enable people across Northern Ireland with palliative and end of life care needs to have choice in their preferred

Services to be Commissioned

4. The LCG will commission the opening of Omagh Local Enhanced Hospital, expansion of Enniskillen Health Centre and Lisnaskea Primary Care Centre as hubs in line with the HSCB's Primary Care Infrastructure programme and continue to progress hubs in Cityside, Limavady and Strabane

5. LCG judges that the completion of Phase 5.1 in 2017 leading to reduction of theatre capacity by 25% means it is imperative that 5.2 progresses as soon as possible. Improved accommodation for the Emergency Department and clinical adjacencies will also considerable improve patient flow and clinical decision-making.

6. LCG, working closely with Western ICPs, will commission 8 initiatives agreed within programme.

Securing Service Delivery

1. LCG in collaboration with WHSCT and Primary Care GPs deliver development of relevant Tranches of PCI programme for Western locality

2. The Trust will bring forward an Outline Business Case for the proposed Altnagelvin Hospital Phase 5.2.

3. The Programme is being delivered by the HSCB/PHA in partnership with Marie Curie working with statutory, voluntary and independent sector providers.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency Readmissions (MT14), Excess bed days (MT27)

Appendix 1 - Programme of Care Definitions

Acute Services (POC 1)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in an acute specialty. It also includes all activity, and resources used, by a hospital consultant in an acute specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

Acute specialties are all hospital specialties with the exception of the following (specialty codes in brackets); Geriatric Medicine (430), Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), GP Maternity (610) and mental health specialties (710 to 715).

Maternity and Child Health (POC 2)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), and GP Maternity (610). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts by any health professional where the primary reason for the contact was maternity or child health reasons. All community contacts to children under 16 are included as long as the contact was not in relation to mental health, learning disability or physical and sensory disability.

Family and Child Care (POC 3)

This programme is mainly concerned with activity and resources relating to the provision of social services support for families and/or children. This includes

Children in Care; Child Protection; Child Abuse; Adoption; Fostering; Day Care; Women's Hostels / Shelters and Family Centres. This is not a definitive list of the type of support which may be offered under this programme. This programme includes community contacts by any health professional where the primary reason for the contact is because of family or child care issues.

Elderly Care (POC 4)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Geriatric Medicine (430), Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts with those aged 65 and over except where the reason for the contact was because of mental illness or learning disability. All community contacts where the reason for the contact was dementia are also included, regardless of the patient's age, as well as all work relating to homes for the elderly, including those for the Elderly Mentally Infirm.

Mental Health (POC 5)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Mental Illness (710), Child & Adolescent Psychiatry (711), Forensic Psychiatry (712) and Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to mental health. If the reason for contact is that the patient has dementia, the activity is allocated to the Elderly Care programme of care.

Learning Disability (POC 6)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in the Learning Disability specialty (710). It also includes all activity, and resources used, by a hospital consultant in this specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to learning disability. All community contacts with Down's Syndrome patients who develop dementia, for any dementia related care or treatment are included as are all contacts in learning disability homes and units.

Physical and Sensory Disability (POC 7)

This programme includes all community contacts by any health professional where the primary reason for the contact is physical and/or sensory disability. All patients and clients aged 65 and over are excluded. These contacts should be allocated to the Elderly Care programme.

Health Promotion and Disease Prevention (POC 8)

This programme includes all community and GP based activity relating to health promotion and disease prevention. This includes all screening, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisation and community dental screening and prevention work.

Primary Health and Adult Community (POC 9)

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

Appendix 2 - Ministerial Priorities & Targets

Ministerial Theme:

To improve and protect population health and wellbeing and reduce health inequalities

Standards and Targets

Bowel cancer screening

1. By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited.

Tackling obesity

2. From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.

Substance misuse

3. During 2015/16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes.

Family Nurse Partnership

4. By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme.

Ministerial Theme:

To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.

Standards and Targets

Unplanned admissions

5. By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas.

6. During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.

Carers' assessments

7. By March 2016, secure a 10% increase in the number of carers' assessments offered.

Direct payments

8. By March 2016, secure a 10% increase in the number of direct payments across all programmes of care.

Allied Health Professionals (AHP)

9. From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.

Hip fractures

10. From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Cancer services

11. From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of

patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Unscheduled care

12. From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.

13. By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.

Emergency readmissions

14. By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.

Elective care – outpatients / diagnostics/ inpatients

15. From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks.

16. From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken.

17. From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.

Organ transplants

18. By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.

Stroke patients

19. From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.

Healthcare acquired infections

20. By March 2016 secure a reduction of x% in MRSA and *Clostridium difficile* infections compared to 2014/15. **[x to be available in April/May 2015 following analysis of 2014/15 performance and benchmarking process.]**

Patient discharge

21. From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

Mental health services

22. From April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Children in care

23. From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.

24. By March 2016, ensure a three year time frame for 90% of children who are adopted from care

Patient safety

25. From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.

Normative staffing

26. By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.

Ministerial Theme:

To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

Standards and Targets

Excess bed days

27. By March 2016, reduce the number of excess bed days for the acute programme of care by 10%.

Cancelled appointments

28. By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment.

Delivering transformation

29. By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model.

Pharmaceutical Clinical Effectiveness Programme

30. By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

Appendix 3 - Summary of Unfunded Service Pressures

As indicated within the Commissioning Plan the funding position for 2015/16 means that a range of key service developments cannot be progressed or can only be taken forward at a significantly reduced scale and/or pace. These service areas are listed below along with the location of relevant information.

Service Area	Section	Page
Maternity services	3.10	15
Physical and sensory disability services	3.11	16
Implementation of the regional reform programme	4.3.2	38
Health Protection Services	6.1.5	48
Services for older people	6.2.3	53
Unscheduled care waiting times	6.3.2	58
Services for people with long-term conditions	6.3.5	61
Cancer services	6.3.6	63
Mental Health services	6.5.2	71
Learning Disability services	6.5.2	71
Family & Childcare Services	7.1	82
Specialist acute services	7.2	87
Access to NICE treatments	7.2	87
Ambulance response times	7.4	94
Primary care and adult community services	7.5.1	98
Elective care waiting times	8.0	108

Steps are being taken, where possible, to mitigate risk and HSCB will continuously review commitments to ensure best use of all available resources.

In addition the HSCB have supported the DHSSPS in preparing bids for June Monitoring amounting to £89m –the bids remain subject to approval.

Bid	Amount £m
Learning Disability Resettlement	6.0
Public Health	4.0
Unscheduled care/Patient Flow	6.0
Revenue Consequences of Capital	7.0
Elective Care/Diagnostics	45.0
Specialist Services	7.5
Mental Health and Learning Disability	4.0
Children's Services	2.0
Transforming Your Care	5.0
Other Departmental Priorities	2.5
	89

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the DHSSPS in N Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / longterm conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the HSCB and PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction – A document published by the Minister on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not publicly funded. Also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

Cord blood is blood that remains in the placenta and in the attached umbilical cord after childbirth. Cord blood is collected from the umbilical cord because it contains cells called stem cells, which can be used to treat some blood and genetic disorders.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Directed cord blood donations - These are collected from the umbilical cord of new born siblings of children with a condition such as acute leukaemia (sometimes referred to as saviour sibling donations). They are arranged with the haematologist treating the affected child.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a

range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector.

Lesbian, Gay, Bisexual & Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the HSCB arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Neoplasm – Any new and abnormal growth of tissue. Usually a cancer.

Palliative Care – The active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of N Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) – these pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Reablement - range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Service Framework - a document which contains explicit standards underpinned by evidence and legislative requirements. Service Frameworks set standards, specific timeframes and expected outcomes

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Transforming Your Care – Published in 2011 the Review of Health and Social Care in Northern Ireland "Transforming Your Care", sets out a model of care for health and social care which makes recommendations about how we change our services to enhance prevention, early intervention, care closer to home, and greater choice and access. The HSCB is taking forward the implementation of around 70 of the 99 proposals sets out in the TYC Report.

Trust Delivery Plans – In response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Ministerial targets, key themes and objectives outlined for the year ahead.

Unrelated cord blood donations - Also known as undirected or public donations, these are altruistic donations of blood taken from volunteers' umbilical cords at the time of delivery. They are processed and typed for storage in a public cord bank. Registers of public cord banks can be searched internationally to provide the best match for a stem cell transplant.

HSCB/PHA Commissioning Plan 2015-16

Equality, Good Relations, Disability Duties and Human Rights
Screening Report

HSC Health and Social Care Board

HSC Public Health Agency

Accessibility statement

Any request for the document in another format or language will be considered.

Further Information

For further information on this Equality Screening report or to request an alternative format, please contact:

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Contents

1. Introduction

The Health and Social Care Board (HSCB), together with its Local Commissioning Groups (LCGs) is accountable to the Minister for Health, Social Services and Public Safety and translates the Minister's vision for health and social care into a range of services that deliver high quality and safe outcomes for users, good value for the taxpayer and compliance with statutory obligations.

The Public Health Agency (PHA) is a multi-disciplinary, multi-professional body with a strong regional and local presence. The Agency has four key functions; namely, health and social wellbeing improvement; health protection; public health support to commissioning and policy development; and HSC research and development.

A key role of the HSCB with the Public Health Agency (PHA) is effective engagement with providers, Patient Client Council (PCC), local government, service users, local communities, other public sector bodies and the voluntary and community sectors.

1.1 Equality, Good Relations, Disability Duties & Human Rights

Promoting equality is at the heart of the HSCB's and PHA's values and both organisations seek to ensure they recognise the value of diversity, tackle the barriers faced by many diverse groups and promote equality opportunity for everyone to ultimately improve health outcomes across Northern Ireland.

People are affected by different things, at different times in different ways; therefore diversity affects us all. There are however groups of people, who by virtue of their differences can sometimes be collectively disadvantaged. It is recognised that to deliver equality for everyone there is a need to understand diversity and that diversity exists even within and between equality groups.

The HSCB & PHA ensures that decisions are informed and underpinned by human rights standards and principles with attention given to those areas of commissioning that have a higher risk of raising human rights issues such as those involving older people, disability, mental health and children. HSCB/PHA continue to take measures to ensure that commissioning decisions support required duties as outlined in legislation, policy and the relevant UN Conventions.

HSCB/PHA also seek to enhance the impact of commissioning decisions on vulnerable people and communities by engaging and promoting supportive and sustainable communities. This includes those living in disadvantaged areas and population groups who require additional or more specific support, such as travellers, migrants, lesbian, gay, bisexual and/or transgender people (LGB&T), looked after children, those living with a disability, and homeless people.

The health promotion and prevention approach utilised by the PHA is underpinned by partnership models which include the active engagement of those most affected, alongside other agencies that can influence the determinants of health. Similarly, the LCGs, seek to engage directly with communities in the identification of their health needs, working in partnership with the community to address them.

HSCB/PHA have embedded equality, diversity and human rights into the mainstream commissioning cycle. This is to ensure that, in the developmental stage, commissioning decisions are informed by an explicit consideration of the needs, experiences of, and impacts on, those across the 9 categories protected by the equality duties.

1.2 Purpose of Equality Screening Report

Schedule 9 of the Northern Ireland Act 1998 provides for a comprehensive consideration by public authorities of the need to promote equality of opportunity, giving effect to Section 75 of the Act, between:

- people of different religious belief, political opinion, racial group, age, marital status or sexual orientation;

- men and women generally;
- people with a disability and people without one; and
- people with dependants and people without dependants.

These are called ‘Section 75 groups’ because the relevant law is section 75 of the Northern Ireland Act 1998. In addition, without affecting the above duty, public authorities must have regard to the desirability of promoting good relations between people of different religious beliefs, political opinions and racial groups.

Equality Schemes must be prepared, which among other things must set out arrangements for assessing the likely impact on the promotion of equality of opportunity of the policies adopted or proposed.

As part of the assessment

- consideration must be given of anything that could reduce any adverse impact on equality of opportunity of the policies proposed;
- consideration of what opportunities exist to better promote equality; and
- consideration must also be given to alternative policies that might better promote equality of opportunity

This screening report relates to the HSCB/PHA Commissioning Plan 2015/2016 and should be viewed alongside that document. **The report seeks to secure a sense of the cumulative impacts of the entire Commissioning Plan on the population of Northern Ireland, based on section 75 characteristics.**

2. The Commissioning Plan 2015-16

2.1 Background

The Commissioning Plan is a response to the Commissioning Plan Direction issued by the Minister for Health, Social Services and Public Safety for 2015/16. It includes the underpinning financial plan and outlines how commissioning will serve to deliver the planned transformation of services consistent with Transforming Your Care. Consequently, a key area of focus within the plan is the shift left of services from hospital into primary and community.

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

The plan provides an overview of regional commissioning themes and priorities for 2015/16 together with information on the priorities and decisions being taken forward at local level by the five Local Commissioning Groups (LCGs).

It is important to note that the Plan does not attempt to encompass all of the many strands of work that HSCB and PHA will continue to progress with providers during 2015/16. Rather it provides focus on a discrete number of key strategic and service priorities which will have the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level, and those which represent a step change in how we deliver our services, within available resources.

2.2 Key Themes and Strategic Direction

The Commissioning Plan 2015/16 priorities are reflected in the key themes of the Plan. The overall strategic direction of the Plan involves:

- Improving and protecting population health and reducing inequalities;

- Providing care closer to home;
- High quality, safe and effective care;
- Promoting independence and choice;
- Safeguarding the most vulnerable;
- Efficiency and Value for Money;

2.3 Placing communities at the centre of commissioning

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

There are five Local Commissioning Groups (LCGs): Belfast; Northern; South Eastern; Southern; and Western. LCGs are responsible for assessing local health and social care needs; planning health and social care to meet current and emerging needs; and supporting the HSCB to secure the delivery of health and social care to meet assessed needs, within available resources.

Local commissioning priorities, reflect the regional themes, but are presented by Programme of Care (PoC). PoCs are divisions of health care, into which activity and finance data are assigned, so as to provide a common management framework. They are used to plan and monitor the health service, by allowing performance to be measured, targets set and services managed on a comparative basis. In total, there are nine PoCs.

Initial screening of the high level proposals in the Commissioning Plan has taken place. When specific proposals are developed further detailed equality screening will be undertaken and impact assessments may be required, depending on the proposal.

3. Section 75 - Key findings

This section outlines the key screening findings across the nine equality groups outlined in Section 75(1) of the Northern Ireland Act 1998.

This analysis has been produced following a desktop review of available local, National and International literature and engagement with local communities through Local Commissioning Groups, and a regional stakeholder engagement event. Details of the data sources used are outlined within Appendix 1 and have been hyperlinked for ease of access.

Across the following nine equality categories details are provided on

- population profile
- needs and experiences
- identified Commissioning Plan impacts
- identified mitigating actions

In accordance with Equality Commission advice Appendix 2 provides a summary of identified impacts and mitigating actions.

3.1 Gender

Population Profile
The population of Northern Ireland on Census Day 2011 was 1,810,900 Males 887,300 (49%) Females 923,500 (51%) Accurate figures on the number of transgender people are not currently available. McBride (2011) 'Healthcare Issues for Transgender People Living in Northern Ireland' estimates that the number of people who say they are transgender in Northern Ireland is 8 per 100,000 (120) people (aged 16 and over). There is a higher proportion of male to female transitions. There is a marked difference in the life expectancy between men and women.)Women lived on average 4.4 yrs longer for the period 2009-2011) reflecting higher premature deaths in men from conditions which are either avoidable or amenable to health care intervention if caught early enough. As the life expectancy of women is longer, they are therefore disproportionately represented in older people's services.
Needs and experiences
There is a higher level of disability among adult females (23%) compared to adult males (19%). Generally men access services later, due to a reluctance to go to the doctor. Evidence suggests that men are also more likely to consume more than the recommended weekly limit of alcohol and therefore are potentially over-represented in addiction services. Negative attitudes are displayed towards transgender people, according to the 2011 Equality Awareness Survey by the Equality Commission. This found that 35% of respondents would mind (a little or a lot) having a transgender person as a work colleague, while 40% would mind having a transgender neighbour and 53% would mind having a transgender in-law. Negative attitudes were stronger among people over 65 years old.

At the May 2015 Commissioning Plan stakeholder event, participants raised the lack of research into alcohol related issues for women and therefore the lack of programmes. In addition to this, there is evidence that men are more likely to be diagnosed with autism spectrum disorder and females are more likely to report pain, discomfort, anxiety or depression. Women also have a higher uptake rate of the bowel cancer screening programme, with a differential of 5.5%.

In working to provide care closer to home, it is acknowledged that men and women, particularly women from minority ethnic backgrounds, may wish to have carers and care providers of the same gender. Transgender men and women generally experience disadvantages in terms of lack of access to specialist healthcare and there is a general lack of transgender awareness across much of the health and social care system.

Identified Commissioning Plan Impacts

Many of the Commissioning Plan proposals will have no impact on gender as service users will be screened at the point of access and decisions taken on clinical need. However a range of high level impacts were identified across the Commissioning Plan priorities and for some of the specific proposals, for men and women generally, including transgender service users and carers. These issues will be fully explored, reflected and addressed in the individual screening exercises when the proposals are being taken forward.

Identified Mitigating Action / Actions already in place

- Specific Health promotion initiatives, engaging men's groups, will be considered as part of encouraging less alcohol consumption;
- Engagement with men's groups and tailoring messages towards men will be considered a part of efforts to increase the uptake of bowel cancer screening services for men;
- Any request for a care giver from the same gender will be, as far as reasonably possible, provided; and
- Gender identity equality awareness training will be offered to staff as appropriate

3.2 Age

Population Profile
Compared with the England, Scotland and Wales, Northern Ireland had the fastest-growing and youngest population between 2001 and 2011, with an estimated increase of 7.5%. It is projected to have the youngest population during 2011-2021. This equates to 24% or 432,814 children and young people aged less than 18 years. (Source: NISRA 2009 Mid-year Population Estimates) At the same time, the population of Northern Ireland is getting older. Between the 2001 and 2011 censuses the median age increased from 34 years to 37 years. According to NISRA, the population aged 85 and over has increased by 9,000 people (38 per cent) in the 10 year period between June 2002 and June 2012. This is five times faster than the overall population growth of just over seven per cent over this same period. Within Northern Ireland this population is projected to grow from the 31,800 at the 2011 census to 100,000 by 2041.
Needs and experiences
In March 2013 Age UK launched a twenty page fact sheet highlighting those over 85 whom they labelled as the 'oldest old'. Some key points to note from the Age UK briefing were: • Almost three quarters (74.8%) of the oldest old live on their own. • Malnutrition rather than obesity was an issue (33% of admissions to hospital in 80+ , 40% of 90+ were thought to be malnourished). Malnutrition of those entering care homes over 85 is at 52%. • Significantly more likely to have fallen. • A 'considerable' number are vitamin D deficient. • Dementia affects one in six over eighty and one in three over ninety-five. • Only 8.5% of those dying of cancer aged over eighty-five die in a hospice compared with 20% of all cancer deaths. and a lower proportion of those over eighty-five access specialist palliative care. • In the UK nearly 50,000 people aged over 85 provide unpaid care to a partner, family member or other person.

- The ‘oldest old’ are as a group at greater risk of poverty than the ‘younger’ old.
- Ninety per cent of those over eighty-five are estimated to spend an average of 80% of time in their home.
- Thirty per cent of those over 80 have limited access to services such as shops and GPs and 25% are cut off from friends and family.
- About 40% of the ‘oldest old’ have a ‘severe disability’ (but 60% do not).
- The Newcastle 85+ study found urinary incontinence in 21.3%, hearing impairment in 59.6% and visual impairment in 37.2%.

Instances of stroke increase with age. Further to this it is recognised that in 2012, 52% of all births in NI were to mothers aged 30 or older. It is also more likely that women over 35 years of age will have multiple births, than those under 35, which could increase the risk for expectant mothers.

The highest prevalence of anxiety and depression is among persons aged 45-64, and people in this age band are also more likely to have a psychiatric disorder.

75% of the traveller population is under 30 years of age, and only 1% of the population is over 65 years old.

Autism is largely diagnosed in childhood and whilst services for children are well developed, this is limited, including in assessments, for adults. It is estimated that at present in Northern Ireland there are 19,000 people living with dementia, the majority of those older people. For diabetes, as with most long term conditions , the percentage of the population with the condition increases with age as does the percentage of the population associated with having a chronic condition.

Identified Commissioning Plan Impacts

Many of the Commissioning Plan priorities potentially have positive impacts on older and younger people. The delivery by the PHA of the Department of Agriculture and Rural Development MARA project to reduce social isolation has the potential to have significant positive benefits for rural older people, who are more likely to experience isolation.

The expansion of the bowel cancer screening programme will have positive impacts for people over 60 years old, as the expansion of the flu immunisation programme will for younger, school aged children. Priorities such as the reform of palliative care services will have a positive impact on older people and their families, enabling enhanced planning and a key worker function, as will the introduction of alternative care pathways for frail elderly patients, meaning potentially less waiting times and less travel times.
Identified Mitigating Action / Actions already in place
• Any referrals for service users under 18 years old to the Emotional Well Being Hubs will be appropriately signposted to relevant service. • Older carers needs will be considered when assessed as part of carers assessment. • The dementia service will establish a process to secure early diagnosis for all patients of all ages, with a specific focus on patients who are difficult to diagnose, including younger people. • The proposed developments to stroke service will take account of the specific access and mobility needs of older service users. • When a referral is received at the Hub for primary care talking therapies for service users under 18 years of age, the coordinator will liaise with the GP to discuss the alternative care available to ensure there is no delay; and • The diabetes service will take account of specific access and mobility needs of older people, who may also have aged related illnesses, such as dementia and COPD. The service will target older people as one of the at risk groups in respect of Type 2 diabetes and related complications.

3.3 Marital Status

Population Profile

Table 1: Marital Status of Northern Ireland residents aged 16+ years, Census 2011 (Source: NISRA (2012) Table KS103)

Marital status	Count	Percentage
Married	680,831	47.6
Single	517,393	36.1
Same-sex civil partnership	1,243	0.1
Separated	56,911	4.0
Divorced	78,074	5.5
Widowed or surviving partner	97,088	6.8

The table shows that almost half (48%) of people aged 16 years and over on Census Day 2011 were married, and over a third (36%) were single. Just over 1,200 people (0.1%) were in registered same-sex civil partnerships. A further 9.4% of residents were separated, divorced or formerly in a same-sex civil partnership, while the remaining 6.8% were either widowed or a surviving partner (Source: NISRA (2012) Table KS103).

The urban areas of Belfast and Derry/Londonderry had the largest proportions of single people (47% and 42% respectively), while Ards and Banbridge (both 54%) had the highest proportion of married people.

Needs and experiences

Not applicable

Identified Commissioning Plan Impacts

There is no evidence of negative impacts on the grounds of marital status on the high level Commissioning Plan priorities;

however priorities will be screened during implementation phase to explore impacts on section 75 grounds, including marital status, in more depth.
Identified Mitigating Action / Actions already in place
Not applicable

3.4 Religion

Population Profile

In Northern Ireland most people are of Christian faith, as shown in the table below. There are gaps in the information about those of non-Christian faiths and those with no faith.

On Census Day 2011, the population of Northern Ireland was 1,810,863. The table shows the change in the religious make-up of Northern Ireland between the 2001 and the 2011 Census..

Table 2: Changes in religious make up of Northern Ireland between 2001 and 2011 censuses
(Source: NISRA, Table KS07b (2003); KS212 (2012))

	Census 2001		Census 2011		
Religion/ religion brought up in	Count	Percentage (%)	Count	Percentage (%)	Percentage change (%)
Protestant/other Christian	895,377	53.1	875,717	48.4	-2.2
Roman Catholic	737,412	43.8	817,385	45.1	10.8
Other religions	6,569	0.4	16,592	0.9	152.6
None	45,909	2.7	101,169	5.6	120.4

Needs and experiences
Not applicable
Identified Commissioning Plan Impacts
There was little evidence of high level impacts based on religious background on the Commissioning Plan priorities. A number of the proposals require consideration at implementation phase, including around domiciliary care, acute care at home and additional community nursing inputs as people may request carers of their own gender, based on religious and cultural grounds. Moreover, an understanding of minority religious customs will be important in the context of the reform of palliative care services. Each priority will be screened at implementation phase, to explore more in depth impacts on section 75 groups, including religious background.
Identified Mitigating Action / Actions already in place
As above

3.5 Ethnicity

Population Profile

Since the 2001 Census, there has been a marked change in Northern Ireland's ethnic diversity. On Census Day 2011, 1.8% (32,400) of the resident population belonged to minority ethnic groups, more than double the proportion in 2001 (0.8%). The main minority ethnic groups were Chinese (6,300 people), Indian (6,200), Mixed (6,000) and Other Asian (5,000), each accounting for around 0.3% of the population.

	Census 2001		Census 2011		Difference
Ethnic group	**Count**	**Percentage**	**Count**	**Percentage**	**Count**
White	1,670,988	99.2	1,778,449	98.2	107,461
Chinese	4,145	0.2	6,303	0.4	2,158
Indian	1,567	0.1	6,198	0.3	4,631
Mixed	3,319	0.2	6,014	0.3	2,695
Other Asian	194	0	4,998	0.3	4,804
Other	1,290	0.1	2,353	0.1	1,063
Black African	494	0	2,345	0.1	1,851
Irish Traveller	1,710	0.1	1,301	0.1	- 409
Pakistani	666	0	1,091	0.1	425
Black other	387	0	899	0.1	512
Bangladeshi	252	0	540	0	288
Black Caribbean	255	0	372	0	117

Table 3: Changes in ethnic makeup of Northern Ireland between 2001 and 2011 censuses
(Source: NISRA, Table KS06 (2003); KS201 (2012)

Irish Travellers comprised 0.1% of the population. Since 2001, the minority ethnic count rose from 14,300 to 32,400. Increases were recorded for all groups with the exception of Irish Travellers, whose number fell from 1,700 in 2001 to 1,300 in 2011.Belfast (3.6%), Castlereagh (2.9%), Dungannon (2.5%) and Craigavon (2.1%) had the highest proportions of residents from minority ethnic groups. According to the "All-Ireland Traveller Health Study" (AITHS), the Traveller

population in Northern Ireland is estimated at 3,905, with 1,562 families. The age profile of this community is markedly different from that of the general population. Some 70% of Travellers are aged 30 or under, and only 1% are aged 65 and over. This partly reflects a higher birth rate, a higher death rate and inward migration

Residents born outside Northern Ireland in March 2011 accounted for 11% (202,000) of the population, compared with 9% (151,000) in April 2001. This change resulted largely from inward migration by people born in the 12 countries that have joined the European Union since 2004 (EU 12). These accounted for 2% (35,700) of Northern Ireland residents on Census Day 2011, compared with 0.1% in 2001.

The rest of the population born outside Northern Ireland consisted of 4.6% born in Great Britain, 2.1% born in the Republic of Ireland, 0.5% born in countries that were EU members before 2004, and 2% born elsewhere. The detail is shown in Table 5 overleaf.

The number of requests received per annum by the Northern Ireland Health and Social Care Interpreting Service has risen from 10,257 in 2005/6 to 63,868 in 2011/12, showing the increasing demand on services responding greater diversity in the population. Responses to the TYC Vision to Action consultation noted how important it was to have foreign-language interpreters available.

Table 4: Breakdown of country of birth for the population of Northern Ireland (Source: NISRA (2012) Table KS204).

Country of birth	**Count**	**Percentage**
Northern Ireland	1,608,853	88.8
Outside Northern Ireland	202,000	11.2
England	64,717	3.6
Scotland	15,455	0.9

Wales	2,552	0.1
Republic of Ireland	37,833	2.1
EU before 2004	9,703	0.5
EU 12	35,704	2.0
Other	36,046	2.0

Needs and experiences

National research suggests there are differences within black and minority ethnic (BME) groups generally when compared with the white population. Ill health often starts at an earlier age in BME groups than among white people. There are variations from one health condition to another; for example, BME groups have higher rates of cardiovascular disease than white people but lower rates of many cancers. Diabetes is more common in BME groups and high blood pressure is more common in Asian groups.

Evidence suggests a lack of knowledge among BME groups about social care services. There is a particular lack of knowledge about services for those with dementia and their carers.

People from BME groups face particular difficulties in accessing services, making complaints and getting mistakes corrected. The Health Professions Council's 'Scoping Report on Existing Research on Complaints Mechanisms' says this can partly be explained by a relative lack of knowledge about how services work. People from BME groups may also be more likely to fear the consequences of complaining or asserting themselves.

While most difficulties centre on language barriers, there are a range of other issues, including:

- lack of awareness and lack of appropriate information of the services available;
- low levels of registration with GPs amongst certain groups;

- fears about entitlements to health care;
- lack of confidence, frustration and stress reported by the process of accessing the healthcare system, often a system different to their country of origin;
- failure to meet basic cultural needs e.g. dietary requirements and religious observance;
- institutional racism and the negative attitudes of some healthcare staff;
- immigration restrictions.

Healthcare officials are also 'restricted by or unsure of the level of responsibility in light of limited rights and entitlements'.

In addition to this, type 2 diabetes is six times more common in people of South Asian origin and up to three times more common amongst African and African Caribbean people. There are also higher instances of cardiovascular disease and hypertension, which may contribute to increased stroke risk.

Women of South Asian origin also report experiencing higher rates of anxiety and depression than the general population. BME people also experience higher rates of drug dependence whilst white people experience higher rates of alcohol dependence. Migrants also experience higher rates of both drug and alcohol abuse.

75% of the traveller population is under 30 years of age, and only 1% of the population is over 65 years old.

The 2010 All Ireland Traveller Health Study highlighted that:

- average life expectancy for Traveller men has decreased since1987;
- life expectancy of Traveller women is still 11.5 years lower than women in the general population;
- suicide rates are almost seven times higher for Traveller men than in the general population;
- mortality rates are considerably higher than the general population at all age ranges for both men and women;
- Traveller infants are 3.6 times more likely to die than their counterparts, a deterioration on comparable figures

since 1987.

The Department of Health and Social Services and Public Safety's S75 Action Plan has also highlighted that maternal and infant mortality are higher among BME groups. BME women are also more likely to access services late (e.g. ante-natal appointments) and to have complications.
The limited evidence that is available suggests that health outcomes are generally worse for Roma than for the majority population. Factors that impact on their health status include poverty, low levels of education, poor housing and sanitary conditions, low levels of health screening and late presentation for medical assistance.

A2 nationals including Roma have been able to access free health care since 1 January 2014. However, anecdotal evidence from those working within the healthcare sector suggests that some A2, especially Roma, continue to experience difficulties in registering with a GP.

Identified Commissioning Plan Impacts

Many of the Commissioning Plan proposals will have no impact on ethnicity as service users will be screened at the point of access for the service, which will be based on clinical need. However a range of high level impacts were identified across the Commissioning Plan priorities and for some of the specific proposals, for minority ethnic communities. These issues will be reflected and addressed in the individual screening exercises when the proposals are being taken forward.

With a slightly increasing black and minority ethnic (BME) community, the need for services to respond to be fully accessible is greater.

New priorities such as the introduction of the direct access to physiotherapy in the SE Trust, the introduction of acute Oncology teams at the cancer centre, the promotion of personalised care, independence and choice, and carers support may not be accessible if information is not provided in appropriate formats for minority communities.

The changing demographics of BME communities, with settled communities and transitional migrants present challenges

for health and social care around caring for the elderly.
Identified Mitigating Action / Actions already in place
• All communications will be in accessible formats and translated as appropriate, based on demographics and assessment of ethnicity of those accessing service; • Information will be readily available, such as in EDs, as appropriate, as ethnic minority people use secondary care more than primary care services; • Staff will be informed of the NIHSC Interpreting Service and any service user requiring this service will be offered the service; • Any request for a care giver from the same gender will be, as far as reasonably possible, provided; • Staff in the palliative care services will undertake cultural competency and racial awareness training as appropriate; • The language, cultural and other ethnic related needs of service users will be addressed by the diabetes service

3.6 Political Opinion

Population Profile

There is limited data available; however the Electoral Commission's data on the first-preference votes per party in the Northern Ireland Assembly Elections 2011 gives a good guide to political preferences in the province as a whole.

Table 5: First preference votes per party in Northern Ireland Assembly Elections 2011 (Source: Electoral Office NI, 2011)

Political party	Votes
Democratic Unionist Party	198,436
Sinn Fein	178,222
Social Democratic and Labour Party	94,286
Ulster Unionist Party	87,531
Alliance	52,384
Other	**52,284**

Needs and experiences

Not applicable

Identified Commissioning Plan Impacts

There was little evidence of high level impacts based on religious background on the Commissioning Plan priorities.

A DHSSPS literature review of equality and human rights on fair access to health and social care said it is difficult to know how statutory health and social services perform as regards political opinion. This is partly because of a lack of research (See http://www.dhsspsni.gov.uk/eq-literature-review).

Each priority will be screened at implementation phase, to explore more in depth impacts on section 75 groups, including political opinion.

Identified Mitigating Action / Actions already in place

As above

3.7 Disability

Population Profile

Census figures show that in 2011 just over one in five of the resident population (21%) had a long-term health problem or disability that limited their day-to-day activities, similar to the proportion in 2001 (20%). Strabane and Belfast (both 24%) had the highest proportions of residents with a long-term health problem or disability.

Table 6: Long-term health problem or disability of Northern Ireland **Population** (Source: NISRA (2012) Table KS301 – Health and unpaid care)

Disability	Count	%
Long-term health problem or disability: day-to-day activities limited a lot	215,232	11.9
Long-term health problem or disability: day-to-day activities limited a little	159,414	8.8
Long-term health problem or disability: day-to-day activities not limited	1,436,217	79.3

According to a NISRA survey carried out in 2006, some 37% of households include at least one person with a disability and 20% of these include more than one disabled person.

For both men and women, the rate of disability increases with age. As noted earlier, women on average live longer than men therefore disability tends to be more common among women. The rate is particularly high for women aged 75 and above (at 62%). It is only among the youngest adults aged 16 to 25 that the rate for men (at 6%) is higher than for women (4%) (Northern Ireland Survey of Activity Limitation and Disability (2006/07).
Some 32% of the 1,860 people receiving direct payments from their local Health and Social Care Trust have a physical or sensory disability (January 2011).
In Northern Ireland there are about 16,500 people with a learning disability. McConkey et al (2006) predict this will

increase by 20.5% by 2021. Any change to older people's services must take account of the needs of older people with learning disabilities as well as other forms of disability. (McConkey et al, 'Accessibility of healthcare information for people with a learning disability. A Review and Discussion Paper' (2006)

Table 7: Percentage of People in Northern Ireland population by type of long term condition or disability (Census 2011)

Type of long – term condition	**Percentage of population with condition %**
Deafness or partial hearing loss	5.1
Blindness or partial sight loss	1.7
Communication Difficulty	1.6
Mobility of Dexterity Difficulty	11.4
Learning, intellectual, social or behavioural difficulty.	2.2
Emotional, psychological or mental health condition	5.8
Long – term pain or discomfort	10.1
Shortness of breath or difficulty breathing	8.7
Frequent confusion or memory loss	1.9
A chronic illness (such as cancer, HIV, diabetes, heart disease or epilepsy.	6.5
Other condition	5.2
No Condition	68.5

Needs and experiences

Disabled people are more likely to suffer isolation.
There are potential barriers in in respect to access for disabled women to sexual health and maternity services.

Access to appropriate information is an area of concern to disabled people, in the format best suited to a person's needs.

Mental illness has been identified as one of the major causes of ill health and disability in Northern Ireland with twenty

five per cent (25%) higher overall prevalence of mental health problems than in England.

A Health Survey for Northern Ireland 2010/11 highlighted that one in five respondents showed signs of a possible mental health problem and that women were more likely to show signs of such a problem (23%) than men (17%).

Following independent evaluation the Directed Enhanced Service for LD annual health checks in Primary care was continued in 2014/15.During 2015/ 16 this will be supplemented by LD specific health promotion activities which were recommended by the Evaluation.

Identified Commissioning Plan Impacts

A range of high level impacts were identified across the Commissioning Plan priorities and for some of the specific proposals, for people with disabilities generally. These issues will be reflected and addressed in the individual screening exercises when the proposals are being taken forward.

A key strategic aim of the Commissioning Plan, in line with Transforming Your Care, is to provide the right care, in the right place at the right time. This will in many instances involve bringing care closer to the home. A range of the Commissioning Plan proposals will therefore have potential positive impacts for people living with a disability.

The delivery by the PHA of the Department of Agriculture and Rural Development MARA project to reduce social isolation has the potential to have significant positive benefits for rural people with disabilities. Moreover the alternative care pathway for frail elderly people, who are proportionately more likely to have a disability, should result in better care and less waiting times.

In addition to this, the reform of palliative care services will also have positive impacts for people with disabilities and their families, with quicker access to a key worker and better end of life planning, particularly for those with chronic and acute life threatening conditions.

Identified Mitigating Action / Actions already in place
• The development of acute care at home services will take account of the particular needs of service users who have other disabilities, accounting for issues such as physical access, communication needs timing of appointments and the provision of information; and • The specific needs of disabled women will be considered in maternity services, to ensure that as far as possible, all needs are met to ensure a normal birth.

3.8 Dependants

Population Profile

In the 2011 Census respondents were asked whether they provided any unpaid help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health/disabilities, or problems related to old age. Twelve per cent of the population (213,980) provided such unpaid care, around a quarter (26%) of whom did so for 50 or more hours a week, a total of 56,000 people.

Between the 2001 and the 2011 Censuses there was an increase in the number of people providing unpaid care.

Table 8: Changes in the provision of unpaid care in Northern Ireland between 2001 and 2011 censuses

	2001 Census		2011 Census	
Care provided	**Count**	**Percentage %**	**Count**	**Percentage %**
Provides no unpaid care	1,500,201	89.0	1,596,883	88.2
Provides 1-19 hours unpaid care per week	110,407	6.6	122,301	6.8
Provides 20-49 hours unpaid care per week	28,000	1.7	35,369	2.0
Provides 50+ hours unpaid care per week	46,659	2.8	56,310	3.1
Total	1,685,267	100	1,810,863	100

(Sources: NISRA Univariate table UV021(2001 numbers) and NISRA (2012) Table KS301 – Health and unpaid care (2011 numbers))

In 2006 the DHSSPS published a *Survey of Carers of Older People in Northern Ireland*. Findings indicate that, of those providing this care over three-quarters (77%) were female and almost a quarter were male. Fifteen per cent were aged 75 or over, 48% were aged 55-74, 35% were aged 35-54 and only 2% were aged under 35. Just over three-quarters of the male carers (76%) were aged 55 or more, compared with three-fifths (60%) of female carers. Almost a quarter (24%) of

the male carers and 12% of the female carers were aged 75 or more.

The majority of informal care is provided by family members, usually spouses or adult children.

Needs and experiences

Based on information from Carers Northern Ireland (June 2011), the following facts relate to carers:

- 1 in every 8 adults is a carer;
- There are about 207,000 carers in Northern Ireland;
- One quarter of all carers provide over 50 hours of care per week;
- People providing high levels of care are twice as likely to be permanently sick or disabled as the average person;
- About 30,000 people in Northern Ireland care for more than one person; and
- 64% of carers are women; 36% are men.

There has been a policy drive in recent years towards supporting carers in their caring role and ensuring that health and social services assist carers in maintaining their own health and well-being. Yet, despite this many carers continue to feel marginalised and often believe that their own particular health and social care needs are overlooked (Arksey et al, 2003:1).

Identified Commissioning Plan Impacts

Many of the high level Commissioning Plan priorities have been identified as having no impact on people with and without dependants. Some of the proposals have been identified as having positive impacts on carers, such as Self Directed Support, which involves giving service users and carers independence and control over their own care.

Potential positive impacts for carers has also been identified in the proposals to move care closer to home, the introduction of acute care in the home and domiciliary care services, as this will involve less travel time and more control of care and support needs.

Day opportunities for people with learning disabilities will also potentially have positive impacts for carers, giving people with learning disabilities more choice and opportunities to avail of. The delivery of the Dementia Strategy, with the inclusion and involvement of carers and timelier access to appropriate information, has also been identified as having positive impacts for carers.
Identified Mitigating Action / Actions already in place
Not applicable

3.9 Sexual Orientation

Population Profile
Accurate figures are not available on the sexual orientation of the general population, and estimates vary considerably. The Northern Ireland Statistics and Research Agency (NISRA), along with other UK census offices, concluded that the census was not suitable for obtaining such information. The 2011 Census does provide some information, based on same-sex civil partnerships. Research by HM Treasury shows that from 5%–7% of the UK population say they are gay, lesbian, bisexual or ´trans´ (transsexual, transgendered and transvestites). The 2010 Northern Ireland Life and Times survey (1,205 adults) reported the figure as only 1%. The Office for National Statistics 2010 report (450,000 respondents) found that in Northern Ireland 92.5% said they were heterosexual and 0.9% of respondents said they were LGB, although 0.4% reported as 'other' and 6.2% said they didn't know or refused to respond. The 2012/13 Health Survey from the DHSSPS(NI) Information Analysis Directorate provided the following population split 93% Heterosexual/Straight; 1% Gay/Lesbian; 2% Bisexual; 1% Other; and, 3% Not specified.

Between 2006 and 2012, there were 715 recorded Civil Partnerships regionally. However, this is not indicative of the LGB population.
Needs and experiences
Proportionately more lesbian, gay and bisexual people drink alcohol daily, smoke and are three times more likely to take illegal drugs. Moreover, lesbian, gay and bisexual people are disproportionately impacted by mental health issues, more than a quarter of gay men have reported attempting suicide and three quarters have reported suicide ideation. In addition to this, people with minority sexual orientations may be impacted during the implementation of a number of the priorities, due to a potential lack of staff awareness of issues of same sex relationships, next of kin and general attitudes from service providers.
Identified Commissioning Plan Impacts
A number of impacts have been identified on the grounds of sexual orientation on the high level Commissioning Plan priorities.
Identified Mitigating Action / Actions already in place
• Staff across a number of work programmes, including Community Care Hubs, Acute Care in the Home, Domiciliary Care Services, Palliative Care Services, Alternative Care Pathways for frail elderly service users, Carers Support and Dementia Services will be trained in sexual orientation awareness as appropriate; and • In partnership with the LGB&T community, health promotion campaigns and service delivery initiatives will continue to be under taken across mental health, drug and alcohol dependence and suicide prevention Commissioning priority areas.

3.10 Section 75 - Screening decision

The Commissioning Plan proposals themselves are in large part a response to the health and social care needs and inequalities faced by many groups including older people and disabled people generally.

Priorities such as day opportunities for people with learning disabilities, dementia services or the introduction of Self-Directed Support are examples of this.

Due to the high level nature of the Commissioning Plan, which outlines the priorities to be implemented in 2015-2016 across health and social care, this document has identified a number of impacts. However, these are high level impacts, the detail of which will not be fully known until the implementation phase.

As outlined within the previous 9 sections, HSCB/PHA have identified potential mitigation / or actions which are already in place so that when proposals are being progressed, the experiences and needs of section 75 groups will be embedded in the implementation phase.

As the Commissioning Plan proposals are at a high level we will ensure that each new proposal and significant service change in the plan will be subject to an equality screening. We also recognise the major changes to social care with the proposed introduction of Self Directed Support and consequently, an Equality Impact Assessment has already commenced.

4. Good Relations

We have identified no issues impacting on good relations during this screening of the high level Commissioning Plan priorities. However, each priority will be screened for good relations impacts during their development.

5. Disability Duties

Through the development of the Commissioning Plan proposals, HSCB/PHA have consistently considered obligations under both the Disability Discrimination Act 1995 and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). The screening process for the Commissioning Plan coincided with the review of the HSCB Disability Action Plan, which allowed an opportunity to succinctly align the work of both documents.

5.1 United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) Duties

The development and implementation of many of the Commissioning Plan proposals contributes to meeting the UK Government's obligation under the UNCRPD, namely:

Article 9 Accessibility

1 To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban an in rural areas.

Article 21 Freedom of expression and opinion, and access to information

States Parties shall take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice, as defined in article 2 of the present Convention, including by:

- Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate

to different kinds of disabilities in a timely manner and without additional cost

Article 25 Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- Provide these health services as close as possible to people's own communities, including in rural areas.

- Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care

Article 26 Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

2. Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

5.2 Disability Discrimination Act 1995 Duties

The implementation and out workings of the priorities in the Commissioning Plan 2015-16 can significantly contribute to the duties of the HSCB of the Disability Discrimination Act 1995, namely:

1. Encouraging disabled people to participate in public life

During the development of the Commissioning Plan, local commissioning groups held stakeholder engagement events to seek the views of service users and carers to contribute to the development of the Commissioning Plan. These events targeted and included people with disabilities. A regional stakeholder event was also held with service users and carers to discuss the regional themes and priorities of the commissioning plan, which involved people with disabilities.

Further to this, a range of priorities outlined in the Commissioning Plan have to be progressed and implemented. We are committed to including disabled people in the development of a range of proposals. These are detailed in the HSCB Disability Action Plan, which was reviewed for 2015-2018.

Examples of these include hosting a number of focus groups, work streams and 'task and finish groups' which will include participation of people living with dementia and their carers, in the implementation of the Dementia Strategy and involving disabled people in the measurement of quality of life outcomes for people in receipt of Self-Directed Support.

2. Promoting positive attitudes towards disabled people

A number of actions highlighted in the HSCB Disability Action Plan seeks to promote positive attitudes towards disabled people, which permeates the work of the whole HSCB, including Commissioning. These including:

- Ensuring a consistent approach is taken to the provision of accessible formats;
- Providing guidance to staff on declaring that they have a disability and increasing the rate of disclosure;

- Improve the awareness of depression and related illnesses for all Well Being Hub Coordinators; and
- Assessing the HSCB website and ensuring it is accessible to disabled people.

6. Human Rights

The Commissioning Plan will inevitably impact on the lives of individuals in Northern Ireland by its very nature; it will therefore potentially impact on people's human rights.

The overall aim in commissioning as identified in the Commissioning Plan is to ensure that the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. This also relates to people's human rights. It is intended that Commissioning outcomes will, within available resources positively impact on people.

As part of the training provided to Commissioning Teams on improving the links between Equality, Inequalities, Human Rights and Commissioning, human rights issues are also addressed. This will assist in on-going work in relation to implementation of the Commissioning Plan including any screening activity and engagement.

The HSCB is also considering best practice in relation to adopting and promoting a Human Rights Based Approach. The HSCB will also be conscious of the recommendations of the Northern Ireland Human Rights Commission Enquiry into Emergency Health Care and respond appropriately.

As the precise elements of the Commissioning Plan are further screened and implemented the human rights aspects of decisions will be examined in order to identify the extent to which human rights issues are relevant and if so, if there is a potential positive impact or if they are potentially interfered with. The HSCB will assess this against all Articles in the Human Rights Act with a particular emphasis on:

- Article 2 – Right to life
- Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment

- Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour
- Article 6 – Right to a fair & public trial within a reasonable time
- Article 7 – Right to freedom from retrospective criminal law & no punishment without law
- Article 8 – Right to respect for private & family life, home and correspondence

7. Monitoring

7.1 Commissioning Plan Monitoring Framework

Each year the key actions and commissioning intentions outlined within the Commissioning Plan are monitored so that performance against these actions can be measured. These include delivery of:

- Ministerial Targets
- Regional Priorities
- Local Priorities

The HSCB, PHA and Trusts monitor the trends in indicators, taking early and appropriate action to address any variations / deterioration in unit costs or performance in order to ensure achievement of these targets and priorities.

Throughout this process, the actions outlined in the Equality, Good Relations, Disability Duties and Human Rights Screening report will be embedded within this framework and monitored accordingly, with correcting action taken as appropriate.

8. Conclusions

- As the Commissioning Plan proposals are at a high level HSCB/PHA will ensure that each new proposal and significant service change in the plan will be subject to an equality screening and impact assessments undertaken where required.
- Acknowledging the major changes to social care with the proposed introduction of Self Directed Support an Equality Impact Assessment has commenced.
- In screening the regional and local Commissioning Plan proposals against section 75 Groups sections 3.1 – 3.9 outlined a number of positive as well as negative impacts. These sections also provided detail of proposed mitigation or actions already in place to minimise any adverse impact.
- There was no identification of issues impacting on good relations during this screening of the high level Commissioning Plan priorities. Proposals will be screened further for Good Relations during implementation.
- The development and implementation of many of the Commissioning Plan proposals contributes to meeting the UK Government's obligation under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)
- The implementation and out workings of the priorities in the Commissioning Plan 2015-16 will significantly contribute to the duties of the HSCB/PHA of the Disability Discrimination Act 1995
- HSCB are committed to including disabled people in the development of a range of proposals. These are detailed in the HSCB Disability Action Plan, which was reviewed for 2015-2018
- The overall aim of the Commissioning Plan is to ensure that in as far as possible within available resources, the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. This also relates to people's human rights and it is intended that Commissioning outcomes will positively impact on people.

Appendix 1 - Data Sources

The data listed informed the screening of the Commissioning Plan and this will be scrutinised further as decisions are taken and recommendations made by commissioning teams and Local Commissioning Groups during 2054/16. This information is categorised under each of the section 75 categories.

General Equality

- Demographic information on the population of NI including the latest NI census 2011 data
- Information on area based deprivation from the health inequalities monitoring systems. http://www.dhsspsni.gov.uk/index/stats_research/stats-equality.htm
- DHSSPS Section 75 analysis of mortality patterns 2003-2007 http://www.dhsspsni.gov.uk/hscims_s75_analysis_of_mortality_patterns_2003-07.pdf
- Cancer Registry data
- Analysis of health and social care information systems
- Results of Patient and Client Council Survey *The People's Priorities* (2012)
- Local and national research studies and needs assessment
- Consultations with individuals, carers, patients & professionals in relation to the development of the Service Framework documents
- Bamford Review of Mental Health and Learning Disability (2006)
- Through patient and public involvement at both local and regional level.
- Through engagement with Trusts and clinicians (for example, through Managed Clinical Networks and other established forums).
- Complaints
- Consultation with Unions and Professional Bodies.
- Information compiled and made available through their website in the equality and human rights information bank by the Business Service organisation to support the equality agenda within HSC.

http://www.hscbusiness.hscni.net/services/1798.htm

- Preparing for the HSC Equality Action Plans - Audit of Inequalities: Section 75 Equality Groups - Emerging Themes (October 2010)
- Information sources produced for Audit of Inequalities and Action Plans (2010)
- A Sure Start to Later Life Ending Inequalities for Older People
- A Social Exclusion Unit Final Report, Office of the Deputy Prime Minister (January 2006)
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- Population projections - pyramids from NISRA - http://www.nisra.gov.uk/demography/default.asp3.htm
- Age Gender costs http://www.dhsspsni.gov.uk/cfrg5_presentation_delivered_as_part_of_the_consuultation__capitation_formula_review_group.pdf & http://www.dhsspsni.gov.uk/the-fifth-report-from-the-capitation-formula-review-group.pdf
- Projections for people aged 85+ for Northern Ireland: http://www.nisra.gov.uk/demography/default.asp134.htm
- Northern Ireland Life and Times Survey 2008 http://www.ark.ac.uk/nilt/2008/(attitudes to age issues) http://www.dhsspsni.gov.uk/ni_gpps_commentary_18_june_final_version.pdf
- GP Patient Survey in Northern Ireland Commentary Report 2009 -2010 http://www.dhsspsni.gov.uk/index/hss/gp_contracts/gp_contract_qof/gp_patient_survey.htm
- Information presented at the PHA scientific conference on elderly June 2013 and associated tables http://www.publichealth.hscni.net/publications/director-public-health-annual-report-2012-and-core-tables-2011

Gender

- Birth proportions – NISRA http://www.nisra.gov.uk/demography/default.asp8.htm
- Life expectancy by gender NI-NISRA http://www.nisra.gov.uk/demography/default.asp130.htm
- Death risk ratios – DPH annual report 2008 Core Tables http://www.publichealth.hscni.net/sites/default/files/core%20tables%20amended%20monica%20sloan%20170810_1.pdf
- Risk Behaviour and GP consultation rates – primarily NISRA Continuous Household Survey http://www.csu.nisra.gov.uk/survey.asp29.htm
- Transgender risk levels Hansson U and Hurley M 2007 Equality Mainstreaming – Policy and Practice for Transgender People Institute for Conflict Research http://www.ofmdfmni.gov.uk/transgenderequality22may07.pdf
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Religion

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- Labour Force Survey Religion 2008,OFMDFM

Research Branch (November 2009)

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- Marriage trends – NISRA http://www.nisra.gov.uk/demography/default.asp11.htm
- Northern Ireland Health and Wellbeing survey 2005/6 NISRA http://www.csu.nisra.gov.uk/survey.asp5.htm

Race and Ethnicity

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

Specific information in relation to Travellers

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Sexual Orientation / LGB&T

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- Effectiveness of interventions to prevent suicide and suicidal behaviour: A systematic review, Scottish Government Social Research (Leitner et al, 2008)
- Making it effective: A guide to evidence based mental health promotion, Radical mentalities briefing paper 1. (Friedli,2003) http://www.scmh.org.uk/pdfs/makingiteffective.pdf
- UK Inquiry into mental health and wellbeing in later life (2006) http://www.mhilli.org/index.aspx?page=stage2promotion.htm#Inquiryreport
- Royal College of Psychiatrists Council Report CR122 (2004) http://www.rcpsych.ac.uk/files/pdfversion/cr122.pdf
- Foresight report. Mental capital and wellbeing project (2008) http://www.bis.gov.uk/foresight/our-work/projects/published-projects/mental-capital-and-wellbeing

- NICE guidelines/guidance documents. http://www.nice.org.uk
  - Antenatal and postnatal mental health clinical management and service provision (2007)
  - Social and emotional wellbeing in primary education (NICE, 2008)
  - Social and emotional wellbeing in secondary education (NICE, 2009)
  - Self harm–The short-term physical and psychosocial management of self harm in primary and secondary care (NICE, 2004)
  - Promoting mental wellbeing at work (NICE, 2009)
  - Mental wellbeing and older people (NICE, 2008)
- Think child, think parent, think family: a guide to parental mental health and child welfare (Social Care Institute of Excellence (SCIE), 2009) http://www.scie.org.uk/publications/guides/guide30/files/guide30.pdf
- PHA health intelligence brief on mental health and suicide
- Quarterly returns on Self harm and suicide ideation attendances at A&E from the Northern Ireland Self Harm Register.

Alcohol and Drugs

- Alcohol-use disorders. Diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE, 2011) www.nice.org.uk/nicemedia/live/13337/53191/53191.pdf
- Alcohol-use disorders - preventing the development of hazardous and harmful drinking (NICE, 2010) www.nice.org.uk/nicemedia/live/13001/48984/48984.pdf
- Drug misuse: psychosocial interventions. (NICE, 2008) www.nice.org.uk/nicemedia/live/11812/35975/35975.pdf
- Drug Misuse Opiod Detoxification. (NICE, 2007)

www.nice.org.uk/nicemedia/live/11813/35997/35997.pdf

- Alcohol use disorders: Diagnosis and clinical management of alcohol related physical complications. (NICE, 2010) www.nice.org.uk/nicemedia/live/12995/48989/48989.pdf

Prisons and Prisoner Health

The Board takes as an underlying principle of prisoner healthcare delivery that people in prison should be entitled to the same level of healthcare as those in community and therefore the relevant strategies, policies and key strategic divers detailed sections 1.4 and 2.1 will apply when appropriate across the various programmes, specialties and health care initiatives.

Appendix 2 - Identified Impacts and Mitigation

Overall Plan

Issue	Proposed action
Commissioning Plan proposals are at a high level	Each new proposal and significant service change will be subject to equality screening

Self-Directed Support

Issue	Proposed action
Self-Directed Support is a major policy change for social care, introducing person centred social care support	An Equality Impact Assessment has commenced on this policy

Age

Issue	**Proposed Action**
Emotional Well-being hubs pilots will be for service users over 18 years old only	Any referrals for service users under 18 years old will be appropriately signposted to relevant service
Packages of Care for Carers – there is a recognition that many carers are older (approx. 30% of adults have carers over 70 years old)	Older carers needs will be considered when assessed as part of carers assessment
It is estimated that at present in NI, 19000 people are living with dementia, under 1000 have early onset dementia	The dementia service will establish a process to secure early diagnosis for all patients of all ages, with a specific focus on patients who are difficult to diagnose, including younger people
The prevalence of stroke will increase with age	The proposed new service will take account of the specific access and mobility needs of older service users

Primary care talking therapies are restricted to referrals of service users over 18 years of age only	When a referral is received at the Hub for service users under 18 years of age, the coordinator will liaise with the GP to discuss the alternative care available to ensure there is no delay
For diabetes, as with most long term conditions, the percentage of the population with the condition increases with age	The service will take account of specific access and mobility needs of older people, who may also have aged related illnesses, such as dementia and COPD. The service will target older people as one of the at risk groups in respect of Type 2 diabetes and related complications

Ethnicity

Issue	**Proposed Action**
The following priorities may be inaccessible to minority ethnic communities due to language/communication barriers: • **Weight to a healthy pregnancy** • **Reform of palliative care services** • **Establishment of minor injury stream in EDs** • **Alternative care pathways for frail elderly service users** • **Introduction of acute oncology teams at cancer centre and units** • **Carers support** • **Implementation of learning**	All communications will be in accessible formats and translated as appropriate, based on demographics and assessment of ethnicity of those accessing service Information will be readily available, such as in EDs, as appropriate, as ethnic minority people use secondary care more than primary care services Staff will be informed of the NIHSC Interpreting Service and any service user requiring this service will be offered it

disabilities day opportunities	
Minority ethnic women may request a care giver from the same gender across a range of services	Any request for a care giver from the same gender will be, as far as reasonably possible, provided
Minority ethnic religious customs may not be understood by staff responsible for delivering palliative care services following the reform	Staff in the palliative care services will undertake cultural competency and racial awareness training as appropriate
Type 2 diabetes is six times more common and three times more common in people of South Asian and African/Caribbean origin respectively	The language, cultural and other ethnic related needs of these service users will be addressed by the diabetes service
People from particular minority ethnic communities are less likely to register, or have difficulty registering with a GP	This issue will be addressed by HSCB generally, and is detailed in the HSCB Inequalities Action Plan. A range of focus groups with minority communities is being arranged to explore these issues, and others, with a view to addressing barriers

Sexual Orientation

Issue	**Proposed Action**
A lack of awareness of LGB issues, such as use of language, next of kin and sensitivity may present barriers for LGB people accessing services across the following priorities • **Community Care Hubs** • **Acute Care in the Home**	Staff across these work programmes will be trained in sexual orientation awareness as appropriate

• **Domiciliary Care Services** • **Palliative Care Services** • **Alternative Care Pathways for frail elderly service users** • **Carers Support** • **Dementia Services**	
LGB people suffer disproportionately from poorer mental health outcomes, drug and alcohol dependence and suicide ideation	In partnership with the LGB&T community, health promotion campaigns and service delivery initiatives will continue to be under taken across these Commissioning priority areas

Gender

Issue	**Proposed Action**
Men are more likely to consume the recommended daily intake of alcohol	Specific Health promotion initiatives, engaging men's groups, will be considered as part of encouraging less consumption
Men are under-represented in uptake figures for bowel cancer screening service	Engagement with men's groups and tailoring messages towards men will be considered a part of efforts to increase the uptake of bowel cancer screening services for men
Minority ethnic women may	Any request for a care giver from

request a care giver from the same gender across a range of services	the same gender will be, as far as reasonably possible, provided
Transgender people experience disadvantages in terms of lack of access to specialist healthcare and a general lack of transgender awareness across the HSC sector	Gender identity equality awareness training will be offered to staff as appropriate

Disability

Issue	**Proposed Action**
Patients with diabetes are likely to have other disabilities including diabetes related conditions	The proposed new service will take account of the particular needs of service users who have other disabilities, accounting for issues such as physical access, communication needs timing of appointments and the provision of information
Physical and sensory disability prevalence increases with age, this will impact on the provision of acute care at home	The proposed new service will take account of the particular needs of service users who have other disabilities, accounting for issues such as physical access, communication needs timing of

	appointments and the provision of information
There may be barriers for disabled people, particularly women, in accessing sexual health and maternity services	The specific needs of disabled women will be considered to ensure that all needs are met to ensure a normal birth

Additional references

Indicators of equality and diversity

- Indicators of equality and diversity in Northern Ireland (Jamison J, Buchanan R, Carr-Hill R, McDade D and Dixon P, 2007)
- Patterns of social difference
  - Section 1 - chapters 1 and 2
  - Section 2 - chapters 3 and 4
  - Section 3 - chapters 5 and 6
  - Section 4 - chapters 7 to 10
  - Section 5 - chapters 11, 12 and annex
- Measuring change (Carr-Hill R and Dixon P) http://www.ofmdfmni.gov.uk/measuring_change.pdf
- Carr-Hill R, R Buchanan R Dixon P and Jamison J

http://www.ofmdfmni.gov.uk/project_executive_summary.pdf

- Carr-Hill R, R Buchanan R Dixon P and Jamison J http://www.ofmdfmni.gov.uk/index/equality/equalityresearch/research-publications/publication-az.htm

- Fit Futures: Focus on Food, Activity and Young People, (Investment In Health, 2006)
- A Fitter Future for All: Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022 (DHSSPS, 2012)
- Sexual Health Promotion Strategy and Action Plan, 2008- 2013 (DHSSPS, 2008)

DIRECTION

2015 No. 1

The Health and Social Care Commissioning Plan Direction (Northern Ireland) 2015

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by sections 6 and 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(1):

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan Direction (Northern Ireland) 2015 and shall come into operation on 6 March 2015.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission regionally and for each of the five LCG areas, for the period 1st April 2015 to 31st March 2016, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include the underpinning financial plan, and set out how commissioning will serve to deliver the planned transformation of services, including *Transforming Your Care*. It should set out clear timescales and milestones for the delivery of commissioning intentions and the agreed service changes arising from the implementation of TYC.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board and the underpinning financial plan align with and support the delivery of the Executive's Programme for Government (PfG) commitments and associated milestones, its Economic Strategy and its Investment Strategy; the Minister's vision and priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998(2), the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); and Departmental standards, policies, strategies and guidelines.

3.—(1) The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will deliver the following three overarching strategic themes:

(a) *To improve and protect population health and wellbeing, and reduce health inequalities.*

(1) 2009 c.1 (N.I.) as amended by 2014 c.5
(2) 1998 c.47

The Commissioning Plan must demonstrate how the services to be commissioned will improve and promote the health and wellbeing of local populations, contribute to the prevention of ill health and reduce health inequalities, in accordance with Section 2(3) (g) of the Act. It should outline how commissioning will support the aims and outcomes of the Public Health Strategic Framework 2013-23 and related population health strategies, and indicate how the Regional Board and Regional Agency are working collaboratively with communities and partner organisations to address the determinants of health.

(b) *To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.*

The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board will deliver high quality, safe and effective care in the most appropriate setting. The Plan must demonstrate how services will be commissioned to improve access to treatment, care and support closer to home, and facilitate people to live as independently as possible in the community. This should include preventing people unnecessarily entering hospital, enabling them to return home safely as soon as they are fit to do so, and supporting people with health and care needs living in the community, as well as their families and carers. The Plan should set out how progress will be made towards implementing the Delivering Care Framework, including Delivering Care for Health Visiting, Delivering Care for Emergency Departments and Delivering Care for District Nursing. The Plan should also detail how commissioning will be used to promote innovation and appropriate use of technology in the delivery of health and social care services – on the basis of single solutions for the region.

The Commissioning Plan must demonstrate how the services to be commissioned will fulfil the statutory duty on the Regional Board under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(3); reflect the principles, values and standards set out in the Quality 2020 Strategy; improve the safety and effectiveness of services to deliver safe, high quality care that meets recognised standards, including those set out in Service Frameworks; and improve the patient and client experience. The Plan must explain the outcomes which will be delivered for patients, clients and carers and outline how the Regional Board will take account of their views in the commissioning of services, including through reference to reports produced and priorities highlighted by the Patient and Client Council, the outcomes of the 10,000 voices project and the audit of the five standards of patient experience.

The Commissioning Plan must demonstrate that the services being commissioned ensure that the most vulnerable in society, including children and adults at risk of harm, are looked after effectively across all our services, and detail how statutory responsibilities to assess needs, safeguard, protect and support vulnerable groups, including through the discharge of delegated statutory functions, will be met. There should be an emphasis on prevention and early intervention, in particular in connection with those families whose children are on the edge of care. The Plan will demonstrate how all HSC Trusts, as corporate parents, will be expected to meet the specific needs of looked-after children by providing high quality, enduring placements for them and supporting their transition out of care and into adult life.

(c) *To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.*

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations, and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act. The Plan should incorporate plans for each of the five LCGs, and should reflect the use of an evidence-based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCG's target fair share, and the actual resources deployed for the respective populations.

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(3) S.I. 2003/431 (N.I. 9)

It must also demonstrate how the Regional Board will commission services in a cost effective manner, including commissioning across provider boundaries and utilising alternative providers where appropriate, and by ensuring that performance and costs are benchmarked and that best practice is shared and implemented across all HSC Trusts. The Plan should also explain how the Regional Board, in consultation with the Regional Agency as appropriate, will address significant under-performance against requirements by providers.

Commissioning and the use of financial allocations

4.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1st April 2015 to 31st March 2016, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

(3) This information shall be provided separately for each of the five LCGs, for provider organisations and for services commissioned regionally by the Regional Board in the manner specified by the Department in its budget allocation letters.

(4) This information shall include an analysis of how the Regional Board plans to shift the proportion of spend from hospital services to primary and community services in accordance with the planned transformation of health and social care services.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 6 March 2015.

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Standards and Targets for 2015/16

Theme	*Standard/ Target*
To improve and protect population health and wellbeing, and reduce health inequalities.	**Bowel cancer screening** 1. By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited. **Tackling obesity** 2. From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited. **Substance misuse** 3. During 2015/16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes. **Family Nurse Partnership** 4. By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme.
To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.	**Unplanned admissions** 5. By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas. 6. During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.

	Carers' assessments 7. By March 2016, secure a 10% increase in the number of carers' assessments offered. **Direct payments** 8. By March 2016, secure a 10% increase in the number of direct payments across all programmes of care. **Allied Health Professionals (AHP)** 9. From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment. **Hip fractures** 10. From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. **Cancer services** 11. From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days. **Unscheduled care** 12. From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours. 13. By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area. **Emergency readmissions** 14. By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.

	Elective care – outpatients / diagnostics/ inpatients 15. From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks. 16. From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken. 17. From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks. **Organ transplants** 18. By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors. **Stroke patients** 19. From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis. **Healthcare acquired infections** 20. By March 2016 secure a reduction of x% in MRSA and *Clostridium difficile* infections compared to 2014/15. **[x to be available in April/May 2015 following analysis of 2014/15 performance and benchmarking process.]** **Patient discharge** 21. From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours. **Mental health services** 22. From April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to

	access psychological therapies (any age). **Children in care** 23. From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%. 24. By March 2016, ensure a three year time frame for 90% of children who are adopted from care. **Patient safety** 25. From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points. **Normative staffing** 26. By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.
To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.	**Excess bed days** 27. By March 2016, reduce the number of excess bed days for the acute programme of care by 10%. **Cancelled appointments** 28. By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment. **Delivering transformation** 29. By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model. **Pharmaceutical Clinical Effectiveness Programme** 30. By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE COMMISSIONING PLAN DIRECTION (NORTHERN IRELAND) 2015

1. This direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister's vision and priorities during the year 1st April 2015 to 31st March 2016.

2. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2015/16 financial year are resourced through the underpinning financial plan and will serve to deliver on the agreed planned transformation of services, including TYC.

3. The targets and standards included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.

4. Effective performance management of the health and social care system requires availability of a range of indicators to help track trends. An Indicators of Performance Direction will be produced alongside the Commissioning Plan Direction to ensure that the HSC has a core set of indicators in place, with common definitions applied across the sector. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

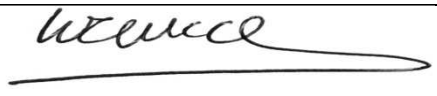
PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	18 June 2015
Title of Paper	Draft PHA Budget 2015/16
Agenda Item	8
Reference	PHA/02/06/15

Summary

The Draft Budget sets out the total resources which the PHA has available in 2015/16.

Appendix 1 of the document provides Members with a more detailed breakdown of how the programme funding available to the Public Health Agency (PHA) in 2015/16 will be deployed to advance its work in improving and protecting health and well-being. In particular it identifies a number of new investment priorities that it is proposed to progress.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The draft budget was approved by AMT on 10 June.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	10 June 2015

Public Health Agency

2015-16 Draft Budget

For Approval

PHA Draft Budget 2015-16

Introduction

This paper sets out the total resources which the PHA has available in 2015-16. These funds have been set out in their high level summary areas including Commissioning with HSC Trusts, Non-Trust Programme activity and the Management & Administration costs of the PHA.

Available Resources

The PHA receives an allocation from the DHSSPS each year and this is supplemented by income from other sources, e.g. income for Research & Development projects and receipts for PHA staff on secondment to other organisations.

A summary of the total funding available for 2015-16 is set out in the table below.

Source of Funding	£'000
DHSSPS allocation	94,050
Assumed allocation for SBNI	757
Other assumed allocations for Administration (incl. Clincial Excellence Awards, Special Needs Schools, Accommodation costs)	740
Assumed allocations for Programme (MARA, ISCYP, EITP)	2,058
DHSSPS allocation for R&D (National Research Initiative)	3,199
Assumed R&D income	719
Assumed income from secondments	258
TOTAL RESOURCES AVAILABLE	**101,781**

Please note the funding for SBNI is included within this paper as it is consolidated within the PHA Financial Accounts. However, the responsibility for financial breakeven lies between the Chair of SBNI and the DHSSPS.

Reduction in Management & Administration Funding

In March 2015 the PHA was notified by the DHSSPS of a 15% reduction in M&A funding for 2015-16. This equates to a total of £2.8m and has presented a significant challenge for the Agency. A proposal to minimise the impact of this funding cut on frontline services by making the savings across both administration costs and programme expenditure has been agreed in principle by the Department.

In the short term, the Agency intends to reduce its non-pay expenditure, not renew temporary contracts as they expire, reduce travel expenditure by at least 20%, and formalise the scrutiny process around vacancies. A more strategic review will be conducted in the medium to longer term to reshape the organisation to best meet the priorities for the future within the reduced funding available.

The absence of an exit or redundancy scheme means there is no feasible mechanism to allow the Agency to reduce its staff costs. A further complication is the extent to which the DHSSPS are prepared to agree to the curtailment or cessation of areas of current PHA business which would result from staff reductions. In the light of this, it has been agreed that for 2015-16 the PHA will manage its budgets to meet the required £2.8m by achieving a £1.5m efficiency in Programme expenditure and a £1.3m reduction in Administration costs.

This Budget paper has been prepared on this basis, and the Agency Management Team are asked to review it and, if appropriate, approve it for presentation to the Board.

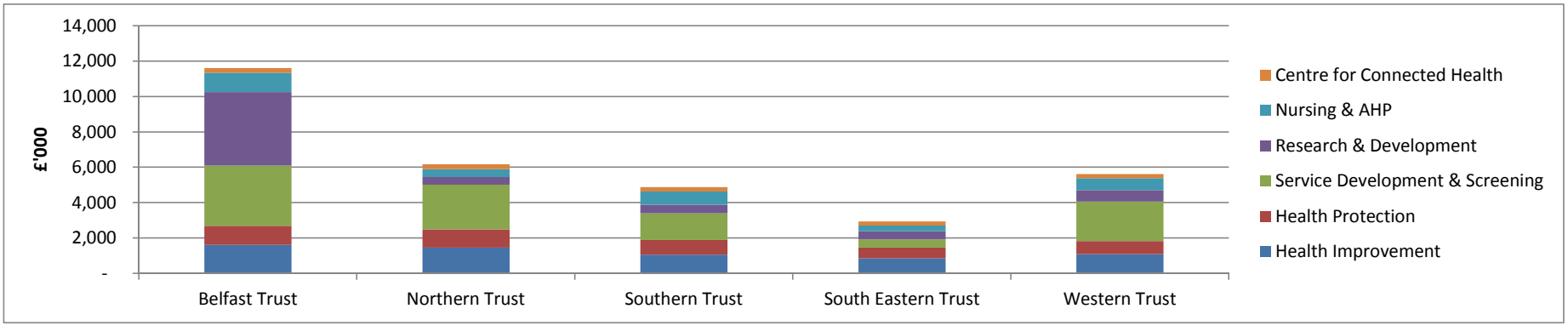
An Investment Plan is also being presented to the Board for approval, and is attached as an Appendix to this paper.

Public Health Agency
2015-16 Budget Summary

	Trust	Programme Non-Trust	Total	Mgt & Admin	Total
	£'000	£'000	£'000	£'000	£'000
Available Resources					
Departmental Allocation - PHA	31,250	46,926	**78,176**	15,874	**94,050**
Transfer to cover M&A retraction	-	(1,500)	**(1,500)**	1,500	**-**
Adjusted Departmental Allocation	31,250	45,426	**76,676**	17,374	**94,050**
Departmental Allocation - SBNI	-	-	**-**	757	**757**
Assumed further allocations	-	5,257	**5,257**	740	**5,997**
Income from Other Sources	-	719	**719**	258	**977**
Total Available Resources	31,250	51,402	**82,652**	19,129	**101,781**
Proposed Budgets					
Trusts & BSO	31,250	-	**31,250**	-	**31,250**
Non-Trust Programme *	-	51,402	**51,402**	-	**51,402**
PHA Administration	-	-	**-**	19,129	**19,129**
Total Proposed Budgets	31,250	51,402	**82,652**	19,129	**101,781**

* *Includes amounts which may transfer to Trusts during the year.*

Programme Expenditure with Trusts
2015-16 Budget

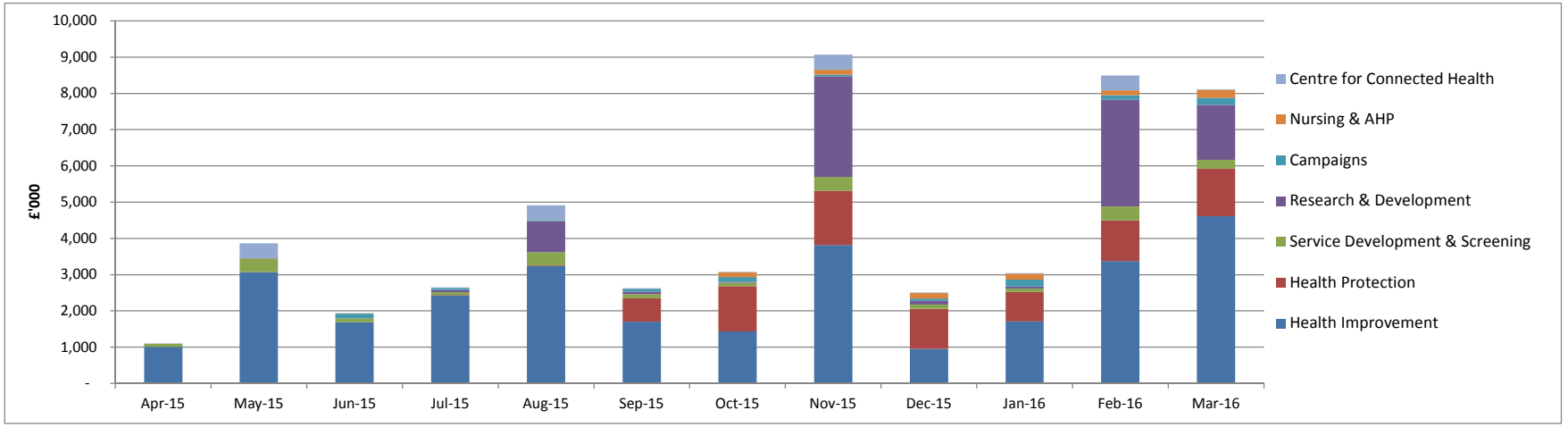


	Belfast Trust £'000	Northern Trust £'000	Southern Trust £'000	South Eastern Trust £'000	Western Trust £'000	Total £'000
Health Improvement	1,626	1,461	1,074	870	1,097	**6,128**
Health Protection	1,074	1,040	820	602	742	**4,278**
Service Development & Screening	3,404	2,520	1,520	460	2,227	**10,130**
Research & Development	4,147	427	464	458	657	**6,153**
Nursing & AHP	1,099	445	765	327	677	**3,312**
Centre for Connected Health	254	290	244	233	226	**1,248**
Total allocation per SBAs	**11,604**	**6,183**	**4,887**	**2,950**	**5,626**	**31,250**

As part of a service improvement project the Finance Directorate has coded the opening SBAs to their budget area, a high level summary of which is shown above. Budget holders will now be provided with all PHA commitments coded to their budget area, instead of Trust commitments being held in a central line.

Finance will liaise with budget holders when the first budget reports are produced to ensure this is a smooth transition. This will provide improved reporting on budgets and greater visability of Trust commitments, with expenditure against these budgets being reported in the monthly Finance reports to the Board.

Non-Trust Programme Expenditure
2015-16 Budget



Budget	Apr-15 £'000	May-15 £'000	Jun-15 £'000	Jul-15 £'000	Aug-15 £'000	Sep-15 £'000	Oct-15 £'000	Nov-15 £'000	Dec-15 £'000	Jan-16 £'000	Feb-16 £'000	Mar-16 £'000	Total £'000
Health Improvement - Belfast LCG	49	1,365	250	270	1,436	219	320	1,467	240	154	1,514	860	**8,144**
Health Improvement - West LCG	363	787	338	1,398	641	561	557	638	312	498	644	57	**6,794**
Health Improvement - South LCG	183	506	275	171	373	360	184	375	353	187	364	2,457	**5,788**
Health Improvement - South East LCG	-	265	496	-	265	499	-	752	8	495	271	16	**3,067**
Health Improvement - North LCG	416	142	327	586	526	64	375	585	40	378	585	1,220	**5,244**
Health Improvement	**1,011**	**3,064**	**1,686**	**2,425**	**3,241**	**1,703**	**1,436**	**3,817**	**951**	**1,713**	**3,378**	**4,610**	**29,037**
Health Protection	-	15	-	12	13	649	1,246	1,502	1,109	810	1,121	1,316	**7,793**
Service Development & Screening	83	368	108	83	368	108	93	378	118	96	381	242	**2,424**
Research & Development	-	-	2	60	847	71	23	2,772	113	52	2,941	1,514	**8,394**
Campaigns	-	1	131	58	32	80	135	50	50	190	130	195	**1,052**
Nursing & AHP	-	3	3	-	3	-	130	134	153	169	134	225	**955**
Centre for Connected Health	12	412	12	12	412	12	12	412	12	12	412	13	**1,746**
Total Non-Trust Budget	**1,106**	**3,864**	**1,942**	**2,650**	**4,916**	**2,623**	**3,075**	**9,065**	**2,506**	**3,043**	**8,497**	**8,115**	**51,402**

The PHA expects that, due to unanticipated events, in-year slippage will accrue from these budgets during 2015-16, as this has historically been the case. To ensure timely reinvestment of these resources into key programme activities a prioritised list of non-recurrent service developments is being developed.

A further breakdown of this activity by thematic area has been prepared by the Operations Directorate and is included as an Appendix to this Budget Paper.

PHA Administration
2015-16 Directorate Budgets

	Nursing & AHP £'000	Public Health £'000	Operations £'000	PHA Board £'000	Centre for Connected Health £'000	SBNI £'000	Total £'000	
Recurrent Allocation								
Salaries	2,201	9,615	3,366	269	295	-	**15,746**	
Goods & Services	194	472	942	30	79	62	**1,780**	
Total Recurrent Allocation	2,395	10,087	4,308	299	374	62	**17,525**	*
Assumed Allocation	140	200	400	-	-	757	**1,497**	
Assumed Income	225	32	-	-	-	-	**258**	
Additional Saving required	-	-	-	(151)	-	-	**(151)**	
Total Budget	2,761	10,319	4,708	147	374	819	**19,129**	

* Total recurrent budgets allocated to Directorates have been reduced by the actual 14-15 surplus and a 20% travel saving, totalling £1.1m. A further £0.151m saving remains to be identified against the £1.3m target.

The Management & Administration budget for the PHA has been reduced by the DHSSPS in 2015-16 by 15% which equates to £2.8m.

As set out in the introduction to this report (page 1) the delivery of this level of savings within 2015-16 is challenging. After discussion and liaison with the DHSSPS, it has been agreed that a total of £1.3m will be generated from within M&A budgets and the shortfall will be managed across the total PHA budget. This process will allow a more strategic review to be completed in order to deliver a recurrent 15% reduction in future years.

HSC Public Health Agency

Appendix 1

Programme Investment Plan 2015/16

1.0 PHA Baseline Programme Budget

1.1 PHA has been allocated £78.2m of programme funding for 2015/16. This excludes assumed additional allocations that PHA is expecting to receive from DHSSPS of £5.257m and external income of £0.719m linked to R&D, giving a total programme budget of £84.2m (this includes £1.5m retracted towards £2.8m savings – ref para 4.1).

1.2 The breakdown of how this budget is allocated across budget areas is summarised in the table 1 below:

Table 1: Summary of PHA Programme Budget

Programme Area	£(m)
Health Improvement	35.2
Health Protection	12.0
Screening and Service Development	12.6
Research and Development	14.6
Nursing and AHP	4.3
Connected Health (CCHSC)	3.0
Campaigns	1.0
Planned savings	1.5
Total	84.2

1.3 A more detailed breakdown of how the baseline programme funding is allocated across specific areas of activity is included as schedule A.

1.4 The assumed additional income of £5.257m from DHSSPS is to cover a number of programme commitments that have been agreed. This includes: £3.2m to be allocated for the National Institute for Health Research; £1.45m for the Early Intervention Transformation Programme; £0.27m to support the Delivering Social Change Programme; £0.135m for Integrated Services for Children and young People programme; and, £0.195m to be transferred from DSD for the MARA project.

2.0 New Programme Funding 2015/16

2.1 In total, £5.9m of new programme funding has been allocated to PHA in 2015/16. £4.56m has been earmarked specifically for the flu vaccination programme for Children and the Shingles vaccination programme and £0.075m has been allocated to complete the implementation of the new digital mammography service.

2.2 As part of the allocation for 2015/16, PHA received a pay and price uplift of £1.25m on its baseline programme budget. In line with the HSCB, PHA has applied a pay and price uplift of 1.0% to Trust SBAs. Further to reviewing possible options for managing contracts with non-Trust providers, it is proposed that a consistent approach is taken and a 1.0% uplift is also applied to all core contracts that PHA has with partners in the community and voluntary sector and other statutory sectors. By doing this, it is possible to redirect circa £0.8m of this funding to help address wider budget pressures and progress important new developments.

A summary of how the new programme funding allocated has been managed is set out in table 2 below.

Table 2: Summary of New Programme Funding Allocated to PHA baseline 2015/16

Area of Funding	Available for Investment (£m)	Allocated (£m)	Unallocated (£m)
New Vaccination Programmes	4.56	4.56	0
Pay and Price uplift (2015/16)	1.25	0.35	0.9
Retraction of 14/15 pay uplift awarded *	(0.1)	(0.1)	(0.1)
Digital mammography	0.075	0.075	0
Total	5.9	5.1	0.8

*DHSSPS retracted a % of the pay uplift applied in 2014/15 as the pay award was not consolidated.

3.0 Review of Baseline Programme Budgets

3.1 As part of the annual investment planning process, PHA has undertaken a detailed review of its existing baseline programme budgets and has identified a

number of areas would funding could be released to meet service pressures and priorities:

- In 2014/15, PHA was required by DHSSPS to delay a number of key service developments to help release funding to meet wider HSC pressures. It is expected that there will be slippage of £0.2m against these developments in 2015/16 as they will require a lead in time to get established.
- Based on an assessment of projected demand in 2015/16, it is expected that there will continue to be a lower level of uptake for smoking cessation services, including Nicotine Replacement Therapy, due to the smaller scale advertising campaign and increase in e-cigarettes. Based on an assessment expenditure incurred in 2014/15, £0.4m can be released from the baseline budget to support new developments.
- There have been some planned investments that have not been able to progress or existing investments that have now come to an end. As a result of this, it has been possible to release additional funding of £0.6m for re-investment.

Based on the above, it is projected that PHA could release a total of £1.2m of programme funding for reallocation against identified pressures and priorities. This is summarised in table 3 below.

Table 3: Summary of Areas where Funding can be released from Existing programme baseline.

Area of Funding	Available for Prioritisation (£m)
Slippage on Investments delayed from 14/15	0.2
Decrease in uptake of smoking cessation services	0.4
Funding released from 2014/15 baseline	0.6
Total	1.2

4.0 Allocation of Available Programme Funding 2015/16

4.1 Overall, PHA has £2.0m of programme funding that is available to meet budget pressures and support new investment priorities (£0.8m from new programme funding unallocated and £1.2m from releasing funding from existing baseline funding).

4.2 PHA has agreed with DHSSPS that in 2015/16, up to £1.5m of programme funds can be used to help address the £2.8m of savings that is required to meet wider HSC pressures. This leaves £0.5m available to invest in new developments. PHA Management Team has identified a number of important developments that it would recommend for approval to be progressed in 2015/16 which are summarised in the table below.

Table 4: Proposed New Developments 2015/16

	Proposed Development	£(000's)
1	Establishment of a centralised call and recall service for Diabetic Retinopathy and new data management system for Newborn Screening programmes	190
2	On-going support for Family Support Programmes (Strengthening Families and Incredible years)	100
3	Increase in baseline budget to meet demand for Telehealth and Telecare services	145
4	One Stop Shop service pressure	35
5	Additional clinic for STI testing	30
	Total	500

In addition to the above, a number of other high priority developments have also been identified. It is proposed that these developments listed below are progressed should additional funding become available on an in-year basis.

Table 5 : Additional Priorities for Progressing in 2015/16

	Proposed Development	£(000's)
1	Public Information Campaigns	300
2	Expansion of the Men's Shed Initiative	55
3	Increase breastfeeding support in neonatal units	20
4	Additional support for the Active Travel initiative	20
5	Expansion of Walking for Health	20

	Proposed Development	£(000's)
6	Support for CAMHS	20
7	Review of AHP support for Children with special needs	20
8	Evaluation of RSE programme	25
9	Infant mental health training	20
	Total	500

5.0 Implementation

5.1 The programme expenditure proposals will be taken forward by respective programme leads across the PHA Directorates. This will includes agreeing SLAs/contracts as appropriate, performance review and reporting to senior management and the board of the PHA.

5.2 To provide assurance on expenditure plans and assumptions for example in relation to monthly expenditure profiles and on demand-led areas, there will be ongoing monitoring and reporting throughout the year.

****

Schedule A

Area of Spend	Baseline Budget 2015/16
Drugs and Alcohol	£6,025,422
Food & Nutrition/Obesity/Fit Futures/Physical Activity/Education	£3,604,173
Healthy Living Centres	£1,163,072
Hidden Harm	£310,902
Accident Prevention	£482,823
Inequality Funding	£303,999
Investing for Health	£2,846,104
Local Gov't Allocation	£490,110
Mental Health Promotion	£1,377,668
Older People	£582,872
One Stop Shop	£887,726
Smoking Cessation	£4,586,535
Suicide Prevention Strategy / Lifeline	£7,284,151
Sustainable Communities	£241,452
Teen Pregancy/Sexual Health	£1,804,767
Travellers	£228,000
Workplace Health	£144,109
New Parent Programme	£175,000
Early Years (Regional)	£1,071,981
Roots of Empathy	£335,122
Poverty	£445,000
Migrant HSWI (Regional)	£290,300
Other	£212,397
Shankill and Beechall Health & Wellbeing Impovement Centre	£270,398
HEALTH & SOCIAL WELLBEING IMPROVEMENT	**£35,164,082**

HCAI	£499,890
Immunisation	£2,183,607
Flu vaccination	£9,165,498
National Poisons Information Service	£147,451
Support to Hep C Clinical Network	£15,000
HIV Surveillance	£60,000
HEALTH PROTECTION	**£12,071,446**

Abdominal Aortic Aneurysm	£490,181
Cervical Screening Programme	£833,723
Bowel Cancer Screening Programme	£3,032,149
Breast Screening Programme	£5,658,424
Digital mammography	£462,000
High Risk Screening	£294,350
Diabetic Retinopathy Screening Programme	£120,669
New Born Screening Programme	£348,862
Cancer Registry	£802,094
Cerebral Palsy	£94,963
Screening & Service Development (Other)	£356,806
SCREENING & SERVICE DEVELOPMENT	**£12,554,221**

CCHSC	**£2,993,289**

Ward Sister Initiative	£2,164,599
Family Nurse Partnership	£1,026,390
Nursing & AHP (Other)	£95,000
Public Health Nursing	£200,000
Early Intervention Programme	£781,127
NURSING / AHP	**£4,267,116**

CAMPAIGNS	£1,052,481

RESEARCH & DEVELOPMENT	£14,547,804

TOTAL BASELINE BUDGET	**£82,652,439**
Funding reserved for Savings	£1,500,000
Total Programme Budget	£84,152,439

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	18 June 2015
Title of Paper	PEMS Report 2014/15
Agenda Item	9
Reference	PHA/03/06/15

Summary

The End of year PEMs report provides AMT and PHA board with a summary of how the Programme funding available was allocated during 2014/15. Key points to note include:

- A reported underspend of £800k against the smoking cessation budget due to decease in uptake of services.
- Significant increase in the budget for vaccination programmes as a result of introduction of several new programmes in 2014/15.
- Completion of the implementation of new screening programmes for Bowel and Digital Mammography now mean that budgets are being fully utilised.
- Activity under Telehealth contract has increased significantly during 2014/15 resulting in the budget being fully spent.
- PHA continues to invest funding in small allocations. PEMS includes 686 allocations of £20k and under in value. It is recognised that some of these may be additional allocations to existing baseline contracts on an in-year basis.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This Report was approved by AMT on 10 June.
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Operations
Date	10 June 2015

End of Year Programme Expenditure Monitoring Report 2014/15

Background

The Programme Expenditure Monitoring System (PEMS) was developed to provide the PHA with more detailed information regarding how programme funding is allocated across the organisation. Its main purpose is to provide an overview of the wide range of programmes being supported on the ground and to provide up to date information on how planned initiatives are progressing to ensure that funding is being utilised as expected and that any opportunities for using funding, on an in-year basis, are maximised.

It is important to note that PEMS does not replace the formal financial reporting systems for the PHA but works alongside these to enable timely and informed decisions regarding funding priorities to be made.

Programme Budget Breakdown

Programme funding of £ 81.2m was recorded on PEMS. This was distributed, as follows:

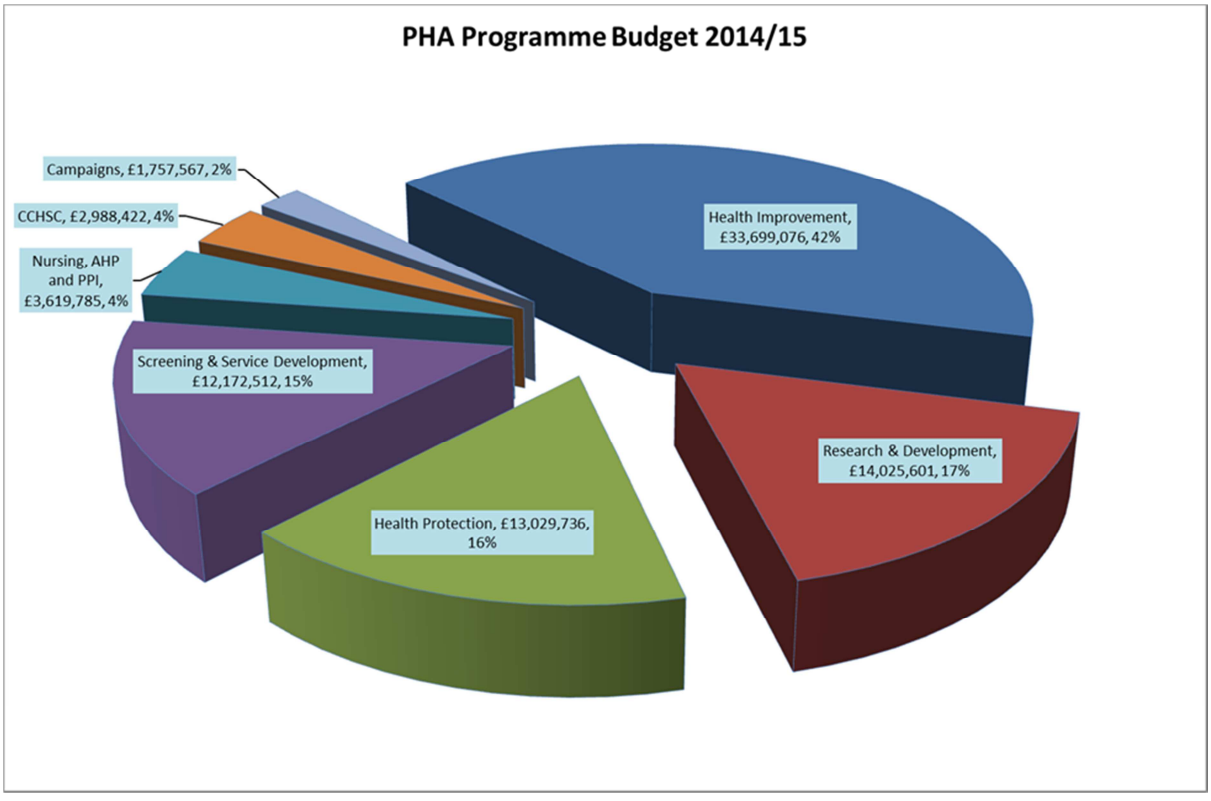
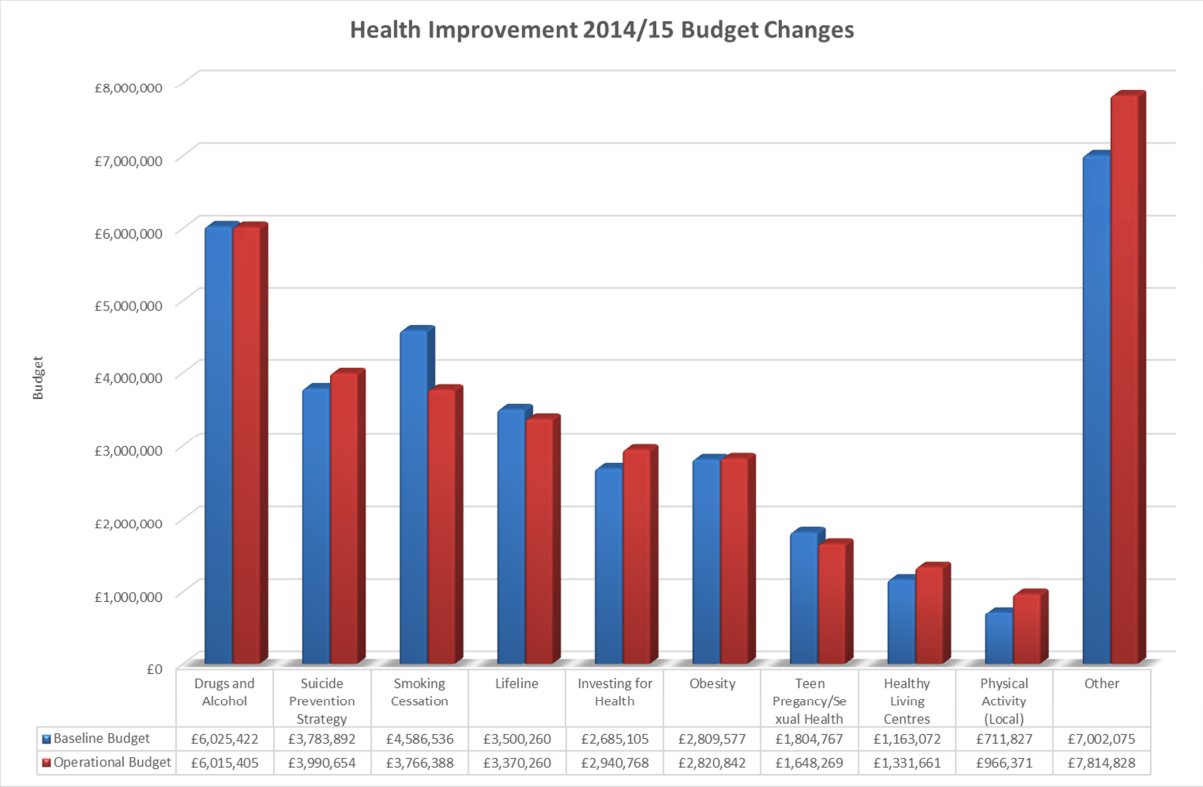


Fig 1. PHA Programme Budget 2014/15

Breakdown of Programme Funding 2014/15

Health Improvement

£33.7m (42%) of all programme funding was invested in health improvement as broken down in the graph below.



	Drugs and Alcohol	Suicide Prevention Strategy	Smoking Cessation	Lifeline	Investing for Health	Obesity	Teen Pregancy/Sexual Health	Healthy Living Centres	Physical Activity (Local)	Other
Baseline Budget	£6,025,422	£3,783,892	£4,586,536	£3,500,260	£2,685,105	£2,809,577	£1,804,767	£1,163,072	£711,827	£7,002,075
Operational Budget	£6,015,405	£3,990,654	£3,766,388	£3,370,260	£2,940,768	£2,820,842	£1,648,269	£1,331,661	£966,371	£7,814,828

Fig 2. Health Improvement 2014/15 Budget Changes

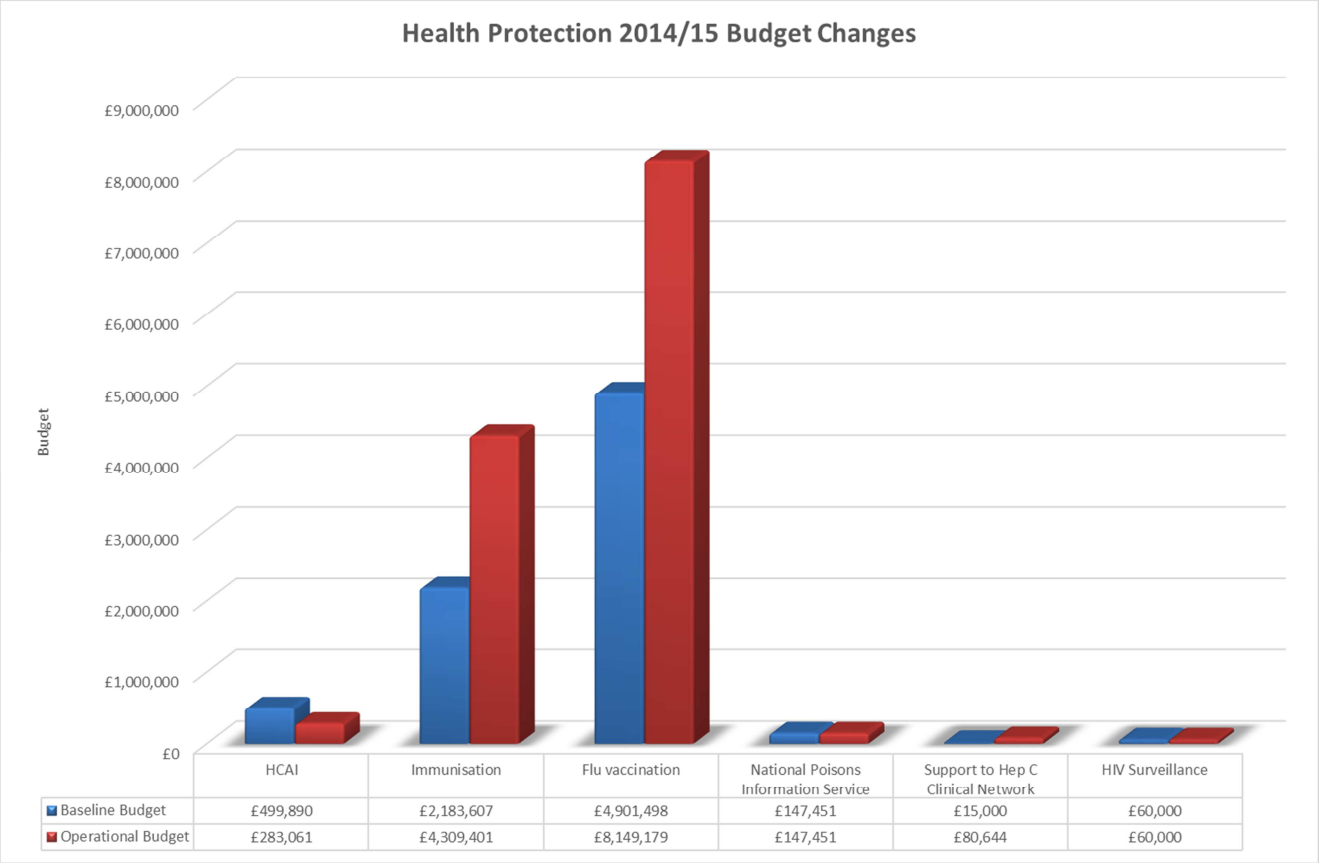
£17.2m (46%) of this funding was invested in 3 main areas of activity: Drugs and Alcohol (£6.0m); Smoking Cessation (£3.8m); and, Suicide Prevention / Lifeline (£7.4m).

During 2014/15, there was a significant reduction in the demand for smoking cessation services resulting in the budget being underspent. This is due, in part, to a reduction in the scale of the smoking campaign that can be funded by PHA due to wider budget thresholds that have been set on campaign expenditure by DHSSPS and the increase in uptake of e-cigarettes.

**(note : the baseline budget referred to in the graphs is the recurrent budget allocated to specified programme areas. The Operational budget is the actual funding allocated during the year taking into account an additional allocations made in-year by DHSSPS or transfers made across budgets)*

Health Protection

£13.0m (16%) of programme funding was allocated to health protection. This was broken down as follows:



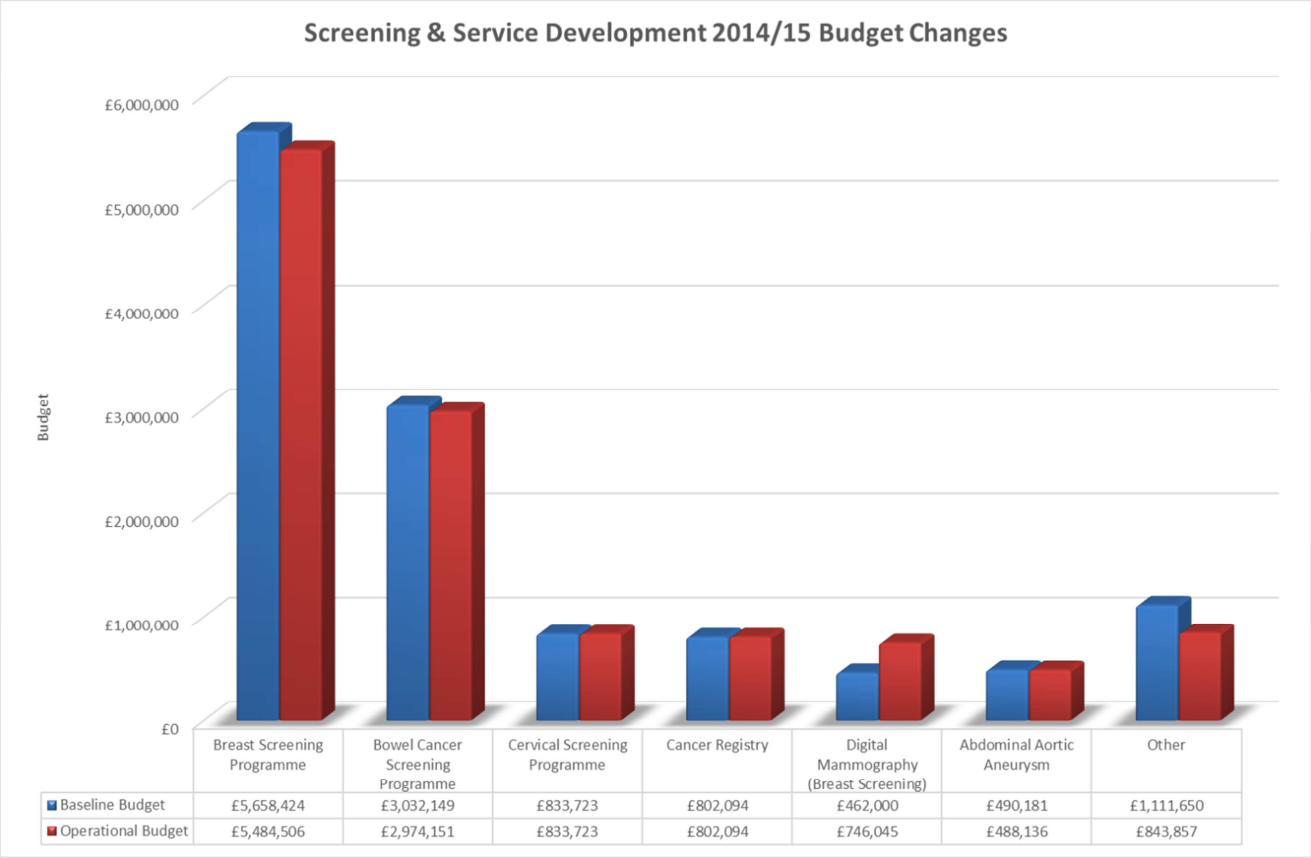
	HCAI	Immunisation	Flu vaccination	National Poisons Information Service	Support to Hep C Clinical Network	HIV Surveillance
Baseline Budget	£499,890	£2,183,607	£4,901,498	£147,451	£15,000	£60,000
Operational Budget	£283,061	£4,309,401	£8,149,179	£147,451	£80,644	£60,000

Fig 3. Health Protection 2014/15 Budget Changes

The majority of the health protection budget was spent on the purchase, distribution and administering of the seasonal flu vaccination programme. There has been a significant expansion in the number of vaccination programmes now being implemented by PHA. During 2014/15 an additional £4.6m was allocated by DHSSPS to take forward the roll out of the Childrens' vaccination programme and a new Shingles vaccination programme.

Screening and Service Development

£12.2m (15%) of programme funding was spent on screening services in 2014/15.



	Breast Screening Programme	Bowel Cancer Screening Programme	Cervical Screening Programme	Cancer Registry	Digital Mammography (Breast Screening)	Abdominal Aortic Aneurysm	Other
Baseline Budget	£5,658,424	£3,032,149	£833,723	£802,094	£462,000	£490,181	£1,111,650
Operational Budget	£5,484,506	£2,974,151	£833,723	£802,094	£746,045	£488,136	£843,857

Fig 4. Screening & Service Development 2014/15 Budget Changes

All new screening programmes such as Bowel and Digital Mammography are now fully operational and funding is being fully utilised. The operational budget for the Digital mammography service is over the baseline budget allocated as the full funding for this service still needs to be transferred recurrently from the existing Breast Screening service.

Nursing and AHP

£3.6m (4%) of the programme budget is managed by the Nursing and AHP Directorate. This is broken down as follows:

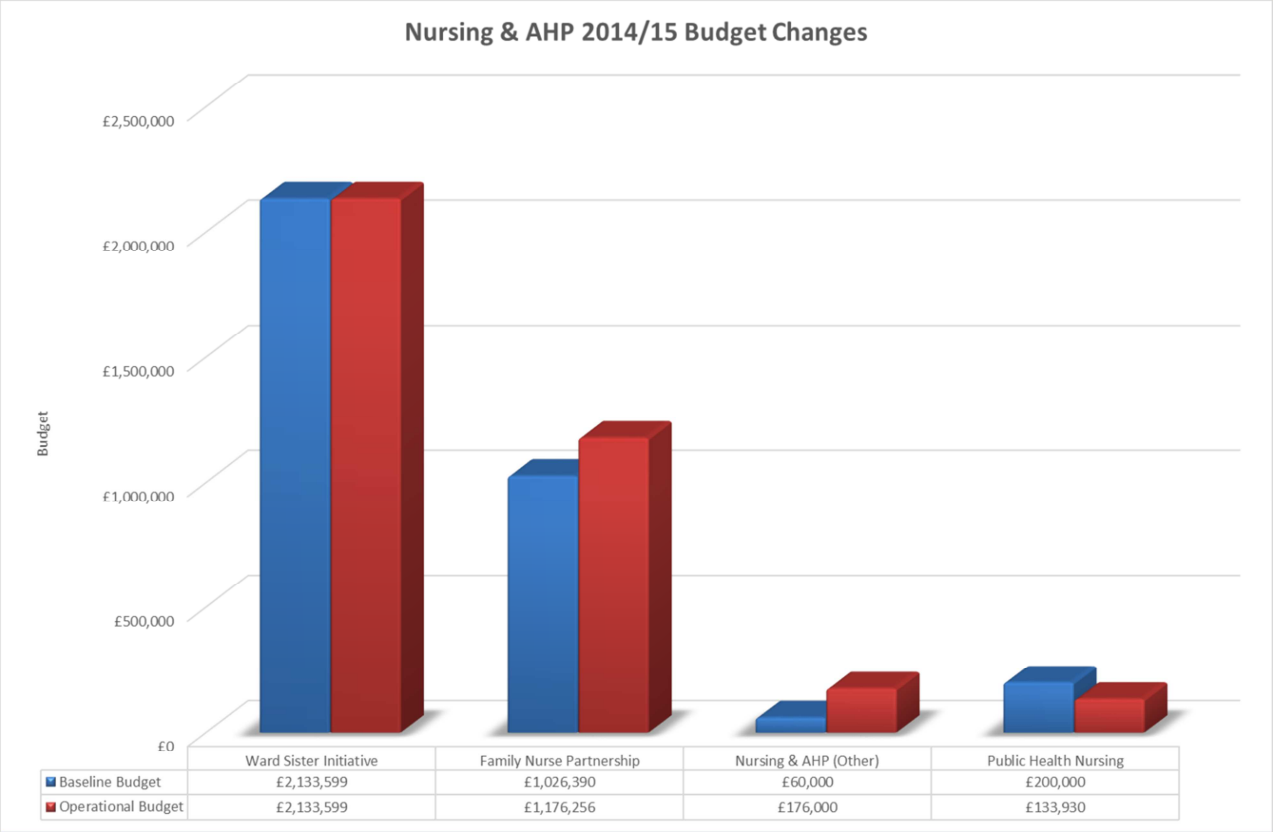


Fig 5. Nursing & AHP 2014/15 Budget Changes

The Family Nurse Partnership budget is now being fully utilised as the 3 sites funded by PHA are operational. Two additional sites are to be funded by HSCB from 2015/16. The new Public Health Nursing posts to support vulnerable groups such as Travellers, people who are homeless and those from the BME community are now in place and will spend as planned in 2015/16.

Centre for Connected Health and Social Care (CCHSC)

Levels of activity for Tele-health and Tele-medicine have increased significantly during 2014/15 and are now nearing the full contract volumes as agreed under the tender for this service. The PHA will need to increase the baseline budget available for this service in 2015/16 to ensure it is able to cover the full service costs anticipated.

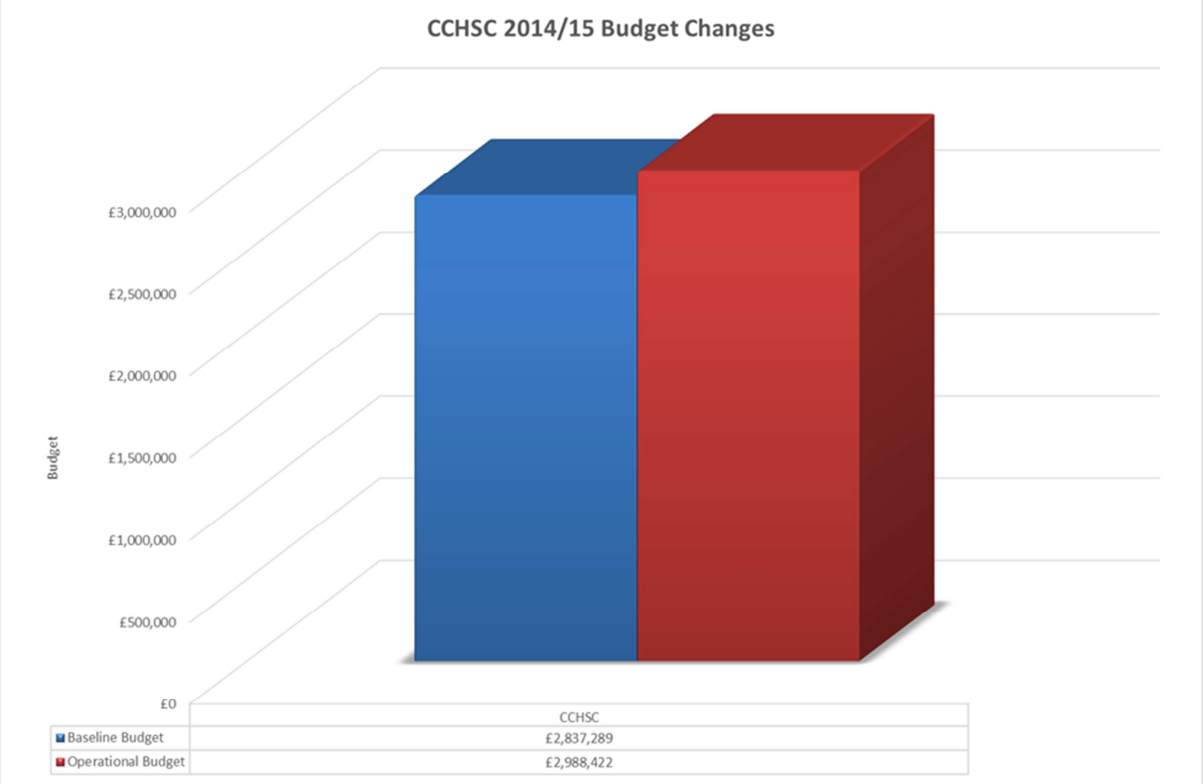
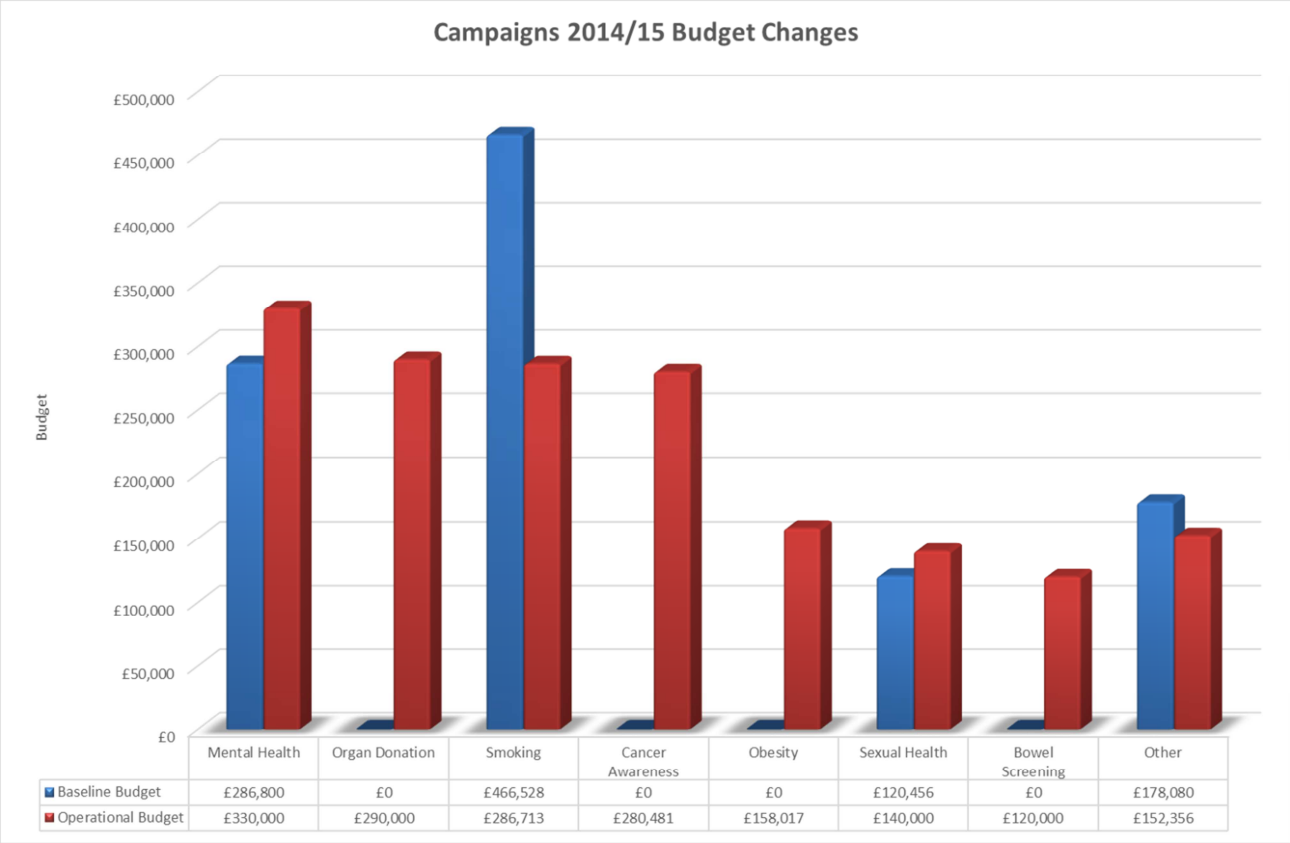


Fig 6. Centre for Connected Health and Social Care 2014/15 Budget Changes

Campaigns

£1.75m (2.0%) was spent on development, running and evaluation of campaigns in 2014/15. The PHA is limited to the amount it can spend overall on the running of Public Information Campaigns and agrees each year with DHSSPS colleagues how this should be targeted. As a result of this, the scale of the smoking campaign has been reduced to allow other high priority areas to be supported.



	Mental Health	Organ Donation	Smoking	Cancer Awareness	Obesity	Sexual Health	Bowel Screening	Other
Baseline Budget	£286,800	£0	£466,528	£0	£0	£120,456	£0	£178,080
Operational Budget	£330,000	£290,000	£286,713	£280,481	£158,017	£140,000	£120,000	£152,356

Fig 7. Campaigns 2014/15 Budget Changes

Research and Development

During 2014/15, £14.0m of expenditure was recorded on PEMs for R&D initiatives. All of the expenditure is against individual projects and is not recorded under specific themes / areas of work. It is not therefore possible to provide summarised information as for other programme areas. Detailed information on R&D actions supported with the funding available is provided to PHA board via routine updates given by the R&D Division.

Breakdown of Expenditure by Sector.

The following information shows how the PHA funding was invested across sectors. There is a small margin of difference between the total funding reflected under this analysis compared to the overall budget spend as some projects recorded on PEMS did not identify the sector.

Overall, £33.0m (40%) of programme spend was allocated to the 5 local Trusts. £48.2m was allocated to other sectors. A more detailed breakdown of how this funding is split across sectors is outlined in the pie chart below.

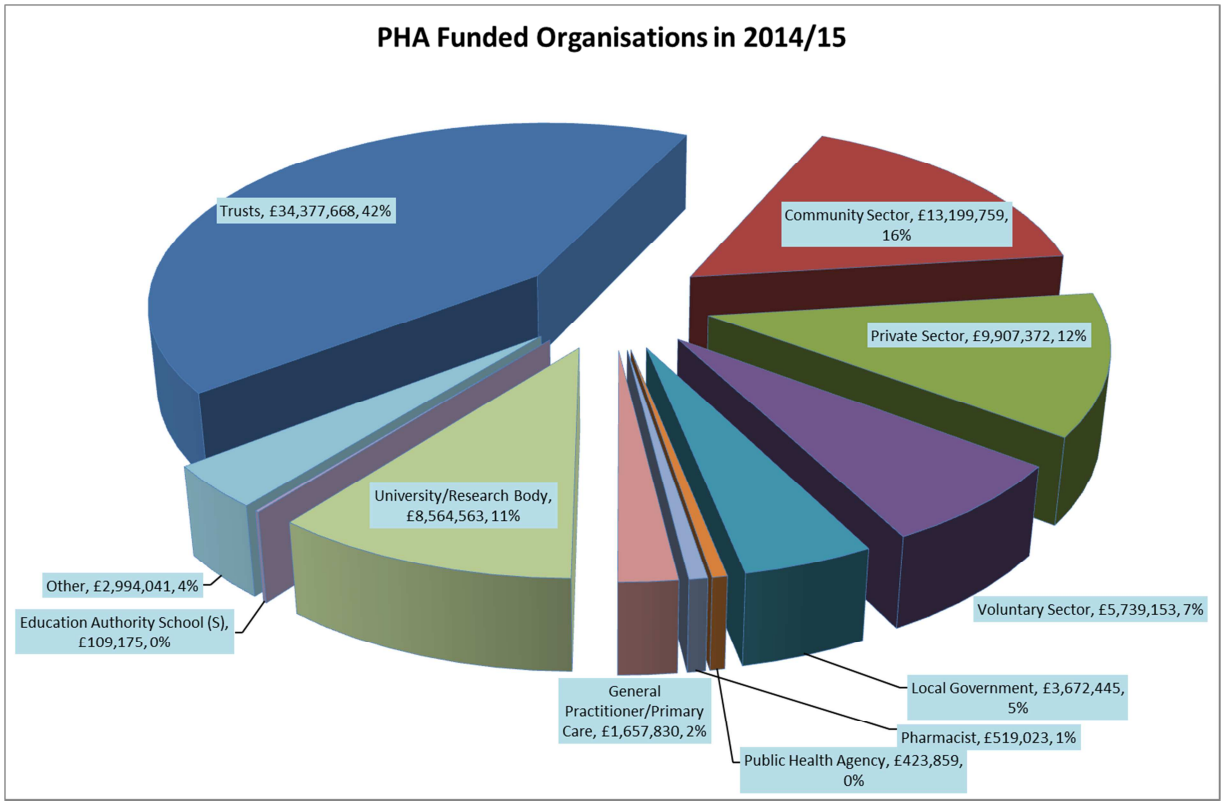


Fig 8. How PHA funding in 2014/15 was split across all sectors

Outwith the funding that is allocated for specific areas of business such as procurement of vaccine, campaign development and media buying and R&D investment with universities, the vast majority of funding that does not go to Trusts is allocated under the various health improvement budgets. A breakdown of how the £36.7m invested in health improvement is distributed across sectors is outlined below.

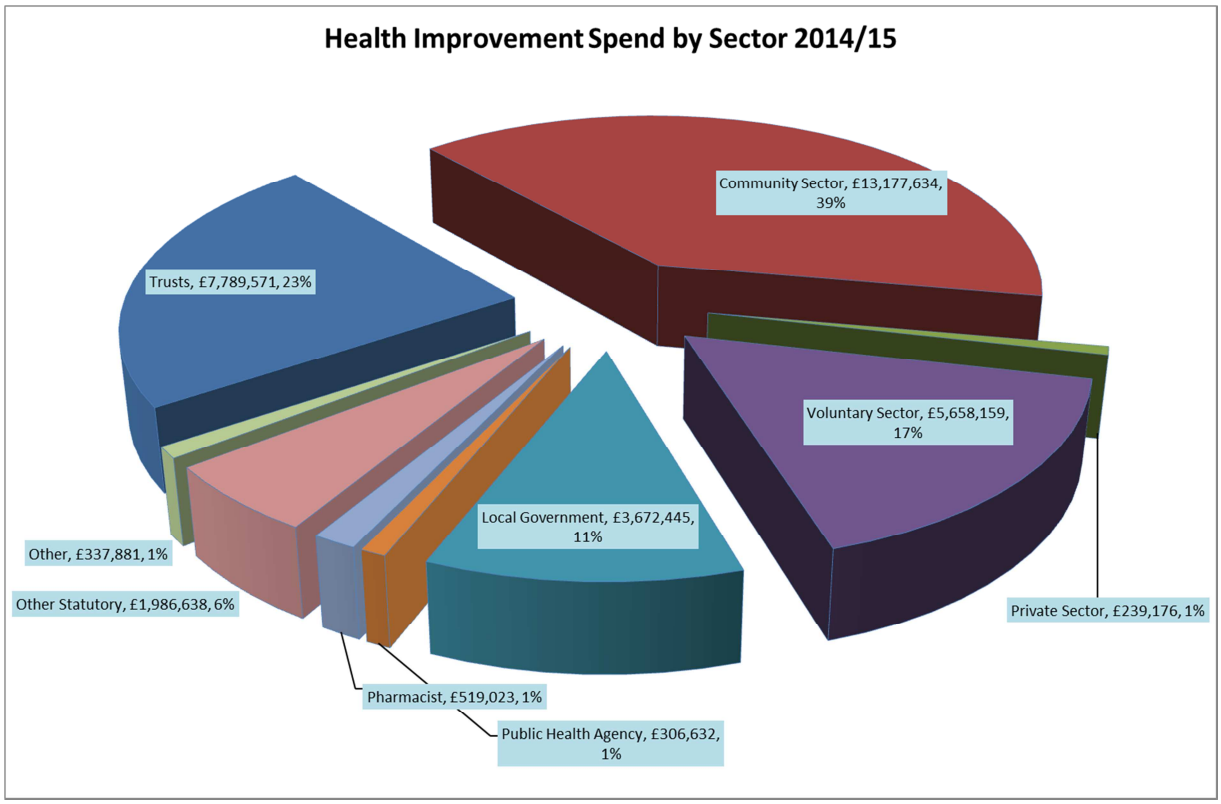


Fig 9. How PHA Health Improvement funding in 2014/15 was split across all sectors

Analysis of Health Improvement Initiatives by volume and value.

By far the greatest number of programmes and activities to tackle health inequalities and improve long term health and social well-being are progressed under the health improvement budget. During 2015/16, circa 900 different activities were recorded on PEMS. These were delivered across all sectors as outlined in the graph over.

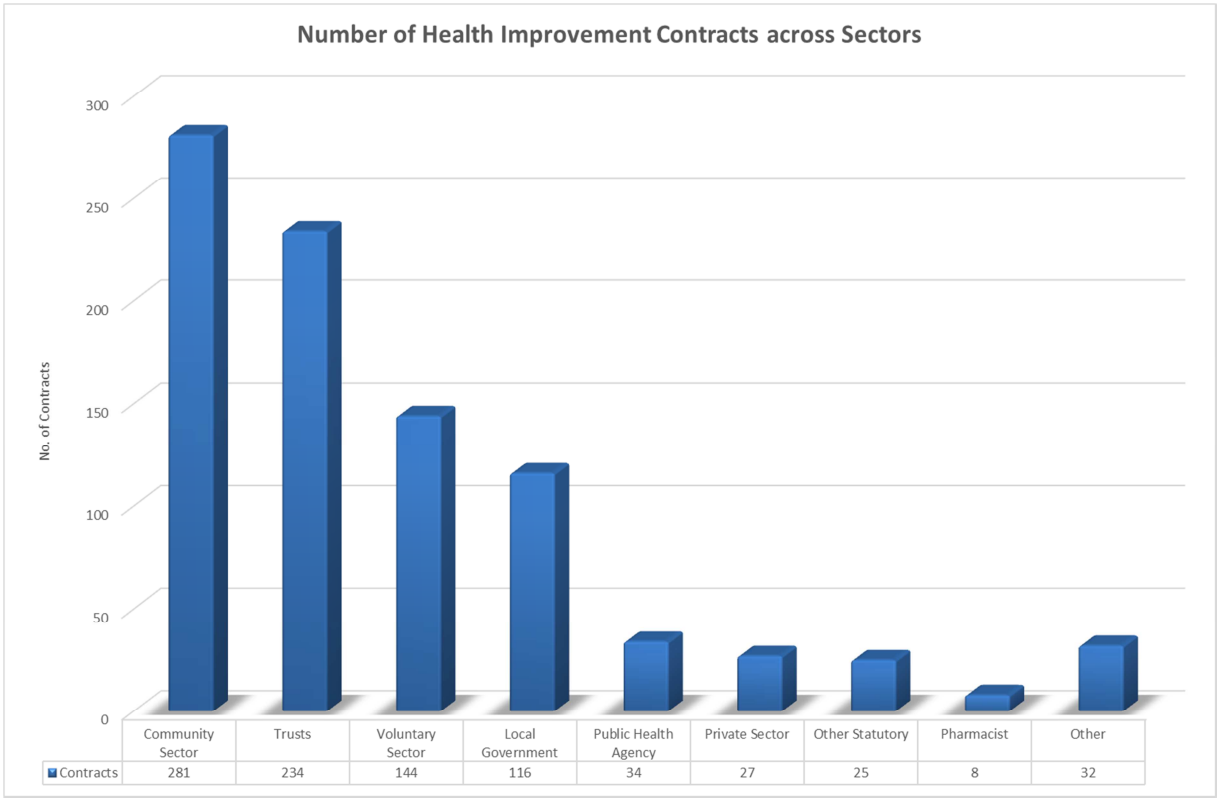


Fig 10. Number of Health Improvement Contracts across Sectors

Summarised in the graph below is the number of initiatives supported, broken down by funding level. 68% (686) of these initiatives are under £20k in value.

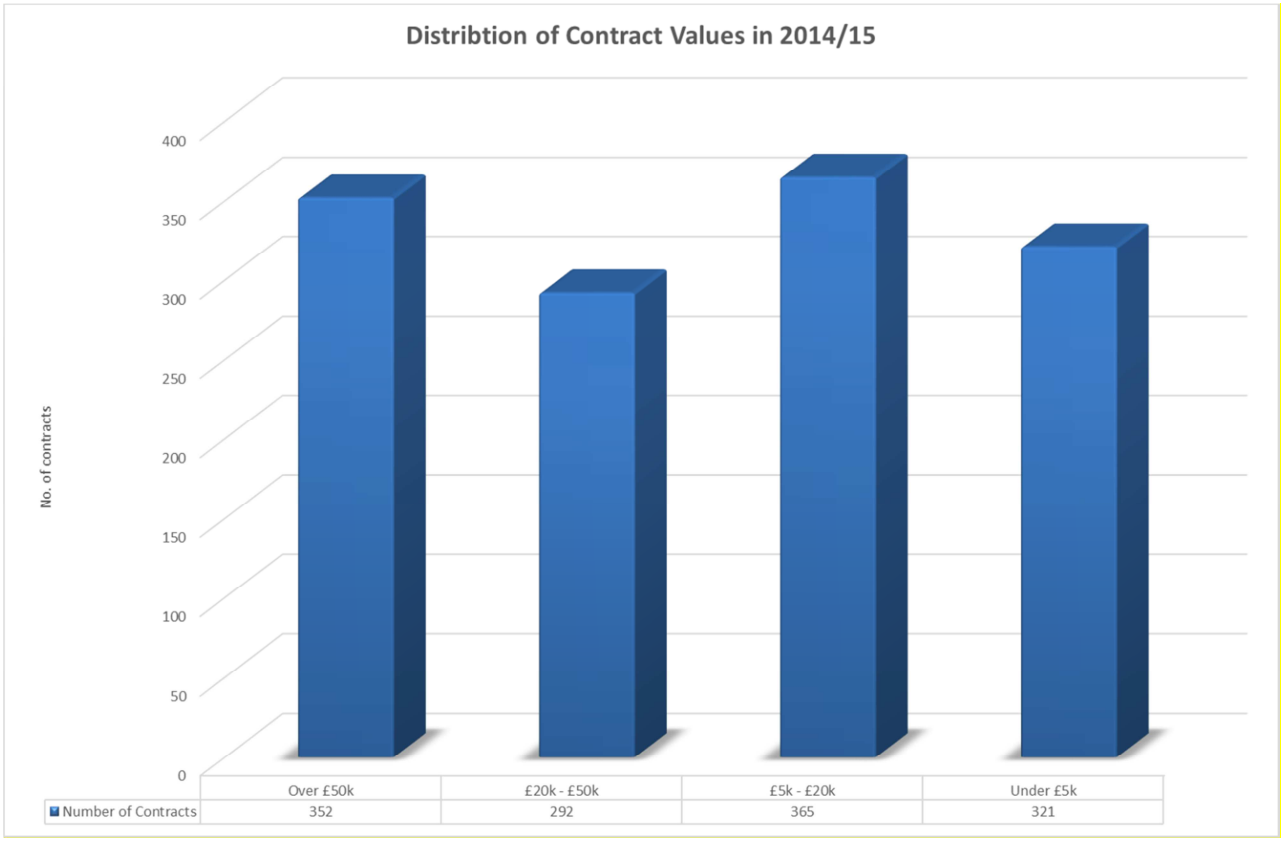


Fig 11. Distribution of Contract Values in 2014/15

It is recognised that not all allocation under £20k in value will be individual projects but will be additional allocations to existing baseline contracts on an in-year basis.

PHA Board is asked **to Note** the paper

HSC Public Health Agency

MINUTES

Minutes of the 29th Meeting of the Governance and Audit Committee held on Wednesday 15 April 2015, at 9.30 am, Meeting Room, 5th floor, 12-22 Linenhall Street, Belfast, BT2 8BS

Present:

Mr Brian Coulter	-	Chair
Mr Thomas Mahaffy	-	Non-Executive Director
Alderman Paul Porter	-	Non-Executive Director

In Attendance:

Mr Edmond McClean	-	Director of Operations,PHA
Mrs Mary Hinds	-	Director of Nursing & AHP, PHA
Mr Paul Cummings	-	Director of Finance, HSCB
Miss Rosemary Taylor	-	AD Planning & Operational Services
Mrs Catherine McKeown	-	Internal Audit
Ms Amanda McMaw	-	ASM
Mr Craig Morrow	-	Northern Ireland Audit Office
Mr Mark Anderson	-	Sponsor Branch, DHSSPSNI
Mrs Mary Black	-	AD Health & Social Wellbeing Improvement (for item 5)
Mrs Cathy McAuley	-	Secretariat

		Action
19/15	**Item 1 - Welcome and Apologies** The Chair welcomed everyone to the meeting and noted there were no apologies received. He welcomed Mrs Mary Hinds (Item 4) and Mrs Mary Black (Item 6).	
20/15	**Item 2 - Declaration of Interests** The Chair asked if anyone had any interests to declare relevant to any items on the agenda. None were declared.	
21/15	**Item 3 - Chair's Business** The Chair advised there was a change to the membership of the committee as Mrs Karp's period of appointment with the PHA had been completed. He acknowledged the contribution brought to GAC committee by Mrs Karp. The Chair advised the committee would be down a member until the new non-executive is appointed.	

22/15	**Item 4 - Notes of previous Meeting – 19 February 2015** The minutes of the previous meeting, held on 19 February 2014 were approved.	
23/15	**Item 5 - Matters Arising** <u>06/15 – CR30 Lifeline Contract</u> Mrs Black joined the meeting and gave the committee a confidential update briefing of the Lifeline Crisis response service in terms of the future provision of the service and the independent clinical review outcomes. The committee thanked Mrs Black for the updated briefing. The Chair acknowledged the evidence of the improved budgetary control and noted that the contact is likely to be extended for a further 18 months, he said that this would require great vigilance when dealing with management issues. Mrs Black reassured the committee that learning had been taken from previous experiences and that work continues monitoring quality and performance issues. <u>11/15 – Management of Health & Social Wellbeing Contracts</u> Mrs Black updated the committee on the implementation of recommendations on specific actions against the priority one finding in respect of the managed obesity network contract. She advised that the culture had now changed and that the PHA has reviewed and strengthened the arrangements for managing contracts with Trusts. Mrs McKeown assured the committee that IA would be applying audit principals to ensure that the change of culture had been implemented and that this would be revisited in the year end follow up report. Mrs Black left the meeting.	
24/15	**Item 6.1- Assurance Framework** Mr McClean presented the PHA Assurance Framework report 2013/15 as reviewed at April 2015. Members were asked to approve the amendments to the assurance framework. Members approved the amendments and subject to minor change "GAC role to approve the annual audit plan" it was recommended to the PHA board for approval.	Mr McClean
25/15	**Item 6.2 – Revised Incident and Near Miss Reporting Policy and Procedure.**	

Members approved the revised policy and procedure.

26/15 **Item 6.3 – Revised Suite of Health and Safety related policies**

Miss Taylor presented the revised policies and advised they will be put on to Connect website if approved by GAC.

Members approved the revised policies and procedures.

27/15 **Item 7.1 – Internal Audit Progress Report.**

Mrs McKeown gave a summary of the progress report against the 2014/15 IA audit plan and the final audit reports.

Members noted the progress report.

Item 7.2 – Follow Up Report

Mrs McKeown advised that progress had been made and 84% of the recommendations have now been implemented. Apart from one exception all recommendations from previous years have been implemented with only those from 2014/15 to be progressed.

Members noted the follow up report.

Item 7.3 – Shared Services

Mrs McKeown presented 3 reports from the BSO shared services audit and gave an overview of the finding and recommendations.

- Recruitment - satisfactory assurance.
- Payments - overall satisfactory assurance, with limited assurance for the management of duplicate payments.
- Payroll - limited assurance

Mrs McKeown said that payments shared services showed an improved position, compared to an earlier audit undertaken during September 2014. She added that limited assurance had been provided around the management of duplicate payments and that a significant number of priority one findings and recommendations remain in the payroll shared services audit. The recommendations in the reports are the responsibility of BSO management to take forward.

Item 7.4 – Head of IA Annual Report

Mrs McKeown presented the HIA annual report for year ended 31 March 2015 and gave a brief overview to members.

Members noted the report.

Item 7.5 – Charter

Mrs McKeown presented the charter for noting.

Members noted the charter.

Item 7.6 – Annual Plan 2015/16

Mrs McKeown presented the proposed Internal Audit strategy plan for 2015/16 and gave an overview of the proposed work schedule. She added she had a meeting with Chair of the GAC ahead of seeking approval of the plan from the Committee. Members were asked to consider the IA plan for 2015/16 and also the PHA management's request to reduce the SLA audit days for 2015/16.

Members raised their concerns at the reduction in SLA audit days. Mr McClean advised the decision to request this reduction was part of the plan to meet the 15% reduction in the PHA management and administration budget in 2015/16. Mr Cummings added that as he was not aware of this decision there was need for further dialogue.

While members stressed the important of internal audit across the organisation and especially during periods of financial constraints, Alderman Porter also noted that while valuing the role of internal audit it would be difficult to defend protecting it when other areas of expenditure were being cut.

Following a lengthy discussion the chair concluded that further discussion and clarity on the 2015/16 budget is required before a decision could be made on the Internal Audit plan and asked officers to take this forward and bring back to the next meeting. In the interim it was agreed that work could commence on actioning the audits set out in the plan. Mrs McKeown

Item 8.1- Finance: Report To Those Charged With Governance Progress Report.

Mr Cummings presented the progress report on the implementation of recommendations of the report.

Members noted the report.

Item 8.2 - Fraud Liaison Officer Report

Mr Cummings gave a summary of the report which detailed a case that was originally reported in error through the HSCB before being opened and closed by the PHA. He added that the National Fraud Initiative (NFI) 2014/15, has now been made available by the audit commission, and the HSCB finance have commenced analysing and investigating the data on behalf of PHA.

Members noted the report.

Item 9 - Governance Statement 2014/15

Mr McClean presented the draft governance statement and highlighted one minor amendment to the CAS table. Mrs McKeown requested that 'audited' be replaced with 'verified' in the column heading. — Mr McClean

Members approved the governance statement and recommended it for approval to the next PHA confidential board meeting.

Item 10 – GAC Annual Report

The Chair presented the GAC annual report which outlined the key activities of the committee during 2014/15.

Members noted the report.

Item 11 – Draft PHA Annual Report 2014/15

Mr McClean shared the draft annual report with members and advised this would go to the next meeting of the PHA Board.

Members approved the draft report and recommended it for approval at the next PHA confidential board meeting. — Mr McClean

Item 12 – Business Continuity Revised Plan and Policy

Mr McClean presented the revised business continuity plan and policy for approval. He added the paper set out the process for review and he summarised the main changes to the plan which included ISO standard recognition. He advised that the three organisations (PHA, BSO,HSCB) had worked collaboratively and periodically in testing the plan. Mr Cummings added that a PHA officer has attended the test of the HSCB Business Continuity plan at

the end of March. Members approved the revised plan and policy and recommended it for approval to the next PHA board meeting. **Item 13 – SBNI Declaration of Assurance** Mr McClean presented the SBNI declaration of assurance to members for approval which confirms that SBNI complies with all PHA policies and procedures in respect of finance, human resources and facilities. Members approved the declaration of assurance. **Item 14 – PHA Complaints Process** Mrs Hinds gave members a brief overview of the PHA complaints procedure. She reported that the PHA's nomination officer is the Director of Nursing. She outlined the process and procedures for the complaints procedure and added that the number of complaints received were small due to the nature of the organisation. Members noted the complaints process. **Item 15 – Any other business** <u>NIAO – Director Responsibility</u> Mr Craig Morrow advised members of a change in the arrangement for audit of PHA; Tomas Wilkinson will replace Mrs Dorinna Carville. **Item 15 - Date and time of next meeting** Date: 10 June 2015 Time: 9.30 am Venue: Meeting Room 5th floor, 12-22 Linenhall Street Belfast	Mr McClean

Signed: Brian Coulter (Chair) Date: 10 June 2015

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	18 June 2015
Title of Paper	Corporate Risk Register
Agenda Item	11
Reference	PHA/05/06/15

Summary

Context

In line with the PHA's system of internal control, a fully functioning risk register has been developed at both directorate and corporate levels. The purpose of the corporate register is to provide assurances to the Chief Executive, AMT, the Governance and Audit Committee and the PHA board that risks are being effectively managed in order to meet corporate objectives and statutory obligations.

Process

To support these assurances, a process has been established to undertake a review of both directorate and corporate risk registers on a quarterly basis i.e. the end of each financial quarter.

The previous review was undertaken as at 31 December 2014 and was approved by AMT on 27 January 2015 and forwarded to the Governance and Audit Committee for approval at its next meeting which took place on 19 February 2015.

The attached Corporate Risk Register reflects the review as at 31 March 2015 and has been carried out in conjunction with individual directorate register reviews for the same period.

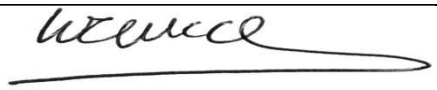
The next review will be undertaken as at 30 June 2015.

Outcome

This quarter saw changes to the Corporate Risk Register as follows:

- **2 new risks has been added to the register:**
  - VOIP Telephone System
  - £2.8m (15%) Reduction in Management and Administrative Funding

- **2 risks have been removed from the register:**
  - Shared Services (de-escalated to Operations Directorate Risk Register)

o Programme Budget Expenditure	
Equality Screening / Equality Impact Assessment	N/A
Audit Trail	The updated Corporate Risk Register was considered by AMT on 5 May and by the Governance and Audit Committee on 10 June.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	10 June 2015

PHA Corporate Risk Register

Date of Review:
31 March 2015

Introduction

Managing risk is a key component of the wider governance agenda for the PHA. It is therefore essential that systems and processes are in place to identify and manage risks as far as reasonably possible.

The purpose of risk management is not to remove all risks but to ensure that risks are identified and their potential to cause loss fully understood. Based on this information, action can then be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The PHA has recognised the need to adopt such an approach and has commenced a systematic and unified process to develop a fully functioning risk register at both corporate and directorate levels that complies with the Australian/New Zealand (AS/NZS) 4360:2004 standard.

The Corporate Register that follows identifies corporate risks, all of which have been assessed using a 'five by five' risk grading matrix (see below) which is in line with DHSSPS guidance. This ensures a consistent and uniform approach is taken in categorising risks in terms of their level of priority so that appropriate action can be taken at the appropriate level of the organisation.

IMPACT	Risk Quantification Matrix				
5 - Catastrophic	High	High	Extreme	Extreme	Extreme
4 – Major	High	High	High	High	Extreme
3 - Moderate	Medium	Medium	Medium	Medium	High
2 – Minor	Low	Low	Low	Medium	Medium
1 – Insignificant	Low	Low	Low	Low	Medium
LIKELIHOOD	A Rare	B Unlikely	C Possible	D Likely	E Almost Certain

Overview of Risk Register Review as at March 2015

Number of new risks identified	2 Corporate Risk 33 VOIP Telephone System Corporate Risk 34 £2.8m (15%) Reduction in Management and Administrative Funding
Number of risks removed from register	2 Corporate Risk 31 Shared Services (de-escalated to Operations Directorate Risk Register) Corporate Risk 32 Programme Budget Expenditure
Number of risks where overall rating has been reduced	0
Number of risks where overall rating has been increased	0

CONTENTS

Key:

Risk rating:

↑ increased from previous quarter

↓ decreased from previous quarter

→ remained the same as previous quarter

Corporate Risk 25				
RISK AREA/CONTEXT: PHA Belfast Accommodation				
DESCRIPTION OF RISK: PHA staff based in Belfast are in unsuitable accommodation with inadequate space (PHA staff in Linenhall street are in an increasingly over-crowded environment – communications staff, previously in Ormeau avenue have had to be relocated to floor 4 south, with access to specialised IT equipment compromised; no space is available for additional staff recruited to Nursing/AHP, Public Health and Operations; lack of meeting rooms and breakout space), compromising privacy and confidentiality, smooth operation of business, potential health and safety issues and resulting in poor staff moral and complaints. The lease for Ormeau Baths is due to end 2017. Leased accommodation in Alexander House is becoming increasingly unsuitable, with significant water ingress on three occasions since May 2014 and a subsequent partial ceiling collapse in May 2014. While the business case for alternative accommodation was approved the landlord withdrew before the lease could be finalised. The risk is therefore increased as there is no alternative accommodation solution at the moment.				**DATE RISK ADDED:** June 2012
LINK TO ASSURANCE FRAMEWORK: Corporate Control Dimension				
LINK TO ANNUAL BUSINESS PLAN 2014/15: Corporate Objective 6				
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**	
	Likely	Major	**HIGH**	
LEAD OFFICER: Mr E McClean, Director of Operations				

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Communications staff have been set up with IT connections to enable routine functionality; • Issue has been highlighted to Health Estates; • ~~Health Estates have established a Steering Group to look at accommodation – (Sept 2012)~~ • Following submission of	Regular reports to Chief Executive ~~Business case approved at PHA board confidential session, September 2013~~	Lack of suitable accommodation for number of staff based in Belfast; ~~Contracts and facilities arrangements to be agreed.~~	• ~~Facilities management contract – June 2015 (timescales PALS led; existing arrangements extended as per PALS advice)~~ • ~~Liaison with Alexander House agents – landlord to carry out repairs to roof initial work commenced, to be finalised (dependent on weather) (March 2015)~~ • ~~Relocation of some staff to~~	~~31 March~~ June 2015

revised business case (September 2013), conditional approval given; • Sponsorship Branch support provided as part of DHSSPS advisors comments. • Business case approved by DHSSPS (19 Nov 2013). • ~~Project manager appointed by Health Estates~~ • ~~Member of CAG for regional organisations facilities management contract~~ • Access to facilities management staff through HSCB contract with BHSCT • SBNI staff moved to HSC Leadership Centre, freeing space in Ormeau Baths • New facilities management contract issued (regional organisations), covering PHA Belfast accommodation. • Landlord has carried out repairs to Alexander House ceiling. • Some nursing staff relocated to Ormeau Baths (March 2015)			~~vacant space in Ormeau Baths and free space in 12-22 Linenhall Street (February 2015)~~ • Continue to raise issue with DHSSPS (on-going) • Meeting with B Smyth (CPD – Health Estates division) – June 2015 • Commencement/implementation of new Facilities Management contract (June 2015) • Commence work on SOC in respect of Ormeau Baths/Alex House (March 2016)	

Corporate Risk 26				
RISK AREA/CONTEXT: Lack of market testing for roll forward contracts and lack of staff capacity to appropriately procure services in a timely way to address this.				
DESCRIPTION OF RISK: Due to roll forward of many legacy contracts, PHA has not undertaken market testing of all baseline contracts as required under procurement regulations. This primarily impacts on the community and voluntary sector contracts under Health Improvement. PHA staff do not have the capacity (time) or skills, knowledge and experience in what is a technically specialist area, and also requires significant management of the process. Additionally there are constraints on BSO PALS and DLS to support and advise.			**DATE RISK ADDED:** September 2012 (Amalgamated with Corporate Risk 28, September 2013)	
LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement Dimension				
LINK TO ANNUAL BUSINESS PLAN 2014/15: Corporate Objective 6				
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**	
	Possible	Moderate	**MEDIUM**	
LEAD OFFICER: Dr E Rooney, Chief Executive				

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
Procurement Plan has been developed and agreed by AMT setting out the timescales for achieiving the re-tendering of baseline contracts. Revised processes and documentation developed for PHA in liaison with PALS to ensure tender process is applied where required in line with Procurement regulations Training has been provided for relevant staff, including legal aspects of procurement.	~~Performance Expenditure Management System Reports brought to AMT and PHA board regularly~~ Progress reports on implementing the Procurement Plan will be provided to AMT Leadership at AMT and Assistant Director level via ~~a~~ PHA Procurement board.	Legacy contracts may not be providing value for money Lack of capacity within BSO PALS Temporary additional capacity in Operations Directorate to support PHA social care procurement at risk due to financial constraints ~~only secured extended to 31 April March 2015~~; skills, knowledge and	Continue to monitor input of additional capacity through PALS framework (~~March~~ June 2015) (Change in timeline of process) ~~Mental Health phase 1 tenders to be issued (January 2015)~~ ~~(Legal and PALS capacity)~~ ~~Review of all existing contracts to be completed and all contracts that need to be tendered identified and included on revised procurement plan.~~ ~~January 2015~~	~~March~~ June2015

Additional staffing resource to provide dedicated support for procurement within PHA. (Sept 2013) External support secured by PALS to provide dedicated resource to PHA. (August 2013) Internal management structures established to oversee implementation of the Procurement Plan.(August 2013) Suite of documentation and guidance for tendering developed. (Sept 2013) Review of Procurement Plan and wider support requirements on agenda of Procurement Board that meets monthly. Procurement awareness briefing sessions held (Nov 2013) Tenders for several work areas now awarded - Drug and Alcohol services MH Training ; LGB&T ; RSE ~~documentation finalised by Legal~~ ~~RSE Tender advertised~~		capacity may be lost from May ~~April~~ 2015 due to financial constraints. No regional HSC agreement on management of social care procurement. Clarification required on the implications and impact of the new Procurement Regulations (2015)	~~RSE Tender awards to be confirmed.~~ ~~(Januray 2015)~~ ~~Drug and Alcohol Phase 1 Tenders to be assessed and awarded.~~ ~~(31st March 2015)~~ ~~Drug and Alcohol Phase 2 Tenders to be advertised.~~ ~~(January 2015)~~ Drug and Alcohol Phase 2 Tenders to be awarded. (~~April~~ May 2015) Seek funding extension to enable the additional capacity to support procurement plan implementation to remain in place. (April 2015) Training on new Procurment Regulations for relevant staff (June 2015)	

Corporate Risk 30				
RISK AREA/CONTEXT: Management of Lifeline Contract			**DATE RISK ADDED: December 2013**	
DESCRIPTION OF RISK: : Reported demand for the lifeline service has increased considerably, exceeding the designated budget. Additionally analysis of data download has raised a number of questions about the invoiced activity. The management of the new Lifeline Contract requires ongoing attention, to deal with the above and to ensure that the key performance indicators(KPIs) are delivered within all Trust areas and that appropriate arrangements are in place for signposting or referral where appropriate to other statutory or non-statutory providers. Independent Clinical Review findings have also given rise to a number of concerns.				
LINK TO ASSURANCE FRAMEWORK: Operational Performance and Service Improvement Dimension				
LINK TO ANNUAL BUSINESS PLAN 2014/15: Corporate Objective 2				
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**	
	Possible	Major	**HIGH**	
LEAD OFFICER: Dr C Harper, Medical Director/Director of Public Health				

Existing Controls	**Internal and External Assurances to the Board**	**Gaps in Controls and Assurances**	**Action Plan/Comments/ Timescale**	**Review Date**
Existing monitoring of Lifeline Contract. Lifeline Steering Group (chaired by Assistant Director of Public Health) meets regularly. Regular meetings between the provider and commissioner to monitor all aspects of the contract, through the following sub-groups: • Clinical and Social Governance • Performance management and Evaluation	Improvements have been seen in demand management, however, work continues to examine challenges to contract delivery regarding demand, data quality, accountability, clinical and governance review. Rigorous monitoring of performance. Detailed analysis of performance including data categorisation.	Difficulty in data analysis due to changes in categorisation fields. Delays in response from provider to issues raised by PHA. Deficiencies in original contract controls. Difficulty in provision of sufficient data on use of CORE (Clinical Assessment tool) to allow assessment of client outcomes. Delay in required DHSSPSNI/Ministerial approval	Additional internal project meetings planned and clear data log of decision making to be held. (ongoing) Outcomes of the independent clinical audit will continue to be monitored through the Clinical and Social Care Governance Subgroup. Proposal developed to conduct a further clinical review review of ~~cases~~ outcomes and approval	June 2015

• Communications PHA internal Lifeline Project Management Group meets regularly to co-ordinate management and monitoring of all aspects of the contract Regular meetings of senior staff (PHA and Contact) to ensure management of the new contract and building relationships and clear communication with other key providers. Letter issued to provider in respect of demand management and data quality issues. DHSSPS has been advised of issues. Findings of an independent clinical audit has been shared with Contact. Current contract due to end 31 Mar 2015, however, a 9 month extension has been granted pending outcome of the business case process. Letters have been issued to provider regarding specific	Clear communication channels and reporting to CE, Directors and AMT on progress. Independent Clinical Review undertaken. Plan has been developed to ensure continuity of service and regular meetings held with provider and Communications Staff, PHA. Ongoing monitoring and regular interchange between senior staff of both organisations on a regular basis. Decision taken, based on outcome from above, regarding potential clawback and correspondence issued regarding same. Further correspondence issued to provider to seek further information. Analysis of data has been considered by senior management of PHA, Legal and Finance and actions have been agreed. The process is ongoing.	in order to proceed with follow up clinical review.	awaited from DHSSPSNI. Business case an Single Tender Action approval was submitted to DHSSPS by PHA but approval is still outstanding. (timescale dependant on DHSSPSNI) Consultation now complete and findings are being used to inform business case for service. A business case is being prepared with a shortlist of options being prepared following approval by AMT to procure future Lifeline service. ~~(Jan 2015)~~ (May 2015) Staff continue to work on addressing the issue of 'demand management', the action plan emerging from the clinical review, review of raw data on performance and matching with key performance indicators. ~~(Mar 2015)~~ (June 2015) ~~Business case for extension to clinical review continues to be developed approved by PHA and DHSSPSNI and~~	

actions that remain outstanding. Implementation of the 6 directives continue to be monitored and have shown improvement in demand and management.	Outcomes of the independent clinical audit were presented to PHA Board in August 2014.		~~awaits Ministrerial approval (Mar 2015).~~	

Corporate Risk 33				
RISK AREA/CONTEXT: VOIP Telephone System			**DATE RISK ADDED: March 2015**	
DESCRIPTION OF RISK: The new VOIP telephone system presents a risk to the daily running of the Health Protection Duty Room as contact is made via telephone by health professionals seeking advice and reporting incidents/outbreaks.				
LINK TO ASSURANCE FRAMEWORK: Operational Performance				
LINK TO ANNUAL BUSINESS PLAN 2014/15: Corporate Objective 1, 2, 4				
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**	
	Likely	Major	**HIGH**	
LEAD OFFICER: Dr C Harper, Director of Public Health and Mr E McClean, Director of Operations				
Existing Controls	**Internal and External Assurances to the Board**	**Gaps in Controls and Assurances**	**Action Plan/Comments/ Timescale**	**Review Date**
• Public Health Management Team is aware of the issue and is currently looking at addressing the issue with Operations Directorate and HSCB. • VOIP system designed with resilience in mind. • Issue rasied with HSCB as Landlord.	• Provide senior management and PHMT/AMT with updates on a monthly basis.	Likelihood of telephone system going down and BSO IT taking corrective action within a reasonable time period.	• Continue to monitor VOIP telephone system down-time. • Look at alternative arrangements such as mobile/blackberry should the VOIP system go down. • BSO IT to look at a resilience telephone system.	June 2015

Corporate Risk 34				
RISK AREA/CONTEXT: £2.8m (15%) Reduction in Management and Administrative Funding				**DATE RISK ADDED: March 2015**
DESCRIPTION OF RISK: Potential inability to discharge all functions, departmental, corporate and statutory responsibilities as a result of the potential impact of £2.8m reduction in management and administration funding.				
LINK TO ASSURANCE FRAMEWORK: Operational Performance				
LINK TO ANNUAL BUSINESS PLAN 2014/15: Corporate Objective 1, 2, 4				
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**	
	Likely	Major	**HIGH**	
LEAD OFFICER: Dr E Rooney, Chief Executive				

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Chief Executive and Executive Directors engaged in discussion with DHSSPS on the impact this would have and potential flexibility in how it is achieved. • Establishment of scrutiny committee • Reporting to PHA board. • Staff update sessions undertaken by Chief Executive, and Directors in each PHA office (March 2015) • Finance reports to AMT and PHA board	• AMT in discussion with DHSSPS to seek to obtain best result to allow PHA to discharge its functions • Regular briefings to board members	Uncertainty about implications and impact until final plan agreed within PHA and with DHSSPS; Potential that budget reductions makes it impossible to discharge all functions as required in a safe and effective manner.	• Ongoing discussion at AMT and senior level within PHA • Directors reviewing budgets with Finance • Discussion ongoing with DHSSPS (ongoing) • Voluntary Exit Scheme currently being drawn up (DHSSPS leading and determining timescales) • Schemes to reduce costs such as reduction in travel, courses and conferences to be drawn up (June 2015) • Liaison with other HSC bodies on potential implications and means	June 2015

			of mitigating these	

APPENDIX

RISKS REMOVED FROM CORPORATE RISK REGISTER AS AT 31 MARCH 2015

Corporate Risk 31

RISK AREA/CONTEXT: Shared Services De-escalated to Operations Directorate risk register	**DATE RISK ADDED: June 2014**

DESCRIPTION OF RISK: PHA is reliant on BSO shared services for payments functions (goods, services and payroll). The draft Report to Those Charged with Governance (June 2014) identified a number of issues in respect of the services provided by shared services, including payroll information, incorrect scanning, coding and processing of invoices by the scanning centre, supplier amendments to standing data and prompt payment. There have also been significant problems with staff payments across the wider HSC system. There is a risk that suppliers, providers and staff will be incorrectly paid, with the potential for reputational and financial risk to the PHA.

LINK TO ASSURANCE FRAMEWORK: Financial Control Dimension

LINK TO ANNUAL BUSINESS PLAN 2014/15: Corporate Objective 6

GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Possible	Major Moderate	

LEAD OFFICER: Director of Operations with HSCB Director of Finance

Existing Controls	**Internal and External Assurances to the Board**	**Gaps in Controls and Assurances**	**Action Plan/Comments/ Timescale**	**Review Date**
• Financial management reports and controls; • HSCB finance scruntiny and dialogue with BSO finance and shared services on behalf of PHA; • Regional organisations meeting with BSO Shared Services • Chief Executive raised this issue at PHA End of Year Accountability Review meeting with DHSSPS on 18 June	• Monthly financial reports to AMT and PHA board; • Quarterly reports to PHA Governance and Audit Committee	Prompt payment target not being met Lack of assurance that BSO shared services systems fully & correctly functioning	• HSCB to monitor and work with BSO to ensure that the necessary improvements and controls are in place (on-going, by March 2015)	March 2015

~~2014.~~ • ~~Letter sent from GAC chair to BSO CE.~~ • ~~BSO Chief Executive & Director of Finance attended GAC meeting (Oct 2014);~~ • ~~Shared services customer forum for HSCB/PHA established – meets monthly.~~				

Corporate Risk 32			
RISK AREA/CONTEXT: Programme Budget Expenditure Funding has now been resolved with DHSSPS – Risk Removed			**DATE RISK ADDED: December 2014**
***DESCRIPTION OF RISK**: The DHSSPS retracted £1.5m from the PHA programme budget. Further, OFMDFM advised that it could not provide Delivering Social Change and New Parenting (£0.2m) Funds. The result is a £1.7m reduction in the PHA programme budget. Management action has been taken through delaying planned investments to ensure that PHA breaks even at year end. As a result the PHA will not be able to take forward all the actions planned for 2014/15 to meet its priorities and objectives.*			
***LINK TO ASSURANCE FRAMEWORK:** Operational Performance and Service Improvement Dimension*			
***LINK TO ANNUAL BUSINESS PLAN 2014/15:** Corporate Objective 1, 2, 4*			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	Likely	Major	**HIGH**
***LEAD OFFICER:** Director of Public Health and HSCB Director of Finance*			

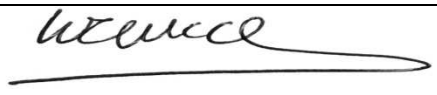
Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments/ Timescale	Review Date
• Budget holders continue to review and manage their budgets to bring maximum benefit; • Recording of expenditure on PEMS system • DHSSPS advised of potential impact.	• Monthly financial reports to PHA board; • Quarterly performance reports to PHA board	Opportunity cost of actions that cannot be taken forward in 14/15	• Continue to monitor budget/expenditure to year end ((31 March 2015); • Investment planning for 2015/16 to ensure maximum benefit from resources (depending on agreement and notification of 2015/16 budget) • Continue to advise DHSSPS of issues (ongoing) **Funding has now been resolved with DHSSPS**	March 2015

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	18 June 2015
Title of Paper	Data Protection/Confidentiality Policy
Agenda Item	12
Reference	PHA/06/06/15

Summary

The PHA developed and approved its Data Protection/Confidentiality Policy in March 2010 and previously reviewed it in February 2013. The Policy has now been revised and updated, and takes account of any revised guidance issued since 2013.
The Policy sets out the framework for ensuring compliance with the principles set out in the Data Protection Act 1998.

Equality Screening / Equality Impact Assessment	No equality implications were identified.
Audit Trail	This Policy was approved by the Information Governance Steering Group on 7 May, by AMT on 2 June and by the Governance and Audit Committee on 10 June.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	10 June 2015

Data Protection/Confidentiality Policy

Version	**1.2 Draft**
Approved by	**IGSG**
Date Approved	**07/05/15**
Review Date	**February 2017**
Version	1.1
Approved by	IGSG & GAC
Date Approved	Jan13 & Feb13
Original	March 2010

Version 1.2, February 2015

Contents

1.0 INTRODUCTION

1.1 Data Protection policy – Background

The ease, with which personal information can be passed within Public Health Agency (PHA), often by computer, is an undoubted benefit for patients and clients, for those involved in their care and treatment and in the planning and commissioning of Services. However all those concerned need to be aware that there is a legal duty to protect the confidentiality of personal information whether it relates to patients, clients, staff or members.

The PHA recognises that it has a responsibility to respect the individual's rights afforded by the Data Protection Act 1998 and we recognise that there is a legitimate expectation on the part of our service users and staff that their information will be treated as confidential and that sharing of that information will be legitimate, necessary and lawful. This policy is based on that expectation and acknowledges that HSC staff will need to have strictly controlled access to personal information, anonymised wherever possible, to enable the effective and efficient delivery of Health and Social Care Services to the local population within Northern Ireland.

All PHA staff, agents and contractors are reminded of their responsibilities under Data Protection legislation and all associated Codes of Practice and governing Principles that any breach of PHA policy will be treated as a serious matter and may result in disciplinary action

including dismissal, or in the case of an Agent or Contractor, consideration will be given to the review or termination of any formal arrangements.

1.2 Purpose of the Policy

This policy aims to clarify why it is necessary to share information, how personal information may be shared and when personal information may be shared. It also addresses the need to make patients, clients and staff aware of the ways in which their information might be used and emphasises the use wherever possible of anonymised information setting out the circumstances in which information may be passed on for other purposes or as a legal requirement.

It also confirms and reinforces that a Common Law duty of confidence applies to everyone working for or with the HSC and aims to inform all staff working within the PHA of the personal role they must play in the correct, appropriate and legitimate sharing of information, and what measures they must take to protect that information when it is in their charge.

This policy should be read by staff in conjunction with all Information Governance and ICT Security policies. These can be accessed on the PHA Connect site.

This policy should be read alongside the PHA's Facilities Management Policies for each of the locations, which deal with physical security of the PHA's premises and give important guidance in this respect.

The policy has been written in line with current legislation and guidance on data protection, with particular reference to the Department of Health Social Services and Public Safety guidance document "Code of Practice on Protecting the Confidentiality of Service User Information" (January 2012), the Data Protection Act 1998 and with reference to the revised Principles set out in the Caldicott 2 . This policy has been reviewed to reflect the additional Caldicott Principle "*The duty to share information can be as important as the duty to protect patient confidentiality*". Whilst not binding in the context of Northern Ireland, HSC has adopted these

principles in spirit and they remain at the heart of all related policy developments.

1.3 Governing Principles

The following governing principles are at the heart of this policy document, and should be viewed as the defining principles when handling personal data.

1 The use to which Personal Information is to be put within or from an organisation should be clearly defined, justified and regularly reviewed

2 Personal data items should not be included in transfers of information within or between organisations unless it is absolutely necessary and there is a robust business need and sufficient security measures employed to protect the transfer

3 Only the minimum amount of identifiable information should be transferred or be accessible as is necessary for any given, specified and approved function or purpose.

4 Only those individuals who need access to personal information should have access to it, and limited to what they need to see for their particular business need.

5 Managers and 'Information Asset Owners' should take such actions as are necessary on an on-going basis to ensure that all staff are made fully aware of their contractual and legal responsibilities and obligations to respect and protect individuals personal information from unauthorised use, disclosure, loss or destruction.

6 Every use to which personal data is put, should be lawful and comply with all relevant applicable guidance

7 No personal information should be transferred within or between organisations unless adequate, robust and approved security mechanisms are in place

8 When collecting personal data from data subjects, PHA should inform the subject as to the proposed use or uses the data is to be put, who it is to be shared with, how it will be secured and how long it will be retained.

9 Personal Information will, when no longer required, be permanently and verifiably destroyed.

Compliance with this policy will ensure;

- That the data collection is lawful and complies with the Data Protection Act 1998 Fair Processing Provisions.
- That data access is restricted to those with legitimate need to view the data.
- That all records systems, both electronic and manual, are secured and that all information held is a minimum data set, is collected and processed for specific purposes, is held only as long as is necessary for the purpose for which it was collected, is processed fairly and lawfully and is disposed of in a way which continues to protect confidentiality.
- That personal information is shared with those staff who have a legitimate relationship with the service user, are involved in the management and/or delivery of Health and Social Care Services or are regulated and registered Health and Social Care Professionals.

1.4 Definitions

"Personal Data" - The term "personal information" applies to personal data/ information, as is defined in law, about living individuals held in whatever form by or for Health and Social Care organisations, agents or staff. Personal data is data which relates to a living individual who can be identified from those data. This definition covers the obvious such as medical and staff records in addition to personal 'non-health' information such as a patient or client's name and address or details of his or her financial or domestic circumstances. It relates to both computerised and manual records and can be held in different formats, and include, for example, CCTV images microfiche, audio recording or still photographic images.

"Sensitive Personal Data" - Some "personal data" is classed as "sensitive personal data" by the Data Protection Act, and additional safeguards and regulation is afforded to this type of information. This information can only be processed under certain defined circumstances.

'Personal data' becomes 'sensitive personal data' if it includes any of the following types of information about an identifiable, living individual:

- racial or ethnic origin;
- political opinions;
- religious beliefs;
- trade union membership;
- physical or mental health;
- sexual orientation;
- commission of offences or alleged offences.

If you process information containing one or more of the types of information described above, you may seek advice from the Governance Manager if you have any queries relating to the extent of its use, transfer or permanent destruction.

'Data Controller' - For the purpose of this document the Public Health Agency (PHA) is the "Data Controller", and therefore, the organisation and its employees are subject to, and required to be comply with, the principles set out in the 1998 Data Protection Act.

The Ministry of Justice defines the 'Data Controller' as, "*a person who (either alone or jointly or in common with other persons) determines the purposes for which and the manner in which any personal data are, or are to be, processed*".

'Data Processor' - The Ministry of Justice defines the 'Data Processor', in relation to personal data, as any person (other than an employee of the data controller) who processes the data on behalf of the "data controller"

In relation to the PHA, this definition would define, for example, The Business Services Organisation, as a PHA data processor, in so far as the BSO processes information or carries out certain functions on behalf of the PHA.

In a legal context the PHA "owns" the "personal data" it "controls" and is responsible for ensuring compliance with the principles set out in the Data Protection Act 1998.

This extends to ensuring that adequate safeguards, that are at the very least equal to those employed by the PHA, are implemented and operated by a Data Processor to protect and comply with the Principles of the Data Protection Act

when carrying out processing of personal information on our behalf.

1.5 Further Information

Further information regarding this policy or any aspect of protection and use of personal information may be sought from the PHA Governance Manager. The following link will take you to the ICO Website.

http://www.informationcommissioner.gov.uk/

1.6 Accessibility Statement

This document can be made available on request and where reasonably practicable in an alternative format, Easy Read, Braille, audio formats (CD, mp3 or DAISY), large print or minority languages to meet the needs of those for whom English is not their first language.

2.0 BASIC PRINCIPLES

2.1 Every person, irrespective of Nationality, whose information is held by the PHA for Northern Ireland, is afforded certain rights under the United Kingdom Data Protection Act 1998 / Directive EU 95/46. The PHA is legally obliged to respect and maintain these rights in both practice and policy.

2.2 All PHA staff are legally bound by a Common Law duty of confidence to maintain confidentiality of information and abide by the principles of the Data Protection Act 1998.

2.3 Information provided in confidence may not be used for a purpose other than that for which it was collected or be passed to anyone else without the consent of the provider of the information (Data Subject). If occasion arises where it is proposed that personal information be used for another purpose, then expert opinion should be sought before any additional processing takes place.

2.4 Patients, clients and staff should, where it is reasonable and practicable to do so, be informed in advance of the uses to which their information may be put. (Fair Processing Notices)

2.5 Patients and clients' right to refuse the use of their information must be respected (except in exempted circumstances where this is required by law).

2.6 The PHA is required to comply with all legislation and guidance relating to the protection and use of personal information

2.7 Access to, and release of personal information will be strictly controlled; where possible anonymised and aggregate information will be used. Only the minimum data required will be processed by the PHA.

2.8 Personal information will be held only for as long as it is required for the purpose for which it was collected. It will be disposed of in a manner that continues to protect confidentiality. Patients, Clients and Staff should be informed at the outset, the period that their information will be retained for.

2.9 Contractors with access to personal information held by, or on behalf of, the PHA are required to comply with this policy and have in place their own complimentary policies and procedures that will provide the same or greater protection to information processed on behalf of the PHA (see 1.3). The PHA will require that Contractors or Agents acting at the direction of the PHA provide assurances and evidence of this requirement. Where it is deemed necessary, the PHA will require Contractors or Agents to implement certain organisational and/or technical measures to enhance their existing information security measures. Contractors or Agents will also be expected to follow PHA good practice developments in information security, and amend their own processes to meet PHA expectations.

3.0 PROTECTION AND USE OF INFORMATION

3.1 Uses and restrictions

3.1.1 Patients, clients and staff should be advised in advance of the uses to which the information they provide may be put. This may be verbally, in written

form on standard documentation used to collect information or on literature on protection and use of personal information designed specifically for this purpose. These are known as 'Fair Processing Notices'.

3.1.2 Personal information may *in appropriate circumstances* * be used for:

- The delivery of personal care and treatment, including needs assessment and Service Planning
- For assuring, improving or auditing the quality of care and treatment delivered by HSC.
- To monitor and protect public health including the prevention, detection and control of disease.
- To co-ordinate HSC care with that of other associated agencies.
- For effective Health and Social Care administration.
- Teaching, Training and Education of Staff.
- In statistical analysis and/or Health and Social Care research.
- Staff Administration and records including pay, superannuation, work management and discipline
- Accounting and Auditing including the provision of accounting and related services, the provision of an Audit where such an audit is required by statute.
- Crime prevention and prosecution of offenders
- The administration of licensing or maintenance of official registers
- Benefits, grants and loans administration
- Investigation of Complaints
- Defending Legal Challenge
- Auditing of Bodies in receipt of monies from the HSC

*** Note**: This list of possible uses is not exhaustive. If you are unsure whether or not a particular use is covered here, advice should be sought from the PHA Governance Manager.

3.1.3 Sometimes personal information is required by statute or court order and the PHA will be obliged to release the information in these circumstances.

3.1.4 Release of information necessary for the protection of the public, tackling serious crime are covered by the "Code of Practice on Protecting the Confidentiality of Service User Information" (January 2012) which should be studied in conjunction with this policy.

3.1.5 The PHA will not and does not permit personal details to be released or sold on for fundraising or commercial marketing purposes.

3.1.6 The PHA does not permit external Agents or Contractors to pass on information to third parties unless the purpose is legitimate and the PHA has agreed to that sharing.

3.1.7 The PHA is obliged by law to comply with requests from the Comptroller and Auditor General Northern Ireland to provide information in an electronic format relating to PHA staff for the purpose of Data Matching exercises conducted under the National Fraud Initiative. These powers are based on amendments to the Audit and Accountability Order (Northern Ireland) 2003, at Articles 4A and 4G respectively.

3.2 Collection, Retention and Disposal of Information

3.2.1 Data subjects will be advised of the uses to which their information may be put. This should take the form of information to patients and clients as laid out in the DHSSPS "Code of Practice on Protecting the Confidentiality of Service User Information" (January 2012). They will also be advised on request of the rights of access which apply to certain records under the Data Protection Act 1998.

3.2.2 Information sharing between HSC bodies may require a signed Data Access Agreement between

the parties. It is recommended that such an agreement is in place for those information flows regularly shared, for example, between the PHA and their Providers. A sample Data Access Agreement is included (Appendix 1).

3.2.3 Information sharing between HSC bodies and non-HSC bodies must also be covered by a Data Access Agreement.

3.2.4 Patients or Clients who consider withholding or restricting transfer of information should be advised that such restriction could possibly have an adverse impact on their care or treatment as the sharing of personal information between Health and Social Care professionals, critical to ensuring that the highest level of service is afforded to the individual. Legal or statutory requirements should also be explained. HSC staff should ensure that these discussions are handled with sensitivity and care and that the opinion of the individual is respected when making decisions about the use to which their information is to be put.

3.2.5 Only the minimum set of data should be collected, sufficient to the task.

3.2.6 Computerised personal information will be held on systems that are at the very least password protected and comply with the PHA ICT security policies and to which access is restricted to authorised personnel. Guidance on use of passwords is laid out in the PHAs ICT Security Policy. Any unauthorised access to restricted information must be brought to the attention of a senior officer immediately and the Governance Manager must be informed at the earliest opportunity.

3.2.7 Removable media such as PHA approved fob keys and laptops must have encryption software installed to protect against unauthorised access to sensitive information in the event of a loss or theft of that equipment. It is not permitted to store or transfer

sensitive information, either corporate or personal, on media that is not encrypted, such as personal laptops or fob keys.

For security purposes each electronic or physical set of data is assigned an 'information asset owner'. The IAO is responsible for:-

- Identifying all the data within their area of responsibility;
- Specifying how the data can be used;
- Agreeing who can access the data, and what type of access each user is allowed. (See Appendix 1 addendum for PHA 'Data Access Agreement Form').
- Determining the classification or sensitivity level(s) of the data;
- Periodically reviewing that classification;
- Ensuring and Approving appropriate security protection for the data, e.g. encryption software
- Ensuring compliance with security controls;
- Ensuring compliance, where necessary, with the Data Protection Act (1998), and any other relevant legislation covering personal or medical data.
- Ensuring all staff that they are responsible for are aware of their responsibilities and have access to policies and specialist advice when required.

Data classed as 'sensitive' within one system should maintain at least the same sensitivity level across all systems.

Access rights given to users should be consistent across all areas. Particular attention should be paid to data being downloaded to a computer. Corporately sensitive information often ceases to be sensitive after a period of time, for example, when the information has been made public. This should be taken into account, as over-classification can lead to unnecessary expense.

Please note: As a general statement, it is not permitted for PHA personal data or PHA business information to be held on unencrypted desktop or laptop computers. Such information should be held on a dedicated records management system, a dedicated server or at a sufficiently secure location to mitigate against the risk of a loss or theft of that equipment and to ensure there are regular backups of that data to maintain business continuity. It is recognised that business needs will occasionally dictate that sensitive information is held on laptops or desktops. Staff should seek advice from the Governance Manager to ensure adequate alternative safeguards are in place on these occasions.

3.2.8 Manual personal information will be held securely, for example in locked filing cabinets, and access restricted to authorised staff. Access will be granted at the direction of the Information Asset Owner or designated deputy (see 3.2.7)

3.2.9 Staff should operate a clear desk policy whereby personal (or business sensitive) information is not left in clear view of others (see PHA Clear Desk Policy).

3.2.10 Information will be retained only for as long as the purpose/s requires it bearing in mind legal timescales for retention of particular records (Appendix 2). Individual departments within the PHA are required to be familiar and comply with the timescales under which the personal information they hold is governed. Reference should be made to the DHSSPSNI document “Good Management Good Records” and the PHA “Records Management Policy” and “Retention and Disposal Schedule”. These can be found on the PHA Connect site policy section under Information Governance.

3.2.11 Methods used for disposal of confidential information must continue to protect confidentiality. Paper information should be shredded by means of a ‘chip’ or ‘confetti’ shredder. It is not permitted to

shred sensitive information by means of a 'strip' shredder as this method is no longer considered secure.

All redundant, faulty or obsolete PHA removable storage media, such as fob keys or external hard drives which did or which may have contained sensitive or valuable information during their life cycle, should be returned to the BSO Information Security Team (ITS) for complete and verifiable destruction rendering them unusable. An INFRA call should be logged to facilitate this type of equipment disposal. Officers responsible for the formal disposal of media should ensure that a disposal certificate is sought from any contractor employed to carry out this task. Further information on this area can be found in the PHA Waste Management Policy.

3.3 Processing and Presentation

3.3.1 Staff who are authorised to do so will process and present information in line with uses and restrictions set out in 3.1.

3.3.2 Information will be presented in an aggregate, anonymised form where disclosure of an individual's information would not be authorised for the purpose. Anonymisation does not in itself remove the duty of confidence in relation to the information. Confidentiality must still be protected.

3.3.3 With increasing usage of geographical information mapping tools (GIS) it is important to emphasise that, within the PHA, mapping systems are utilised only by trained staff who are fully aware of their personal responsibilities in protecting individual information from disclosure, both in its raw form and in any way in which it is potentially represented.

3.3.4 To allow the sharing of personal identifiable data within the terms of the Data Protection Act 1998, it is essential that when information is being gathered, that the purpose or purposes to which that information is to be used, is clearly defined and

understood by the data subject and that they agree to the proposed usage. If you have captured this consent, sharing is legitimate within the terms and conditions of use to which the subject agreed. Any secondary use of patient level data should be considered in conjunction with advice from the PHA Governance Manager or in conjunction with the third party from which the information was received, in many cases, this will involve Trust providers input.

3.3.5 Information labelling and handling.

Sensitive information should be labelled appropriately and output from systems handling such data should carry an appropriate classification label (in the output). The marking should reflect the classification of the most sensitive data in the output. Output includes all types of storage media and file transfers.

The document "Code of Practice on Protecting the Confidentiality of Service User Information" was issued by the DHSSPSNI in 2012. Care should be taken to meet its requirements. This document can be found at the following web address: http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf

3.4 Disclosure

3.4.1 Disclosure of personal information will be on a strictly "need to know" basis and in accordance with the uses detailed in 3.1 and where necessary, in consultation with the Information Asset Owner

3.4.2 Information disclosed will be the minimum dataset, sufficient to carry out the task.

3.4.3 All requests made to the PHA by an individual, other than from a member of PHA staff, seeking access to their own personal information should be forwarded to the Governance Manager at Towerhill who will process the request in accordance with relevant statutory obligations.

3.4.4 Where information has been sought for research purposes by external organisations/individuals, a Data Access application should be issued and returned before an informed decision is taken on appropriateness of disclosure (Appendix 3).

3.4.5 For some guidance in relation to the risks associated with information requests, refer to the Department's revised "Code of Practice on Protecting the Confidentiality of Service User Information" (January 2012).

3.4.6 In line with guidance laid down in the PHA's ICT Security Policy and various protocols operating within the PHA, disclosure of any information must be via media appropriate to the sensitivity of the information concerned. Security measures such as passwords and encryption must be employed when transferring or storing personal (or corporately sensitive data) and that transfer or storage must be authorised by the department's nominated Information Asset Owner. You should refer to the Information Governance Leaflets titled 'Information Transfers: Your Options' and 'Information Security Leaflet' for advice. Further advice can be sought from the Governance Manager or the Business Services Organisations Information Security Department (BSO ITS).

3.5 Data Access Requests

Data subjects (individuals whose information we hold) have the right to see or request a copy of data which is held about them, whether this be computerised or manual. The current maximum charge applicable for access is £10 for records held on computer and £50 for paper records or other media (e.g. X-ray). These charges are defined by the 'Data Protection (Subject Access) (Fees and Miscellaneous Provisions) Regulations 2000'. Having considered the findings of Caldicott 2, and being mindful that an individual's financial circumstances should not restrict their ability to exercise their rights to access their information there are no applicable fees in respect of requests for access to personal

information under section 7 ‘subject access provisions’ of the Data Protection Act 1998.

All requests for access to personal information must be received in writing. The procedures for dealing with such requests are laid out at (Appendix 4). Further advice may be sought through the Governance Manager.

3.6 Information for Statistics and Research

The sharing of PHA information for statistics and research purposes is governed primarily by the principles and schedules of the Data Protection Act 1998 and other complimentary Legislation and Regulatory Codes of Practice. The Body / Organisation requesting information is required to complete an ‘Application for Access to Personal Level Data for Research Purposes’ (Appendix 3) which must be submitted to the PHA for consideration. In the event that the PHA approves a disclosure of patient level data, a Data Access Agreement (Appendix 1 addendum) would be drafted to cover the disclosure and describe the use and extent of the disclosure. Note; Using information for research purposes is addressed within the Data Protection Act 1998, however, strict guidelines will apply, and appropriate safeguards must be present, in order for data to be used for research purposes within the strict definitions provided within the Act. Further advice may be sought from the Governance Manager or PHA designated Data Guardian.

3.7 Human Resources Records

Personal information is collected for recruitment purposes, for salaries and wages, for maintenance of the employment relationship between the PHA and its staff and to ensure that the PHA complies with its HR policies and procedures. HR policies are available on the PHAs Connect site. It is important to recognise that any staff information held by managers should be afforded the highest levels of privacy and security. It should be noted, that rights afforded to the individual under the Data Protection Act 1998, extend to employees of the PHA and these rights are not lessened by virtue of the employer / employee relationship. (Note: The PHA is a Public Authority as defined by the Freedom of Information Act 2000. In certain circumstances, information

relating to employees public role within the PHA may be disclosed, for example, on receipt of a Freedom of Information request.)

3.8 Audit Records

The PHA is required to provide access to all its records to Internal Audit. This access extends to all records, documents and correspondence relating to any financial or other relevant transaction, or function or activity conducted by the PHA or its Officers, and includes documents of a confidential nature. This disclosure of information is covered by the PHA's Data Protection registration with the Information Commissioner and Internal Auditors are contractually bound to maintain the security and confidentiality of all records in their care as with all personal information held at PHA level. Further to this, The Comptroller & Auditor General under powers conferred to his Office through the introduction of the 'Audit and Accountability (Northern Ireland) Order 2003' will periodically require disclosure of information from the HSC when conducting Data Matching Exercises under the National Fraud Initiative. It should be noted that the HSC is legally bound to comply with any request for access to information held on both employees and contractors. Release of such information does not require the consent of the individuals concerned under the Data Protection Act 1998. Staff will be notified prior to any disclosure and additional information can be sought at that time from the PHA Governance Manager.

3.9 Responsibilities of Staff and Contractors

3.9.1 All staff are bound contractually to protect the confidentiality of information to which they have access in the course of their employment (see Appendix 6 for contract extract)

3.9.2 Provision currently exists in contracts between the PHA and its Providers to maintain confidentiality of information that is utilised in any dealings arising from the operation of the contract (see examples at Appendix 7). Providers should ensure that any information disclosed to the PHA is anonymised where possible. Where identification of individuals is necessary,

Providers should ensure that appropriate consent of data subjects is in place for the purpose of disclosure and that disclosure is in line with the provisions of all relevant legislation and applicable guidance. Providers should describe any conditions which are attached to the data at the time of transfer, such as retention and disposal timescales.

3.9.3 Comprehensive confidentiality clauses are currently written into contracts between the PHA and Computer Companies/Agencies and general maintenance contractors which refer directly to the protection of personal data and confidentiality; (see examples at Appendix 7).
All contractors have a responsibility under this policy and existing legislation to protect the information to which they have access under the terms of their contract.

3.9.4 Protocols, such as those for faxing information and operation of 'safe haven' addresses and associated contact persons, are currently shared with those Providers/contractors to whom they may apply.

3.10 Out of the Office

It is PHA policy that patient/client-identifiable information remains on-site where possible. The PHA expects that no patient, client or employee identifiable information will be removed from the building without the approval of a sufficiently authorised officer, normally that will be the Information Asset Owner or an Officer of Assistant Director level or above. Note; Information Security measures such as passwords and encryption software should be present on any removable media device, such as a laptop, external hard drive or PHA approved and issued 'SafeStick' USB device, before any decision to allow information to leave the premises is taken. Reference should be made to PHA ICT Security Policy.

Requests for remote internet access can be made by completing the 'Secure Remote Access Application Form'

which can be found on the Information Governance Section of the PHA Connect site. This form must be signed off at Assistant Director Level before it is considered by the Governance Manager.

3.11 Breaches of policy

3.11.1 All staff, contractors and agents are reminded that they are bound by a Common Law duty of confidence in the protection and use of personal patient, client and staff information. All staff contractors and agents should be aware of and abide by the contents of this policy.

3.11.2 **Any suspected breach of this Policy must be reported to the Governance Manager immediately, or by contacting another member of the Governance Team. The incident can then be assessed and appropriate immediate and remedial corrective action can be taken to contain the breach.**

4.0 PHA RESPONSIBILITIES

4.1 Management Arrangements

4.1.1 The PHA has approved this policy document in recognition of its responsibilities in relation to the protection and use of personal information as governed by the Data Protection Act 1998.

4.1.2 The PHA requires that Management make appropriate arrangements to ensure communication of this policy to all levels of staff within the organisation, and ensure that staff receive and attend training courses relating to this particular subject.

4.1.3 Any queries arising in relation to this policy should be directed to the Governance Manager

4.2 Resources

4.2.1 The PHA will consider the use of resources in developing materials to inform patients, clients and staff of the uses to which their information will be put and to their rights of access where appropriate.

4.2.2 Training to communicate the responsibilities laid out in this and associated policy documents and practical measures that can be taken to comply with the contents will be provided for all PHA staff in formats that meet the identified need with emphasis on e-learning packages.

4.2.3 Practical guidance for compliance with this policy and the ICT Security Policy will be provided for all staff. This information will also be provided on Hardcopy and through the PHAs Connect site and through e-learning packages delivered to staffs desktops.

4.2.4 It is envisaged that all new staff will be informed of their responsibilities in relation to this policy and the ICT Security Policy as part of the PHA induction to the organisation. All Managers will be responsible for ensuring staff are familiar with both policies and are aware of their responsibilities in relation to their particular business activity.

4.2.5 Periodically, internal audit will review the PHA's arrangements for adequately protecting and appropriate usage of personal information.

4.2.6 The Governance Manager will make arrangements for periodic 'audits' of the main PHA buildings to ensure that all staff are familiar with and abiding by the contents of the policy and its associated guidance. Reports on these audits will be prepared for consideration by the relevant directing committees of the PHA.

4.2.7 Contractors will be made aware of the contents of this policy and their associated responsibilities. In addition, they will be required to provide the PHA

with their own policy guidelines relating to the protection and use of patient, client and staff information, and provide assurances that they will abide by their legal responsibilities.

4.3 Ensuring Adherence

4.3.1 Through effective communication, the PHA requires that staff act responsibly and within the confines of this policy document. However, breaches will be dealt with as serious matters and the PHA will not hesitate in exercising its rights in such situations.

4.3.2 Contractors working with or on behalf of the PHA will be informed that they too are bound by the principles laid down in this policy and the relevant clauses included in all contracts.

4.4 Equality and Human Rights Screening

This policy has been screened in accordance with the PHA's requirements under Section 75 of the Northern Ireland Act 1998. Cognisance has also been taken of human rights. The policy and screening outcomes are published as part of our agreed process for publication.

4.5 Review of policy

This policy will be periodically reviewed and updated to ensure that it is in line with current guidance and legislation relating to protection and use of patient and client information. This policy will be reviewed no later than February 2017 or once the revised Directive 95/46 EC is incorporated into United Kingdom legislation.

Appendix 1

PHA DATA ACCESS AGREEMENT FORM (DAA)

The PHAs ‘Data Access Agreement’ pro-forma is provided as a separate file and can be accessed on the PHA Connect site under the Information Governance Section – Insert link**.**

Appendix 2

Retention of Records

The retention and disposal of PHA records must be in line with both the PHA's Records Management Policy and the corresponding Retention and Disposal Schedule. The Retention and Disposal Schedule is based on the DHSSPS publication 'Good Management, Good Records (2013)' and outlines minimum retention periods for records created in the PHA. The Schedule also details the final action for PHA records by identifying those which need to be transferred to the Public Record Office for Northern Ireland (PRONI) and those which can be destroyed once they have been retained for the sufficient period of time.

The following link will take you to the Good Management, Good Records facility on the DHSSPS website - link

Appendix 3

APPLICATION FOR ACCESS TO PERSONAL LEVEL DATA FOR RESEARCH PURPOSES

1. Personal Details – Researcher / Planner

Surname :_____

Forenames :_____

Postal Address :_____

_____

_____

Postcode:_____

Organisation :_____

Telephone No. :_____

Fax No. :_____

Email :_____

2. Project Details

Title of Project :_____

_____

Project purpose:_____

/ background _____

_____

_____

_____

_____

_____

_____

Proposed Start Date : _____

Duration : _____

3. Approval sought by the Researcher / Planner

Identify organisations or individuals from which assurances of co-operation will be required and whether these assurances have yet been given

Name of individual/organisation and contact name	**Co-operation confirmed (Y/N)**

Has this research been cleared by the Ethical Committee (where appropriate): _____

(*copy of authorisation to be attached to this application)*

Terms and Conditions of Support

The following are the Terms and Conditions under which the Public Health Agency (PHA) will consider supporting the proposed research:

4. GENERAL CONDITIONS

4.1 The Applicant will acknowledge the support of the PHA in any final report

4.2 The Applicant will provide the PHA with an opportunity to contribute to the design of the research

4.3 The Applicant will provide the PHA with a presentation of the findings of the research if requested to do so

4.4 The Applicant will comply with all Data Protection requirements and will exercise proper safeguards to prevent any breach of confidentiality and/or privacy. Any disclosed results of the research shall not be able to identify an individual without that individual's written consent.

4.5 Data made available by the PHA to the Applicant is done so in confidence solely for the purpose of the above research project.

4.6 Data made available by PHA to the Applicant directly will not be divulged to any individual not associated with the research

4.7 When the research project is concluded, all personal data will be entirely destroyed.

4.8 The Applicant will provide the PHA with a pre-publication draft of any report generated from the research prior to publication.

4.9 The Applicant will pay for any reasonable costs incurred by the PHA in supporting the research, including costs incurred by other organisations.

5. AGREEMENT (To be completed by the Researcher / Planner)

I agree to the terms and conditions laid out in this document.

Signed
Project Leader: _____
Organisation: _____
Date: _____

6. Declaration of Data Protection Co-ordinator and Data Custodian

I declare that the Public Health Agency's involvement in the above research complies with the Data Protection Act and that all notification requirements have been completed.

Signed: _____ (Data Guardian)
Date: _____

Signed: _____(Governance Manager)
Date: _____

6.1 Chief Executive PHA (or Designated Deputy)

Signed: _____ (Chief Executive/Deputy)
Date: _____

Appendix 4

Procedure for dealing with subject access requests

Sample Letter

PHA Governance Department
ADDRESS

Dear Sir / Madam

The Data Protection Act 1998 (DPA), gives everyone the right to seek access to their own personal information.

To request access to Health and Social Care records held by the Public Health Agency (PHA), please complete the attached 'application form' (2 pages). A letter of application is also acceptable (e.g. from a Solicitors office) but it should provide us with all necessary information to allow us to search for any relevant records.

Please include as much detail as possible about the records you are seeking e.g. type, location or any reference number you may have received from the PHA during previous correspondence.

The completed Application Form or letter of application should be returned along with;

a) A valid form of identification (e.g. driving licence, birth certificate, ID card, passport. – originals will be returned)
b) If the application is from someone other than the subject of the information, signed consent from the data subject
c) The relevant fee (see Application Form)

I am required to inform you that the 40 days, allowed under DPA, to process your request will not commence until we receive the applicable fee and all necessary documentation as indicated above.

If you have any queries about completing this Application Form, or about our procedures for processing such requests, please do not hesitate to contact me at the address provided.

Yours Sincerely

_____

Application for access to personal Health and Social Care records

(The relevant fee and a valid form of identification should accompany all requests; see form for details of any documentation required to validate your application)

PART A

Your details (person to whom the information relates)

Surname Forenames

Date of Birth Other identifying Information

Address

Tel / Contact Number

If the details provided above are different from those that we may hold about you, please provide us with the following information

Previous Surname (1)_____ (2) _____

Previous Address (1)_____ (2) _____

Applicable dates _____

To help us identify the records you are seeking, please indicate what type of record you believe we may hold (eg Complaints records, Social Services records, Health records)

PART B I require access to the records in the following format: Fee required Please Tick

I only wish to view my records	Facilitated free of charge if the request is deemed appropriate
Printout of records held on computer systems	£no fee
A copy of Social Services Records (paper records only)	£no fee
A copy of Health care Records (paper records) and/or copies Of X-Ray film	£no fee

Note: A maximum of £50 is applicable for any combination of the above under the The Data Protection (Subject Access) (Fees and Miscellaneous Provisions) Regulations 2000 PHA does not apply fees in respect of Subject Access Requests

Part C Applicant's details (if not the person to whom the data relates)

If you are applying to see records that are not your own, please provide details:

What is your relationship to the person to which the information relates

Your surname Your Forenames

Your Address

Your Tel / Contact Number

(this is the address to which a reply or other correspondence will be sent, unless otherwise stated)

Please indicate below by ticking relevant box or deleting as appropriate

I have been asked to act on behalf of the person whose information is being sought and their written permission is included (Part E below) ☐

I am acting in parental capacity as the person whose information is being sought is under 16 years of age and: is incapable of understanding the request* OR has consented to my making this request*
(*delete as appropriate)

The person is over the age of 16, however is incapable of understanding the request and I therefore act as his/her personal representative ☐

The person is deceased and I am the next of kin ☐

The person is deceased and I am his/her personal representative and attach legal documents confirming my position ☐

PART D To be completed by the person requesting access to records

I declare that the information given by me is correct to the best of my knowledge and that I am entitled to request access to the records detailed above.

_____ _____ _____/_____/_____
Print Name(capitals) Signed Date

PART E To be completed by the person to whom the information relates to authorise release of records to the individual named at **PARTC**

I hereby authorise the Public Health Agency to release the records detailed on this form to

_____(representative named at **PART C**)

Signed_____ Date_____
(person to whom information relates)

Appendix 5

Example: CONFIDENTIALITY AS DETAILED IN STAFF CONTRACTS

CONFIDENTIALITY

You shall not as an employee of the PHA, or following the termination of your employment with the PHA, disclose other than to authorised person or in the course of duty without lawful authority, any matter or information which you have obtained or to which you have had access, owing to your official position. Breaches of confidence may result in disciplinary action, which may involve dismissal, or possibly render you liable to Criminal Proceedings

CONFIDENTIALITY OF INFORMATION HELD ON COMPUTERS

Your personal data will be held by the PHA on manual and computer records and will be processed in accordance with the Data Protection Act 1998. Further information is available from the Human Resources Department. You are also advised that you have a statutory obligation under principle 7 of the Data Protection Act to protect any personal data to which you have access in the course of your employment. Any employee who unlawfully discloses personal data may be subject to disciplinary action by the PHA. You should also be aware that regardless of any action by the PHA, unauthorised disclosure of personal data could render you liable to Criminal Proceedings/Civil Action under the Data Protection Act 1998.

Appendix 6

Example: Confidentiality in Provider contracts

The Protection and Use of Patient and Client Information

The Trust or any organisation who under formal agreement provides services for the PHA will be expected to follow DHSS&PS “Code of Practice on Protecting the Confidentiality of Service User Information” (January 2012)and the recommendations and principles set out in the Caldicott Committee Report. Arrangements should be continually reviewed to ensure ongoing compliance with above named guidance and any further guidance issued. In addition all providers will be required to comply with the Data Protection Act 1998 and all other relevant and applicable legislation.

Public Access to Information about the HSC

The provider will be required to comply with the provisions of the Freedom of Information Act 2000 and provide whatever assistance is required by the PHA to allow it to meet its statutory obligations under this Act

Appendix 7 (a)

Example: CONTRACTORS AND CONFIDENTIALITY

CONTRACTS WITH COMPUTER SERVICES COMPANIES

14. Confidentiality

14.1 Without prejudice to the application of the Official Secrets Acts 1911 to 1989 to any Confidential Information the CONTRACTOR acknowledges that any Confidential Information obtained from or relating to the Crown, its servants or agents is the property of the Crown.

14.2 The CONTRACTOR acknowledges that it has access to and will regard as Confidential Information all data of whatever nature relating to patients.

14.3 In further consideration of the AUTHORITY executing this Agreement with the CONTRACTOR, the CONTRACTOR hereby warrants that:

14.3.1 the CONTRACTOR (and any person employed or engaged by the CONTRACTOR in connection with this Agreement in the course of such employment or engagement) shall only use Confidential Information for the purposes of this Agreement;

14.3.2 the CONTRACTOR (and any person employed or engaged by the CONTRACTOR in connection with this Agreement in the course of such employment or engagement) shall not disclose any Confidential Information to any third party without the prior written consent of the AUTHORITY;

14.3.3 the CONTRACTOR (and any person employed or engaged by the CONTRACTOR in connection with this Agreement) shall take care at all times of all media, including storage media (including the data thereon) and all papers (including patient records), placed in its possession for the purpose of this Agreement. The CONTRACTOR hereby acknowledges that it has

access to and will regard as Confidential Information all data of whatever nature relating to patients and Clients and undertakes to keep the AUTHORITY indemnified against all proceedings, actions, claims, demands, expenses and liabilities whatsoever arising out of breach of this Clause by itself, its servants, agents and sub-contractors and the servants and agents of such sub-contractors. The CONTRACTOR also hereby acknowledges that the Computer Misuse Act 1990 is particularly relevant with regard to this Agreement.

14.3.4 the CONTRACTOR shall take all necessary precautions to ensure that all Confidential Information is treated as confidential and not disclosed (save as aforesaid) or used other than for the purposes of this Agreement by the CONTRACTOR's employees, servants, agents or sub-contractors; and

14.3.5 without prejudice to the generality of the foregoing neither the CONTRACTOR nor any person engaged by the CONTRACTOR whether as a servant or a consultant or otherwise shall use the Confidential Information for the solicitation of business from the AUTHORITY or another part of the Crown by the CONTRACTOR or by such servant or consultant or by any third party.

14.4 The AUTHORITY:

14.4.1 shall treat as confidential all Confidential Information obtained from the CONTRACTOR (see sec; 35.1.1 and 35.1.2)

14.4.2 shall not subject to Clauses 14.6 and 35, disclose to any third party without firstly giving consideration to consulting with the CONTRACTOR any Confidential Information obtained from the CONTRACTOR. (see sec; 35.1.1 and 35.1.2)

14.5 The provisions of Clauses 14.1, 14.3 and 14.4 shall not apply to any information which:

14.5.1 is or becomes public knowledge other than by breach of this Clause 14;

14.5.2 is in the possession of the receiving party without restriction in relation to disclosure before the date of receipt from the disclosing party;

14.5.3 is received from a third party who lawfully acquired it and who is under no obligation restricting its disclosure.

14.5.4 is independently developed without access to the Confidential Information.

14.6 Nothing in this Clause shall be deemed or construed to prevent the AUTHORITY from disclosing any Confidential Information obtained from the CONTRACTOR:

14.6.1 to any other department, office or agency of the Crown, provided that the AUTHORITY has required that such information is treated as confidential by such departments, offices and agencies, and their servants or agents, including requiring servants or agents to enter into a confidentiality undertaking where appropriate; and

14.6.2 to any consultant, contractor or other person engaged by the AUTHORITY in connection herewith, provided that the AUTHORITY shall have obtained from the consultant, contractor or other person a signed confidentiality undertaking on substantially the same terms as are contained in this Clause.

14.7 Nothing in this Clause 14 shall prevent the CONTRACTOR or the AUTHORITY from using data processing techniques, ideas and know-how gained during the performance of this Agreement in the furtherance of its normal business, to the extent that this does not relate to a disclosure of the AUTHORITY's Data, any data generated from the AUTHORITY's Data, a disclosure of any Confidential Information, or an infringement by the AUTHORITY or the CONTRACTOR of any Intellectual Property Right.

Protection of Personal Data

33.1 The CONTRACTOR's attention is hereby drawn to the Data Protection Act 1984 and the Data Protection Act 1998 (together the "Data Protection Acts").

33.2 Both parties warrant that they will duly observe all their obligations under the Data Protection Acts which arise in connection with this Agreement.

33.3 Without prejudice to the generality of Clause 33.2 and with reference to Schedule 1 Part II Paragraph 12 of the Data Protection Act 1998, the CONTRACTOR, as data processor, shall:

33.3.1 act only on instructions from the AUTHORITY, as data controller, and

33.3.2 take appropriate technical and organization measures against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

Publicity

34.1 Except with the written consent of the AUTHORITY, the CONTRACTOR shall not make any press announcements or publicise this Agreement in any way.

34.2 The CONTRACTOR shall be permitted to name the AUTHORITY as a customer in responses to requests for information or responses to invitation to tender provided by Government

Departments, Agencies or other Government bodies or organisations. Names and contact details of AUTHORITY personnel shall not be supplied without the AUTHORITY's prior written consent.

34.3 The AUTHORITY shall provide the CONTRACTOR with a copy of any media announcement, prior to its release, in respect of the CONTRACTOR's role or performance in respect of this Agreement.

35. Disclosure of Information

35.1 Notwithstanding the provisions of Clause 34, the AUTHORITY shall be entitled to disclose any information relating to this Agreement without consulting the CONTRACTOR in the following circumstances:

35.1.1 for the purpose of any examination of this Agreement by the National Audit Office pursuant to the National Audit Act 1983 or otherwise;

35.1.2 for parliamentary, governmental, statutory or judicial purposes; or in relation to any other legal or quasi legal obligation on the AUTHORITY, such as FOI or EIR legislation, or where/when a "public interest test" may apply

"**Confidential Information**" means all information designated as such by either party in writing together with all other information which relates to the business, affairs, products, developments, trade secrets, know-how, personnel, customers and suppliers of either party or information which may reasonably be regarded as the confidential information of the disclosing party.

Appendix 7 (b)

EXAMPLE: CONTRACTORS AND CONFIDENTIALITY

General Maintenance

The Contractor, his employees and Agents shall at all times keep confidential and secret and shall not disclose to any person other than a person authorised by the Business Services Organisation all information and other matters acquired by the Contractor, his employees and Agents during the course of the works.

Statutory Obligations

The Contractor shall comply with all current statutory obligations and any amendments to those obligations as they may arise during the term of this contract. The Contractor shall comply with, and give all notices required by, any statute, any statutory instrument, rule or order or any regulation or by-law applicable to the work and shall pay all fees and charges in respect of the work legally recoverable.

Official Secrets and Confidentiality

The contractor shall take all reasonable steps to ensure that all persons employed by him or his subcontractors in connection with the Contract are aware of the Official Secrets Act 1989 and, where appropriate, of the provisions of Section 11 of the Atomic Energy Act 1946, and that these Acts apply to them during the execution of the Works and after the completion of the Works or earlier determination of the Contract.

Any information concerning the Contract obtained either by the Contractor or by any person employed by him in connection with the Contract is confidential and shall not be used or disclosed by the Contractor or by any such person except for the purposes of the Contract.

Appendix 8

DATA PROTECTION PRINCIPLES, 1998 ACT

The principles of protection of personal data are contained within the Data Protection Act 1998. These impose specific requirements on PHA staff when handling Personal Data.

First Principle: Personal data shall be processed fairly and lawfully, and, in particular, shall not be processed unless:

- At least one of the conditions in Schedule 2 is met.
- In the case of sensitive personal data, at least one of the conditions in Schedule 3 is also met.

(NB: H&SS data are by nature sensitive data and consequently require grounds drawn from both schedules to justify processing. In legal terms, if data subject consent, explicit or otherwise, is lacking, then performance of functions under enactment of government functions or performance of a medical function may suffice.)

Second Principle: Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.

Third Principle: Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.

Fourth Principle: Personal data shall be accurate and, where necessary, kept up to date.

Fifth Principle: Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.

Sixth Principle: Personal data shall be processed in accordance with the rights of the data subjects under this Act.

Seventh Principle: Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to personal data.

Eighth Principle: Personal data shall not be transferred to a country or territory outside the European Economic Area, unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

More detailed information on the Data Protection Act 1998 is available from the Information Governance Manager or the Information Commissioners website at www.ico.gov.uk

Appendix 9

The Caldicott Principles (Best Practice)

The principles for dealing with patient-identifiable information are:

1) Justify the purpose(s). Every proposed use of transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented with continuing uses regularly reviewed by an appropriate guardian.

2) Don't use personal confidential data unless it is absolutely necessary. Personal confidential data should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3) Use the minimum necessary personal confidential data. Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data transferred or accessible as is necessary for a given function to be carried out.

4) Access to personal confidential data should be on a strict need to know basis. Only those individuals who need access to personal confidential data should have access, and then, only to the specific data items they need. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

5) Everyone with access to personal confidential data should be aware of their responsibilities. Action should be taken to ensure that those handling personal confidential data – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6) Comply with the law. Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

7) The duty to share information can be as important as the duty to protect patient confidentiality. Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be

supported by the policies of their employers, regulators and professional bodies.

Health and Social Care

DATA ACCESS AGREEMENT

Personal Identifiable Data for Non-Direct Care Purposes

Introduction

All Health and Social Care organisations (HSC) must ensure that when sharing HSC data for non-direct care (secondary purposes), assurances are provided by the requesting organisations that they comply with the Data Protection Act (1998) and that staff are aware of the relevant DPA Policies and Procedures in place.

Researchers undertaking studies and who require access to patient identifiable information and / or anonymous HSC data should follow the research protocol (Research Governance Framework for Health and Social Care in Northern Ireland).

Please be aware that it may be more appropriate to make use of the Honest Broker Service (HBS) rather than completing a Data Access Agreement. The HBS will enable the provision of anonymised, aggregated and in some cases pseudonymised health and social care data to the DHSSPS, HSC organisations and in the case of anonymised data for ethically approved Health and Social care related research.

Arrangement for access to personal data may already be covered by a contract (eg a contract for supplier support on an information system) therefore organisations need to be clear that any proposed data sharing is either covered adequately by that contract or make sure that a Data Access Agreement is completed.

The following Data Access Agreement must be completed by any organisation wishing to access HSC Trust data. It must be considered for approval and signed by the supplier organisation's Personal Data Guardian.

In the event of a breach of this agreement which results in a financial penalty, claim or proceedings, the parties agree to co-operate to identify and apportion responsibility for the breach and the defaulting party will accept responsibility for any such claim.

Please refer to Appendix 2, 'Principles Governing Information Sharing' for guidance.

The form is divided into Sections (A-I) as detailed below:

Section A: Details of Requesting Organisation
Section B: Commissioning Organisation
Section C: Details of data items requested
Section D: Consent issues
Section E: Data Protection
Section F: Measures to prevent disclosure of Personal Identifiable Information
Section G: Data Retention
Section H: Declaration: Requesting Organisation
Section I: Declaration: Owner Organisation

Appendix 1: Data Destruction Notification and checklist
Appendix 2: Principles Governing Information Sharing

Please ensure that this form is returned to: _____

_____

_____

_____

Internal Reference: _____

Internal Contact:

Name _____

IAO_____

Service Group (if relevant):_____

Title of Agreement	
Date of Request	

Please state if this is an update of a previous agreement or a new request for personal identifiable information

Date Access Begins: _____

Date Access Ends: _____

Review date if on-going agreement:_____

An update of an earlier extract ☐ New application ☐

(A) Details of Requesting Organisation	
Name of Requesting Organisation: Please note that the Data Access Agreement will be immediately returned unless the requesting organisation has signed section H.	
Name of Authorised Officer Requesting Access to Trust Data (please print)	
Position/Status	
Address Postcode	
Sector of the requesting organisation eg Voluntary, Public, Private etc	
Telephone Number	
Email Address	
Name and Telephone Number of Requesting Organisation or Personal Data Guardian	

If you require the data to carry out work on behalf of another organisation, please complete section (B) below. If not, please go straight to section (C).

(B) Commissioning Organisation	
Name of Commissioning Organisation	
Contact Name	
Title	
Contact Number	
Email Address	

(C) Details of 'Data Items' Required:	**Rationale for data Items**
Please provide a list and description of the data to which the request applies, eg include all identifier attributes, (eg Name, Address, Postcode, Date of Birth, Gender, HSC Number, Diagnosis Code, Religion etc)	Please indicate the reasons for requiring each of these data items
1 _____ 2_____ 3 _____ 4_____ 5_____ 6_____ 7_____ 8_____	1_____ 2 _____ 3_____ 4 _____ 5_____ 6 _____ 7_____ 8 _____
Please state in as much detail as possible, the purpose for which the data are required by the organisation named in section (A) including any record linking or matching to other data sources. Please continue on a separate sheet if necessary or attach any relevant documentation.	

Processing of Data	
Please indicate how you propose to process the data once received (eg to extract and anonymise Service User information; for auditing and monitoring of Service User care and treatment.	

System(s) from which Data is to be extracted (If Known) Please include sites or Geographical locations (If Known)	
For example PAS, RVH	
Is the Data to be Viewed only (V); or Viewed and Updated (U); or Transferred and Viewed (T)?	Please specify: _____
Will Data contain Client Identifiable Details?	**(Please Tick)** Yes ☐ No ☐
If you have answered "No" to the question above have you considered whether the data could be released via the Honest Broker Service?	**Yes** ☐ No ☐
Frequency of transfers	Once Only ☐ Other ☐ _____ (Please specify)

(D) Consent Issues	
Do you have the individuals' consent?	Yes ☐ No ☐
If yes please provide a copy of the consent form i.e Explicit consent should be obtained for the processing of sensitive personal data.	
If no, why is it not practical to obtain consent?	

(E) Data Protection (of Requesting Organisation)	
Do you have a confidentiality / privacy policy which complies with the Data Protection Act 1998?	Yes ☐ No ☐
Are confidentiality clauses included within contracts of all staff with access to the person identifiable information?	Yes ☐ No ☐
Are all staff trained and aware of their responsibilities under the Data Protection Act 1998 and adhere to the eight Data Protection Act Principles?	Yes ☐ No ☐
Provide details /copy of your ICT security policy for your organisation	
Provide confirmation that your organisation has Data Protection notification for purposes of analysis. Please provide your ICO notification/registration number	
Have you conducted a Privacy Impact Assessment? If yes please include a copy with this form.	Yes ☐ No ☐

(F) Measures to Prevent Disclosure of Person Identifiable Information (of Requesting Organisation)	
Will this data be accessed or transferred by you to another organisation?	Yes ☐ No ☐ (If Yes, please give details including in what country it will be stored)
If Yes, has your Data Controller/Data Processor granted permission for onward disclosure?	
How will you secure the information provided being transferred?	
If Applicable how will you secure information provided being transferred by you to another organisation	
Describe the physical security arrangements for the location where person identifiable data is to be: – processed; and – stored*(if different to above).*	

System Information	
Provide details of access and/or firewall controls implemented on the system, and measures to encrypt which are in place.	

(G) Data Retention (of requesting Organisation)	
Please state the date by which you will be finished using the data.	
If the retention period which you require the data is greater than one year, please indicate the reasons. (The maximum data retention period is 2 years, after this time a review of this agreement is required)	
Describe the method of data destruction you will employ when you have completed your work using person identifiable data	

Please ensure that the Data Destruction Notification (Appendix 1) is completed within the specified retention period and returned to the contact person on the front of the form.

(H) Declaration: Requesting Organisation

Data Protection Undertaking on Behalf of the Organisation Wishing to Access the Data

My organisation requires access to the data specified and will conform to the Data Protection Act 1998 and the guidelines issued by the DHSSPS Executive in January 2009 in *"The Code of Practice on Protecting the Confidentiality of Service User Information".*

I confirm that the information requested, and any information extracted from it,

- Is relevant to and not excessive for the stated purpose
- Will be used only for the stated purpose
- Will be stored securely
- Will be held no longer than is necessary for the stated purpose
- Will be disposed of fully and in such a way that it is not possible to reconstitute it.
- That all measures will be taken to ensure personal identifiable data will not be disclosed to third parties.
- The Health and Social Care organisation will be informed of the data being deleted / destroyed.

I *(name:printed)* _____, as the Authorised Officer of *(Organisation)* _____, declare that I have read and understand my obligations and adhere to the conditions contained in this Data Access Agreement.

Signed: _____
(Personal Data Guardian)

Signed: _____
(IAO/SIRO)

Date: _____

(I) Declaration – Owner Organisation

DATA ACCESS AGREEMENT

I CONFIRM THAT:

1. _____ Organisation consents to the disclosure of the data specified, to the organisation identified in Section A of this form.
   The disclosure of the data conforms to the guidelines issued by the DHSSPS NI Code of Practice on Protecting Confidentiality of Service User Information, 2009.

2. The data covered by this agreement are: **(*delete as appropriate)**

   - Either data which are exempt from the Data Protection Act 1998, or
   - Are notified under the Data Protection Act 1998 and their disclosure conforms to the current notification under The Act.

Signed: _____

(Personal Data Guardian) OR (Senior Information Risk Owner SIRO)

Date: _____

Please note that this organisation has the right to inspect the premises and processes of the requesting organisation to ensure that they meet the requirements set out in the agreement.

Any loss, theft or corruption of the shared data by the requesting organisation must be immediately reported to the Personal Data Guardian of the owning organisation. Please also notes that any serious breaches of data loss, theft or corruption should also be reported to the ICO by the Data Controller.

Appendix 1

Data Destruction Notification and checklist

Authorised users of the person identifiable data have, under the terms and conditions of the Data Access Agreement, a requirement to destroy the data on or before the retention date stated in Section (H).

This form should be completed on destruction of the data and returned to the Personal Data Guardian.

This form should be completed on destruction of the data, and returned to:-

ENTER ADDRESS

Data Destruction Notification	
Name of Organisation	
Name of Authorised Officer (please print)	
Position/Status	
Address	
Telephone Number	
Mobile Number (Optional)	
Fax Number	
Email Address	
Title of Agreement	
Date Declaration Signed	
Date Data Received	
Date Data Destroyed	

Signature	
Date	

Health and Social Care Checklist

Termination of Data Access Agreement - Trust Checklist	
Name of Internal Trust Contact	
Position/Status	
IAO	
Telephone Number	
Mobile Number (Optional)	
Email Address	
Title of Agreement	
Can you confirm Data flow has stopped	
Have you advised IT to stop facilitating transfer	
Have you received confirmation from receiving organisation that all information has been destroyed or returned	

Signature	
Date	

Once the Destruction Notification Form and the Organisation Checklist has been completed please return both to the contact person detailed on the agreement.

Appendix 2 - Principles Governing Information Sharing[1]

Code of Practice 8 Good Practice Principles[2]	DPA Principles	Caldicott Principles[3]
1. All organisations seeking to use confidential service user information should provide information to service users describing the information they want to use, why they need it and the choices the users may have. **2.** Where an organisation has a direct relationship with a service user then it should be aiming to implement procedures for obtaining the express consent of the service user. **3.** Where consent is being sought this should be by health and social care staff who have a direct relationship with the individual service user. **4.** 'Third Party' organisations seeking information other than for direct care should be seeking anonymised or pseudonymised data. **5.** Any proposed use must be of clear general good or of benefit to service users. **6.** Organisations should not collect secondary data on service users who opt out by specifically refusing consent. **7.** Service users and/or service user organisations should be involved in the development of any project involving the use of confidential information and the associated policies. **8.** To assist the process of pseudonymisation, the Health and Care Number should be used wherever possible.	**1.** Data should be processed fairly and lawfully. **2.** Data should be processed for limited, specified and lawful purposes and not further processed in any manner incompatible with those purposes. **3.** Processing should be adequate, relevant and not excessive. **4.** Data must be accurate and kept up to date. **5.** Data must not be kept longer than necessary. **6.** Data must be processed in line with the data subject's rights (including confidentiality rights and rights under article 8 of the Human Rights Act). **7.** Data must be kept secure and protected against unauthorised access. **8.** Data should not be transferred to other countries without adequate protection.	**1.** Justify the purpose(s) for using confidential information. **2.** Only use it when absolutely necessary. **3.** Use the minimum that is required. **4.** Access should be on a strict need-to-know basis. **5.** Everyone must understand his or her responsibilities. **6.** Understand and comply with the law.

[1] These principles must be followed by health and social care organisations when considering use and disclosure of service user information.
[2] Code of Practice, paragraph 3.17.
[3] PDG Principles are adopted from the Caldicott Principles established in England and Wales.

PUBLIC HEALTH AGENCY BOARD PAPER

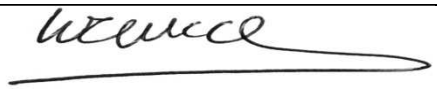
Date of Meeting	18 June 2015
Title of Paper	Gifts and Hospitality Policy
Agenda Item	13
Reference	PHA/07/06/15

Summary

The purpose of the Gifts and Hospitality Policy is to ensure that the PHA meets its obligations under all relevant legislative requirements and associated guidance, in particular the Bribery Act 2010

The PHA Gifts and Hospitality Policy was originally developed and approved in 2012 and has now been reviewed in May 2015. There has been no change to any of the detail of the policy, however it was noted that a paragraph on Equality and Human Rights was missing and this has now been included in the policy).

The policy has also been updated to record that it will be reviewed by 31 March 2019 at the latest, or earlier if relevant new guidance is issued.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This Policy was approved by AMT on 2 June and by the Governance and Audit Committee on 10 June.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	10 June 2015

GIFTS AND HOSPITALITY

POLICY

Version	**2.0**
Date version 1 approved by PHA board	**18/10/12**
Review completed	**21/05/15**
Reviewed policy approved by AMT	
Reviewed policy approved by GAC	
Scheduled review date	**31/03/19**

CONTENTS

1.0 INTRODUCTION

The purpose of the Gifts and Hospitality Policy is to ensure that the Public Health Agency (PHA) meets its obligations under all relevant legislative requirements and associated guidance, in particular the Bribery Act 2010.

All decisions by PHA staff on the acceptance or provision of gifts and hospitality must be able to withstand both internal and external scrutiny. The Gifts and Hospitality policy is intended to provide advice to all PHA staff who may, in the course of their day-to-day work or as a result of their employment, receive offers of gifts, hospitality or considerations of any kind from contractors, agents, organizations, firms or individuals. The policy also provides advice on the provision of gifts and hospitality to others on behalf of the PHA.

The policy should be read in conjunction with: Section 6 of PHA's Standing Orders "Code of Conduct and Code of Accountability"; Standing Financial Instructions 12.2.6(d) and 18 and; the PHA Code of Conduct (January 2011).

The Gifts and Hospitality policy is part of the PHA's overall Governance Framework and is one of the key requirements of the Controls Assurance Standards established by the Department of Health, Social Services and Public Safety (DHSSPS).

All offers of gifts, hospitality or invitations either accepted or rejected must be recorded in the Gifts and Hospitality Register as set out in this policy.

2.0 GIFTS

2.1 Acceptance of Gifts

The general principle is that all gifts offered should be refused. Token gifts (generally at Christmas) of low intrinsic value, such as diaries or calendars, may be accepted from persons outside the PHA with whom staff have regular contact. At present a value of less than £50 is used as a guide to identifying gifts of low intrinsic value but the nature or number of gifts may mean that items whose value is less than this may be considered inappropriate. The number of gifts accepted shall be limited within any financial period.

Apart from trivial/inexpensive seasonal gifts such as diaries, no gift or hospitality of any kind from any source should be accepted by anyone involved in the procurement or monitoring of a contract. This will ensure that no criticism can be made regarding bias to a particular company or supplier.

More expensive or substantial items, valued at £50 or more, and gifts of lottery tickets, cash, gift vouchers or gift cheques cannot, on any account, be accepted. All gifts offered, even if they are declined/returned, need to be recorded in the register.

If in doubt, staff should decline a gift or consult their Line Manager/Director before accepting it.

2.2 Gifts Received in Recognition of Work Done

On no account should a gift or gratuity be solicited or requested. Where gifts by the way of gratuities, vouchers or book tokens for lectures, broadcasts or similar occurrences are offered, their acceptance should be based on how much of the preparatory work for the event was done in the employee's own time, how much in official working time and the extent to which PHA resources, other than for example, use of an officially issued laptop at home, were used in the preparation. The following guidelines should be applied:

a) If the preparation was carried out entirely in the individual's own time and the event took place outside normal working hours at no expense to the PHA, it would be acceptable for the individual officer to retain the token or other gift.

b) If the preparation was carried out wholly in PHA time, with the use of PHA resources, no gifts or fee should be accepted unless the event took place outside normal working hours when a gift or token up to the value of £50 is acceptable.

c) If the preparation was carried out and the event attended in an officer's own time but PHA facilities were used for typing, preparation of presentation material etc, then a gift or token to the value of not more than £50 is acceptable.

In the case of either (b) or (c), the PHA can, if it so chooses, charge the organisation or body a fee based on the salary costs of the individual and/or the use of resources. If a series of gifts from the same source exceed the monetary limits set out above the same rules apply.

2.3 Trade, Loyalty or Discount Cards

Trade, loyalty or discount cards, by which an officer might personally benefit from the purchase of goods or services at a reduced price are classified as gifts and should be politely declined and, if already accepted, returned to the sender and recorded in the register. The pro-forma to be used are included at Appendix 1 Gift/Hospitality Approval Form and also at Appendix 2 Template for Return of Offer of Gift/Hospitality.

While Frequent Flyer cards from airlines can be used by staff to avail of special departure lounges and priority booking and check-in, staff must not make personal use of any flights/air miles, which derive from flights paid for from the public purse.

2.4 Provision of Gifts by PHA

Occasionally the PHA may wish to make a small presentation to speakers or other volunteers in acknowledgement of services provided to the PHA. Such gifts or awards should be of a token nature and should certainly not exceed £50 in value. Prior approval for the provision of gifts or awards is required from the appropriate Director and such approval should be formally documented.

3.0 AWARDS OR PRIZES

Staff should consult their Director or the Director of Operations if they are offered an award or prize in connection with their official duties. They will normally be allowed to keep it provided:

- there is no risk of public criticism;
- it is offered strictly in accordance with personal achievement; and
- it is not in the nature of a gift nor can be construed as a gift, inducement of payment for publication or invention to which other rules apply.

4.0 HOSPITALITY

4.1 Acceptance of Hospitality

The handling of offers of hospitality is recognised as being much more difficult to regulate but it is an area in which staff must exercise careful judgment. In exercising this judgement it is acknowledged that there can be difficulty in distinguishing between a “gift” and “hospitality”. It is also recognised that it can be as embarrassing to refuse hospitality as it can be to refuse a gift.

The acceptance of what would be accepted as conventional hospitality, for example working lunches should, in the main, cause no problem provided that it is limited to isolated occasions and its acceptance is in the interests of the PHA. Hospitality which would not be acceptable, includes invitations to frequent or more expensive social functions where there is no direct link to official business (sporting events, the theatre etc) particularly where these come from the same source, and those which involve travel, hotel or other subsistence expenses.

There may also be instances where staff receive invitations to events run by voluntary organisations such as Annual Conferences or Dinners. Attendance at such events is considered an integral element in building and maintaining relationships with these sectors and any hospitality received is likely to be reasonable and proportionate, and therefore acceptable.

It is particularly important to ensure that the PHA is not over represented at an event or function and care should be taken to ensure that this does not happen, for example, by enquiring from the host as to other staff who have received similar invitations. To guard against the multiple acceptance of invitations to the same event, the PHA should make reasonable checks to ensure that corporate consideration is given to all invitations.

In accepting hospitality staff need to ensure that it places no obligation or perceived obligation on them, and be aware of, and guard against, the dangers of misrepresentation or perception of favouritism by a competitor of the host.

4.2 Provision of Hospitality

The provision of hospitality from public funds should be carefully considered and capable of being justified as reasonable in the light of general practice in the public sector. The use of restaurants for entertaining guests or for conferences or seminars will only be appropriate in exceptional circumstances and will require the approval of the Chief Executive.

The provision of external hospitality should be modest and appropriate to the circumstances. In all instances, the expenditure involved must constitute good value for money.

Hospitality should not be offered solely as a return gesture or be automatically recurrent on a regular basis unless circumstances indicate that it is appropriate to do so. The use of public monies for hospitality purposes at conferences and seminars should be carefully considered, as the PHA must be able to demonstrate good value in committing public funds. Approval should be sought in advance from the appropriate Line Manager or Director.

4.2.1 Celebratory Events

There may be justification for some hospitality expenditure on celebratory events designed to provide recognition of good performance, successful innovations etc. Financial support may be provided for such events as long as there is due regard for efficiency, economy and public confidence, and only with the explicit approval of the Chief Executive.

4.2.2 Venues

Venues for conferences, training, away days, larger gatherings and so on should ideally be on HSC premises. There are several good venues within the wider public sector (including local government) which should be used in preference to private sector venues. Hotels and other private accommodation should only be used if there is no viable alternative and after following appropriate procurement procedures, and in any such case a justification should be submitted to the relevant Director.

Events organized should not include the provision of dinners or overnight stays unless there are highly exceptional reasons.

4.2.3 Hospitality Expenditure

All hospitality expenditure should be identified as such by the requisitioner/ authorizing officer so that it can be allocated to specific financial coding to assist in the collation of management information and to facilitate the monitoring and control of the use of this facility.

5.0 REPORTING GIFTS AND HOSPITALITY OFFERED BY EXTERNAL ORGANISATIONS AND APPROVAL PROCESS TO BE FOLLOWED

In all instances where hospitality (other than conventional hospitality such as infrequent working lunches) is offered by external organisations, this should be declared and the approval of the Director sought using the form at Appendix 1 Gift/Hospitality Approval Form, which should be copied to the Chief Executive and Committee Manager to record in the Gifts and Hospitality Register.

If the recipient has, or will, reject the offer of hospitality they only need to send details to their Line Manager for inclusion in the Gifts and Hospitality Register. Appendix 1 Gift/Hospitality Approval Form should be used to record the offer of a gift, hospitality or invitation and Appendix 2 Template for Return of Offer of Gift/Hospitality should be used to return it to the provider.

All offers of gifts, hospitality or invitations either accepted or rejected must be recorded in the Gifts and Hospitality Register.

6.0 ROLES AND RESPONSIBILITIES IN RELATION TO THE ACCEPTANCE OF GIFTS AND HOSPITALITY

6.1 Public Health Agency

The PHA adopted the Code of Conduct and Code of Accountability as part of its Standing Orders at its meeting on 1 April 2009. These are reviewed on an annual basis and approved by the PHA board. The Code states that

> *"Public service value, must be at the heart of the National Health Service. High standards of corporate and personal conduct….have been a requirement throughout the NHS since its inception."*

The PHA is committed to ensuring that it fully discharges its responsibility for the proper stewardship of public funds in all aspects of Health and Social Care. As with all public expenditure, provision of hospitality expenditure should represent value for money and be incurred in accordance with the principles of regularity and probity.

6.2 Governance and Audit Committee

The Governance and Audit Committee will periodically review the PHA's Gifts and Hospitality Register and provide general advice on good practice.

6.3 Chief Executive

As Accounting Officer, the Chief Executive of the PHA has a personal responsibility for: the propriety and regularity of the public finances for which he is accountable; the keeping of proper accounts; prudent and economical administration; the avoidance of waste and extravagance; and the efficient and effective use of available resources.

6.4 Directors

Directors are responsible for implementing the Gifts and Hospitality Policy and ensuring that the policy is drawn to the attention of all staff within their Directorates. In compliance with circulars FD (DFP) 19/09 and DAO (DFP) 10/06 revised as at 3 Sept 2009, each Director has a responsibility to ensure that all staff within their Directorate record the receipt of any gifts or hospitality in the Corporate Gifts and Hospitality Register.

6.5 Director of Operations

The Director of Operations has lead responsibility for the Gifts and Hospitality Policy in the PHA, ensuring that guidelines are in place in respect of the provision of gifts or hospitality, and that any possible conflicts of interest are identified and appropriate action taken to resolve them. If there is any doubt on the receipt and/or disposal of hospitality and gifts received, this should be referred to the Director of Operations.

He/she is responsible for ensuring the submission of a periodic report on the PHA's Gifts and Hospitality Register to the Governance and Audit Committee and for including a reference to the Gifts and Hospitality Register on the PHA website.

6.6 Line Managers

Line Managers should be satisfied that any expenditure on gifts and hospitality incurred is in the best interest of the PHA, provides value for money and complies with current policies and guidelines. Line Managers should ensure that all staff comply with current guidance on the acceptance of hospitality.

6.7 Employees

It is the responsibility of all staff to adhere to this policy. Any recipient of gifts or hospitality must complete the 'Gifts/Hospitality Approval Form' (Appendix 1) for inclusion in the Gifts and Hospitality Register.

Employees must not use public resources for personal benefit or receive benefits in kind from a third party which may be seen to compromise their judgement or integrity. When in doubt about accepting a gift, hospitality or an invitation, staff should consult with their Line Manager or Director.

Any breach of the rules of conduct can lead to disciplinary action and in some circumstances can be a criminal offence.

6.8 Internal Audit (Business Services Organisation)

Internal Audit has a role in the monitoring of compliance against policy and guidance.

7.0 RECORD OF GIFTS, HOSPITALITY, INVITATIONS ETC

The PHA will maintain a Gifts and Hospitality Register which will be available for periodic review. This Register is held by the Chief Executive's Office and Committee Manager.

All completed forms should be forwarded to the Chief Executive's Office and Committee Manager who will maintain the Register.

This Gifts and Hospitality Register will be presented to the Governance and Audit Committee for review annually.

8.0 EQUALITY AND HUMAN RIGHTS CONSIDERATIONS

8.1 Equality

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were no negative impacts on any grouping. This policy will therefore not be subject to an Equality Impact Assessment.

8.2 Human Rights

This policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

This policy will be included in the PHA's Register of Screening documentation and maintained for inspection whilst it remains in force**.**

This document can be made available on request in alternative formats and in other languages to meet the needs of those who are not fluent in English.

9.0 REVIEW OF POLICY

The PHA is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.

This policy will be reviewed by the Director of Operations on 31 March 2019 or earlier if relevant guidance is issued. That review will be noted on a subsequent version of this policy, even where there are no substantive changes made or required.

APPENDIX 1

HSC Public Health Agency

GIFT/HOSPITALITY APPROVAL FORM

PART 1 – To be completed by recipient of gift/hospitality

Gift / Hospitality Authorisation Form	
Name of person to whom offer made:	
Date of event or gift offered:	
Name of originator of offer:	
Description of offer and reason:	
Estimated/actual value of offer:	
State whether the offer was declined:	
Is there a current/potential contract with the donor? If yes, provide details:	
Signature of recipient:	Signed: Date:

PART 2 – To be completed by the Director

Gift / Hospitality Authorisation Form (Outcome)	
Decision: (Approved/Not Approved)	
Reason why approval has/has not been granted:	
Is gift being returned? (If so, letter as per Appendix 2 should be used)	
Has the gift been used or disposed of? If so, give details:	
Has the gift been donated to a nominated charity?	
Has the Gifts and Hospitality register been updated?	
Signature of the Director:	Signed: Date:

Please return completed form to the Chief Executive Office/Committee Manager

HSC Public Health Agency

TEMPLATE FOR RETURN OF OFFER OF GIFT/HOSPITALITY

(The content of this template should be tailored to suit each circumstance)

Contact name

Contact details etc

Date

Dear

The Public Health Agency operates a Gift and Hospitality Policy to ensure high standards of propriety in the conduct of its business.

On account of public confidence, perception is as important as reality and because of this I am obliged to return your kind offer of……..

This is not meant in any way to offend or imply that your [gift/hospitality] was offered in anything but the utmost of good faith, but is designed to protect both individual members of staff and the Public Health Agency. I hope you will accept our response in that spirit and that we can look forward to continued effective working relationships.

Yours …….

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	18 June 2015
Title of Paper	Annual Progress Report 2014/15 to the Equality Commission
Agenda Item	14
Reference	PHA/08/06/15

Summary

This paper presents the draft annual progress report to the Equality Commission on implementation of Section 75 and the duties under the Disability Discrimination Order. The submission deadline is 31 August 2015.

Board members will note the new format of the report, reflecting the revised reporting template by the Equality Commission.

The report showcases a wealth of PHA initiatives that are likely to produce tangible benefits for a range of Section 75 groups. It also highlights a series of projects that clearly demonstrate close engagement and consultation with the voluntary sector.

Much effort has been invested during the year by staff across a number of divisions in giving careful consideration to the equality implications of their work – in particular in the context of procurement decisions. Considerable progress has been made in relation to equality screenings and staff are commended for this. Likewise, monitoring activities have been advanced by integrating the collection of equality monitoring data into contracted services.

With regards to the particular questions asked in the annual progress report, the following points are drawn to the attention of Board members:

- only two equality screenings were published during 2014-15 (both relate to corporate documents), a gap thus remains in bringing screenings to a close and publishing these (as required under Section 75)
- only one Equality Impact Assessment (EQIA) was undertaken, in conjunction with the HSCB (eHealth)
- all equality screenings undertaken to date by the PHA have been screened out for EQIA – this remains a concern, not least in light of feedback issued previously by the Equality Commission
- no monitoring has been undertaken to date of policies previously equality screened.

In conclusion, it is proposed that, building on the considerable momentum created in 2014-15, efforts in 2015-16 are focused on:

- undertaking equality screenings (in particular upstream at points of strategic decision-making) and ensuring the timely publication of completed screening

templates
- where relevant undertaking EQIAs and
- undertaking monitoring on policies screened.

In addition, by making small changes to current practices relating to engagement and consultation valuable equality data could be gathered to inform decision-making, namely by:

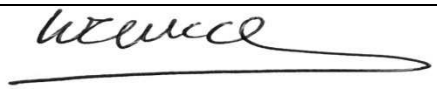
- weaving engagement with Section 75 groups (alongside other voluntary sector groups) into any pre-consultation exercises and integrating relevant equality questions into this engagement
- issuing equality screening documents alongside policy documents in any policy consultations.

To further enhance the practical implementation of Section 75 requirements, PHA will build on the work undertaken with its staff through including identification of screening and impact assessments when preparing directorate and related plans.

The report includes a set of appendices:

- Appendix 1: Equality Action Plan Progress Report 2014-15
- Appendix 2: Screening Report 2014-15
- Appendix 3: Mitigation
- Appendix 4: Equality Action Plan 2013-18 - updated June 2015
  (N.B.: all updates suggested by the respective leads have been highlighted as tracked changes)
- Appendix 5: Disability Action Plan Progress Report 2014-15

Please note: no return was received for Theme 2 (Cancer Screening) of the Equality Action Plan Progress Report 2014-15. In its absence, the report cannot be completed.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was brought to AMT on 9 June 2015.
Recommendation / Resolution	For Approval
Director's Signature	
Title	Director of Operations
Date	10 June 2015

Public Authority Statutory Equality and Good Relations Duties Annual Progress Report 2014-15

Contact:

• Section 75 of the NI Act 1998 and Equality Scheme	Name: Edmond McClean Telephone: 03005550114 Email: edmond.mcclean@hscni.net
• Section 49A of the Disability Discrimination Act 1995 and Disability Action Plan	As above

We receive support services on the implementation of our Section 75 duties from the Equality Unit at the Business Services Organisation. For further information you can contact our equality advisor:
Anne Basten, Equality, Diversity and Human Rights Manager, Business Services Organisation, Anne.Basten@hscni.net 028 9536 3814

Documents published relating to our Equality Scheme can be found at: http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality

Signature:

This report has been prepared using a template circulated by the Equality Commission.

It presents our progress in fulfilling our statutory equality and good relations duties, and implementing Equality Scheme commitments and Disability Action Plans. This report reflects progress made between April 2014 and March 2015

Appendix 1: Equality Action Plan Progress Report 2014-15

Appendix 2: Screening Report 2014-15

Appendix 3: Mitigation

Appendix 4: Equality Action Plan 2013-18 - updated June 2015

Appendix 5: Disability Action Plan Progress Report 2014-15

PART A – Section 75 of the Northern Ireland Act 1998 and Equality Scheme

Section 1: Equality and good relations outcomes, impacts and good practice

1 In 2014-15, please provide **examples** of key policy/service delivery developments made by the public authority in this reporting period to better promote equality of opportunity and good relations; and the outcomes and improvements achieved.

[Please relate these to the implementation of your statutory equality and good relations duties and Equality Scheme where appropriate.]

Please see Table 1 below.

Table 1:

	Outline new developments or changes in policies, practices, service planning or delivery and the difference they have made.
Persons of different religious belief	**Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf
Persons of different political opinion	**Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf
Persons of different racial groups	**Service Development and Screening** • **Newborn Hearing Screening Programme** Translation of pre-screening information leaflets for parents and a corresponding checklist relating to hearing and speech and language development (in 10 languages). These provide information about the screening programme and help parents, whose first language is not English, make informed choices in response to the offer of screening, as well as provide parents with information about relevant developmental milestones and what to do if they have any concerns that their child is not achieving those milestones. • **Cervical Screening Programme**

	New translations of the cervical screening programme leaflets were undertaken and are now available for use. It is anticipated that these will support women for whom English is not their first language to make an informed decision on attending for cervical screening. • **Regional Infectious Diseases in Pregnancy Screening Programme** Translation of infection information leaflets into 11 languages to support women who do not have English as a first language. Liaison between Trust antenatal screening coordinators, the appointments manager in the Royal Victoria Hospital and interpreters to encourage and support pregnant women to attend hepatology appointments. • **Regional antenatal screening** coordinator inputting into the training for new interpreters through presentations and lectures. • A scoping report into the **maternity needs of black and minority ethnic women in Northern Ireland** was produced by Dr Jillian Johnston, PHA. It was disseminated widely following approval by the Chief Medical Officer. This will inform the development of more tailored maternity care for these women. **Health and Wellbeing Improvement** **(1) Minority Ethnic** • Further development of the Northern Ireland New Entrant Service (NINES) which is working toward providing an holistic service for migrants in the southern area. This service will include health checks, screening, health promotion information and advice on how to access mainstream health and social care services. • A three year regional pilot project to improve the mental health and emotional wellbeing of BME communities has been commissioned.

	• A regional BME Carers Sub- group, which operates under the auspices of the regional BME Health and Social Wellbeing Steering group, has, in collaboration with the 5 Trusts, produced a regional leaflet (in 11 languages) aimed at BME carers, which is available on the PHA website. • In addition, the BME Carers Sub- group in collaboration with Trusts, has delivered networking events during March/April 2015 to help identify BME carers and raise awareness of particular health and social wellbeing issues which impact on BME carers. **(2)Travellers** • PHA has commissioned 6 development posts to provide coordination, capacity and support within the Belfast, southern and western localities to improve the health and social wellbeing improvement of Travellers. The proposed model for the service relates to a key recommendation of the All Ireland Travellers Health Study and a key priority outlined in the PHA/HSCB Traveller Health and Social Wellbeing Forum action plan. The work reflects a commitment toward empowering Travellers and supporting their active engagement in all matters which relate to health and wellbeing. The evidence suggests that one of the most successful interventions with Travellers relates to Traveller Health Workers, connecting families to primary care and other targeted services. The context for focus on the health and wellbeing needs of Travellers is based on the Departmental supported All Ireland Travellers Health Study (2009). This, together with other research, highlights that there are huge disparities in life expectancy and other health and wellbeing outcomes for Travellers compared to settled people. Consequently, addressing improvements in the circumstances in which Travellers live and work, as well as progressing a health improvement agenda with Travellers, is of critical importance. In addition, the HSCB/PHA Commissioning Plan requires that “all Trusts should ensure that existing provision is tailored to meet the needs of vulnerable groups including Looked after Children, LGBT and Travellers.”

	• PHA has also commissioned Belfast Trust/Bryson House Roma Health Project to employ two part time officer posts, one community development officer and one Roma lay health worker. The Project ensured the establishment of relationships within the Belfast based Roma and addresses their particular needs through health improvement and promoting access to health and healthcare. **Nursing and Allied Health Professions** • The eHealth and Care Strategy (jointly led by HSCB and the PHA) sets objectives to use technology to support person centred health and social care in Northern Ireland. eHealth technology is a key enabler to support the vital changes in how health and social care is delivered to those groups where language could be a potential barrier to accessing services • The 10,000 Voices Initiative is targeted at men and women generally who have availed of HSC Services. The purpose of the Initiative is to ask patients and clients their experience of the HSC Service they have received in order to shape and inform the design and delivery of future services. Through this survey we ask a range of demographic details (i.e.) gender, age group, ethnicity and sexual orientation. This information is used to ensure that the responses are statistically representative. **Operations** • The Health Intelligence team produced a new Health Intelligence brief on BME census data for PHA staff • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%2

	0-%20Diversity%20data.pdf
Persons of different age	**Service Development and Screening** • The bowel cancer screening programme was extended to include people up to the age of 74 (previously 71) from April 2014. This has increased access to screening for older people and is expected to increase the rate of earlier detection and successful treatment of colorectal cancers in this group. **Research and Development Office** • Research call on dementia -2nd stage - the aim is to improve the evidence base for service planning and delivery for dementia patients (amongst whom older people are highly represented) and their carers and families – ultimately to address key health and wellbeing needs of these groups across the illness trajectory and in different care settings that currently remain unmet. **Health and Wellbeing Improvement** **(1) Older People** • A range of coordinated interventions and services have been developed to reduce the risk of social isolation among older people in all localities. This attention has included the development of 'Age Friendly' environments with the aim of promoting Northern Ireland as an age friendly region. The Belfast Strategic Partnership has prioritised active ageing and an Action Plan is currently being implemented, based on the active engagement of older people. Age Friendly continues to be supported and progressed in the council areas of Derry/Strabane, Omagh/Fermanagh and Limavady. • The Southern Strategic Health Improvement Partnership (SSHIP) continues to support the

	work carried out in all areas to engage older people through 'community conversation' events. Engagement continues with older people in all areas with the development of Local Implementation Groups (LIG) and development of local action plans to address identified needs. The Newry and Mourne Age Friendly Initiative aims to make Newry and Mourne a welcoming and supportive place to grow older. The priorities and concerns of older people have been the driving force behind an intense year of discussions, consultations, and meetings to shape direction of the initiative. • A broader alliance includes representatives in the southern area from a range of organisations, including Council, the Senior Citizens Consortium, U3A, PHA, SHSCT policing, education, housing, churches, transport, and the voluntary sectors. In the northern area engagement with councils continues through the Northern Area Partnership Framework and Local Government Joint Working Arrangements to influence the development of Age Friendly Communities. • PHA continues to work closely with Alzheimer's Association to plan the roll out of Dementia Friendly communities. • PHA continues to work with Artscare NI to engage older people in arts based activities to promote health and wellbeing. Over 250 workshops and 5 Arts and Health festivals have taken place, with over 3,000 older people participating. • The RIPE exhibition at Crescent Arts Centre Belfast showcased the work of emerging artists over the age of 60 who had come to their artwork later in life. • 'In Full Bloom' showcased over 100 Artworks produced by participants from all trust areas which were displayed in the Ulster Hall in Belfast. • 'Aloud, Allowed, Aloud' was the showcase event for all the performance work of the project,

	music, dance and drama and was staged at the Strule Arts centre in Omagh. • PHA continues to work in partnership with Arts Council NI to deliver the Arts and Older People programme. The strategic themes of the programme are loneliness, social inclusion, poverty, health/dementia and advocacy. As part of this programme some 31 grant awards were made to a variety of projects with 3,178 participants taking part. • The Arts and Older People Programme is also developing a portal and website which can be accessed by carers, artists, people living with dementia and decision makers. The portal will encourage engagement regarding the best way to deliver art and creativity programmes for those who have dementia and will also cite emerging research and evidence in the importance of using of art [as a medium for treatment]. • Funding has been awarded to provide training for community artists to develop skills to work with those who have a dementia diagnosis. This is being delivered in eight different care home settings. • Creative Local Action Response & Engagement (C.L.A.R.E.) programme – the PHA has supported the development of an innovative programme in North Belfast which is a new community-led initiative that aims to build the capacity of local people to support vulnerable adults and older people to live independently in caring and responsive communities, achieving better outcomes for clients, volunteers, the community and HSC. **(2) Young People** • Eight One Stop Shops have been commissioned across Northern Ireland, in Ballymena, Carrickfergus, Belfast, Newry, Banbridge, Bangor, Enniskillen and Derry/Londonderry with peripatetic services reaching into the rural hinterlands of these towns. These universal services are based on engagement with young people and services are made more accessible by the use of 'youth friendly' environments. The One Stop Shops target young

	people aged 11- 25yrs and provide a range of services, support and training to address their needs. • The PHA has been working with the SHSCT and Further Education Colleges to develop sexual health services for young people in college settings. Clinics ran in 3 colleges and in Drumglas 16+ centre and continues to expand and develop with clinics planned for 6 colleges in 2015/16. The services offered include a comprehensive contraceptive, STI testing, information / support and treatment service. • The Strengthening Families Programme continues to be delivered in all five HSC Trust areas and is a parenting programme for 12-16 year olds and their families where alcohol and drug misuse is a particular concern. The 14 week programme uses separate structured sessions for parents and children to allow both to work on parenting and life skills. • Barnardos has been commissioned to provide support for young people experiencing the effect of parental alcohol abuse, as well as family support services in 2014/15. This entailed one to one therapeutic support for young people and parents, group work and residentials for the young people experiencing 'hidden harm'. • In 2014/15 the PHA, in partnership with the Southern Education and Library Board (SELB), provided funding for GCSE support for pupils who were expected to achieve Grade D to help them attain grades A*-C in English or Mathematics. 13 schools availed of the funding. The success of the programme will be determined following release of GCSE grades in August 2015. **Nursing and Allied Health Professions** • The eHealth and Care Strategy (jointly led by HSCB and the PHA) sets objectives to use technology to support person centred health and social care in Northern Ireland. eHealth technology is a key enabler to support the vital changes in how health and social care is

	delivered. For older people the use of technology may support them to live independently. For younger people technology enabled access to HSC resources may be seen as advantageous. • Dementia Strategy – investment into memory services including the recruitment of Dementia Navigators which 1. Enhance the number of memory clinics sessions available. 2. Improve the experience of this group as they navigate through the various statutory community and voluntary services. This should direct people to the correct service in a more timely manner. • The 10,000 Voices Initiative is targeted at men and women generally who have availed of HSC Services. The purpose of the Initiative is to ask patients and clients their experience of the HSC Service they have received in order to shape and inform the design and delivery of future services. Through this survey we ask a range of demographic details (i.e.) gender, age group, ethnicity and sexual orientation. This information is used to ensure that the responses are statistically representative. **Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf
Persons with different marital	**Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%2

status	0-%20Diversity%20data.pdf
Persons of different sexual orientation	**Health and Wellbeing Improvement** • On-going support for the LGB&T HSC Staff Forum continues. A dedicated website www.lgbtstaff.hscni.net has been launched and provides a source of information for LGB&T staff working across all HSC Organisations. In June 2014 the LGB&T HSC Staff Forum won Healthcare People Management Award (HPMA) for work in partnership with Human Resources and Trade Union organisations. The current Chair of the HSC Staff Forum facilitated a workshop at the BSO Annual Equality Conference in February 2015. • The PHA Director of Public Health Report 2013 focused on the theme of Diversity and included key health intelligence relating to Sexual Orientation. • The Public Health Scientific Conference in June 2014 focused on the theme of Diversity and included members of the LGB&T community in the conference planning group and on the conference programme. Three of the parallel sessions focused on specific programmes focused on addressing the needs of the LGB&T community. “Don’t Leave it to chance” – a sexual heath campaign targeting Men who have Sex with Men (MSM) and “See me, hear me, know me”, guidelines to support the needs of older LGB&T people; and the lgbt elearning programme http://www.lgbtelearning.hscni.net – “Creating inclusive workplaces”. • The MSc in Public Health included a session on LGB&T Health under the theme of Vulnerable Groups. A presentation on the LGB&T Regional Thematic Action Plan was delivered as well as input from The Rainbow Project relating to Sexual Health programmes. • The PHA has been working with the Rainbow Project and colleagues in BSO to take forward the Diversity Champions Northern Ireland programme. The programme enables organisations to be recognised as having equality and diversity policies and practices on

	LGB&T issues as well as promoting inclusive workplace cultures. As part of the process a review of all HR Policies, which have been benchmarked against best practice, has taken place as well as training for key personnel from HR and Equality Units within the PHA, BSO and others from across the wider HSC family which was really well received. • An LGB&T subgroup of the Children and Young People Strategic Partnership was established and includes representation from LGB&T sector organisations such as The Rainbow Project, HSC Trusts, HSCB, Department of Education and the Northern Ireland Anti-Bullying Forum. The group, which is chaired by PHA, has developed an Action Plan which includes a range of actions to help address the issues impacting on the lives of young people who identify as Lesbian, Gay, Bisexual and Transgender. • PHA has also worked with professional groups to address the needs of the LGB&T community. In March 2015, the Royal College of General Practitioners NI launched guidelines, one of which was to support the care of Lesbian, Gay and Bisexual Patients in Primary Care. • These guidelines, which were supported by the PHA, involved a number of key stakeholders including members of the LGB&T communities such as The Rainbow Project, HERe NI and Support Acceptance, Information, Learning (SAIL). • PHA has commissioned The Rainbow Project to provide a range of services in each PHA locality across Northern Ireland for LGB+T clients, including counselling, information workshops, personal development courses, training courses for service providers, production and distribution of safer sex packs and outreach in clubs and bars frequented by LGB&T people. Furthermore, the Rainbow Project, in the southern area specifically, has: • Provided counselling, group work sessions and personal development courses to

	individuals who are LGB&T • Distributed safer sex packs to MSM at sites and venues • Provided training for counsellors from within the southern area on Gay Affirmative Therapy and co-cultural counselling • Provided workshops for health professionals on LGB&T Health and Social Wellbeing issues • Provided 'rapid testing' for HIV and syphilis for MSM The PHA in the southern area commissioned Positive Life to: • Provide a free confidential helpline and telephone support service for individuals with living with HIV • Provide one to one support and counselling to those affected by HIV on a wide range of issues whether via telephone or in person • Provide a range of complimentary therapy sessions to those affected by HIV • Facilitate peer support groups for men and women living with HIV • Provide support programmes for newly diagnosed clients (N.B. HIV is experienced by both heterosexual and homosexual individuals) **Nursing and Allied Health Professions** • The 10,000 Voices Initiative is targeted at men and women generally who have availed of HSC Services. The purpose of the Initiative is to ask patients and clients their experience of the HSC Service they have received in order to shape and inform the design and delivery of future services. Through this survey we ask a range of demographic details (i.e.) gender, age group, ethnicity and sexual orientation. This information is used to ensure that the responses are statistically representative.

	Operations • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf • The Health Intelligence team updated the Health Intelligence brief on Lesbian, Gay and Bisexual people for PHA staff.
Men and women generally	**Service Development and Screening** • A scoping report into the **maternity needs of black and minority ethnic women** in Northern Ireland was produced by Dr Jillian Johnston, PHA. It was disseminated widely following approval by the Chief Medical Officer. This will inform the development of more tailored maternity care for these women. **Health and Wellbeing Improvement** • In March 2015 the Royal College of General Practitioners NI launched guidelines to support the care of Trans* Patients in Primary Care. These guidelines which were supported by the PHA involved a number of key stakeholders including members of the Transgender community and the Gender Identity Clinic. • The MSc in Public Health included a session on LGB&T Health under the theme of Vulnerable Groups. A presentation on the LGB&T Regional Thematic Action Plan was delivered as well as input from the Gender Identity Clinic which included developments rerating to services to support Gender Variant Children and Young People and Transgender adults in Northern Ireland.

	• On-going support for the LGB&T HSC Staff Forum continues. A dedicated website www.lgbtstaff.hscni.net has been launched and provides a source of information for LGB&T staff working across all HSC Organisations. In June 2014 the LGB&T HSC Staff Forum won Healthcare People Management Award (HPMA) for work in partnership with Human Resources and Trades Union organisations. The current Chair of the HSC Staff Forum facilitated a workshop at the BSO Annual Equality Conference in February 2015. • The PHA Director of Public Health Report 2013 focused on the theme of Diversity and included key health intelligence relating to Gender Identity. • The Public Health Scientific Conference in June 2014 focused on the theme of Diversity and included members of the LGB&T community in the conference planning group and on the conference programme. Two of the parallel sessions focused on specific programmes focused on addressing the needs of the T community alongside the LGB community: “See me, hear me, know me”, guidelines to support the needs of older LGB&T people; and the lgbt elearning programme – “Creating inclusive workplaces”. • The PHA has been working with the Rainbow Project and colleagues in BSO to take forward the Diversity Champions Northern Ireland programme. The programme enables organisations to be recognised as having equality and diversity policies and practices on LGB&T issues as well as promoting inclusive workplace cultures. As part of the process a review of all HR Policies which have been benchmarked against best practice has taken place as well as Training for key personnel from HR and Equality units within the PHA and BSO and others from across the wider HSC family which was really well received. • An LGB&T subgroup of the Children and Young People Strategic Partnership was established and includes representation from LGB&T sector organisations SAIL, HSC Trusts, HSCB, Department of Education and the Northern Ireland Anti-Bullying Forum. The group, which is chaired by PHA, has developed an Action Plan which includes a range of

	actions to help address the issues impacting on the lives of young people who identify as Lesbian, Gay, Bisexual and Transgender. • Furthermore, the Rainbow Project in the southern area specifically, has provided counselling, group work sessions and personal development courses to individuals who are Trans (alongside those who are lesbian, gay or bisexual). Likewise, workshops have been provided for health professionals on Health and Social Wellbeing issues for Trans people, alongside those who are lesbian, gay or bisexual. **Nursing and Allied Health Professions** • The 10,000 Voices Initiative is targeted at men and women generally who have availed of HSC Services. The purpose of the Initiative is to ask patients and clients their experience of the HSC Service they have received in order to shape and inform the design and delivery of future services. Through this survey we ask a range of demographic details (i.e.) gender, age group, ethnicity and sexual orientation. This information is used to ensure that the responses are statistically representative. **Operations** • The Health Intelligence team updated the Health Intelligence brief on Trans people for PHA staff. • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf
Persons	**Service Development and Screening**

with and without a disability	• Ongoing progression of an initiative to ensure learning disabled men who are eligible for screening are able to make an informed decision about whether or not to attend for screening. Too early to report on final outcomes at present. • Production of Audio CDs and braille versions of initial screening invitation leaflet and the three screening results leaflets on NI Abdominal Aortic Aneurysm Screening Programme website for men with a visual impairment. In process of identifying a mechanism for establishing impact of initiative. • A new alternative pathway was introduced into the bowel cancer screening programme for people with a visual or physical disability. The alternative pathway seeks to simplify as far as possible the sample collection method required with the home test kit for those who may have reduced visual acuity or dexterity. The pathway involves the use of two kits and fewer samples. A new leaflet has been developed to support the pathway. • New patient information videos were developed for the cervical and bowel cancer screening programmes to promote informed choice. The videos explain the screening pathways and are available in subtitled and sign-language versions to improve access to information for those with a hearing impairment. **Research and Development Office** • Research call on dementia – 2nd stage-the aim is to improve the evidence base for service planning and delivery for dementia patients (who fall under the definition of disability) and their carers and families – ultimately to address key health and wellbeing needs of these groups across the illness trajectory and in different care settings that currently remain unmet

	Health and Wellbeing Improvement • The Regional Health and Social Wellbeing Improvement Forum (one of three work-streams of the Regional Learning Disability Health Care and Improvement Steering Group) has developed a 2 year work-plan to deliver / implement on the Health & Social Wellbeing Improvement recommendations and actions contained in the regional Learning Disability Health Care & Improvement Steering Group's Action Plan. The Regional Health & Social Wellbeing Improvement Forum's Action Plan was approved by the Regional Learning Disability Health Care and Improvement Steering Group in July 2014. Examples of Impacts, Outcomes and Good Practice include: • 80% of Health Facilitators across the five Trusts received Smoking Cessation Brief Intervention Training by 31 March 2015. The training of the remaining 20% in this area is planned for the April – June 2015. • The Step by step for health, fitness and fun walking booklet for people with a learning disability was published by the PHA in March 2015. 1000 copies of the booklet have been sent to each of the Physical Activity co-ordinators in the Health & Social Care Trusts. • The 'Cook It' programme was adapted and a resource guide developed for those with learning disabilities by the PHA in 2014/15. The practical tool kit provides training for tutors and includes recipe cards in user friendly formats. These will be available from April 2015. • The PHA, in conjunction with the Northern Health & Social Care Trust, has developed a pictorial information leaflet about Type 2 Diabetes for people with a Learning Disability. • 'On Yer Bike' programme funded to allow Cedar Foundation to support people with differing disabilities and needs aged between 16-65 years, to get involved in accessible cycling.

	• ‘Learn to Cycle’ programme funded to enable Autism Initiatives to create an opportunity for children aged 5 - 15 years old with a diagnosis of ASC to participate in an innovative Autism specific “Learn to Cycle‟ programme. As part of Active Schools programme, Autism Initiatives NI provided training to Sustrans staff who deliver the programme currently in 120 primary schools. The PHA is represented on the Health and Social Care Board led Physical and Sensory Disability Strategy Group, to progress initiatives which relate to the objective ‘Examine how disabled people can be targeted in future health promotion initiatives’. Action has included: • The PHA has a contract with Action on Hearing Loss in partnership with HSCB. Campaigns that have been taken forward during 2014/15: o ‘Damage’ campaign. This is designed to raise awareness among young people of the dangers of overexposure to loud music and the consequences for their hearing. This includes a social media campaign and engagement with relevant digital platforms – due to complete in May 2015. o ‘Isolation Campaign’. This outdoor poster campaign was delivered through billboards and adshels throughout N.I. and encouraged people with unaddressed hearing loss and their families to take action to address their hearing loss. A local radio advertising campaign also accompanied this through local stations throughout Northern Ireland. The disability checklist continues to be a work in progress. It is intended that the development of a checklist/screening document which will act as a prompt for anyone planning a health resource/campaign etc – to ensure that the needs of people with physical and sensory disabilities have been taken into consideration. A wide range of HSC documents pertaining to accessible communication accessible formats

	and portrayal of people with disabilities are in existence and are located in a range of different departments and organisations. Early discussions are underway to develop a portal so that these documents (which include publications such as 'Making Communication Accessible' and 'Guidance on the positive portrayal of Disabled People') can be put into the one accessible place. **Nursing and Allied Health Professions** • The 'implementing recovery through organisation change' programme in mental health has resulted in changing day to day interactions and quality of service user experience through:- 1. the development of mental health service team recovery implementation plans 2. redefining service user involvement 3. the establishment of recovery colleges in every Trust area using a hub and spoke model 4. delivering comprehensive user-led education and co-produced training programmes 5. transforming the workforce, by the establishment of 18 posts for people with lived experience as peer support workers in acute in patient and community mental health teams. • The eHealth and Care Strategy (jointly led by HSCB and the PHA) sets objectives to use technology to support person centred health and social care in Northern Ireland. The aim is to enhance the care and support given to those people with disabilities and their carers and families care through the use of enabling technology. • Direct Access Physiotherapy. The aim is to enable patients to self-refer for musculoskeletal conditions. This has Positive impacts for people with a disability who will be able to access physiotherapy.

	Operations • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf • Website development reflects best practice in relation to accessibility, eg sub-titles for online videos **Health Protection** • Production of a suite of patient and visitor information leaflets in alternative formats. There were nine leaflets in total: Hand Hygiene, Healthcare Associated Infections, Extended spectrum beta lactamase (ESBL) bacteria, Multi-drug resistant bacteria, Scabies, Laundry advice, Norovirus, Clostridium difficile and MRSA. These are all available in accessible formats. Accessible formats are alternatives to printed information, used by people who are blind or visually impaired. These accessible formats include HTML, audio and braille.
Persons with and without dependants	**Research and Development Office** • Research call on dementia –2nd stage- the aim is to improve the evidence base for service planning and delivery for dementia patients and their carers and families – ultimately to address key health and wellbeing needs of these groups across the illness trajectory and in different care settings that currently remain unmet **Nursing and Allied Health Professions** • The eHealth and Care Strategy sets objectives to use technology to support person centred health and social care in Northern Ireland. The aim is to enhance the support for

	those people with dependents using technology and improving information with HSC. **Operations** • Supporting tables on diversity for Directorate of Public Health conference – published on PHA website for use by the PHA and partner organisations. http://www.publichealth.hscni.net/sites/default/files/PHA%20Annual%20Report%202013%20-%20Diversity%20data.pdf

Engagement on Development of the Corporate Strategy 2016-2020

Engagement events to discuss possible PHA priorities for 2016-2020 were held and measures put in place to invite and include representatives from section 75 groups. Invitations were circulated through the equality consultation list including organisations representing section 75 groups and access requirements put in place if required.

Equality conference

In February 2015, the Equality Unit on our behalf held an equality, diversity and human rights conference. The aim of the conference was to explore the business benefits of Equality, Diversity and Human Rights based approaches to health and social care. Around 80 delegates from across Health and Social Care (HSC) and the community and voluntary sector attended the conference and heard inputs from service users, staff working in health and social care as well as external inputs from the legal and private sector. Participants also attended and participated in a range of workshops. One member of PHA staff delivered a workshop on the HSC Lesbian, Gay, Bisexual and Trans (LGB&T) staff forum.

Equality monitoring

During the year, we worked with the Equality Unit and our partners to develop a generic template for equality monitoring in relation to services. The aim of the work is to improve data quality, achieve greater consistency in the data collected and promote best practice. To support staff involved in data entry, an associated coding scheme was developed.

Likewise, a first draft of a young people's template was produced for comment and engagement with young people and those working in the field.

Prompts to staff on completing equality information on the new Human Resources systems, the HRPTS, were issued at several times during the year.

Accessible Formats Policy – toolkit for staff

We introduced an accessible formats policy and provided staff with access to a toolkit to support them in delivering on the commitments made in the policy. This included awareness materials for staff and managers. We also developed a database to record and monitor our decision-making relating to accessible formats.

We also continued to play an active part in the contract adjudication group for the Regional Contract for the Provision of Interpreting and Translation Services.

Good Relations Statement

Together with our partners, facilitated by the Equality Unit, we developed a draft wording of a good relations statement and commenced engagement with the trade unions.

Trans Employment Policy

We progressed the development of a trans employment policy during 2014-15 jointly with colleagues from the HSC Trusts. To date, this has involved drawing on good practice in GB and engaging with regulators in relation to their practices regarding trans registrants. Close engagement with trans people and organisations is planned for 2015-16.

Bulletins, newsletter, senior briefings, intranet and email

We provided our staff with information in the form of emails and features on our intranet. These focused on the following:

- International Day of Action Against Homophobia and Transphobia update
- Good Relations Week
- Signpost Resource
- World Sight Day
- NI Human Rights Festival
- Depression Awareness Day Video and 4-page Feature
- Equality Conference.

In addition, a number of senior briefings were provided on the following areas:

- Accessible Formats Policy and Support Materials
- Good Relations Statement
- Diversity in Public Appointments Briefing
- Disability Action Plan Year 2 Actions and Training Commitments
- Disability Awareness Days updates
- Equality Conference Updates
- Step by Step Guide to Screening
- Staff Monitoring Guide
- Service Monitoring Template
- Racial Equality Strategy Briefing
- Promoting Compliance and Good Practice in Screening

- Positive Portrayal of Disabled People Guide
- ECNI Guidance on Section 75 and Budgets
- Equality and Human RightsTraining Report 2014-2015
- Case Law update.

Positive Portrayal Resource

The Equality Unit on our behalf developed a new resource for staff entitled ‘Guidance on the Positive Portrayal of People with Disabilities’.

The guidance builds on the recognition that as Health and Social Care Organisations we are constantly providing information in many formats, from websites to information leaflets and that it is vital that when producing information consideration is given to the positive portrayal of people with disabilities. The resource provides practical guidance on the use of positive language, images and narratives. A Disability Checklist for Authors accompanies the guidance.

The Equality Unit drew on good practice recommendations and engaged with disability organisations in the development of the resource.

Staff Forum

We have progressed the establishment of a HSC Disability Staff Forum for staff members in our organisation. Whilst initially focused on the 11 HSC regional organisations, including our own, the focus of this Forum had evolved into exploring a regional approach, to include the six Health and Social Care Trusts.

Work with HSC Trust colleagues to develop and agree a workable and effective structure has been completed; resulting in an agreement for each Trust and the HSC regional bodies to form their own Disability Staff Forum, with a regional group to be formed to link the work of the fora and share learning.

A working group has been established to engage staff in HSC regional organisations on the terms of reference of the Staff Forum including membership criteria, meeting times and the like. It is anticipated that work will be completed and the Disability Staff Forum launched in 2015-2016.

Work Placements

We participated in the pilot of a new disability work placement scheme, led by the Health and Social Care Board and the Business Services Organisation. The 26-week placements were facilitated by Supported Employment Solutions, a consortium of seven disability

organisations in Northern Ireland. Unfortunately no match was found for the placement we offered.

Awareness Days

During the year, we featured two disability awareness days across a range of our office locations: World Sight Day on 9th October 2014 and Depression Awareness Day on 26th January 2015. The work sought to raise staff awareness of specific disabilities, how they impact on people, what barriers people experience, and how staff can support colleagues with a specific disability. It also provided staff (including those who care for a person with a disability) with information on what support services are available. On the day, a coffee morning and workshops were held with inputs from voluntary sector groups and service users in several office locations. Likewise, information materials were developed and circulated to staff. A display board was set up in a number of our offices.

2 Please provide **examples** of outcomes and/or the impact of **equality action plans/** measures in 2014-15 (or append the plan with progress/examples identified).

Please see Appendix 1: Equality Action Plan Progress Report 2014-15

3 Has the **application of the Equality Scheme** commitments resulted in any **changes** to policy, practice, procedures and/or service delivery areas during the 2014-15 reporting period? *(tick one box only)*

☐ **Yes** ☐ No (go to Q.4) ☐ Not applicable (go to Q.4)

Please provide any details and examples:

Please see Table 1 under Question 1 for further information. Please also see Appendix 2 and 3: Screening Report 2014-15 and Mitigation.

3a With regard to the change(s) made to policies, practices or procedures and/or service delivery areas, what **difference was made, or will be made, for individuals**, i.e. the impact on those according to Section 75 category?

Please provide any details and examples:

Please see Table 1 under Question 1 for further information. Please also see Appendix 2 and 3: Screening Report 2014-15 and Mitigation.

3b What aspect of the Equality Scheme prompted or led to the change(s)? *(tick all that apply)*

☐ **As a result of the organisation's screening of a policy *(please give details):***

Please see Table 1 under Question 1 for further information.

Please also see Appendix 2 and 3: Screening Report 2014-15 and Mitigation.

☐ As a result of what was identified through the EQIA and consultation exercise *(please give details):*

Not applicable

☐ **As a result of analysis from monitoring the impact *(please give details):***

Please see Table 3 under Question 21 for further information.

☐ **As a result of changes to access to information and services *(please specify and give details)*:**

Please see Table 1 under Question 1 and Table 3 under Question 21 for further information.

☐ Other *(please specify and give details)*:

Not applicable

Section 2: Progress on Equality Scheme commitments and action plans/measures

Arrangements for assessing compliance (Model Equality Scheme Chapter 2)

4 Were the Section 75 statutory duties integrated within job descriptions during the 2014-15 reporting period? *(tick one box only)*

☐ **Yes, organisation wide**

☐ Yes, some departments/jobs

☐ No, this is not an Equality Scheme commitment

☐ No, this is scheduled for later in the Equality Scheme, or has already been done

☐ Not applicable

Please provide any details and examples:

The following wording is included in job descriptions:

- To lead by example to ensure that the PHA demonstrates commitment through its culture and actions, for all aspects of diversity in the population it serves and the staff who provide the services.
- To promote the corporate values and culture of the organisation through the development and implementation of relevant policies and procedures, and appropriate personal behaviour.
- Maintain good staff relationships and morale amongst the staff reporting to him/her.
- Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the PHA.

- Promote the PHA's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for whom he/she has responsibility.

Equality

- To assist the Public Health Agency to fulfil its statutory duties under Section 75 of the Northern Ireland Act 1998, the Human Rights Act 1998, and other equality legislation.

5 Were the Section 75 statutory duties integrated within performance plans during the 2014-15 reporting period? *(tick one box only)*

- ☐ Yes, organisation wide
- ☐ Yes, some departments/jobs
- ☐ No, this is not an Equality Scheme commitment
- ☐ **No, this is scheduled for later in the Equality Scheme, or has already been done**
- ☐ Not applicable

Please provide any details and examples:

To further enhance the practical implementation of Section 75 requirements, PHA will build on the work undertaken with its staff through including identification of screening and impact assessments when preparing directorate and related plans.

6 In the 2014-15 reporting period were **objectives/ targets/ performance measures** relating to the Section 75 statutory duties **integrated** into corporate plans, strategic planning and/or operational business plans? *(tick all that apply)*

- ☐ Yes, through the work to prepare or develop the new corporate plan
- ☐ **Yes, through organisation wide annual business planning**
- ☐ **Yes, in some departments**
- ☐ No, these are already mainstreamed through the organisation's ongoing corporate plan
- ☐ No, the organisation's planning cycle does not coincide with this

2013-14 report

☐ Not applicable

Please provide any details and examples:

In our Business Plan for 2014-15, we included a wide range of objectives directly related to promoting equality and good relations for the Section 75 groups. These included:

(1) Protecting Health

- Successfully implement the 2nd phase of the children's seasonal flu immunisation programme by achieving a 60% uptake rate for all pre-school children aged 2 years old and over and a 75% uptake rate for all primary school children.

(2) Improving health and wellbeing and tackling health inequalities

- Improve long-term outcomes for the children of teenage mothers by continuing to roll out the Family Nurse Partnership Programme, by expanding to the two remaining Trusts and rolling out the new Information System.
- Support implementation of the Early Intervention Transformation programme and parenting programs under Delivering Social Change (DSC).
- Roll out of Infant Mental Health training to HSC and early years workforce.
- Take forward with partners the PHA approach to healthy ageing including: reducing isolation; signposting and referral to services; falls prevention; and health and wellbeing improvement programmes
- Develop and implement the Hidden Harm Action Plan.
- Implement the DHSSPS Obesity Strategy including, weight management programmes for children, adults, and pregnant women; development of a common regional Physical Activity Referral programme; implementation of Active Travel programme in schools; and public information.
- Develop a commissioning plan with agreed standards and commission a range of mental health promotion and suicide prevention services.

(3) Improving the quality of HSC services

- Take forward the Mixed Gender Accommodation work which

provides assurance of gender segregation in inpatient accommodation based on an agreed regional policy statement on gender segregation / gender appropriate accommodation which will be developed in partnership with DHSSPS

- Lead on phase 2 of the review of Allied Health Professions support for Children with statements of Special Educational Needs within Special Schools and Mainstream Education.
- Commission patient and carer education programmes for people with long term conditions, subject to funding.

(4) Improving the early detection of illness

- Continue to improve informed choice in cancer screening (particularly amongst groups in greatest need).
- Introduce the extension of the Bowel Cancer Screening Programme to invite people up to the age of 74 years with a screening uptake of at least 55% in those invited.
- Lead the implementation of the new UK Newborn Blood Spot Screening Programme standards.

(5) Using evidence, fostering innovation and research

- Work with stakeholders to explore themes for a potential call in obesity research.
- Work with stakeholders to explore themes for a potential call in Suicide research.

Equality action plans/measures

7 Within the 2014-15 reporting period, please indicate the **number** of:

Actions completed:	7	Actions ongoing:	18	Actions to commence:	0

Please provide any details and examples (*in addition to question 2*):

Please see Appendix 1: Equality Action Plan Progress Report 2014-15.

8 Please give details of changes or amendments made to the equality action plan/measures during the 2014-15 reporting period *(points not identified in an appended plan)*:

Please see Appendix 4: Revised Equality Action Plan 2015-16.

9 In reviewing progress on the equality action plan/action measures

during the 2014-15 reporting period, the following have been identified: *(tick all that apply)*

- ☐ **Continuing action(s), to progress the next stage addressing the known inequality**
- ☐ **Action(s) to address the known inequality in a different way**
- ☐ Action(s) to address newly identified inequalities/recently prioritised inequalities
- ☐ Measures to address a prioritised inequality have been completed

Arrangements for consulting (Model Equality Scheme Chapter 3)

10 Following the initial notification of consultations, a targeted approach was taken – and consultation with those for whom the issue was of particular relevance: *(tick one box only)*

☐ All the time ☐ **Sometimes** ☐ Never

Where relevant we tend to engage with targeted groups as part of our work preceding formal consultation. This is to inform our consultation documents.

11 Please provide any **details and examples of good practice** in consultation during the 2014-15 reporting period, on matters relevant (e.g. the development of a policy that has been screened in) to the need to promote equality of opportunity and/or the desirability of promoting good relations:

Table 2

Policy consulted on	**What equality document did you issue alongside the policy consultation document? (screening template/EQIA report/none)** (NB: if you only issued an EQIA report and not a policy consultation document please include this information)	**What consultation methods did you use?**	**Which of the methods you used drew the greatest number of responses from consultees?** (NB: if the consultation started in 2014-15 but is still on-going, please give an interim indication of methods most used and outline the closing date)	**If consultees raised concerns, did you review your initial screening decision?**	**Do you have any comments on your experience of this consultation?**

Service Development and Screening Suitability of existing information materials for men with a learning disability (LD).	None	Liaised with Regional Learning Disability Health Care and Improvement Group to ensure no similar exercise was being undertaken. This Group were supportive of the initiative and advised working with the Regional Health Facilitators' Group for LD men. Currently the PHA, NIAAASP Programme Office at the Belfast Trust, Belfast Trust Health Facilitator for LD Men and a senior Speech & Language Therapist at the Belfast Trust are working towards undertaking a focus group with LD men to review newly developed easy-read	NA	The main issue raised concerned the Trust requiring access to the patient identifiable data of LD men eligible for screening which would be provided by the Health Facilitators. This issue is currently being considered by the Information Commissioner's Office and we are awaiting an outcome.	No

		AAA screening information materials.			
HSC Research & Development Personal & Public Involvement in Research (PPI Strategy-2nd edition)	None	Email	Email	Consultees raised concern about the use of language and corporate images which were off putting to service users-language was made clearer and images were changed to include softer images with local service users. At the suggestion of one PPI representative, the introduction to the strategy was done by a	This process involved PPI representatives who had been involved in implementing the first strategy as well as PPI Leads in the trusts. Targeting key stakeholders ensured that the group had ownership of the final document and that it was acceptable to patients and public involved in HSC research

				service user	
Health and Wellbeing Improvement Draft PHA/HSCB Volunteering Plan 2014/17	Screening undertaken and published as part of consultation papers.	All documents available on HSCB and PHA consultation section of websites. PHA ensured wide dissemination of the draft plan across the voluntary and community sector as well as Trusts. This was achieved through utilising dissemination through Volunteer Now and related databases and networks. 6 consultation events were organised at a Trust level as well as a designated voluntary/community sector stakeholder meeting. Volunteer Now agreed to manage and facilitate	23 separate consultation responses received. Report from each of 5 Trusts based on consultation events 5 Trust responses.	Issues raised from age sector organisations emphasised the need to ensure access and participation of volunteers irrespective of age and value of older people in volunteering roles. (No change/impact – no need to conduct EQIA)	Positive experience.

		these processes.			
Health and Wellbeing Improvement Development of a regional Community Capacity service	None	1. Focus group as part of a regional conference 2. Direct email out to stakeholders requesting wide circulation/distribution 3. Available to download via PHA Corporate site	Direct email.	N/A	Demographic details of the individual completing the form (gender/age/race) were not requested. Consideration will be given to how this could be included in future consultations.
Health and Wellbeing Improvement Pre-development consultation on Bereavement Support section of PHA Quality Standards for Services Promoting Mental and Emotional	None	Focus sessions with bereavement support groups during 2014/15 (previous consultation included focus group as part of regional seminar, emails out to stakeholders)	Only one method used 2014/15	None	Individuals attending focus groups were mainly female Caucasian. Additional methods could have been applied to encourage input from wider ethnic groups. However previous

Wellbeing					consultation on this issue drew wider responses, demographic information not fully collected. Consideration will be given to how this could be included in future consultations
Health and Wellbeing Improvement Age friendly Cities Derry & Strabane	None	21 Coffee table Talks with up to 200 participants in total.			Informal setting at an existing event/meeting best approach including hardest to reach minorities. Included a group of older people from the Chinese community.
Health and Wellbeing Improvement City Health Plan	None	Workshops in 4 NR areas plus 1 rural area Reponses fed in to consultation.			Very important to explain what you are doing and why – then have face to face

engagements /One Plan (Derry/Londonderry)					discussions as to how this may impact on older people in their own lives.
Health and Wellbeing Improvement Western Area Active Ageing Strategy consultation	None	Round table discussion / providing feedback to OFMDFM staff who facilitated the session Age Friendly membership fed back by e-mail and responses were collated			Good opportunity to get the input of older people and the groups working with them to feed in directly to the consultation process.
Nursing and Allied Health Professions eHealth & Care Strategy 2015-2020 (joint HSCB and PHA)	EQIA Report (strategy not formally launched to date)	• Online questionnaire • Paper based questionnaire • Roundtables • Offered one to one meetings • Attendance at forums	Roundtables		

12 In the 2014-15 reporting period, given the consultation methods offered, which consultation methods were **most frequently used by consultees**: *(tick all that apply)*

- ☐ Face to face meetings
- ☐ **Focus groups**
- ☐ **Written documents with the opportunity to comment in writing**
- ☐ **Questionnaires**
- ☐ **Information/notification by email with an opportunity to opt in/out of the consultation**
- ☐ Internet discussions
- ☐ Telephone consultations
- ☐ Other *(please specify)*:

Please provide any details or examples of the uptake of these methods of consultation in relation to the consultees' membership of particular Section 75 categories:

Please see Table 2 under Question 11 above.

13 Were any awareness-raising activities for consultees undertaken, on the commitments in the Equality Scheme, during the 2014-15 reporting period? *(tick one box only)*

☐ **Yes** ☐ No ☐ Not applicable

Please provide any details and examples:

In our quarterly screening reports we raise awareness as to our commitments relating to equality screenings and their publication.

14 Was the consultation list reviewed during the 2014-15 reporting period? *(tick one box only)*

☐ **Yes** ☐ No ☐ Not applicable – no commitment to review

Arrangements for assessing and consulting on the likely impact of policies (Model Equality Scheme Chapter 4)

Information on our completed equality screenings can be accessed via our website (please find link at the bottom of this site):

http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality

15 Please provide the **number** of policies screened during the year (*as recorded in screening reports*):

2

16 Please provide the **number of assessments** that were consulted upon during 2014-15:

1	Policy consultations conducted with **screening** assessment presented.
1	Policy consultations conducted **with an equality impact assessment** (EQIA) presented.
	Consultations for an **EQIA** alone.

In addition, two policies and their equality screening templates were included in our screening reports.

17 Please provide details of the **main consultations** conducted on an assessment (as described above) or other matters relevant to the Section 75 duties:

Please see Table 2 under Question 11 above.

18 Were any screening decisions (or equivalent initial assessments of relevance) reviewed following concerns raised by consultees? *(tick one box only)*

☐ Yes ☐ **No concerns were raised** ☐ No ☐ Not applicable

Please provide any details and examples:

Please see Table 2 under Question 11 above.

Arrangements for publishing the results of assessments (Model Equality Scheme Chapter 4)

19 Following decisions on a policy, were the results of any EQIAs published during the 2014-15 reporting period? *(tick one box only)*

☐ Yes ☐ No ☐ **Not applicable**

Arrangements for monitoring and publishing the results of monitoring (Model Equality Scheme Chapter 4)

20 From the Equality Scheme monitoring arrangements, was there an audit of existing information systems during the 2014-15 reporting period? *(tick one box only)*

☐ Yes

☐ **No, already taken place**

☐ No, scheduled to take place at a later date

☐ Not applicable

Please provide any details:

We published the report on the outcome of our audit of information systems in 2012. It can be accessed from our website:

http://www.publichealth.hscni.net/directorate-operations/planning-and-corporate-services/equality

21 In analysing monitoring information gathered, was any action taken to change/review any policies? *(tick one box only)*

☐ **Yes** ☐ No ☐ Not applicable

Please provide any details and examples:

Please see Table 3 below.

Table 3

Service or Policy	What equality monitoring information did you analyse?	Did the way you used the data result in improved access to information or services?
Research and Development Office Building Research Partnerships Training	Sex of participants Whether or not people had a disability	More efforts made to advertise course to wider groups including those with a disability. This has worked to ensure that service users have attended the course with a range of conditions including addiction, mental health, disability, sight and hearing problems, diabetes and cancer.
Health and Wellbeing Improvement Early Intervention Support Services	Religious background information.	The data analysed was used to consider the community background population balance in the designated service pilot sites.
Health and Wellbeing Improvement Annual Health Needs Assessment of Prisoners in Northern Ireland	Quantitative data: Data collected on the health needs of prisoners across the three prison sites in NI from existing Trust data information systems for prison healthcare. Qualitative data: Feedback from prisoners and prison and healthcare staff regarding prisoner health needs.	Health Needs Assessment data used to plan improvements in data collection so that prisoner healthcare needs might be more accurately identified. On-going work took place to address identified health need gaps—such as BBV testing, availability of national screening programmes, etc. While the 2013/14 Health Needs

		Assessment (completed May 2014) identified the need to continue work on improving information systems for all health conditions, a decision was made to focus the 2014/15 assessment specifically on the collection of data regarding the mental health and addiction needs of prisoners. Data gathered as part of the Health Needs Assessment process was also used to provide direction for health improvement initiatives to the newly appointed Health Development Worker.
Nursing and Allied Health Professions eHealth & Care Strategy 2015-2020 (joint HSCB and PHA)	Qualitative data: feedback from organisations and individuals representing Section 75 groups specifically age, disability and ethnic groups	During implementation of eHealth technologies Trusts and other organisations within HSC will remain engaged in developing user centric interfaces and user friendly technologies to meet the needs of Section 75 groups specifically age, disability and ethnic groups.
Nursing and Allied Health Professions 10,000 Voices	Fewer men than women participating – visited factory with male dominated workforce	Slight increase in number of men participating

22 Please provide any details or examples of where the monitoring of policies, during the 2014-15 reporting period, has shown changes to differential/adverse impacts previously assessed:

No monitoring was undertaken of policies previously assessed.

23 Please provide any details or examples of monitoring that has contributed to the availability of equality and good relations information/data for service delivery planning or policy development:

Please see Table 3 under Question 21 above.

Staff Training (Model Equality Scheme Chapter 5)

24 Please report on the activities from the training plan/programme (section 5.4 of the Model Equality Scheme) undertaken during 2014-15, and the extent to which they met the training objectives in the Equality Scheme.

Face-to-face training:

Course	**No of Staff Trained**
Screening Training	23
Equality Impact Assessment Training	6
Total	**29**

eLearning: Discovering Diversity

Module 1 to 4 – Diversity	**13**
Module 5 – Disability	**8**
Module 6 – Cultural Competencies	**7**

25 Please provide any examples of relevant training shown to have worked well, in that participants have achieved the necessary skills and knowledge to achieve the stated objectives:

The PHA avails of the joint Section 75 training programme that is coordinated and delivered by the BSO Equality Unit for staff across all 11 partner organisations. The following statistics thus relate to the evaluations undertaken by all participants.

(1) Equality Screening Training

The figures in bold represent the percentage of participants who

selected ‘Very Well’ or ‘Well’ when asked the questions below. Remaining participants selected ‘Adequately’.

Participants were asked: Overall how well do you think the course met its aims:

To develop an understanding of the benefits of screening: **95.2%**
To develop an understanding of the screening process: **95.2%**
To develop skills in practically carrying out screening: **91.9%**

The figure in bold represents the percentage of participants who selected ‘Extremely Valuable’ or ‘Valuable’ when asked the question below. The remaining participant selected ‘Of Some Value’.

How valuable was the course to you personally? **98.4%**

(2) Equality Impact Assessment Training

Staff were asked to self-assess how well they thought they had achieved the intended learning outcomes. While overall, assessments were markedly positive, participants assigned slightly lower scores to the acquisition of basic skills in carrying out an EQIA, as opposed to the knowledge-based learning outcomes.

This echoes findings from the equality and human rights screening training. Given the challenging nature of equality screenings and EQIAs it is arguably to be expected that the development of practical skills cannot be completed within the timeframe of a 3h session.

Public Access to Information and Services (Model Equality Scheme Chapter 6)

26 Please list **any examples** of where monitoring during 2014-15, across all functions, has resulted in action and improvement in relation **to access to information and services**:

Please see Table 3 under Question 21 above.

Complaints (Model Equality Scheme Chapter 8)

27 How many complaints **in relation to the Equality Scheme** have been received during 2014-15?

Insert number here: 0

Please provide any details of each complaint raised and outcome: n/a

Section 3: Looking Forward

28 Please indicate when the Equality Scheme is due for review:

27 April 2016

29 Are there areas of the Equality Scheme arrangements (screening/consultation/training) your organisation anticipates will be focused upon in the next reporting period? *(please provide details)*

- equality screenings and the timely publication of completed screening templates
- where relevant EQIAs
- monitoring, including of policies screened
- engagement with Section 75 groups (alongside other voluntary sector groups) as part of pre-consultation exercises and collection of equality information by this means
- issuing equality screening documents alongside policy documents in any policy consultations

30 In relation to the advice and services that the Commission offers, what **equality and good relations priorities** are anticipated over the next (2015-16) reporting period? *(please tick any that apply)*

☐ Employment

☐ **Goods, facilities and services**

☐ Legislative changes

☐ Organisational changes/ new functions

☐ Nothing specific, more of the same

☐ **Other (please state):**

Equality screening of business cases and budget decisions

PART B - Section 49A of the Disability Discrimination Act 1995 (as amended) and Disability Action Plans

When we produced our Disability Action Plan we decided that it is important to do so in a language and format that is easy to understand. A copy of our Plan for 2013-2018 is available on our website.

In the same way, we want to make sure that people can easily follow what we do from year to year as we carry out our plan. We have produced a report for 2014-15. It is attached as Appendix 5. This report contains the information required for the statutory reporting in what we hope is an accessible language and format.

PART B

1. Number of action measures for this **reporting period** that have been:

Fully achieved	Partially achieved	Not achieved

2. Please outline below details on all **actions that have been fully achieved** in the reporting period.

2 (a) Please highlight what **public life measures** have been achieved to encourage disabled people to participate in public life at National, Regional and Local levels:

Level	Public Life Action Measures	Outputs[i]	Outcomes / Impact[ii]
National[iii]			
Regional[iv]			
Local[v]			

2(b) What **training action measures** were achieved in this reporting period?

	Training Action Measures	Outputs	Outcome / Impact
1			
2			

2(c) What Positive attitudes **action measures** in the area of **Communications** were achieved in this reporting period?

	Communications Action Measures	Outputs	Outcome / Impact
1			
2			

2 (d) What action measures were achieved to '**encourage others'** to promote the two duties:

	Encourage others Action Measures	Outputs	Outcome / Impact
1			
2			

2 (e) Please outline **any additional action measures** that were fully achieved other than those listed in the tables above:

	Action Measures fully implemented (other than Training and specific public life measures)	Outputs	Outcomes / Impact
1			

2			

3. Please outline what action measures have been **partly achieved** as follows:

	Action Measures partly achieved	Milestones[vi] / Outputs	Outcomes/Impacts	Reasons not fully achieved
1				
2				

4. Please outline what action measures **have <u>not</u> been achieved** and the reasons why.

	Action Measures not met	Reasons
1		
2		

5. What **monitoring tools** have been put in place to evaluate the degree to which actions have been effective / develop new opportunities for action?

PART B

(a) Qualitative

(b) Quantitative

6. As a result of monitoring progress against actions has your organisation either:

- made any **revisions** to your plan during the reporting period or
- taken any **additional steps** to meet the disability duties which were **not outlined in your original** disability action plan / any other changes?

Please select

If yes please outline below:

	Revised/Additional Action Measures	Performance Indicator	Timescale
1			
2			
3			
4			
5			

7. Do you intend to make any further **revisions to your plan** in light of your organisation's annual review of the plan? If so, please outline proposed changes?

[i] **Outputs** – defined as act of producing, amount of something produced over a period, processes undertaken to implement the action measure e.g. Undertook 10 training sessions with 100 people at customer service level.

[ii] **Outcome / Impact** – what specifically and tangibly has changed in making progress towards the duties? What impact can directly be attributed to taking this action? Indicate the results of undertaking this action e.g. Evaluation indicating a tangible shift in attitudes before and after training.

[iii] **National** : Situations where people can influence policy at a high impact level e.g. Public Appointments

[iv] **Regional**: Situations where people can influence policy decision making at a middle impact level

[v] **Local :** Situations where people can influence policy decision making at lower impact level e.g. one off consultations, local fora.

[vi] **Milestones** – Please outline what part progress has been made towards the particular measures; even if full output or outcomes/ impact have not been achieved.

Equality Action Plan 2013 – 2018: Report on the progress we made during 2014-15

June 2015

This document summarises progress made during 2014-15 against the actions we identified in our Equality Action Plan. The plan covers the period 2013-18 and is available on our website: www.publichealth.hscni.net/sites/default/files/PHA%20EAP.pdf

Any request for this document in another format or language will be considered.

Theme 1: Provision of Accessible Information

Action Point	Progress to end Mar 2015 and Comments	Outcomes for Section 75 groups
Ensure new sites are compliant with relevant guidelines and standards (such as W3C A4)	Conducted compliancy checks as new sites were developed and rolled out, ie becancerawareni.info	Through correct design, development and editing, enabling equal access to online information and functionality by people with disabilities.
Identify photo opportunities to begin the development of an image library to include images that reflect our commitment to inclusiveness	Relates to photo opportunities presented by programme areas – limited by opportunity and budget in 2014/15	Promote inclusion and recognise equality and diversity of the equalities communities we work with.

Theme 2: Cancer Screening

Action Point	Progress to end Mar 2015 and Comments	Outcomes for Section 75 groups
Implement actions from the action plan on promoting informed choice in cancer screening.		

Theme 3: Childhood Immunisation

Action Point	Progress to end Mar 2015 and Comments	Outcomes for Section 75 groups
Feed back individual uptake rates to health professionals, along with comparative data, so they know how they are performing compared with their peers.	These rates were fed back to practices, so they were aware of their performance. **Completed.**	
Visiting individual practices with low rates to discuss how these can be improved.	Practices visited and discussions took place. **Completed.**	
Develop a one stop shop for new migrants that will include a range of services including bringing children up to date with their immunisations.	This service is now up and running and has recently won the Community Practitioners and Health Visitors Association (CPHVA) award for 'community practitioner team of the year'. **Completed.**	An improved service is being offered to migrants and ethnic minorities.
Work with Trusts to develop initiatives to promote childhood immunisations with the Travelling community.	Trusts have built this into their overall work programme.	An improved service is offered to the Travelling community.
Continue to monitor uptake closely and work with professionals to achieve ongoing improvement.	MMR uptake has improved to 96% at 2 years of age – the highest in the UK.	This level of uptake provides herd immunity ensuring that all sections of the community are protected. Northern Ireland now has no endemic measles

		or rubella and spread from any imported cases is minimal and very quickly brought under control.

Theme 4: Migrants

Action Point	Progress to end Mar 2015 and Comments	Outcomes for Section 75 groups
PHA to continue to liaise with key stakeholders on the commissioning, development, implementation and review of the Northern Ireland New Entrant Service (NINES) (Mar 2015).	Action is being undertaken in the PHA Southern Office, working in collaboration with Southern Local Commissioning Group colleagues, to provide a new entrant service to meet identified BME need in the southern area. Work is also underway to increase provision to meet increased demand in the existing Belfast based NINES.	Improvement in equity and quality of care offered to migrants; prompt identification of need and early intervention/onward referral will help ensure that risks identified are minimised; reduction in inappropriate attendances at Emergency Care.
Continue to work to improve data collection of migrants and their health and social wellbeing needs with a particular focus on community systems (SOSCARE); hospital systems (PAS) and GP systems. (Mar 2018)	Awareness raising posters and leaflets have been produced by the Regional Ethnic Monitoring Group. Completion rates: NIMATS and CHS for 2014/15. **NIMATS – valid records** Ethnic group: 20,410 out of 24,078 mothers = 84.8% Country of birth: 20,439 out of 24,078 mothers = 84.9% First language: 20,413 out of 24,078	Information provided for service users and staff on the introduction of ethnic monitoring into HSC systems. This will help to ensure more effective monitoring which, in turn, will benefit migrants by allowing providers to assess numbers accessing services, highlight possible inequalities, investigate their underlying causes and remove any unfairness or disadvantage.

	mothers = 84.8% **CHS – valid records** Ethnic group: 21,963 out of 24,094 mothers = 91.2% Country of origin: 19,980 out of 24,094 mothers = 82.9% First language: 16,805 out of 24,094 mothers = 69.7% Work is ongoing to develop the PAS system.	
Continue to work with HSCB, Trust, BSO and community and voluntary sector colleagues to provide an effective information and good practice sharing Migrant Health and Social Wellbeing Collaborative Network for health and social care professionals, ME groups and others. (Mar 2015)	The Stronger Together, minority ethnic health and social wellbeing network has continued to effectively deliver its objectives during 2014/15.	The Stronger Together Network benefits ethnic minority communities and migrants by facilitating regional co-operation and creating a common forum for accessing and sharing information, good practice, knowledge and skills relating to the holistic health and social wellbeing of ethnic minorities. This is contributing to increased awareness of the health and social wellbeing needs of migrants and ethnic minority communities and of opportunities for addressing those needs.
Develop a proposal to review the evidence on approaches taken to	A three year regional pilot project to promote mental and emotional	The findings from the pilot project and the review of evidence will help to

improve minority ethnic mental health and emotional wellbeing, elsewhere across the UK and internationally, to help inform local commissioning and decision making. (Mar 2015)	wellbeing for ethnic minority communities in NI has been commissioned by the PHA. Action to be undertaken includes a review of evidence based approaches to improving minority ethnic mental health and emotional wellbeing.	ensure that local commissioning and decision making in relation to minority ethnic mental health and emotional wellbeing is better informed and more effective.
Continue to work with key agencies and organisations across the sectors to review, develop and implement an annual regional action plan to address minority ethnic health and social wellbeing issues. (annually)	A regional 2014/15 action plan to address minority ethnic health and social wellbeing issues was developed and is being implemented by key agencies and organisations across the sectors that have come together, under the auspices of the PHA, as the Regional Minority Ethnic Health and Social Wellbeing Steering Group.	The 2014/15 action plan continues to address the fact that ethnic minority communities are at increased risk of health inequalities and has adopted a co-ordinated, cross – sectoral, partnership approach to tackle identified issues, reflecting best practice and evidence from the literature.

Theme 5: Lesbian, Gay, Bisexual and Transgender

Action Point	Progress to end Mar 2015 and Comments	Outcomes for Section 75 groups
Engage with key stakeholders on eLearning programme (Mar 2018).	E-learning programme disseminated to HR/Equality leads and all staff. Feedback invited from participants. LGB&T HSC Staff Forum engaged in the development of the e-learning programme. Work endorsed by Chief Executive Officer, HR Director and Organisational Workforce Development Group (Director/Assistant Director level).	Benchmarking with stakeholders provides an opportunity for shared learning. LGB&T participants given an opportunity to feedback during development of the programme.
Promote e-learning programme (Mar 2018).	E-learning programme circulated to all staff and to members of the LGB&T HSC Staff Forum via confidential mailing list. E-learning programme also publicised in HSC sites via leaflets/flyers and on intranet sites, including PHA Connect. Link to the programme also exists on the dedicated LGB&T website for HSC staff.	Increased awareness among employees. Promotes inclusion. Seeks to change attitudes/challenge behaviour and educate staff where appropriate. Encourages single status and equity/fairness/respect. Common messages and themes promoted through all HSC sites by the same means.
Continue to support the HSC LGB&T Staff Forum (Mar 2018).	Ongoing support and promotion for the Forum continues. New Chair	Provides a confidential mechanism of communication. Members are welcome to attend meetings or engage by e-mail

	commenced position early 2015.	only. Forum continues to raise awareness of topical issues such as entitlement to access goods/services and paternity/maternity information and so forth. Posters also developed by Forum members to raise awareness and promote visibility. Engagement continues with other LGB&T Staff Forums such as Belfast City Council and Department of Justice.
Develop a dedicated website for the Forum (Mar 2018).	A dedicated website (www.lgbtstaff.hscni.net) was launched and provides a source of information, contact details, advice, support, news and events. Website endorsed by and contains welcome message from Chief Executive, PHA.	Provides a source of information, advice and resources.
Explore potential for staff survey to assess staff attitudes in the workplace across HSC Settings (Mar 2018).	Survey live from 14 May until 29 May 2015	Increased visibility. Reduction in fear of 'coming out' or speaking with colleagues openly. Survey seeks to identify areas where the organisation needs to focus in terms of policy/procedure and culture.
Work with AgeNI, RQIA, LGB&T Sector, Unison and the Independent Care Sector to develop guidelines to support older LGB&T people in	Work continues with stakeholders. 'See me, hear me, know me' guidelines launched March 2015 to support the needs of Older Lesbian, Gay, Bisexual	Increased visibility. Care in residential/day care/home setting improved as a result of increased knowledge of service providers.

residential and day care facilities.	and Transgender people in nursing, residential, and day care settings and those who live at home and receive domiciliary care.	Creates a more open and honest relationship between carer and resident/patient.
Work with RCGP to develop guidelines to support the needs of LGB&T people in General Practice (Mar 2018).	In March 2015, the Royal College of General Practitioners NI launched two sets of guidelines. One was to support the care of Lesbian, Gay and Bisexual Patients in Primary Care and the other to support the care of Trans* Patients in Primary Care. These guidelines which were developed in partnership with PHA and involved a number of key stakeholders including members of the LGB&T communities.	Increased visibility. Increased awareness/education from health care professionals when LGB&T patient is seeking treatment/advice.

Theme 6: Personal and Public Involvement

Action Point	**Progress to end Mar 2015 and Comments**	**Outcomes for Section 75 groups**
Finalise the design, development and roll out plans for a PPI awareness raising and training programme for use across HSC. (Mar 2015)	The programme was designed and developed by March 2015. Roll out has been delayed whilst work is undertaken with HSC partners to update the e-learning component of the training programme. It is anticipated that the full programme will be completed and available by the autumn of 2015.	Although the programme has not yet been finalised or made available across the HSC, the focus on the needs of service user/carers and in particular on many of the section 75 groups in the design and development of the programme has helped to raise awareness of the need to be

		conscious of the potential differential impact commissioning, service development and delivery can have on different people.
Commission research with a focus on lessons to be extrapolated & shared across the HSC. (Mar 2015)	The research has been commissioned into PPI. The Research team comprising QUB, UU, HSC Trust staff and Service Users and Carers were delayed due to ethical and governance requirements and permissions. The work is now well underway with the survey being completed and a series of focus groups currently happening. It is anticipated that the final report will be available by the autumn of 2015.	Research into PPI is helping to identify barriers to involvement and ways to overcome these. ny particular problems faced by any of the section 75 groups will require specific and targeted action to attempt to address these.

Theme 7: PHA as an employer

Action Point	Progress to end Mar 2015 and Comments	Outcomes for Section 75 groups
Engage with staff to (a) provide information on existing policies and pension arrangements (b) find out about staff preferences for working on beyond previous retirement age and suggestions for additional support (Mar 2016).	Communication on pending changes to pension arrangements issued by HSC Pensions to all staff.	Staff are in a better position to take informed decisions relating to their pensions.
Work with BSO and partner organisations to develop a line manager guide on reasonable adjustments for staff from a range of Section 75 groups (Mar 2015).	Guidance still in draft format and is currently a work in progress. Likely completion for final draft is end of June 2015. Signposting to relevant voluntary sector organisations will be highlighted in the guidance with the opportunity to access further information if required. The guidance will be consulted with the trade unions and disseminated to all managers for information and appropriate action. It is likely that this will be done by end of September 2015.	The outcome of this guidance is that managers will have much more awareness and knowledge of S75 categories. The documents will include further signposting for managers should they require any further information on any of the S75 groupings.

Develop communication strategy for staff on rationale for collecting data. Collect staff data. (from 2014-15 onwards)	Prompts for staff to update their equality and diversity data have been issued by Human Resources. In context of disability awareness days, case was made to staff for benefits of declaring a disability.	Better quality of staff equality data will allow PHA staff to consider and monitor the equality implications of policies and decisions more robustly. Ultimately, this should benefit staff as to their needs being better met.

Theme 8: Board composition

Action Point	Progress to end Mar 2015 and Comments	Outcomes for Section 75 groups
Approach Office for Public Appointments or Public Appointments Unit to welcome thoughts on the matter and seek advice on how greater diversity can be achieved (Mar 2018)	Scheduled for 2017-18 This will take into consideration the report published by the Commissioner for Public Appointments in January 2014 on Lack of Diversity in Public Appointments in Northern Ireland.	n/a

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For text relay please prefix with 18001
Website: www.publichealth.hscni.net

June 2015

Equality and Human Rights Screening Report

April 2014 - March 2015

Table 1

*1	'screened in' for equality impact assessment (EQIA)
2	'screened out' with mitigation
3	'screened out' without mitigation

Org.	Policy / Procedure and Screening Documentation	Policy Aims	Date	*Screening Decision
PHA	Annual Business Plan 2014-15	The Annual Business Plan 2014-2015 details how we will make best use of our resources to achieve our core goals, as set out in the final year of our Corporate Strategy 2011-2015.	Mar-14	2
PHA	Accessible Formats Policy and Practical Advice	The purpose of this policy is to support the Public Health Agency meet the information and communication needs of individuals as effectively as possible. We want to make sure that our approach to the provision of written accessible information is clear, balanced, fair, transparent and accurate.	Oct-14	2

Appendix 2 – Changes to policies or practices using screening (mitigation)

See also web link http://www.hscbusiness.hscni.net/services/2166.htm

Annual Business Plan 2014-15 – March 2014

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
The Annual Business Plan development included ensuring that it fully reflected the PHA role in reducing health inequalities. Some of these explicitly aim to address key equality issues. Using our Communication department's expertise in public information the Business Plan was written in a style to make it accessible and understandable for a wide range of external stakeholders as well as PHA staff.	The key actions and focus on reducing health inequalities contained within the plan will guide the work of the PHA throughout the year and will be closely monitored through a variety of established performance monitoring systems. When preparing the plan we took the opportunity to review the direction set out in the Corporate Strategy to ensure its continued relevance to our work. The Annual Business Plan will be widely accessible and will be available in alternative formats. As each of the actions are taken forward equality issues will be reviewed and addressed as appropriate. Service leads have been reminded to keep under

	constant review the need for screening at an early stage when planning. We will also implement the actions detailed in our action plan which accompanies our Equality Scheme 2013-18. Ultimately, however, we remain committed to equality screening, and if necessary equality impact assessing, the policies we develop and decisions we take.

Accessible Formats Policy and Practical Advice – October 2014

Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
Section 2 of the policy states as its ultimate purpose that is to help our organisation meet the information and communication needs of individuals as effectively as possible. It offers commitments that are about ensuring that our approach to the provision of accessible information is clear and accurate. By adopting this approach we believe the public will benefit as the policy offers the commitment as to the standards people can expect from health and social care and public safety organisations when they provide information. In Section 3 of the policy makes explicit reference to the legal requirements under Section 75 of the Northern Ireland Act, Human Rights Act, Race Relations and Disability legislation. It also draws on equality scheme commitments to ensure accessibility of information. Section 6 adds an accessible statement for adoption by the	Section 8 of the policy outlines the structure and process for implementation which will be in accordance with individual organisations' arrangements The policy however places responsibilities on staff within the organisations Monitoring of the policy is therefore key and should be in accordance with agreed timeline.

organisation Section 7 of the Policy provides detailed guidance to staff to assist in addressing the barriers.	

Section 75

Equality Action Plan

2013 – 2018

Public Health Agency

Any request for this document in another format or language will be considered.

Updated June 2015

Introduction

In 2010 the Equality Commission NI asked the Public Health Agency to develop an action plan outlining actions to promote equality of opportunity and good relations and address inequalities. Our first action plan was developed for a period of two years (2011-2013), to align it with our corporate and business planning cycles at the time.

This document presents the reviewed and updated action plan for the period 2013-18. In its development consideration was given to a review of existing priorities and consideration of new priorities. This plan is a 'live' document and as such will be reviewed on an annual basis.

The actions in this plan are reflective of the goals and common themes defined in the PHA's corporate strategy 2011-15. Each theme in the action plan includes a reference to the relevant goal or theme in the strategy, for ease of reference.

Equality Scheme commitments

Our action plan outlined actions related to our functions and took account of our equality scheme commitments relating to Section 75 of the Northern Ireland Act 1998. Our Equality Scheme is available on our website: www.publichealth.hscni.net

The law requires us when we carry out work that we promote equality of opportunity across nine equality categories; age, gender, disability, marital status, political opinion, caring responsibilities, sexual orientation, religion and ethnicity. The appendix provides examples of groups covered under these categories. It also requires us to consider good relations in relation to political opinion, religion and ethnicity.

In our Equality Scheme we gave a commitment to monitoring progress and updating the plan as necessary. We also said we would engage and consult with stakeholders when reviewing the action plan.

During the last two years we have kept our Equality Action Plan under review and reported annually, to the Equality Commission, on what we have done.

How we carried out the review

As we are coming to the end of our two years we undertook a larger scale review, to consider what actions to include in our new equality action plan.

In carrying out our review we considered a number of questions.

1. Have actions been delivered? If not these were carried over into our new plan.
2. Have intended outcomes been achieved? If actions were delivered but the intended outcome has not been achieved we carried over the priority into the new plan with new actions.
3. Were there actions identified in our first audit of inequalities but not prioritised for our first plan? If these are still relevant we carried them over into the new plan.

We also looked at a range of sources of information such as:

- new research
- new data having become available
- new equality screening exercises having been completed
- issues raised in consultations or through other engagement with staff and service users since our first action plan.

From this we considered if new actions needed to be developed for 2013-2018.

What we do

The Public Health Agency is part of health and social care in Northern Ireland. We were set up in April 2009.

We do things like:

- We find out what things people need to protect them from diseases and other hazards.
- We find out what services people in Northern Ireland need to keep healthy.
- We do not provide the services but work with other organisations that are called Trusts and other voluntary and private organisations that do so.
- We buy services from Trusts including, for example, hospital services.
- We organise and buy screening services. This is about finding out at an early stage whether a person is ill or is at risk of becoming ill.
- We try to make it easier for people to make healthier choices, for example in what they eat.

- We work with other organisations to try and reduce the big differences between different groups of people in Northern Ireland in how healthy and well they are.
- We develop and run campaigns for the general public in Northern Ireland on important health topics, for example on smoking.
- We develop websites on a number of health topics, for example on drugs, alcohol and smoking. Some sites are for specific groups such as young people or health professionals.
- We support research. We also buy and pay for research. We carry out some of the research ourselves.
- We make sure we learn from when something goes wrong in how health care is provided in Northern Ireland.
- We work with other organisations to improve the range and quality of services, for example for people of all ages with learning disabilities.
- We need to make sure services are good quality and check out that they are.
- We work with other health and social care organisations to improve how they engage with those who use their services, with carers and with the public.
- We also employ staff.
- We have to make sure that we obey the laws about employment, services, equality and rights.

Addressing inequalities in health and wellbeing is at the core of our work. As we face a difficult economic climate, inequalities may worsen over the coming period. For this reason, the PHA will redouble its efforts, working with partners in many different sectors, as well as directly with communities, to ensure we make best use of our collective resources.

The PHA has been systematically examining evidence of best practice and effectiveness to ensure that investment and joint working will bring clear benefits. We are setting out four key themes to our work:

Give every child and young person the best start in life

Investment in early years brings significant benefits later in life across areas such as health and wellbeing, education, employment, and reduced violence

and crime. We are committed to pursuing strongly evidenced programmes to build resilience and promote health and wellbeing.

Ensure a decent standard of living for all

Lower socioeconomic groups have a greater risk of poor health and reduced life expectancy. We will focus efforts in a number of areas where, working with partners, we can impact on achieving a decent standard of living for all.

Build sustainable communities

The views, strengths, relationships and energies of local communities are essential in building effective approaches to improving health and wellbeing. We are committed to community development, engaging people in decision-making and in shaping their lives and social networks.

Make healthy choices easier

Creating an environment that encourages and supports health is critical. We are committed to working across a range of settings to ensure that healthier choices are made easier for individuals.

What is in our Equality Action Plan?

The following table outlines our key actions for the next five years. It does not reflect all of our work to address inequalities in health and wellbeing. Rather, it presents a set of priority actions relating to the nine categories under Section 75.

We will keep this plan under regular review and report annually on progress to the Equality Commission NI. We will undertake a wider review in five years. We will involve Section 75 equality groups and individuals in this review. This document is also available on our website: www.publichealth.hscni.net

The PHA Equality Action Plan 2013-2018

Theme 1: Provision of Accessible Information Link to Corporate Strategy: 'Ensuring effective processes'	**Key inequalities and opportunities to promote equality and good relations:** • people with a disability experience barriers in accessing website information • opportunity to mainstream consideration of accessible information needs in all projects involving the production of information materials **Evidence** • http://www.w3.org/standards/webdesign/accessibility			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**By When**
complete review of existing sites and ensure new sites are compliant with relevant guidelines and standards (such as W3C A4)	Highest level of accessibility enables people with a disability to have equal access to information	Annual compliance check	Public and Professional Information Manager	Ongoing
Monitor and review resources for positive images of equalities communities	Positive images promote inclusion and recognise equality and diversity of the equalities communities we work with	Annual check	As above	

Theme 2: Cancer Screening Link to Corporate Strategy: 4.6: Working with communities to increase the uptake of screening programmes.	**Key inequalities and opportunities to promote equality and good relations:** **BME Groups** - There are a number of factors that can influence participation by some BME groups in cancer screening, including: • Divergence in perceptions held by screening staff and migrant ethnic groups regarding cancer screening. • Suspicion of authority. • The degree of knowledge about screening. • The type of health care in individuals' native countries, i.e. no experience of these types of programmes. • Lack of access to primary care. **Learning Difficulties** - Cancer screening uptake is lower amongst the population of women with learning difficulties than among women in the general population. Barriers to accessing cancer screening include: • communication issues, including literacy problems; • consent issues; • physical health; • inability to undergo screening due to physical limitations **LGB&T** - Lesbian women are less likely to participate in preventive health care, including breast and cervical cancer screening than heterosexual women. There is an assumption that they do not need to undertake cervical screening.

	Physical and Sensory Disability - A key issue affecting those with sensory and/or physical disabilities is the availability of accessible information. The bowel cancer screening test kit is completed by individuals at home. Due to the nature of the test (collecting a stool sample) individuals with a physical or sensory disability will have difficulty accessing the screening programme. **Evidence** • People from these minority groups may have problems accessing or understanding information about cancer screening and in some cases the methods of screening may create obstacles for some individuals. The PHA does not have data of uptake of cancer screening by individuals from section 75 groups. Our data collection is not specific enough. There is anecdotal evidence that uptake of cancer screening is lower amongst some section 75 groupings. A Strategy Group to promote informed choice in cancer screening has been established and led by the Quality Assurance Reference Centre. This Group has considered a range of research literature and held a series of meetings with community and voluntary organisations that represent people from section 75 groups. Organisations have offered an insight into the obstacles and inequalities that people face in accessing cancer screening and confirmed the research findings. A workshop with key stakeholders to promote informed choice in cancer screening was held in November 2011. The attendees advised what the obstacles were to people and groups understanding and accessing cancer screening programmes and suggestions to improve informed choice and hopefully then to improve uptake. The action plan from this workshop was published in March 2013.

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	By When
A workshop with key stakeholders to promote informed choice in cancer screening was held in November 2011. Implement actions from the action plan that was drafted following the workshop.	Actions to be undertaken that will improve uptake of cancer screening amongst section 75 groups and people living in deprived areas.	That actions from the plan are completed. Further links are established with internal PHA departments and external organisations who represent these section 75 groups. *It will be difficult to link changes in the uptake of cancer screening programmes directly to this work. Cancer screening programmes do not collect data on all section 75 groups.*	QARC	March 2014 and on-going into 2014/15.

Theme 3: Childhood Immunisation Link to Corporate Strategy: 1.8: Targeting immunisation programmes on areas of low uptake to help reduce inequalities.	**Key inequalities and opportunities to promote equality and good relations:** • Whilst childhood immunisation uptake levels are generally very good in Northern Ireland and above the UK average there is variation in uptake. Lower levels occur in some areas of deprivation and also in some groups e.g. the Traveller community. There can also be problems with some recent migrants accessing vaccination services. **Evidence** • Vaccination uptake figures and reports from professionals working with affected groups. • NICE Public Health Guidance 21: Reducing differences in uptake of immunisations in children and young people aged under 19 years. This guidance identifies the following groups as being at risk of not being fully immunised: o those who have missed previous vaccinations (whether as a result of parental choice or otherwise) o looked after children o those with physical or learning disabilities o children of teenage or lone parents o those not registered with a GP o younger children from large families o children who are hospitalised or have a chronic illness o those from some minority ethnic groups o those from non-English speaking families o vulnerable children, such as those whose families are travellers, asylum seekers or are homeless.

Action Point	Intended Outcome	Performance Indicator and Target	By Whom	By When
Continue to offer a one stop shop for new migrants that will include a range of services including bringing children up to date with their immunisations. (Known as NINES – Northern Ireland New Entrant Service).	The gap in uptake rates between the highest and lowest performing areas will be reduced as much as possible.	NINES will continue to offer service to new entrant children.	Belfast Trust working with PHA	Ongoing Service started, new elements still being added and developed
Continue to monitor uptake closely and work with professionals to achieve ongoing improvement.		Uptake levels will be monitored on a quarterly basis as immunisation statistics are produced.	Consultant health protection & health protection nurses.	ongoing

Theme 4: Migrants (relevant to both duties under Section 75) Link to Corporate Strategy: 2.7: Focusing on communities experiencing significant social deprivation and health need, as well as social groupings that have fallen behind levels of health expected by our society.	**Key inequalities and opportunities to promote equality and good relations:** • There is a lack of robust data on the health and social wellbeing needs of migrants in NI; • There is a need for more partnership working among all key stakeholders, in particular with migrant groups; and • for a more co-ordinated approach in addressing migrant health and social wellbeing issues across NI. **Evidence:** • Health and Social Needs among Migrants and Minority Ethnic Communities in the Western area (Jarman, 2009); • Barriers to Health: migrant health and wellbeing in Belfast. A study carried out as part of the EC Healthy and Wealthy Together project (Johnston, Belfast Health Development Unit 2010); • Health Protection Issues Affecting Immigrants – A Literature Review (Veal and Johnston 2010 unpublished).			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**By When**
Improve data collection of migrants and their health and social wellbeing needs with a particular focus on community systems (SOSCARE); hospital	Improved data collection on the health and social wellbeing needs of minority ethnic communities in NI	Review and amendment, as required, of the identified data sources across NI	Pilot Ethnic Monitoring Project	Mar 2016

systems (PAS) and GP systems.				
Evaluation of the Stronger Together Network to be undertaken to assess the extent to which the project has achieved its aims and objectives.	A report of the evaluation findings to be produced which will consider processes, outputs and outcomes and make recommendations to help inform future decision making relating to the project.	Consultation with key stakeholders and network users (minimum 55%) from across HSC and ethnic minority groups across Northern Ireland.	South Tyrone Empowerment Programme (STEP)	Mar 2016
Develop a pilot service to support the mental health and emotional wellbeing needs of ethnic minority communities across Northern Ireland	Increased knowledge of effective approaches relating to promoting minority ethnic mental health and emotional wellbeing.	Three year service delivery plan developed including details of geographical reach; key milestones and timeframes.	South Tyrone Empowerment Programme (STEP)	Mar 2016
Continue to work with key agencies and organisations across the sectors to review, develop and implement an annual regional action plan to address minority ethnic health and social wellbeing issues	Co-ordinated, cross-sectoral action undertaken to address identified minority ethnic health and social wellbeing needs	Annual Action plan developed and being implemented	Regional ME Steering Group	Annually by Mar

Theme 5: Lesbian, Gay, Bisexual and Transgender Link to Corporate Strategy: 2.7: Focusing on communities experiencing significant social deprivation and health need, as well as social groupings that have fallen behind levels of health expected by our society.	**Key inequalities and opportunities to promote equality and good relations:** Employment generally • atmosphere and culture of discrimination, exclusion, homophobia and heterosexism (language, jokes, comments, graffiti) • lack of confidence in reporting and disciplinary procedures • lack of visibility of LGB&T people in the health and social care workplace Services • research in England on LGB&T experience of healthcare suggests numerous barriers including homophobia and heterosexism, misunderstandings and lack of knowledge, lack of appropriate protocols, poor adherence to confidentiality and the absence of LGB&T -friendly resources • LGB&T people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse, and deliberate self-harm than heterosexual people. Other issues include; access to services and attitudes. Issues regarding Older LGB&T in communal facilities, with concerns around negative responses on the grounds of their sexuality from institutions when life changing events occur for example, loss of independence through hospitalisation, going into residential home or having home carers. Research • To date very little general LGB&T health research has been published in Northern Ireland **Evidence** • publications summarised and referenced in: PHA (2011): Health Intelligence Briefing on Lesbian, Gay, Bisexual and Transgender (LGB&T) health related issues HSC (2010): Section 75 Emerging Themes across Health and Social Care. Section 9

	• The Rainbow Project (2011) Through Our Eyes: Experiences of Lesbian, Gay and Bisexual People in the Workplace.			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**By When**
(1) eLearning				
engage with key stakeholders Promote e-learning programme.	Increased capacity of staff working across HSC settings to better meet the needs of the LGB&T population.	E-learning programme promoted to staff working across HSC Settings by e-mail and on intranet sites. E-Learning programme used as part of induction programme and ongoing Equality and Diversity Training. Use of programme monitored and feedback from learners used to inform changes. Link to training publicised on dedicated LGB&T website. E-learning programme promoted as part of KSF requirements for all staff.	Deirdre McNamee Human Resources Deirdre McNamee Human Resources	end March 2018

(2) HSC staff forum				
Continue to support the HSC LGB&T Staff Forum. Develop a dedicated website for the Forum.	LGB&T staff working within HSC organisations feels valued, equal and are empowered to contribute to effect change in the organisation. HSC organisations visibly demonstrate their commitment to promoting equality for LGB&T staff	LGB&T staff are willing to engage with the Forum and contribute to action plan for the year. New members join the Forum and e-mail circulation list. Forum members contribute to the development of and ongoing updating of the Forum website.	Deirdre McNamee	end Mar 2018
(3) Research				
conduct survey with staff across HSC settings Research proposal developed by PHA which will be commissioned in 2013/2014	Organisation has robust evidence to develop actions to support LGB&T individuals working in the HSC sector LGB&T individuals will feel that their needs are being considered organisation is in a position to measure outcomes of agreed actions	Survey completed and report produced research carried out and report produced findings disseminated and learning/feedback considered	PHA Health Intelligence	end Mar 2018

(4) Guidelines for older LGB&T people in residential and day care facilities				
Work with AgeNI, RQIA, LGB&T Sector, Unison and the Independent Care Sector to develop guidelines to support older LGB&T people in residential and day care facilities.	Staff working within a range of settings to support older people will be better informed of the needs of older LGB&T people and the implications for their Health and Social care.	Proposal developed. Research carried out to inform the development of guidelines. Guidelines developed and disseminated. Training to support the guidelines provided as part of LGB&T awareness training.	Deirdre McNamee Chris Totten	end March 2018

Theme 6: Personal and Public Involvement Link to Corporate Strategy: 'Personal and public involvement'	**Key inequalities and opportunities to promote equality and good relations:** • Work to embed the culture of Personal and Public Involvement (PPI) within this, and other HSC organisations. Strategically promote and enhance the concept and culture of personal and public involvement. **Evidence** • Research on service user and carer involvement and experience throughout HSC			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**By When**
Develop a protocol to evidence compliance with personal and public involvement for planning, delivery & evaluation of services.	Identify opportunities for involvement of service users and carers including Section 75 groups	Protocol developed	PHA PPI Team	Dec 2013
Include Section 75 as scoring criteria in the allocation of funds from the Promotion and Advancement of PPI Programme.	Section 75 groups will have an opportunity to become engaged in PPI activity through PHA funding.	25% of PPI Projects will involve Section 75 groups.	PHA PPI Team	March 2014
Commission PPI training programme for use across HSC.	To raise awareness and understanding of the principles, values and practice of PPI. Helps to ensure HSC organisations are pro-	PPI Training Programme commissioned.	PHA PPI Team	March 2014

	active in their involvement of service users, carers and Section 75 groups.			
Develop a PPI communication and promotional strategy.	Promote the concept of PPI. Ensure that Section 75 groups are represented in PPI Communication Strategy.	Communication Plan developed.	PHA PPI Team	March 2014
PHA to identify gaps in PPI research, theory & practical application. Commission research with a focus on lessons to be extrapolated & shared across the HSC.	Ensure that PPI is actively researched in a Northern Ireland Context, taking into consideration Section 75 groups.	GAP analysis. Research commissioned. Learning applied.	PHA PPI Team/PHA R&D Office	Dec 2013 June 2014 onwards

Theme 7: PHA as an employer Link to Corporate Strategy: 'Ensuring effective processes'	**Key inequalities and opportunities to promote equality and good relations:** • opportunity to better promote equality for older staff who may wish to work on (potential lack of dedicated information) • lack of comprehensive staff equality data **Evidence** • feedback from staff; submission from Older People's Advocate			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**By When**
(1) Older people				
engage with staff to find out about staff preferences for working on beyond previous retirement age and suggestions for additional support	PHA staff are in a position to make informed choices in relation to working beyond previous retirement age Older staff are choosing to work on are supported	engagement event has taken place	Operations & Human Resources	Mar 2016
(2) Meeting section 75-related needs of staff				
work with BSO and partner organisations to develop a line manager guide on reasonable adjustments for staff from a range of Section 75 groups	Increased capacity of line managers to identify and respond to the range of Section 75 needs of their staff staff feel that their needs are being met	resource produced	Human Resources	Mar 2016

(3) Section 75 monitoring				
Monitor completion figures Continue to encourage staff to complete equality data section on HR system via self-service	robust data is in place to allow assessment of impacts and developing targeted actions	gaps have been identified and staff datasets are comprehensive	Human Resources	Mar 2016

Theme 8: Board composition Link to Corporate Strategy: 'Ensuring effective processes'	**Key inequalities and opportunities to promote equality and good relations:** • lack of comprehensive data on the Section 75 profile of members of HSC boards; indications that some groups are under-represented (including ethnic minorities, younger people, people with a disability) **Evidence** • no robust information available; submission from Older People's Advocate			
Action Point	**Intended Outcome**	**Performance Indicator and Target**	**By Whom**	**By When**
Approach Office for Public Appointments or Public Appointments Unit to welcome thoughts on the matter and seek advice on how greater diversity can be achieved	the Agency uses its influence to promote diversity	Engagement undertaken	Operations	Mar 2018

Appendix Examples of groups covered under the Section 75 categories

Please note, this list is for illustration purposes only, it is not exhaustive.

Category	Example groups
Religious belief	Buddhist; Catholic; Hindu; Jewish; Muslim, people of no religious belief; Protestant; Sikh; other faiths.
Political opinion	Nationalist generally; Unionists generally; members/supporters of other political parties.
Racial group	Black people; Chinese; Indians; Pakistanis; people of mixed ethnic background; Polish; Roma; Travellers; White people.
Men and women generally	Men (including boys); Trans-gendered people; Transsexual people; Women (including girls).
Marital status	Civil partners or people in civil partnerships; divorced people; married people; separated people; single people; widowed people.
Age	Children and young people; older people.
Persons with a disability	Persons with disabilities as defined by the Disability Discrimination Act 1995. This includes people affected by a range of rare diseases.
Persons with dependants	Persons with personal responsibility for the care of a child; for the care of a person with a disability; or the care of a dependant older person.
Sexual orientation	Bisexual people; heterosexual people; gay or lesbian people.

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For text relay please prefix with 18001
Website: www.publichealth.hscni.net

Updated June 2015

Disability Action Plan 2013-2018

Public Health Agency (PHA)

What we did between April 2014 and March 2015

If you need this document in another format please get in touch with us. Our contact details are at the back of this document.

(1) Communication

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
1. Work with disabled people to consider the diversity of images used and potential for portraying wider range of individuals when developing information materials including websites.	Disabled people are portrayed in a positive manner.	Checklist for authors developed and in use.	Business Services Organisation's (BSO) Equality Unit Year 2
Relevant Duty: Promote positive attitudes towards disabled people.			
What we did over the last year • We produced guidance on how to portray people who have a disability in a positive way. It is for our staff who produce documents that get published. It is also for staff who put together websites. We spoke to disability groups to find out what they think about the guidance. We also wanted to know if there were other important things we should include in the document. We then added these in. • We also produced a checklist for staff who create documents and staff who put together websites. This is an easy way for them to check that they portray people with a disability in a positive way. • This work is now completed.			

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
2. Adopt Accessible Information policy and guidance.	Improved accessibility of information.	Common wording relating to alternative formats for inclusion in documents. Protocol on how to deal with requests for alternative formats. For electronic communication, staff are supported to ensure that settings meet needs regarding accessible font size.	Agency Management Team (AMT) Year 2 BSO Information Technology Services (ITS) Year 2

Relevant Duty: Promote positive attitudes towards disabled people AND Encourage participation of disabled people in public life.

What we did over the last year

- We approved our new accessible formats policy in October last year, ahead of World Sight Day.
- We wanted to make sure that all our staff know about this policy. So we put together a short leaflet for them. We also wrote a leaflet for managers because there are a few more things that they need to think about.
- We also thought it was important that all our staff can easily find the tools that we have produced for them. With these tools, we want to help them when they develop documents. The tools also tell staff what to do when somebody asks them for a document in a different format. We created a new place on our staff website where we put all the documents they need.
- This work is now completed.

(2) Awareness Raising and Training

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
3. Encourage staff to declare that they have a disability or care for a person with a disability. Provide guidance to staff on the importance of monitoring. Prompt staff to keep up to date their personal equality monitoring records (via self-service on new Human Resources IT system)	More accurate data in place. Greater number of staff feel comfortable declaring they have a disability.	Awareness raising measure delivered. Prompt issued to staff on a regular basis.	BSO Human Resources Year 2
Relevant Duty: Promote positive attitudes towards disabled people.			
What we did over the last year • We first looked at our staff data to find out where we are starting from. In our organisation staff themselves can keep their equality data up to date on a database. We can't make staff do that. We can only ask them to do so and explain why it is good for them to let the organisation know if they have a disability. Our staff data showed that none of our staff had said that they have a disability. 88.1% had said that they don't have a disability. 11.9% had not said yet whether or not they have a disability. • We then emailed our staff to prompt them to update their equality data. At the end of the year, the staff data hadn't changed much: 0.3% staff said that they have a disability. 85.2% have said that they don't have a			

disability. 14.5% have not said yet whether or not they have a disability.

- We therefore need to keep talking to our staff about this.

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
4. Raise awareness of specific barriers faced by people with disabilities including through linking in with National Awareness Days or Weeks (such as Mind your Health Day).	Increased staff awareness of the range of disabilities and needs.	Awareness Days profiled in collaboration with voluntary sector groups. Stalls set up and road shows organised. Equality event hosted. Features run on Connect (PHA intranet). Staff awareness survey undertaken demonstrates increased awareness.	BSO Equality Unit Year 1 onwards BSO Human Resources Year 3
Relevant Duty: Promote positive attitudes towards disabled people.			

What we did over the last year

- We decided to feature two disabilities this year. When we looked at which ones to pick we went by what people told us when we consulted on this plan. They said we should make sure we look at the wide range of disabilities. They also thought we should include hidden disabilities as they tend to be forgotten about.
- We decided to feature World Sight Day on 9th October 2014 and Mental Health and Depression on 26th

January 2015.

- We wanted to make staff more aware of barriers that people with sight loss experience. The Royal National Institute for the Blind, Guide Dogs for the Blind and Sense NI kindly agreed to help us do so. They came to several of our offices and spoke about the experience of living with sight loss. They also brought 'symspecs' with them. Symspecs are goggles that simulate eye conditions. They gave staff the opportunity to look at their surroundings through the eyes of somebody who has macular degeneration, for example. Staff could also pick up leaflets with information on what support is out there for people with sight loss and their families and carers. We did something similar to feature Mental Health and Depression on 26th January 2015. Staff who volunteer for the Samaritans and for Cruse Bereavement Care came into our offices and gave a talk. Staff had the opportunity to ask questions. We also displayed a lot of information materials.
- On both days we produced a 4-page booklet for staff as part of our series called 'Disability Insight' with key information. We also provided links to videos with testimonials from people who live with these conditions. We wanted staff to have the opportunity to listen to people with a disability first hand.
- After both days we asked staff what they thought. Most staff told us that they had learned a lot about sight impairments and mental health and depression. They told us they knew more about how to help people they work with and care for who have these conditions.

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
5. In collaboration with disabled people design, deliver and evaluate training for staff on disability equality.	Increased staff awareness of the range of disabilities and needs.	All staff trained (general and bespoke) within 2 years through eLearning or interactive sessions and staff awareness initiatives delivered Training evaluation forms and staff awareness survey undertaken demonstrate increased awareness.	BSO Equality Unit; Year 2 onwards BSO Human Resources Year 3
Relevant Duty: Promote positive attitudes towards disabled people.			
What we did over the last year • 8 members of staff completed e-learning training on Disability. The e-learning programme was developed together with people who have a disability.			

(3) Getting people involved in our work, Participation and Engagement

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
6. Identify, provide and promote opportunities for more engagement for people with a disability in key work areas.	Better engagement of people with a disability (adults and children where relevant) in key areas.	Opportunities provided in key areas. Welcoming statement included and announcement issued to local disability organisations.	Directors and Assistant Directors Year 1 onwards
Relevant Duty: Encourage participation by disabled people in public life.			
What we did over the last year • We asked all the teams in our organisation to have a think about what else they could do to give people with a disability more chances to be involved in our work. They have come up with new ideas. We will put them into our plan for the next three years.			

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
7. Explore scope and interest in the establishment of a forum for staff on disability (open to staff with a disability, carers of people with a disability and those with an interest, including trade unions).	Better involvement of staff with a disability in decision-making.	Forum established.	Agency Management Team BSO Human Resources Year 2

Relevant Duty: Encourage participation by disabled people in public life.

What we did over the last year

- We talked to all other Health and Social Care organisations. We wanted to find out what they think about setting up one big staff forum on disability. We found out that some of the Trusts already have a forum. These are big organisations with up to 20,000 staff. They have told us that they prefer to keep their own forum because they think it works better that way. Things that come up can be sorted more easily, they said.

- We have decided therefore that we will work with the 10 other smaller organisations to set up one forum for our staff together. Also, we have agreed with the Trusts that we will form a group made up of people from each of the forums. The idea is that this group can share experiences across the different forums. It can also organise events open to people from all the forums. We have asked who wants to be involved in setting up a forum for the 11 small organisations and some staff agreed to help out.

(4) Recruitment and Retention

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
8. Explore the scope and options for identifying and promoting an advocate or specialist with role to support and advise staff on disability issues.	Improved support for staff.	Scoping completed.	BSO Equality Unit Year 2
Relevant Duty: Encourage participation by disabled people in public life.			
What we did over the last year • We think that staff who have a disability themselves are the ones who should decide on this. We therefore want to bring this suggestion to the staff forum once it is up and running.			

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
9. Offer mentoring opportunities for young adults and older adults with disabilities as appropriate.	People with a disability gain meaningful work experience.	Mentoring opportunities provided as appropriate.	BSO Human Resources Year 2
Relevant Duty: Encourage participation by disabled people in public life.			
What we did over the last year • We looked at the literature on different models of mentoring. • Again we think that staff who have a disability themselves are the ones who should decide on this. We therefore want to bring this suggestion to the staff forum once it is up and running.			

Action Measure	Intended Outcome	Performance Indicator and Target	Timescale and Ownership
10. Create and promote meaningful placement opportunities including for people with disabilities in line with good practice and making use of voluntary expertise in this area. 11. Produce practical guidance on process and external support available.	People with a disability gain meaningful work experience.	Guidance in place. Provide increased number of placements.	BSO Equality Unit BSO Human Resources Year 1 onwards
Relevant Duty: Encourage participation by disabled people in public life.			
What we did over the last year • We offered a six month work placement for a person with a disability. The placement was about support for the Implementing Recovery through Organisational Change (ImROC) Project. This was part of a bigger programme of placements that the organisations we work with – the Health and Social Care Board and the Business Services Organisation – had put together. They had worked with a group of disability organisations called 'Supported Employment Solutions'. Unfortunately, Supported Employment Solutions weren't able to find anybody for our placement. • We want to try again next year. Because Supported Employment Solutions did find people with a disability for the placements that the Health and Social Care Board and the Business Services Organisation had offered we can learn from how things went the first time round.			

(5) Additional Measures

- We always include Disability on our list of things to talk about at our quarterly Equality Forum with our partner organisations.

- We report on progress against our Disability Action Plan to our Board and Agency Management Team (the people at the top of our organisation).

(6) Encourage Others

- We include the duties in Screening Training. Our senior managers and those who take decisions attend this training. We also include the duties in Discovering Diversity e-learning training. All staff have to do this training.

- We include questions relating to the two duties in our screening form. The screening form is completed for all policies and decisions.

(7) Monitoring

- Together with our partners we completed an evaluation of the work placement scheme. To do this, we talked to those who took part in the scheme.

- After each of our awareness days we did a short survey with our staff together with our partner organisations. We asked them whether they felt they knew more as a result of the day. We also asked them what other disabilities they would like us to feature in future.

- We have created two databases for our staff. This is to keep a note of how many requests we get for accessible formats. It is also to keep a note of how many of those requests are met.

(8) Revisions

- Between January and March 2015 we asked all the teams in our organisation to have a think about what else they could do to promote positive attitudes and to give people with a disability more chances to be involved in our work. We wanted to make sure that all parts of our organisation take part. They have come up with new ideas. We will put them into our plan for the next three years.

(9) Conclusions

We have completed 6 actions.

We have not yet done what we said we would do under action 8. This is because we think that staff who have a disability themselves are the ones who should decide on this. We therefore want to bring this suggestion to the staff forum once it is up and running. We will do this before the end of March 2016.

We still have some work to do to complete actions 3, 7 and 9. This is because – for action 3 – we know from our data that a lot of our staff still haven't completed their equality information. For action 7, this is because we did some extra work first to speak to our colleagues across other HSC organisations to see whether we could set up one big forum for all staff. For action 9, this is because again we think that staff who have a disability themselves are the ones who should decide on this. We therefore want to bring this suggestion to the staff forum once it is up and running. We will do this before the end of March 2016.

All of the actions in our action plan are at regional and at local level.

Our action plan is a live document. If we make any big changes to our plan we will involve people with a disability. We will tell the Equality Commission about any changes.

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PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	18 June 2015
Title of Paper	Personal and Public Involvement Update
Agenda Item	15
Reference	PHA/05/06/15

Summary

As part of our Governance & Reporting arrangements, an update Report on PPI is produced and tabled for the PHA Board to consider, on a twice yearly basis.

Attached is the PPI Update Report for the period from December 2014 to May 2015.

Equality Screening / Equality Impact Assessment	N/A
Audit Trail	This report was considered by AMT on 10 June.
Recommendation / Resolution	For Approval
Director's Signature	Mary Hinds
Title	Director of Nursing, Midwifery and Allied Health Professions
Date	10 June 2015

HSC Public Health Agency

Personal and Public Involvement (PPI)

PHA Board Update June 2015

Personal & Public Involvement (PPI)

Personal and Public Involvement – What is it?

PPI is a process; a way of working that empowers and enables people to influence the commissioning, development and delivery of health and social care services in ways that are relevant and meaningful to them. It is a two way process, not solely an approach that we use when we want to hear the views of service users and carers on something which we bring to them for their consideration. People are no longer the passive recipients of health and social care services. People have a right to be and increasingly they expect to be actively involved in decisions that affect them.

The rationale for PPI – Why do it?

There have been a lot of strategic and local initiatives over recent years which have helped set the scene for and which continue to contribute to the push for involvement. These include "Health for All 2000" W.H.O in 1985, equality legislation and policies, the Wanless and Appleby Reports, Clinical & Social Care Governance arrangements and duties, the English legislation "No Decision About me, Without Me" DoH 2010, the Quality 2020 Strategy and specifically DHSSPS Circulars in 2007 and again in 2012.

Recent PfA targets, the inclusion of Involvement in Ministerial Priorities for HSC organisations, along with Transforming Your Care, all keep a focus on the need for Involvement, as do the findings from key reports such as the Francis Report and more recently the Donaldson Report. These have contributed to an increasing acknowledgement of the need to embed PPI approaches into the culture and practice of the NHS.

There is a strong and growing body of evidence for the benefits of involvement through co-design, co-production and partnership working between service users, carers and the HSC system. Examples include shared decision making and supporting self-management for people with long term chronic conditions etc. Where PPI has been embraced, clear evidence is emerging of better outcomes for patients, improved safety, quality and more effective and efficient commissioning of services which are tailored to need, achieving higher levels of satisfaction with services.

Statutory duty

Under the HSC (Reform) Act (NI) 2009, PPI is a legislative requirement. The PHA and other HSC organisations now have a Statutory Duty to Involve & Consult service users, carers and the public on:

1. The planning and provision of care;
2. The development and consideration of proposals for change in the way that care is provided;
3. Decisions that affect the provision of care.

The PHA's role

Through the most recent Policy Circular on PPI, the DHSSPS confirmed and assigned to the PHA, responsibility for the leadership of the implementation of this key policy area across the HSC. It requires the PHA to provide the DHSSPS with assurances that HSC bodies and in particular Trusts, meet their PPI Statutory and policy responsibilities. Additional responsibilities confirmed / assigned at this point also included:

- Ensuring consistency and co-ordination in approach to PPI;
- The identification and sharing of best PPI practice across the HSC;
- Communication and awareness raising about and of PPI;
- Capacity building and training;
- Development of the Engage website;
- Monitoring of and reporting on PPI.

PPI up-date

The following table outlines areas of work and action on PPI.

Priority work area	What did we set out to do?	What have we achieved?
Leadership	Establish and lead the Regional HSC PPI Forum to build understanding of and consistency of approach to PPI.	• Chair, facilitate and service Forum meetings - providing a platform for service users and carers to help shape the direction of travel for Involvement across the HSC system. • Facilitated mutual learning and the sharing of best practice in PPI through the highlighting of selected initiatives at each meeting. • Guidance and support to the PPI Leads in HSC Trusts and other HSC organisations. • Initiated discussions with voluntary and community sector organisations to investigate the establishment of an e-forum group to link into the Regional Forum.
	Provide professional advice and guidance to a range of colleagues across the PHA and other HSC organisations.	• Advice, guidance and support to a range of PHA and external colleagues on PPI issues including work in areas as diverse as Emergency Departments to the development of Care Pathways to the establishment of Reference Groups and eHealth projects.

Priority work area	What did we set out to do?	What have we achieved?
Communication & awareness raising	Develop a Communication Plan to raise awareness of PPI. Produce an Annual Report.	• Established a PPI Brand and strap line – **Involving You, Improving Care**. The PPI brand and strapline were developed with HSC partners and service users/carers who are members of the Regional PPI Forum. Personal and Public Involvement (PPI)  Involving you, improving care • As part of our Communication Plan, we have also worked to increase the profile of PPI by inclusion of articles in Connect (PHA intranet), the HSC Knowledge Exchange website and newsletter, the PCC Newsletter, Trust websites and discussion Forums etc. • Annual Report 2014/15 outlines the key achievements for the year and also showcases best practice.
PPI training	Develop a HSC wide PPI awareness raising and training programme.	Designed and developed a PPI Training programme with the Regional Forum, training sub-group, for the HSC system. This contains 5 core elements: 1. Taught PPI modules; 2. PPI Team briefing; 3. PPI Coaching; 4. Training for PPI trainers; 5. PPI e-Learning. The first 4 elements have been piloted and evaluated and are going through their final write up. Work is on-going to update and finalise the e-learning component. The complete package will be finalised and road tested over the summer with a launch anticipated for the autumn.

Priority work area	What did we set out to do?	What have we achieved?
PPI standards	Develop a set of standards and performance indicators for PPI.	The PHA has, for the first time in Northern Ireland, established a set of standards for involvement, helping to embed PPI into HSC culture and practice, supporting the drive towards a truly person centred system. The five the PPI Standards and associated Key Performance Indicators were finalised and formally endorsed by the Minister, approved by the DHSSPS and launched at an event hosted by PHA in March 2015. The Standards are: 1. Leadership; 2. Governance; 3. Opportunities & support for Involvement; 4. Knowledge & skills; 5. Measuring outcomes.  The Standards aim to help embed PPI into HSC culture & practice, setting out what is expected of HSC organisations and staff. They will help to ensure consistency of approach and practice when it comes to involving service users and carers, be that at the level of one to one care, or in the development of strategy, services etc. They will further strengthen our drive towards truly person centred services.
PPI monitoring & performance management	Develop a PPI monitoring process and performance management mechanisms.	The PHA co-designed a PPI monitoring process and performance management arrangements with service user/carers and HSC partners with agreement and endorsement of the DHSSPS. This process was undertaken externally with HSC Trusts and internally with PHA.

Priority work area	What did we set out to do?	What have we achieved?
	Initiate roll out of PPI monitoring arrangements with HSC Trusts in the first instance.	**External monitoring process:** 1. Initial baseline PPI self-assessment template completed by Trusts in partnership with their PPI panels. 2. Review and analysis of the responses by the PHA PPI team working with in conjunction with service user and carer members of the Regional HSC PPI Forum Monitoring sub group. 3. A verification visit with each HSC Trust to probe the responses and evidence provided as part of the self-assessment. 4. All information has been reviewed and a final report with findings and recommendations has been produced for the DHSSPS as part of the accountability arrangements. **Internal monitoring process:** The PHA also undertook an internal review of PPI, examining structures, processes and operations in much the same way as was conducted for Trusts. 1. Divisional PPI Leads took responsibility for the completion of PPI self-assessment templates for their respective Divisions. 2. Review and analysis was undertaken by the PHA PPI team. 3. Report produced and currently being quality assured before being taken through PHA consideration processes.

Priority work area	What did we set out to do?	What have we achieved?
PPI in practice	Lead by example by undertaking PPI with the aim of improving services, quality and/or safety.	The PPI Team worked in partnership with service users and carers from the Neurological Conditions Reference Group to take forward a recommendation emerging from the Neurological Conditions Engagement Exercise. It concerned the need to raise awareness of the everyday practical challenges facing people who had a Neurological condition, whether that is physical, mental, emotional, financial etc. Working in conjunction with Neurology clinical professionals, an awareness training programme was developed with associated resources including a DVD, hard copy training materials and an e-learning programme. This has been widely disseminated across HSC and other public sector service providers. 
	Test out models of involvement with external partners to inform and shape the development of services.	Utilised slippage funds, were available, to pilot innovative partnership based approaches to secure service user and carer involvement eg. Northern Ireland Rare Disease Partnership, Involvement Project.
PPI research	Commission PPI research	Working with a consortium with QUB and University of Ulster, the PHA has commissioned research in PPI. Although work has been delayed due to ethics approvals this has now been granted. The literature review has been completed and the focus groups for staff and service users/carers commenced in each Trust area in May.

Priority work area	What did we set out to do?	What have we achieved?
Challenges and opportunities	Assessing capacity to comply with PPI responsibilities and the Statutory Duty to Involve.	The monitoring of PPI and compliance with the Statutory Duty to Involve & Consult process has continued to highlight the capacity issue that HSC Trusts have in relation to delivering on the their PPI responsibilities. This is reinforced by an earlier high level analysis conducted by the PHA PPI Team. The Board were previously advised that a business case for Trust PPI infrastructural investment had been developed and was subsequently approved in principle by AMT. Funding is now actively being sought and it has recently been put forward for consideration under Programme for Government funding. In considering the increased range of responsibilities that the PHA now carries under this portfolio, it also became apparent that we are also now at a point where we have to consider how we deliver on these.
	Engage Website & PPI Outreach & Development Programme.	The PHA working in partnership with the Regional HSC PPI Forum generated a proposal surrounding the development of a one stop resource and support programme for PPI, accessible by both the service user, carer and HSC staff. It was then developed into a business case at the invitation of the DHSSPS. The business case for this important development was reviewed and accepted by the DHSSPS. Whilst funding was identified at the time of submission, within the current financial climate it is not clear if the DHSSPS will be in a position to release these funds. The Engage programme of work would be a major breakthrough for the advancement of PPI and compliance with the Statutory Duty of Involvement, were funding to be identified and the initiative realised.

PUBLIC HEALTH AGENCY BOARD PAPER

Date of Meeting	18 June 2015
Title of Paper	Management Statement / Financial Memorandum
Agenda Item	16
Reference	PHA/10/06/15

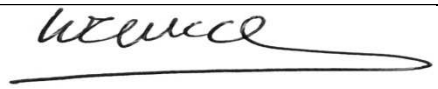
Summary

It is a standard requirement of *Managing Public Money Northern Ireland* that departments must agree a DFP-approved Management Statement/Financial Memorandum (MS/FM) with each of its arm's length bodies (ALBs).

Section 1.1.8 states that the MS/FM is required to be brought to the PHA Board annually for noting.

No changes have been made to the MS/FM since it was last approved by the Board in June 2013.

The Board is asked to note the MS/FM.

Equality Screening / Equality Impact Assessment	N/A
Recommendation / Resolution	For Noting
Director's Signature	
Title	Director of Operations
Date	10 June 2015

REGIONAL AGENCY FOR PUBLIC HEALTH AND SOCIAL WELL-BEING: MANAGEMENT STATEMENT

May 2013

1. INTRODUCTION

1.1 This document

1.1.1 Subject to the legislation noted below, this *Management Statement* establishes the framework, agreed with the Department of Health, Social Services and Public Safety (the sponsor Department), within which the Regional Agency for Public Health and Social Well-being, commonly known as the Public Health Agency, (hereafter referred to as the PHA) will operate. The term 'Department' is used to include the authority of both the Department and its Minister. Only in those cases where reference is intended to his/her personal authority (see, principally, Section 3.1) is the Minister specified.

1.1.2 The associated *Financial Memorandum* sets out in greater detail certain aspects of the financial provisions which the PHA shall observe. However the *Management Statement* and the associated *Financial Memorandum* do not convey any legal powers or responsibilities, nor do they comprise the totality of the guidance, directives etc which have applied and (as determined by the Sponsor Department) continue to apply to the PHA.

1.1.3 The document shall be reviewed by the sponsor Department at least every five years. However, due to changes being considered to the business planning process it is likely that the first review will take place during the 2013-14 financial year.

1.1.4 In addition, the PHA or the Department may propose amendments to this document at any time. Any such proposals by the PHA shall be considered in the light of evolving Departmental policy aims, operational factors and the record of the PHA itself. The guiding principle shall be that the extent of flexibility and freedom given shall reflect both the quality of the PHA's internal controls to achieve performance and its operational needs. The Department shall determine what changes, if any, are to be incorporated in the

document. Legislative provisions shall take precedence over any part of the document. Significant variations to the document shall be cleared with DFP after consultation with the PHA, as appropriate. (The determination of those issues that are "significant" will be made by the Department and DFP on a case by case basis).

1.1.5 This MS/FM has been approved by DFP Supply, and signed and dated by the Department after consultation with the PHA.

1.1.6 Any question regarding the interpretation of the document shall be resolved by the Department after consultation with the PHA and, as necessary, with DFP (and OFMDFM if appropriate).

1.1.7 Copies of this document and any subsequent substantive amendments shall be placed in the Library of the Assembly. Copies shall also be made available to members of the public on the PHA website.

1.1.8 A copy of the MS/FM for the PHA should be given to all newly appointed Board Members, senior executive staff and departmental sponsor staff on appointment. Additionally the MS/FM should be tabled for the information of Board members at least annually at a full meeting of the Board. Amendments made to the MS/FM should also be brought to the attention of the full Board on a timely basis.

1.2 PHA: founding legislation, functions, duties etc

1.2.1 The PHA is established under section 12 (1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009 (hereafter referred to as the Act). The PHA does not carry out its functions on behalf of the Crown.

1.2.2 The PHA is established for the purposes specified in section 13 of the Act. The PHA's general powers etc are listed in Schedule 2 to the Act.

1.3 **Classification**Error! Bookmark not defined.

1.3.1 For policy/administrative purposes the PHA is classified as a Health and Social Care body (akin to an executive non-departmental public body) and for national accounts purposes is classified to the central government sector.

2. AIMS, OBJECTIVES AND TARGETS

2.1 Overall aim

2.1.1 The overall aim of the PHA is to improve the health and social well-being of the population and the quality of care provided, and to protect the population from communicable disease or emergencies or other threats to public health. As well as the provision or securing of services related to those functions, the PHA will commission or undertake programmes of research, health awareness and promotion etc.

2.1.2 This aim will be delivered through three core functions of the PHA:

- Securing the provision of and developing and providing programmes and initiatives designed to secure the improvement of the health and social well-being of and reduce health inequalities between, people in Northern Ireland;
- Protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies; and
- providing professional input to the commissioning of health and social care services which meet established quality standards and which support innovation.

2.1.3 The PHA also has a general responsibility for promoting improved partnership working with local government and other public sector organisations to bring about real improvements in public health and social well-being on the ground and anticipating the new opportunities offered by community planning.

2.2 Objectives and key targets

2.2.1 The PHA's performance framework is determined by the Department in the light of its wider strategic aims and of current Programme for Government objectives and targets. The PHA's key targets, standards and actions are defined by the Department within Commissioning Directions and approved by the Minister. The Department also determines, by direction, the format and broad content of the Commissioning Plan, which is to be drawn up by the HSCB in accordance with section 8 of the Act, i.e. in consultation with the PHA, having due regard for any advice or information provided by the Agency, and published only with its approval. The Commissioning Plan explains how the PHA will meet each of the targets, standards and actions for which it is deemed by the Department to have sole or lead responsibility. The document will also set out the PHA's contribution to the commissioning process through its professional medical expertise.

2.3 Relationship with the Safeguarding Board for Northern Ireland

2.3.1 The Safeguarding Board NI (SBNI) was established under the Safeguarding Board (Northern Ireland) Act 2011 and is a separate entity from the PHA. However the PHA acts as a corporate host for the Safeguarding Board NI (SBNI), supporting the SBNI by providing HR, Financial and other corporate support functions.

2.3.2 The PHA is not accountable for how the SBNI discharges its statutory objectives and functions, but is accountable to the Department for its discharge of corporate host obligations undertaken on behalf of SBNI. In acting as a corporate host the provisions of this MS/FM apply to activities undertaken on behalf of the SBNI.

2.3.3 The respective responsibilities of the Department, PHA and SBNI are set out in a Memorandum of Understanding dated 11 September 2011 a copy of which is attached at Appendix 2.

3. RESPONSIBILITIES AND ACCOUNTABILITY

3.1 The Minister

3.1.1 The Minister is accountable to the Assembly for the activities and performance of the PHA. His/Her responsibilities include:

- approving the Commissioning Plan;
- keeping the Assembly informed about the PHA's performance, as part of the HSC system;
- carrying out responsibilities specified in the founding legislation, including appointments to the PHA's Board and the laying of its annual report and accounts before the Assembly; and
- approving the remuneration scheme for non-executive Board members and setting the annual pay increase each year under these arrangements.

3.2 The Accounting Officer of the sponsor Department

3.2.1 The Sponsor Department's Accounting Officer (the 'Departmental Accounting Officer') has designated the Chief Executive as the PHA's Accounting Officer, and may withdraw the Accounting Officer

designation if he/she believes that the incumbent is no longer suitable for the role. The respective responsibilities of the Departmental Accounting Officer and the Accounting Officers of arm's length bodies are set out in Chapter 3 of *Managing Public Money Northern Ireland* (MPMNI).

3.2.2 In particular, the Departmental Accounting Officer shall ensure that:

- the PHA's plans support the Department's wider strategic aims and will contribute, as appropriate, to the achievement of Programme for Government Commitments, Departmental requirements, Commissioning Plan Directions, standards and actions;
- the financial and other management controls applied by the Department to the PHA are appropriate and sufficient to safeguard public funds, and that the PHA's compliance with those controls is effectively monitored ("public funds" include not only any funds granted to the PHA by the Assembly but also any other funds falling within the stewardship of the PHA); and
- the internal controls applied by the PHA conform to the requirements of regularity, propriety and good financial management.

3.2.3 The Departmental Accounting Officer is also responsible for ensuring that arrangements are in place to:

- continuously monitor the PHA's activities to measure progress against approved targets, standards and actions, and to assess compliance with safety and quality, governance, risk management and other relevant requirements placed on the organization;
- address significant problems in the PHA, making such interventions as he/she judges necessary;
- periodically carry out an assessment of the risks both to the Department's and the PHA's objectives and activities;

- inform the PHA of relevant Government policy in a timely manner; and
- bring concerns about the activities of the PHA to the full PHA Board, requiring explanations and assurances that appropriate action has been taken.

3.2.4 The Health Development Policy Branch within the Department is the sponsoring team for the PHA, forming its primary point of contact with the Department on non-financial management and performance. Regarding such matters, the team is the primary source of advice to the Minister on the discharge of his/her responsibilities in respect of the PHA. It also supports the Departmental Accounting Officer on his/her responsibilities towards the PHA.

3.2.5 The relationship between the PHA and its Departmental sponsoring team, based on the principles of good public administration, is articulated through direction, guidance on good practice as notified to the PHA. The salient requirements are described at Appendix 1.

3.2.6 On financial matters, the primary point of Departmental contact for the PHA is Finance Directorate. That Directorate also supports the Departmental Accounting Officer on his/her responsibilities towards the PHA as regards accounting arrangements, budgetary control and other financial matters. In doing so, Finance Directorate liaises as appropriate with Health Development Policy Branch.

3.3 The Chief Executive's rôle as Accounting Officer

3.3.1 The Chief Executive, as the PHA's Accounting Officer, is personally responsible for safeguarding the public funds of which he/she has charge; for ensuring propriety and regularity in the handling of those funds; and for the day-to-day operations and management of the PHA. In addition, he/she should ensure that the PHA as a whole is run on the

basis of the standards (in terms of governance, decision-making and financial management) set out in Box 3.1 to MPMNI.

3.3.2 In addition, the Chief Executive must, within three months of appointment, attend the training course ‘An introduction to Public Accountability for Accounting Officers’.

3.3.3 Responsibilities for accounting to the Assembly include:

- signing the accounts, and being responsible for ensuring that proper records are kept relating to the accounts and that the accounts are properly prepared and presented in accordance with any directions issued by the Department or DFP;
- signing a Statement of Accounting Officer’s responsibilities, for inclusion in the annual report and accounts;
- signing a Governance Statement regarding the PHA’s system of internal control, for inclusion in the annual report and accounts;
- sign a mid-year assurance statement on the condition of the PHA’s system of internal control;
- acting in accordance with the terms of this document and with the instructions and relevant guidance in MPMNI and other instructions and guidance issued from time to time by the Department and DFP; and
- giving evidence, normally with the Accounting Officer of the Department, if summoned before the Public Accounts Committee on the use and stewardship of public funds by the PHA.

3.3.4 Particular responsibilities to the Department include:

- establishing, with the approval of the Department, the PHA’s Corporate and Business Plans in support of the Department’s wider strategic aims and objectives and targets in the Programme for Government and the Minister’s Commissioning Directions;

- contributing, in accordance with section 8 of the Act, to the establishment by the HSCB of the Commissioning Plan in support of the Department's wider strategic aims and objectives and targets in the Programme for Government and Commissioning Directions;
- informing the Department of the PHA's progress in helping to achieve the Department's wider strategic aims and objectives, and relevant targets in the Programme for Government and Commissioning Directions, while demonstrating how resources are being used to achieve those objectives;
- ensuring that timely forecasts and monitoring information on performance and finance are provided to the Department, including prompt notification of overspends or underspends and that corrective action is taken;
- notifying to the Department any significant problems, whether financial or otherwise, and whether detected by internal audit or by other means, as appropriate and in timely fashion;
- ensuring that a system of risk management, based on Departmental guidance) is maintained to inform decisions on financial and operational planning and to assist in achieving objectives and targets;
- ensuring that an effective system of programme and project management and contract management is maintained;
- ensuring compliance with the Northern Ireland Public Procurement Policy;
- reporting on compliance with controls assurance and quality standards to the Department;
- ensuring that an Assurance Framework is developed and maintained;

- ensuring that a business continuity plan is developed and maintained;
- ensuring that effective procedures for handling complaints about the PHA are established and made widely known within the PHA;
- ensuring that effective procedures for handling adverse incidents are established and made widely known within the PHA;
- ensuring that an Equality Scheme is in place, reviewed and equality impact assessed as required by the Equality Commission and OFMDFM;
- ensuring that Lifetime Opportunities is taken into account;
- ensuring that the requirements of the Data Protection Act 1998 are complied with;
- ensuring that the requirements of the Freedom of Information Act 2000 are complied with and that a publication scheme is in place which is reviewed as required and placed on the website; and
- ensuring that the requirements of relevant statutes, court rulings, and departmental directions are fully complied with.

Responsibilities to the Board of the PHA

3.3.5 The Chief Executive is responsible for:

- advising the Board on the discharge of its responsibilities as set out in this document, in the founding legislation and in any other relevant instructions and guidance that may be, or have been, issued from time to time;
- advising the Board on the PHA's performance compared with its aims and objectives;

- ensuring that financial considerations are taken fully into account by the Board at all stages in reaching and executing its decisions, and that standard financial appraisal techniques are followed; and
- taking action in line with Section 3.8 of *MPMNI* if the Board, or its Chair, is contemplating a course of action involving a transaction which the Chief Executive considers would infringe the requirements of propriety or regularity, or does not represent prudent or economical administration, efficiency or effectiveness.

3.4 The Chief Executive's role as Consolidation Officer

3.4.1 For the purposes of Whole of Government Accounts, the Chief Executive of the PHA is normally appointed by DFP as the PHA's Consolidation Officer.

3.4.2 As the PHA's Consolidation Officer, the Chief Executive shall be personally responsible for preparing the consolidation information, which sets out the financial results and position of the PHA; for arranging its audit; and for sending the information and the audit report to the Principal Consolidation Officer nominated by DFP.

3.4.3 As Consolidation Officer, the Chief Executive shall comply with the requirements of the PHA Consolidation Officer Memorandum as issued by DFP and shall, in particular:

- ensure that the PHA has in place and maintains sets of accounting records that will provide the necessary information for the consolidation process; and
- prepare the consolidation information (including the relevant accounting and disclosure requirements and all relevant consolidation adjustments) in accordance with the consolidation instructions and directions ["Dear Consolidation Officer" (DCO) and

"Dear Consolidation Manager" (DCM) letters] issued by DFP on the form, manner and timetable for the delivery of such information.

3.5 Delegation of the Chief Executive's duties

3.5.1 The Chief Executive may delegate the day-to-day administration of his/her Accounting Officer responsibilities to other employees in the PHA. However, he/she shall not assign absolutely to any other person any of the responsibilities set out in this document.

3.6 The Chief Executive's role as Principal Officer for Ombudsman cases

3.6.1 The Chief Executive of the PHA is the Principal Officer for handling cases involving the Northern Ireland Commissioner for Complaints. As Principal Officer, he/she shall inform the Permanent Secretary of the sponsor Department of any complaints about the PHA accepted by the Ombudsman for investigation, and about the PHA's proposed response to any subsequent recommendations from the Ombudsman.

3.7 The PHA's Board

3.7.1 Board members are appointed by the Minister, following an open competition in accordance with the Code of Practice issued by the Commissioner for Public Appointments for Northern Ireland. The established departmental practice is that initial appointments are usually for a four year period. Re-appointment for a second term of appointment can be considered.

3.7.2 The Board must ensure that effective arrangements are in place to provide assurance on risk management, governance and internal

control. The Board must set up an Audit Committee, which complies with the requirements of DAO 07/07 and any subsequent relevant guidance, is chaired by an independent non-executive member, and comprising solely independent members, to provide independent advice on the effectiveness of the internal control and risk management systems.

3.7.3 The Board has corporate responsibility for ensuring that the PHA fulfils the aims and objectives set by the Department/Minister, and for promoting the efficient, economic and effective use of staff and other resources by the PHA. To this end, and in pursuit of its wider corporate responsibilities, the Board shall:

- establish the overall strategic direction of the PHA within the policy and resources framework determined by the Department/Minister;
- ensure that the PHA's performance fully meets its aims and objectives as efficiently and effectively as possible;
- ensure that the Department is kept informed of any changes which are likely to impact on the strategic direction of the PHA or on the attainability of its targets, and determine the steps needed to deal with such changes;
- ensure that any statutory or administrative requirements for the use of public funds are complied with; that the Board operates within the limits of its statutory authority and any delegated authority set by the Department, and in accordance with any other conditions relating to the use of public funds; and that, in reaching decisions, the Board takes into account all relevant guidance issued by DFP and the Department or other relevant authority;
- ensure that it receives and reviews regular financial information concerning the management of the PHA; is informed in a timely manner about any concerns about the activities of the PHA; and

provides positive assurance to the Department that appropriate action has been taken on such concerns;

- constructively challenge the PHA's executive team in their planning, target setting and delivery of performance;
- ensure that an executive member of the Board has been allocated lead responsibility for risk management;
- demonstrate high standards of corporate governance at all times, including using the independent audit committee (see paragraph 3.7.2) to help the Board to address the key financial and other risks facing the PHA; and
- appoint a Chief Executive to the PHA and, in consultation with the Department, set performance objectives and remuneration terms linked to these objectives for the Chief Executive which give due weight to the proper management and use of public monies.

3.8 The Chair's personal responsibilities

3.8.1 The chair is appointed by the Minister, following an open competition in accordance with the Code of Practice issued by the Commissioner for Public Appointments for Northern Ireland. The established departmental practice is that initial appointments are usually for a four year period. Re-appointment for a second term of appointment can be considered.

3.8.2 The Chair is accountable to the Minister through the Departmental Accounting Officer. Communications between the PHA Board and the Minister should normally be through the Chair (who will ensure that the other Board members are kept informed of such communications). He/she is responsible for ensuring that the PHA's policies and actions support the Department's wider strategic policies, and that the PHA's

affairs are conducted with probity. Where appropriate, these policies and actions should be clearly communicated and disseminated throughout the PHA.

3.8.3 In addition, the Chair has the following leadership responsibilities:

- formulating the Board's strategy for discharging its duties;
- ensuring that the Board, in reaching decisions, takes proper account of guidance provided by the Department,
- ensuring that risk management is regularly and formally considered at Board meetings;
- promoting the efficient, economic and effective use of staff and other resources;
- encouraging high standards of regularity and propriety;
- representing the views of the Board to the general public; and
- ensuring that the Board meets at regular intervals throughout the year and that the minutes accurately record the decisions taken and, where appropriate, the views of individual board members. Meetings must be open to the public, the public should be advised of meetings through the press and the minutes must be placed on the PHA website after formal approval.

3.8.4 The Chair has also:

- ensure that all members of the Board, when taking up office, are fully briefed on the terms of their appointment and on their duties, rights and responsibilities, and receive appropriate induction training, including on the financial management, risk management and reporting requirements of public sector bodies and on any material differences which may exist between private and public sector practice;

- advise the Department of the needs of the PHA when Board vacancies arise, with a view to ensuring a proper balance of professional, financial or other expertise;

- assess, annually, the performance of individual Board members. Board members will be subject to ongoing performance appraisal, with a formal assessment being completed by the Chair of the Board at the end of each year. Members will be made aware that they are being appraised, the standards against which they will be appraised and will have an opportunity to contribute to and view their report. The Chair of the Board will also be appraised on an annual basis by the Departmental Accounting Officer or another official acting on their behalf;

- ensure that a Code of Practice for Board members is in place, based on the 'Code of Conduct and Code of Accountability for Board members of Health and Social Care Bodies'.

3.9 The individual Board member's responsibilities

3.9.1 Individual Board members shall act in accordance with their wider responsibilities as members of the Board – namely to:

- comply at all times with the Code of Practice (see paragraph 3.8.4) adopted by the PHA and with the rules relating to the use of public funds and to conflicts of interest;

- not misuse information gained in the course of their public service for personal gain or for political profit, nor seek to use the opportunity of public service to promote their private interests or those of connected persons or organizations; and to declare publicly and to the Board any private interests that may be thought to conflict with their public duties;

- comply with the Board's rules on the acceptance of gifts and hospitality, and of business appointments as set out in the Financial Memorandum; and
- act in good faith and in the best interests of the PHA.

3.10 Consulting service users and other interest groups

3.10.1. The PHA will, in accordance with Sections 18-20 of the Act, work in partnership with its patients, clients, other service users and carers, and with other interest groups, to commission or deliver the services for which it has responsibility, to agreed standards. It will consult regularly to develop a clear understanding of their needs and expectations of its services, actively seeking out comment from patients, clients, other service users and carers, and from interest groups, in working to deliver a high quality, safe and accessible service. It will disseminate public information about the services for which it is responsible.

3.10.2. The PHA will, in carrying out its equality duties, consult in a timely, open and inclusive way and in accordance with the Equality Commission's guiding principles. It will monitor its policies to ensure that as each policy is revised it promotes greater equality of opportunity.

3.10.3. The PHA must prepare its own consultation scheme which is to be submitted to the Department for approval and reviewed regularly.

4. PLANNING, BUDGETING AND CONTROL

4.1 The Corporate/Business Plan

The process for developing and approving annual business plans is subject to review and change. It is envisaged that this Management Statement will be reviewed again when the business planning process has been agreed.

4.1.1 Consistent with the timetable for Northern Ireland Executive Budgets, the PHA shall submit annually to the sponsor Department a draft of the Corporate Plan covering up to three years ahead. Plans will be subject to Departmental approval. The PHA shall have agreed with the sponsor Department the issues to be addressed in the Plan and the timetable for its preparation. The Plan will be subject to Departmental approval.

4.1.2 The Plan shall reflect the PHA's statutory duties and, within those duties, the priorities set from time to time by the Minister. The Plan shall, to the extent required by the Department, demonstrate how the PHA contributes to the achievement of the Department's strategic aims and Programme for Government objectives. Its contents will also reflect the sponsor Department's decisions on policy and resources taken in the context of the Executive's wider policy and spending priorities and decisions.

4.1.3 The Corporate Plan, amplified as necessary, shall inform the Business Plan. The Business Plan shall include key targets and milestones for the year immediately ahead and shall be linked to budgeting information so that resources allocated to achieve specific objectives can be readily identified by the sponsor Department.

4.1.4 The Plans will include the following, as directed by the Department:

- Key objectives and associated key performance targets (financial and non-financial) for the forward years, and the strategy for

achieving those objectives; forward years, and its strategy for achieving those objectives;

- alternative scenarios to take account of factors which may significantly affect the execution of the plan, but which cannot be accurately forecast;
- a forecast of expenditure and income, taking account of guidance on resource assumptions and policies provided by the sponsor Department. These forecasts should represent the PHA's best estimate of all its available income i.e. not just grant or grant-in-aid; and
- other matters as specified by the sponsor Department

4.15 The Corporate/Business Plan shall be published by the PHA and made available on its website. A summary version shall be made available to staff.

4.2 The PHA's contribution to the Commissioning Plan

4.2.1 In exercising the powers conferred on it by Section 8 (3) of the Act, the Department sets out the Minister's instructions to commissioners in an annual commissioning direction. The commissioning direction sets the framework within which the HSCB (including its LCGs) and the PHA will commission health and social care.

4.2.2 Section 8 of the Act requires the HSCB, in respect of each financial year, to prepare and publish a commissioning plan in full consultation with, and having due regard to any advice or information provided by, the PHA. The commissioning direction specifies the form and content of the commissioning plan in terms of the services to be commissioned and the resources to be deployed. The plan may not be published unless approved by the PHA. In the unlikely event of failure to agree

the commissioning plan, the matter is referred to the Department for resolution.

4.2.3 The plan will also include delivery plans for those Commissioning Direction targets which the HSCB or PHA is deemed by the Department to be in the lead.

4.2.4 The Department's presumption is that all of the standards and targets in Priorities for Action are both achievable and affordable. By exception, the Commissioning Plan should indicate where both the HSCB and PHA believe a particular standard or target not to be achievable and/or affordable, explaining their belief and proposing actions, within existing resources, to mitigate the problems envisaged.

4.2.5 The Commissioning Plan will demonstrate how the totality of revenue resources has been committed to individual organisations, disaggregated by Local Commissioning Group.

4.2.6 The Commissioning Plan will be subject to Ministerial approval.

4.2.7 The PHA will provide the Department with a quarterly assessment of the progress being made in the delivery of the Department's wider strategic aims and objectives, and relevant targets in the current Programme for Government and Commissioning Directions, and demonstrating how resources are being used to achieve those objectives, for those areas for which the PHA is identified as being responsible.

4.2.8 Drawing as appropriate on the views and information supplied by the PHA, the HSCB will provide the Department with a quarterly assessment of the progress being made in the delivery of relevant targets where there is joint responsibility.

4.2.9 The Commissioning Plan shall by be published by the HSCB, with the agreement of the PHA. A copy of the Plan shall be available on the PHA's website, and a summary version shall be made available to its staff.

4.3 Reporting performance to the Department

4.3.1 The PHA shall operate management information and accounting systems which enable it to review, in a timely and effective manner, its financial and non-financial performance against the budgets and targets set out in the approved PHA corporate and business plans and in the Commissioning Plan. Regarding the latter, this requirement applies, as appropriate, both to those targets for which the PHA has lead responsibility (such as screening and health protection) and to those where its support or collaboration is deemed necessary for performance monitoring and service improvement purposes.

4.3.2 The PHA shall take the initiative in informing the Department of changes in external conditions which make the achievement of its objectives more or less difficult, or which may require a change to the budget or objectives as set out in the Commissioning Plan or Corporate/Business Plan.

4.3.3 The PHA's performance in meeting its Commissioning Plan and Corporate/Business Plan objectives shall be reported to the Department as part of the accountability review process.

4.3.4 The PHA shall take the initiative in informing the Department of changes in external conditions which make the achievement of objectives more or less difficult, or which may indicate a change to the budget or objectives as set out in the Corporate/Business plan.

4.3.5 Senior Departmental officials will hold biannual accountability reviews with the PHA to discuss the PHA's overall performance, its current and future activities, any policy developments relevant to those activities

safety and quality, financial performance and corporate control/risk management performance.

4.3.6 The PHA's performance against key Departmental/Ministerial targets shall be reported in the PHA's annual report and accounts.

4.3.7. The PHA is also responsible for monitoring and reporting to the Department on:

- Trust compliance with professional standards for medical, nursing and allied health professionals e.g. professional regulation and training and development; and
- Compliance with statutory supervision requirements; and
- Safety and quality aspects of PHA contracts with voluntary and community sector providers.

4.3.8 The Department will, at its discretion, request evidence of progress against key objectives.

5 BUDGETING PROCEDURES

5.1 The PHA's budgeting procedures are set out in the *Financial Memorandum*.

5.2 Internal audit

5.2.1 The PHA shall establish and maintain arrangements for internal audit in accordance with FD (DFP) 07/09 the Treasury's *Government Internal Audit Standards (GIAS)*, HSS(F)21/03 *Internal Audit Arrangements between a Sponsoring Department and its Non-Departmental Public Bodies and HSS(F)13/2007 Model HPSS Financial Governance Documents* or subsequent Government standards and guidelines.

5.2.2 Those arrangements shall also comply with the Department's requirements on foot of HSC (F) 11/2010 which promulgated DAO

(DFP) 01/10 *Internal Audit Arrangements between Departments and Arm's Length Bodies*. These include:

- having input to the PHA's planned internal audit coverage, to ensure that shared assurance requirements (in relation to risk areas/topics) are built into the PHA's audit plan and audit strategy;
- arrangements for the receipt of audit reports, assignment reports, the Head of Internal Audit's annual report and opinion etc;
- arrangements for the completion of Internal and External Assessments of the PHA's internal audit function against GIAS including advising that the sponsor Department reserves a right of access to carry out its own independent reviews of internal audit in the PHA; and
- the right of access to all documents prepared by the PHA's internal auditor, including where the service is contracted out. Where the PHA's audit service is contracted out the PHA should stipulate this requirement when tendering for the services.

5.2.3. The PHA shall consult with the Department to ensure that the latter is satisfied with the competence and qualifications of the Head of Internal Audit and that the requirements for approving the appointment are in accordance with GIAS and relevant DFP guidance.

5.3 Audit Committee

5.3.1 The PHA shall set up an independent audit committee as a committee of its Board, in accordance with the Cabinet Office's Guidance on Codes of Practice for Public Bodies (FD (DFP) 03/06 refers) and in line with the Audit Committee Handbook DAO (DFP) 07/07.

5.3.2 The sponsor Department will attend one PHA audit committee meeting per organisation, per year, as an observer and will not participate in any Audit Committee discussion.

5.3.3 The Audit Committees meeting agendas and papers shall be forwarded as soon as possible to the sponsoring team.

5.3.4 The sponsor department will review the PHA's audit committee terms of reference. The PHA shall notify the sponsor department of any subsequent changes to the audit committee's terms of reference.

5.4 Fraud

5.4.1 The PHA should include arrangements for preventing, countering and dealing with fraud by:

- assessing, identifying, evaluating, and responding to fraud risks;
- ensuring the Audit Committee formally considers the anti-fraud measures in place;
- reporting immediately all suspected or proven frauds, including attempted fraud to the sponsor Department; and
- complying with all guidance issued by the Department.

5.4.2 The sponsor department will report suspected and actual frauds immediately to DFP and the C&AG. In addition the PHA shall forward to the sponsor Department the annual fraud return, commissioned by DFP, on fraud and theft suffered by the PHA.

5.4.3 The sponsor department will review the PHA's Anti-Fraud Policy and Fraud Response Plan. The PHA shall notify the sponsor department of any subsequent changes to the policy or response plan.

Additional Departmental access to the PHA

5.5.1 In addition to the right of access referred to in paragraph 5.2.3 above, the Department shall have a right of access to all the PHA's records, meetings and personnel for purposes such as audits, operational investigations, and as the Departmental Accounting Officer sees fit (subject to any relevant legal restrictions).

6. EXTERNAL ACCOUNTABILITY

6.1 The annual report and accounts

6.1.1 After the end of each financial year the PHA shall publish as a single document an annual report of its activities together with its audited annual accounts. The report shall also cover the activities of any corporate bodies under the control of the PHA. A draft of the report shall be submitted to the Department two weeks before the proposed publication date although it is expected that the department and the PHA will have had extensive pre-publication discussion on the content of the report prior to formal submission to the department.

6.1.2 The report and accounts shall comply with the most recent version of the Government Financial Reporting Manual (FReM) issued by DFP. The accounts shall be prepared in accordance with any relevant statutes and the specific Accounts Direction issued by the Department.

6.1.3 The report and accounts shall outline the PHA's main activities and performance during the previous financial year and set out in summary form the PHA's forward plans. Information on performance against key financial targets shall be included in the notes to the accounts, and shall therefore be within the scope of the audit.

6.1.4 The report and accounts shall be laid before the Assembly and made available, in accordance with the guidance on the procedures for presenting and laying the combined annual report and accounts as prescribed in the relevant finance circular issued by the Department.

6.1.5 Due to the potential accounting and budgetary implications, any changes to accounting policies or significant estimation techniques underpinning the preparation of annual accounts shall require the prior written approval of the Department.

6.2 External audit

6.2.1 The Comptroller and Auditor General (C&AG) audits the PHA's annual accounts and passes the accounts to the Department who shall lay them before the Assembly. For the purposes of audit the C&AG has a statutory right of access to relevant documents, as provided for in Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003.

6.2.2 The C&AG has agreed to liaise with the PHA on who – the NIAO or a commercial auditor – shall undertake the actual audit on his behalf. The final decision rests with the C&AG.

6.2.3 The C&AG have agreed to share with the Department, information identified during the audit process and the audit report (together with any other outputs) at the end of the audit. This shall apply, in particular, to issues which impact on the Department's responsibilities in relation to financial systems within the PHA. The C&AG will also consider, where asked, providing Departments and other relevant bodies with Regulatory Compliance Reports and other similar reports which the Department may request at the commencement of the audit and which are compatible with the independent auditor's role.

6.3 VFM examinations

6.3.1 The C&AG may carry out examinations into the economy, efficiency and effectiveness with which the PHA has used its resources in discharging its functions. For the purpose of these examinations the C&AG has statutory access to documents, as provided for under Articles 3 and 4 of the Audit and Accountability (Northern Ireland) Order 2003. Where making payment of a grant, or drawing up a contract, the PHA should ensure that it includes a clause which makes the grant or contract conditional upon the recipient or contractor

providing access to the C&AG in relation to documents relevant to the transaction including those relevant to matters of professional competence, misconduct etc. Where subcontractors are likely to be involved, it should also be made clear that the requirements extend to them.

7. STAFF MANAGEMENT

7.1 General

7.1.1. Within the arrangements approved by the Department, the PHA shall have responsibility for the recruitment, retention and motivation of its staff. To this end the PHA shall ensure that:

- its rules for the recruitment and management of staff create an inclusive culture in which diversity is fully valued; where appointment and advancement is based on merit; and where there is no discrimination on grounds of gender, marital status, domestic circumstances, sexual orientation, race, colour, ethnic or national origin, religion, disability, community background or age;
- the level and structure of its staffing, including grading and numbers of staff, are appropriate to its functions and the requirements of efficiency, effectiveness and economy as agreed by the Department;
- the performance of its staff at all levels is satisfactorily appraised;
- its staff are encouraged to acquire the appropriate professional, management and other expertise necessary to achieve the PHA's objectives;
- proper consultation with staff takes place on key issues affecting them;
- adequate grievance and disciplinary procedures are in place;

- o whistle blowing procedures consistent with the Public Interest Disclosure (Northern Ireland) Order 1998, as amended, are in place;
- o a code of conduct for staff is in place based on Annex 5A of Public Bodies: A Guide for NI Departments (available at www.afmdni.gov.uk). This code should be copied to the sponsor team.

8. REVIEWING THE ROLE OF THE PHA

8.1 The role of, and justification for the PHA shall be reviewed periodically, in accordance with the business needs of the sponsor Department and the PHA. Reference should be made to Chapter 9 of the Public Bodies: a Guide for Northern Ireland Departments.

Signed: _____ Date: _____

On behalf of the PHA

Signed: _____ Date: _____

On behalf of the Department

Appendix 1

1. Documentary requirements

1.1 Documentation to be copied to the Sponsor Branch for information

Monthly (or as the occasion arises)

- Board meeting papers (including draft minutes) for each meeting as and when issued to Committee members
- Audit Committee papers (including draft minutes) for each meeting as and when issued to Committee members
- Assurance Committee papers (including draft minutes) for each meeting as and when issued to Committee member

Annually

- Register of Board members' interests
- The annual report, with the draft submitted to the Department two weeks before the publication date (*separate timetable for the annual accounts, Governance Statement etc, set by Finance Directorate*)
- The Assurance Framework (annually)

Once and then when revised

- Code of Conduct for Board members
- Code of Practice for staff
- Audit Committee Terms of Reference
- Audit Strategy
- Assurance/Governance Committee Terms of Reference
- Complaints procedure
- Anti-Fraud Policy
- Fraud Response Plan
- Whistle-blowing procedures

- Grievance and Disciplinary procedures
- Equality scheme
- Publication scheme
- Consultation Scheme
- Business Continuity Plan

1.2 Documentation to be copied to the Sponsor Branch for consideration/ comment/ approval

Quarterly

- Report on quarterly assessment of progress being made in the delivery of the Commissioning Plan's aims and objectives

Bi-annual

- Corporate Risk Register every six months

Annually

- Annual Governance Statement
- Mid-year Assurance Statement (by end-October)
- Annual report on Compliance with Controls Assurance Standards
- Annual Internal Audit work-plan
- Internal Audit Progress Report
- Annual Fraud return
- Corporate Plan (including the Business Plan) must be produced and approved by the Department
- an annual Commissioning Plan established by the HSCB but approved by the PHA
- The Head of Internal Audit's end-of-year and mid-year opinion on risk management, control and governance

Once

- Inspection reports by external bodies (e.g. RQIA, MHRA), as specified in directions
- Internal Audit reports with less than satisfactory assurance
- NIAO management letters

Financial Memorandum
for the
Public Health Agency

May 2013

Contents

I. INTRODUCTION

1 This *Financial Memorandum* sets out certain aspects of the financial framework within which the Public Health Agency (PHA) is required to operate

2 The terms and conditions set out in the combined M*anagement Statement* and *Financial Memorandum* may be supplemented by guidelines or directions issued by the DHSSPS/Minister in respect of the exercise of any individual functions, powers and duties of the PHA.

3 The PHA shall satisfy the conditions and requirements set out in the combined document, together with such other conditions as the DHSSPS/Minister may from time to time impose.

II. THE PHA'S INCOME AND EXPENDITURE - GENERAL

The Departmental Expenditure Limit (DEL)

4 The PHA's current and capital expenditure form part of the sponsoring Department's Resource DEL and Capital DEL respectively.

Expenditure not proposed in the budget

5 The PHA shall not, without prior written Departmental approval, enter into any undertaking to incur any expenditure which falls outside the PHA's delegations or which is not provided for in the PHA's annual budget as approved by the DHSSPS.

Procurement

6 The PHA's procurement policies shall reflect the public procurement policy adopted by the Northern Ireland Executive in May 2002 (refreshed May 2009); Procurement Guidance Notes; and any other guidelines or guidance issued by Central Procurement Directorate (CPD) and the Procurement Board. The PHA shall also ensure that it complies with any relevant EU or other international procurement rules.

~~7~~ Regional Supply Service (RSS), within the Business Services Organisation (BSO), shall carry out procurement activity on behalf of the PHA, governed by a documented Service Legal Agreement. Periodic reviews of the Agency's procurement activity should be undertaken. The results of such review will be shared with DHSSPS.

Competition

8 Contracts shall be awarded on a competitive basis and tenders accepted from suppliers who provide best value for money overall.

Single tender action is the process where a contract is awarded to an economic operator (i.e. supplier, contractor) without competition. In light of their exceptional nature, all single tender actions should be subject to PHA Accounting Officer approval. It is advisable that the PHA seek an assurance from BSO, or their legal adviser, to provide assurance for the Accounting Officer that the use of single tender action is legitimate in a particular case. Further information is published in

Procurement Guidance Note 02/10 on the 'Award of Contracts without a Competition'. www.cpdni.gov.uk/index/guidance-for-purchasers/guidance-notes.htm]

9. The PHA shall send to the DHSSPS after each financial year a report for that year explaining any contracts above £5,000 in which competitive tendering was not employed.

Best Value for money

10 Procurement by the PHA of works, supplies and services shall be based on best value for money, ie the optimum combination of whole life cost and quality (or fitness for purpose) to meet the PHA's requirements. Where appropriate, a full option appraisal shall be carried out before procurement decisions are taken.

Timeliness in paying bills

11 The PHA shall collect receipts and pay all matured and properly authorised invoices in accordance with Annex 4.5 and Annex 4.6 of *Managing Public Money Northern Ireland* and any guidance issued by DFP or the sponsor Department.

Novel, contentious or repercussive proposals

12 The PHA shall obtain the approval of the DHSSPS, and DFP, before:

- incurring any expenditure for any purpose which is or might be considered novel or contentious, or which has or could have significant future cost implications, including on staff benefits;
- making any significant change in the scale of operation or funding of any initiative or particular scheme previously approved by the DHSSPS;
- making any change of policy or practice which has wider financial implications (eg because it might prove repercussive among other public sector bodies) or which might significantly affect the future level of resources required. (The DHSSPS will advise on what constitutes "significant" in this context).

Risk management/Fraud

13 The PHA shall ensure that the risks it faces are dealt with in an appropriate manner, in accordance with relevant aspects of best practice in corporate governance, and shall develop a risk management strategy, in accordance with the Treasury guidance *Management of Risk: A Strategic Overview (The "Orange Book")*.

14 The PHA shall take proportionate and appropriate steps to assess the financial and economic standing of any organisation or other body with which it intends to enter into a contract or to which it intends to give grant or grant-in-aid.

15 The PHA shall adopt and implement policies and practices to safeguard itself against fraud and theft, in line with DFP's guide *Managing the Risk of Fraud* .

16 All cases of attempted, suspected or proven fraud shall be reported to the DHSSPS who shall report it to DFP and the NIAO as soon as they are discovered, irrespective of the amount involved.

Wider markets

17 In accordance with the wider markets policy, the PHA shall seek to maximise receipts from non-Consolidated Fund sources, provided that this is consistent with (a) the PHA's main functions (b) its corporate plan as agreed with the DHSSPS. DHSSPS will confirm with the DFP Supply Officer that such proposed activity is appropriate.

Fees and charges

18 Fees or charges for any services supplied by the PHA shall be determined in accordance with Chapter 6 of MPMNI.

III. THE PHA'S INCOME

Grant-in-aid

19 Grant-in-aid will be paid to the PHA in monthly instalments, on the basis of need. The PHA shall submit a monthly written application to the DHSSPS forecasting its cash requirements and shall certify that the conditions applying to the use of revenue fund have been observed to date and that further grant-in-aid is now required for purposes appropriate to the PHA's functions.

20 The PHA should have regard to the guidance in DAO(DFP)04/03 and to the general principle enshrined in Annex 5.1 of *Managing Public Money Northern Ireland* that it should seek grant-in-aid according to need.

21 Cash balances accumulated during the course of the year shall be kept at the minimum level consistent with the efficient operation of the PHA. Grant-in-aid not drawn down by the end of the year shall lapse. However, where draw-down of grant-in-aid is delayed to avoid excess cash balances at year-end, the DHSSPS will make available in the next financial year (subject to approval by the Assembly of the relevant Estimates provision) any such grant-in-aid required to meet any liabilities at year end, such as creditors.

Fines and taxes as receipts

22 Most fines and taxes (including levies and some licences) do not provide additional DEL spending power and should be surrendered to the DHSSPS.

Receipts from sale of goods or services

23 Receipts from the sale of goods and services (including certain licences), rent of land, and dividends normally provide additional DEL spending power. If a body wishes to retain a receipt or utilise an increase in the level of receipts, it must gain the prior approval of DHSSPS.

24 If there is any doubt about the correct classification of a receipt, the PHA shall consult the DHSSPS, which may consult DFP as necessary.

Interest earned

25 Interest earned on cash balances cannot necessarily be retained by the PHA. Depending on the budgeting treatment of this receipt, and its impact on the PHA's cash requirement, it may lead to commensurate reduction of grant-in-aid or be required to be surrendered to the NI Consolidated Fund via DHSSPS. If the receipts are used to finance additional expenditure by the PHA, DHSSPS will need to ensure it has the necessary budget cover.

Unforecast changes in in-year income

26 If the negative DEL income realised or expected to be realised in-year is less than estimated, the PHA shall, unless otherwise agreed with the DHSSPS, ensure a corresponding reduction in its gross expenditure so that the authorised provision is not exceeded. [NOTE: For example, if the PHA is allocated £100 resource DEL provision by its DHSSPS and expects to receive £10 of negative DEL income, it may plan to spend a total of £110. If income (on an accruals basis) turns out to be only £5 the PHA will need to reduce its expenditure to £105 to avoid breaching its budget. If the PHA still spends £110 the DHSSPS will need to find £5 of savings from elsewhere within its total DEL to offset this overspend.]

27 If the negative DEL income realised or expected to be realised in the year is more than estimated, the PHA may apply to the DHSSPS to retain the excess income for specified additional expenditure within the current financial year without an offsetting reduction to grant-in-aid. The DHSSPS shall consider such applications, taking account of competing demands for resources, and will consult with DFP in relation to any significant amounts. If an application is refused, any grant-in-aid shall be commensurately reduced or the excess receipts shall be required to be surrendered to the NI Consolidated Fund via the DHSSPS.

Build-up and draw-down of deposits

28 The PHA shall comply with the rules that any DEL expenditure financed by the draw-down of deposits counts within DEL. The PHA shall maintain and manage cash balances as working balances only. These shall be held at a minimum level throughout the year. Any interest earned on overnight deposits must be returned to the DHSSPS.

29 The PHA shall ensure that it has the necessary DEL provision for any expenditure financed by draw-down of deposits.

Proceeds from disposal of assets

30 Disposals of land and buildings are dealt with in Section VI below.

Gifts and bequests received

31 The PHA is free to retain any gifts, bequests or similar donations, subject to paragraph 34. These shall be treated as receipts and must be notified to the DHSSPS. [NOTE: Donated assets do not attract a cost of capital charge, and a release from the donated assets reserve should offset depreciation in the operating cost statement.] The latest FReM requirements should be applied]

32 Before accepting a gift, bequest, or similar donation, the PHA shall consider if there are any associated costs in doing so or any conflicts of interests arising. The PHA shall keep a written record

of any such gifts, bequests and donations and of their estimated value and whether they are disposed of or retained.

Borrowing

33 Normally the PHA will not be allowed to borrow but when doing so shall observe the principles set out in Chapter 5 and the associated annexes of MPMNI when undertaking borrowing of any kind. The PHA shall seek the approval of the DHSSPS and, where appropriate, DFP, to ensure that it has any necessary authority and budgetary cover for any borrowing or the expenditure financed by such borrowing. Medium or long term private sector or foreign borrowing is subject to the value for money test in *Section 5.7 of MPMNI*.

34 Any expenditure by the PHA financed by borrowing counts in DEL

IV. EXPENDITURE ON STAFF

Staff costs

35 Subject to its delegated levels of authority the PHA shall ensure that the creation of any additional posts does not incur forward commitments which will exceed its ability to pay for them.

Pay and conditions of service

36 The staff of the PHA, whether on permanent or temporary contract, shall be subject to levels of remuneration and terms and conditions of service (including superannuation) as approved by the DHSSPS and DFP. The PHA has no delegated power to amend these terms and conditions.

37 Current terms and conditions for staff of the PHA are those set out in its Employee Handbook. The PHA shall provide the DHSSPS and DFP with a copy of the Handbook and subsequent amendments.

38 Annual pay increases of PHA staff must be in accordance with the annual FD letter on Pay Remit Approval Process and Guidance issued by DFP. Therefore, all proposed pay awards must have prior approval of DHSSPS and the Minister for Finance before implementation.

39 The travel expenses of Board Members shall be tied to the rates allowed to senior staff of the PHA. Reasonable actual costs shall be reimbursed.

40 The PHA shall operate a performance-related pay scheme which shall form part of the general pay structure approved by the DHSSPS and DFP.

41 The PHA shall comply with the EU directive on contract workers [Fixed Term Employees Regulations (Prevention of Less Favourable Treatment)].

Pensions; redundancy/compensation

42 The PHA's staff shall be eligible for a pension provided by:

- Either the Health and Social Care Superannuation Scheme or the Health and Social Care Pension Scheme.

43 Staff may opt out of the occupational pension scheme provided by the PHA. However, the employer's contribution to any personal pension arrangement, including a stakeholder pension, shall be limited to the national insurance rebate level.

44 Any proposal by the PHA to move from the existing pension arrangements, or to pay any redundancy or compensation for loss of office, requires the approval of the DHSSPS and DFP. Proposals on severance payments must comply with Annex A.4.13.9 of *Managing Public Money Northern Ireland*.

V. NON-STAFF EXPENDITURE

Economic appraisal

45 The PHA is required to apply the principles of economic appraisal, with appropriate and proportionate effort, to all decisions and proposals concerning spending or saving public money, including European Union (EU) funds, and any other decisions or proposals that involve changes in the use of public resources. For example, appraisal must be applied irrespective of whether the relevant public expenditure or resources:

a. involve capital or current spending, or both;

b. are large or small;

c. are above or below delegated limits(see Appendix A).

46 Appraisal itself uses up resources. The effort that should go into appraisal and the detail to be considered is a matter for case-by-case judgement, but the general principle is that the resources to be devoted to appraisal should be in proportion to the scale or importance of the objectives and resource consequences in question. Judgement of the appropriate effort should take into consideration the totality of the resources involved in a proposal.

General guidance on economic appraisal that applies to the PHA can be found in:

- Northern Ireland Guide to Expenditure Appraisal and Evaluation (NIGEAE) – see http://www.dfpni.gov.uk/eag
- The HM Treasury Guide, *The Green Book: Appraisal and Evaluation in Central Government*; and
- The Capital Investment Manual.

Capital expenditure

47 Subject to being above an agreed capitalisation threshold, all expenditure on the acquisition or creation of fixed assets shall be capitalised on an accruals basis in accordance with relevant accounting standards. Expenditure to be capitalised shall include the (a) acquisition, reclamation or laying out of land; (b) acquisition, construction, preparation or replacement of buildings and other structures or their associated fixtures and fittings; and (c) acquisition, installation or replacement of movable or fixed plant, machinery, vehicles and vessels.

48 Proposals for large-scale individual capital projects or acquisitions will normally be considered within the PHA's corporate and business planning process. Subject to paragraph 52, applications for approval within the corporate/business plan by the DHSSPS and, DFP if necessary, shall be supported by formal notification that the proposed project or purchase has been examined and duly

authorised by the Board. Regular reports on the progress of projects shall be submitted to the DHSSPS.

49 Approval of the corporate/business plan does not obviate the PHA's responsibility to abide by the economic appraisal process.

50 Within its approved overall resources limit the PHA shall, as indicated in the attached Appendix on delegations, have delegated authority to spend up to £50,000 on any individual capital project or acquisition. Beyond that delegated limit, the DHSSPS' and where necessary, DFP's prior authority must be obtained before expenditure on an individual project or acquisition is incurred.

Transfer of funds within budgets

51 Unless financial provision is subject to specific Departmental or DFP controls (eg, where provision is ring-fenced for specific purposes) or delegated limits, transfers between budgets within the total capital budget, or between budgets within the total revenue budget, do not need Departmental approval. The one exception to this is that, due to HM Treasury controls, any movement into, or out, of depreciation and impairments within the resource budget will require departmental and possibly DFP approval. [NOTE: Under resource budgeting rules, transfers from capital to resource budgets are not allowed.]

Lending, guarantees, indemnities; contingent liabilities; letters of comfort

52 The PHA shall not, without the DHSSPS' and where necessary, DFP's prior written consent, lend money, charge any asset or security, give any guarantee or indemnities or letters of comfort, or incur any other contingent liability (as defined in Annex 5.5 of MPMNI), whether or not in a legally binding form.

Grant or loan schemes

53 Unless covered by a delegated authority, all proposals to make a grant or loan to a third party, whether one-off or under a scheme, together with the terms and conditions under which such grant or loan is made shall be subject to prior approval by the DHSSPS, and where necessary DFP. If grants or loans are to be made under a continuing scheme, statutory authority is likely to be required. Within its approved overall resource limit the PHA shall have delegated authority to make a grant to a third party.

54 The terms and conditions of a grant or loan to a third party shall include a requirement on the receiving organisation to prepare accounts and to ensure that its books and records in relation to the grant or loan are readily available for inspection by the PHA, the DHSSPS and the C&AG.

55 See also below under the heading *Recovery of grant-financed assets* (paragraphs 79-81).

Gifts made, write-offs, losses and other special payments

56 Proposals for making gifts or other special payments (including issuing write-offs) outside the delegated limits set out in the **Appendix A** of this document must have the prior approval of the DHSSPS and where necessary DFP.

57 Losses shall not be written off until all reasonable attempts to make a recovery have been made and proved unsuccessful.

58 Gifts by management to staff are subject to the requirements of HSC(F)50/2012 or the latest Departmental guidance.

Leasing

59 Prior Departmental approval must be secured for all property and finance leases. The PHA must have capital DEL provision for finance leases and other transactions which are, in substance, borrowing (paragraphs 35-36 above).

60 Before entering into any lease (including an operating lease) the PHA shall demonstrate that the lease offers better value for money than purchase.

Public/Private Partnerships

61 The PHA shall seek opportunities to enter into Public/Private Partnerships where this would be more affordable and offer better value for money than conventional procurement. Where cash flow projections may result in delegated spending authority being breached, the PHA shall consult the DHSSPS. PHA should also ensure that it has the necessary budget cover.

62 Any partnership controlled by the PHA shall be treated as part of the PHA in accordance with guidance in the FReM and consolidated with it [subject to any particular treatment required by the FReM]. Where the judgment over the level of control is difficult the DHSSPS will consult DFP (who may need to consult with the Office of National Statistics over national accounts treatment).

Subsidiary companies and joint ventures

63 The PHA shall not establish subsidiary companies or joint ventures without the express approval of the DHSSPS and DFP. In judging such proposals the DHSSPS will have regard to the Department's wider strategic aim[s] objective and current Public Service Agreement.

64 For public expenditure accounts purposes any subsidiary company or joint venture controlled or owned by the PHA shall be consolidated with it in accordance with guidance in the FReM subject to any particular treatment required by the FReM. Where the judgment over the level of control is difficult, the DHSSPS will consult DFP (who may need to consult with the Office of National Statistics over national accounts treatment). Unless specifically agreed with the DHSSPS and DFP, such subsidiary companies or joint ventures shall be subject to the controls and requirements set out in this *Management Statement* and *Financial Memorandum*, and to the further provisions set out in supporting documentation.

Financial investments

65 The PHA shall not make any investments in traded financial instruments without the prior written approval of the DHSSPS, and, where appropriate, DFP, nor shall it aim to build up cash balances or net assets in excess of what is required for operational purposes. Funds held in bank accounts or as financial investments may be a factor for consideration when grant-in-aid is determined. Equity shares in ventures which further the objectives of the PHA shall equally be subject to Departmental and DFP approval unless covered by a specific delegation.

Unconventional financing

66 The PHA shall not enter into any unconventional financing arrangement without the approval of the DHSSPS and DFP.

Commercial insurance

67 The PHA shall not take out any insurance without the prior approval of the DHSSPS and DFP, other than third party insurance required by the Road Traffic (NI) Order 1981 (as amended) and any other insurance which is a statutory obligation or which is permitted under Annex 4.5 of MPMNI.

68 In the case of a major loss or third-party claim, DHSSPS shall liaise with the PHA about the circumstances in which, in the case of a major loss or third-party claim, an appropriate addition to budget out of the DHSSPS' funds and/or adjustment to the PHA's targets shall be considered. DHSSPS will liaise with DFP Supply where required in such cases.

Payment/Credit Cards

69 The PHA, in consultation with the DHSSPS, shall ensure that a comprehensive set of guidelines on the use of payment cards (including credit cards) is in place. Reference should be made to HSS(F)11/2003.

Hospitality

70 The PHA, in consultation with the DHSSPS, shall ensure that a comprehensive set of guidelines on the provision of hospitality is in place. Reference should be made to DAO(DFP) 10/06 (revised).

Use of Consultants

71 The PHA shall adhere to the guidance issued by DFP, as well as any produced by the DHSSPS in relation to the use of consultants. Please see the delegated limits set out in **Appendix A.**

72 PHA will provide DHSSPS with an annual statement on the status of all consultancies completed and/or started in each financial year.

73 Care should be taken to avoid actual, potential, or perceived conflicts of interest when employing consultants.

VI. MANAGEMENT AND DISPOSAL OF FIXED ASSETS

Register of assets

74 The PHA shall maintain an accurate and up-to-date register of its fixed assets.

Disposal of assets

75 The PHA shall dispose of assets which are surplus to its requirements. Assets shall be sold for best price, taking into account any costs of sale. Generally assets shall be sold by auction or competitive tender [unless otherwise agreed by the DHSSPS], and in accordance with the principles in MPMNI.

76 All receipts derived from the sale of assets (including grant financed assets, see below) must be declared to the DHSSPS, which will consult with DFP, if necessary, on the appropriate treatment.

Recovery of grant-financed assets

77 Where the PHA has financed expenditure on capital assets by a third party, the PHA shall set conditions and make appropriate arrangements to ensure that any such assets individually above a value of £500 are not disposed of by the third party without the PHA's prior consent.

78 The PHA shall therefore ensure that such conditions and arrangements are sufficient to secure the repayment of the NI Consolidated Fund's due share of the proceeds of the sale, in order that funds may be surrendered to the DHSSPS.

79 The PHA shall ensure that if the assets created by grants made by the PHA cease to be used by the recipient of the grant for the intended purpose, a proper proportion of the value of the asset shall be repaid to the PHA for surrender to the DHSSPS. The amounts recoverable under the procedures in paragraphs 77-78 above shall be calculated by reference to the best possible value of the asset and in proportion to the NI Consolidated Fund's original investment(s) in the asset.

VII. BUDGETING PROCEDURES

Setting the annual budget

80 Each year, in the light of decisions by the DHSSPS on the PHA's updated draft corporate plan, the DHSSPS will send to the PHA:

- a formal statement of the annual budgetary provision allocated by the DHSSPS in the light of competing priorities across the DHSSPS and of any forecast income approved by the DHSSPS;

  and

- a statement of any planned change in policies affecting the PHA.

81 The PHA's approved annual commissioning plan will take account both of its approved funding provision and of any forecast receipts, and will include a budget of estimated payments and receipts together with a profile of expected expenditure and of draw-down of any DHSSPS funding and/or other income over the year. These elements will form part of the approved business plan for the year in question.

82 Any grant-in-aid provided by the DHSSPS for the year in question will be voted in the DHSSPS' Estimate and will be subject to Assembly control.

General conditions for authority to spend

83 Once the PHA's budget has been approved by the DHSSPS [and subject to any restrictions imposed by Statute/the Minister /this MSFM], the PHA shall have authority to incur expenditure approved in the budget without further reference to the DHSSPS, (delegated limits are subject to the requirements of HSC(F)67/2012 or the latest Departmental guidance) on the following conditions:

- the PHA shall comply with the delegations set out in **Appendix A** of this document. These delegations shall not be altered without the prior agreement of the DHSSPS and DFP;
- the PHA shall comply with the conditions set out in paragraph 12 above regarding novel, contentious or repercussive proposals;
- inclusion of any planned and approved expenditure in the PHA's budget shall not remove the need to seek formal Departmental [and where necessary, DFP] approval where such proposed expenditure is above the delegated limits set out in **Appendix A** or is for new schemes not previously agreed; and
- the PHA shall provide the DHSSPS with such information about its operations, performance individual projects or other expenditure as the DHSSPS may reasonably require (see paragraph 87 below).

Providing monitoring information to the DHSSPS

84 The PHA, or the HSC Board and BSO on behalf of the PHA, shall provide the DHSSPS with, as a minimum, information on a monthly basis which will enable the satisfactory monitoring by the DHSSPS of:

- the PHA's cash management;
- its draw-down of any grant-in-aid;
- the expenditure for that month;
- forecast outturn by resource headings; and
- other data required for the DFP Outturn and Forecast Outturn Return.

VIII. BANKING

Banking arrangements

85 The PHA is a member of the HSC 'pool' of bank accounts. The PHA's Accounting Officer is responsible for ensuring that the PHA's banking arrangements are in accordance with the requirements of Annex 5.7 of *MPMNI.* This responsibility remains even within the current banking pool arrangements. In particular, he/she shall ensure that the arrangements safeguard public funds and that their implementation ensures efficiency, economy and effectiveness.

86 He/she shall therefore ensure that:

- these arrangements are suitably structured and represent value-for-money. The HSC pool of accounts will be comprehensively reviewed at least every three to five years;
- sufficient information about banking arrangements is supplied to the DHSSPS' Accounting Officer to enable the latter to satisfy his/her own responsibilities;
- the PHA's banking arrangements shall be kept separate and distinct from those of any other person or organisation; and
- adequate records are maintained of payments and receipts and adequate facilities are available for the secure storage of cash.

IX. COMPLIANCE WITH INSTRUCTIONS AND GUIDANCE

Relevant documents

87 The PHA shall comply with the following general guidance documents:

- This document (both the *Financial Memorandum* and the *Management Statement*);
- *Managing Public Money Northern Ireland (MPMNI);*
- *Public Bodies - a Guide for NI Departments* issued by DFP;
- *Government Internal Audit Standards*, issued by DFP
- The document *Managing the Risk of Fraud* issued by DFP;
- The Treasury document *The Government Financial Reporting Manual (FReM)* issued by DFP*;*
- Relevant Dear Consolidation Officer and Dear Consolidation Manager letters issued by DFP;
- *Regularity Propriety and Value for Money* issued by Treasury;
- The Consolidation Officer Letter of Appointment, issued by DFP;
- Other relevant guidance and instructions issued by DFP in respect of Whole of Government Accounts;
- Other relevant instructions and guidance issued by the central Departments (DFP/OFMDFM) including Procurement Board and CPD guidance;
- Specific instructions and guidance issued by the DHSSPS;
- Recommendations made by the Public Accounts Committee, or by other Assembly/Parliamentary authority, which have been accepted by the Government and which are relevant to the PHA.

X. REVIEW OF FINANCIAL MEMORANDUM

88 The *Management Statement* and *Financial Memorandum* will normally be reviewed at least every five years.

89 DFP Supply will be consulted on any significant variation proposed to the *Management Statement* and *Financial Memorandum*.

Signed: _____ Date: _____

On behalf of the PHA

Signed: _____ Date: _____

On behalf of the Department

APPENDIX A

DELEGATED EXPENDITURE LIMITS

GENERAL

These delegated expenditure limits have been agreed by the Department and the Department of Finance and Personnel and are subject to the requirements of HSC(F)67/2012 or the latest Departmental guidance.

1. PURCHASING ALL GOODS AND SERVICES

Table 1 Delegated Authority for the Purchase of Goods and Services

(All costs exclude VAT)

THRESHOLDS	NUMBER/TYPE OF TENDER REQUIRED	AUTHORISATION
Up to £5,000	Price check may be required (see DFP document PGN 04/12)	The Chief Executive/The appropriate officer as notified to the DHSSPS
>£5,000 - £30,000	4 Selected Tenders	The Chief Executive/The appropriate officer as notified to the DHSSPS
> £30,000 – EU Thresholds	Publicly advertised tender competition	The Chief Executive/The appropriate officer as notified to the DHSSPS

Economic Appraisal

The principles of economic appraisal should be applied in all cases where expenditure is proposed, whether the proposal involves capital or current expenditure, or both. The effort put into economic appraisal should be commensurate with the size or importance of the needs or resources under consideration. However, the PHA should undertake a comprehensive business case of all projects involving expenditure of £250,000 and over.

Where the minimum number of quotation/tenders is not obtained

For any purchase where the minimum number of quotations/tenders is not obtained the purchase may proceed if the accounting officer is satisfied that every attempt has been made to obtain competitive offers and that value for money will be achieved. In these cases the accounting officer should complete a report, and records of all correspondence should be retained on file, including any justification given and/or approvals obtained.

2. CAPITAL PROJECTS

The Chief Executive or appropriate officer as notified to the DHSSPS, may authorise capital expenditure on discreet capital projects of up to £50,000. Capital projects over this amount require the approval of the DHSSPS, and may be subject to quality assurance by the Department of Finance and Personnel if requested.

Any novel and/or potentially contentious projects, regardless of the amount of expenditure, require the approvals of the DHSSPS and DFP.

3. DISPOSAL OF SURPLUS EQUIPMENT

See paragraphs 78 - 79

4. LEASE AND RENTAL AGREEMENTS

See paragraphs 64-65

5. APPROVAL OF INFORMATION TECHNOLOGY PROJECTS

The appraisal of Information Technology (IT) projects should include the staffing and other resource implications.

The principles of appraisal, evaluation and management apply equally to proposals supported by information communication technology (ICT) as to all other areas of public expenditure. ICT-enabled projects should be appraised and evaluated according to the general guidance in the Northern Ireland Guide to Expenditure Appraisal and Evaluation (*NIGEAE*) and managed using the new *Successful Delivery (NI)* guidance which was issued in June 2009.

The purchase of IT equipment and systems should be in line with the guidance Procedures and Principles for Application of Best Practice in Programme/Project Management (PPM), (available at www.dfpni.gov.uk/successful-delivery) and be subject to competitive tendering unless there are convincing reasons to the contrary. The form of competition should be appropriate to the value and complexity of the project, and in line with the Procurement Control Limits in Table 1. Delegated authority for each IT project is set out in Table 2.

Table 2 Delegation Arrangements for Information Technology Projects, Systems and Equipment (as per HSC(F)67/2012)
(All costs exclude VAT)

THRESHOLDS	AUTHORISATION
Up to £50,000 capital cost and up to £250,000 total costs	The Chief Executive/The appropriate officer as notified to the DHSSPS
Projects over £250,000	The Chief Executive with prior approval from the DHSSPS

6. ENGAGEMENT OF CONSULTANTS

General

The PHA has authority to appoint consultants for a **single contract** without recourse to the DHSSPS up to a ***total*** cost of £10,000, and subject to any guidance as may be issued by DFP or the DHSSPS. While Departmental approval is not required for consultancy assignments below £10,000, the PHA must notify the Department in advance of any proposal to engage external consultants. Where the PHA intends to appoint consultants via a Direct Award Contract the approval of the Departmental Accounting Officer must be secured in advance, regardless of cost.

The PHA will provide the DHSSPS with a quarterly statement on the status of all consultancies completed and/or started in each financial year.

Care should be taken to avoid actual, potential, or perceived conflicts of interest when employing consultants.

Economic appraisal

A full but proportionate business case should be prepared for all consultancy assignments, regardless of cost.

7. LOSSES AND SPECIAL PAYMENTS

Losses and special payments limits have been agreed by the Department and the Department of Finance and Personnel and are subject to the requirements of HSC(F)50/2012 or the latest Departmental guidance.

A summary note of the losses in any financial year should be included in the PHA's accounts.

Details of all losses and special payments should be recorded in a Losses and Special Payments Register, which will be available to auditors. The Register should be kept up-to-date and should show evidence of the approval by the appropriate officer as notified to the DHSSPS for amounts below the delegated limits, and the DHSSPS, where appropriate.