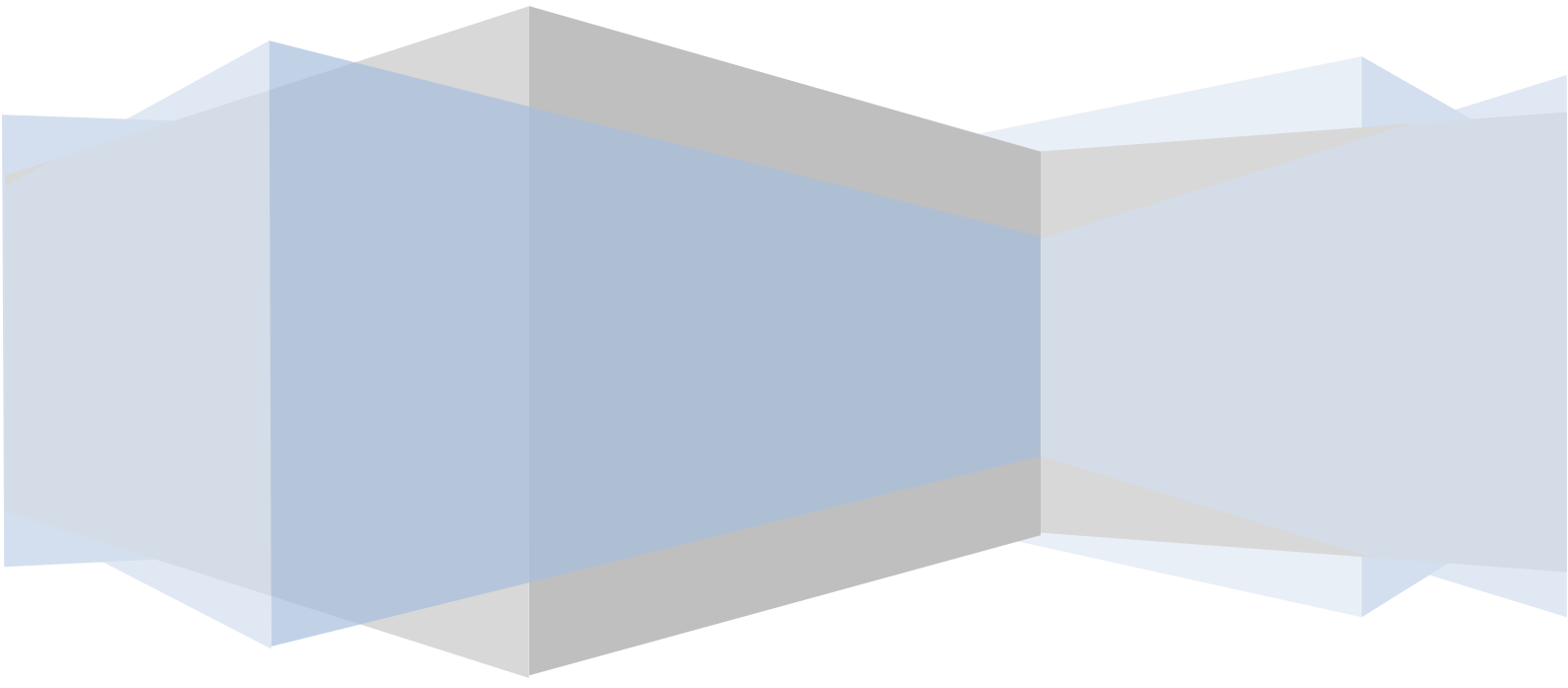
Health and Social Care Board

Public Health Agency

Commissioning Plan 2015/16



Contents

Foreword

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

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

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

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

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

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

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

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

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

1.0 Introduction

1.1 The Purpose of the Plan

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

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

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

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

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

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

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

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

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

1.2 Placing communities at the centre of commissioning

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

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

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

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

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

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

1.3 Monitoring Performance

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

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

2.0 Summary of Key Demographic Changes

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

N Ireland Resident Populations by Local Commissioning Group

Table 1

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

Source: NISRA, 2013 MYEs

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

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

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

3.0 Delivering on Key Policies, Strategies and Initiatives

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

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

3.1 Programme for Government

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

3.2 Quality 2020

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

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

- Develop HSC Trust Annual Quality Reports

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

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

3.3 Institute of Healthcare Improvement Liaison

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

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

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

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

3.4 HSC Safety Forum

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

During 2015/2016 the key deliverables will include:

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

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

3.5 Workforce Planning & Development

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

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

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

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

This includes:

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

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

These include:

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

3.6 Delivering Care: Nurse Staffing in Northern Ireland

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

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

3.7 Service Frameworks

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

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

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

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

3.8 Primary & Community Care Infrastructure

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

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

wide range of services including GP and Trust led primary care services. This model will improve access to, and responsiveness of, primary and community care services, particularly making available more specialised services nearer to where people live and work. This includes provision of an enhanced diagnostic and treatment capability where appropriate.
The priority for 2015/16 is to continue to take forward the hub and spoke model. The key tasks will be to:

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

3.9 Palliative and End of Life Care

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

During 2015/2016 the key deliverables will include:

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

3.10 Maternity Strategy

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

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

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

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

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

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

3.11 Physical and Sensory Disability Strategy

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

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

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

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

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

3.12 Community planning

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

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

3.13 E–Health

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

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

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

4.0 Ensuring Financial Stability & Effective Use of Resources

4.1 Introduction

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

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

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

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

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

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

Summary of 2015/16 Financial Plan

Table 2

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

* includes savings from Pharmaceutical Price Regulation Scheme (PPRS)

4.2 Producing the Financial Plan

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

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

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

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

HSCB – Opening Position

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

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

2014/15 Carried Forward Service Commitments

Table 3

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

Trust Opening Position - Carried Forward Pressures

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

4.2.2 Planned additional investment 2015/16

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

Total new pressures 2015/16

Table 4

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

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

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

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

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

Demography by Programme of Care

Table 5

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

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

FHS Pressures

Table 6

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

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

Primary care investment

Table 7

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

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

Inescapable Service Pressures

Table 8

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

Pressures for which no funding is available

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

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

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

Income 2015/16

Table 9

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

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

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

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

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

Efficiency Savings 2015/16

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

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

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

Efficiency Savings 2015/16

Table 10

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

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

Staff Productivity

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

Non Pay Opportunities

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

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

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

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

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

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

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

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

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

Potential in year funding solutions

Table 11

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

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

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

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

Total Planned Spend by Organisation

Figure 1

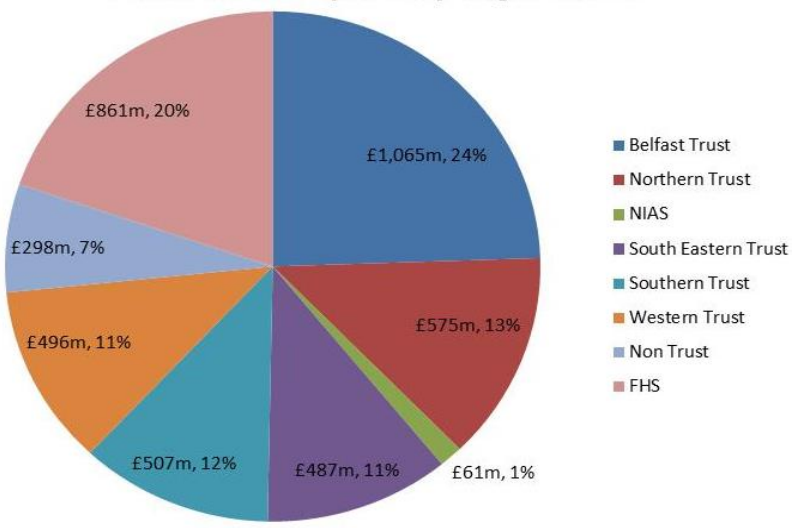


Table 12 sets out how the total resources are planned to be spent across the Programmes of Care and Family Health Services.

Planned Expenditure by Programme of Care

Table 12

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

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

Resources by LCG

Table 13

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

* Includes Mgmt & Admin, BSO, DIS

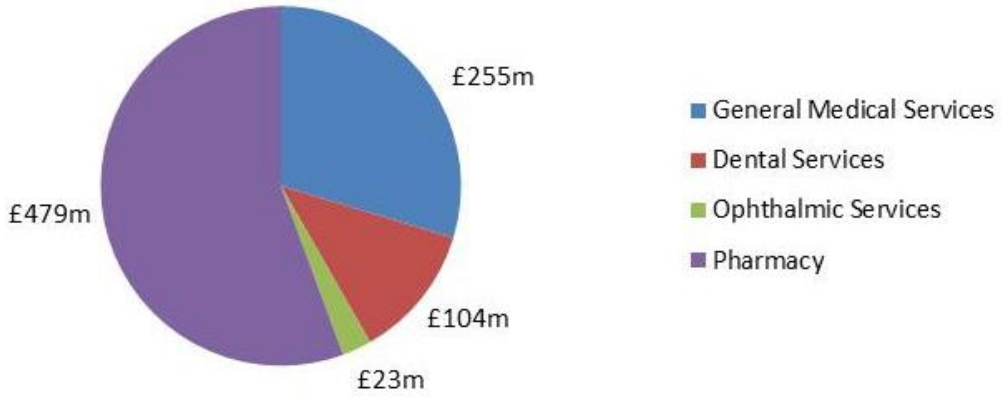
** Non Trust includes voluntaries and Extra Contractual Referrals

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

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

Planned Spend for Family Health Services

Figure 2



4.2.6 Equity

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

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

Capitation Formula

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

Expenditure

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

Impact of 2015/16 Plan Compared to Capitation Share

Table 14

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

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

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

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

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

4.3.1 Effecting the shift

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

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

Integrated Care Partnerships (ICPs)

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

service users, carers and representatives from the voluntary and community sectors.

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

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

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

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

Acute care
It is envisaged that a number of reform initiatives will be undertaken specifically within acute care, which ultimately will shift care out of hospital settings or reduce the hospital activity that would otherwise have occurred. Examples of potential initiatives where shift left from acute care could be delivered in

2015/16 and beyond are listed below. These will be confirmed via the Trusts response to this Commissioning Plan.

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

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

Learning disability & mental health resettlement programmes

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

Recurrent Investment in Reform

Since 2012/13, LCGs have been investing funds recurrently in a number of reform areas. These include Glaucoma Services in Primary Care, Community Nursing to Support Early Discharge, Telemedicine, Palliative Care Services in the Community and Reablement. By the end of 2015/16, it is estimated that £16m will have been invested by LCGs to commission new services from Primary Care, Secondary Care and the Third Sector. This has formed a significant contribution to the achievement of the £45m of Shift Left. Further investment in 2015/16 is likely following finalisation of the financial plan.

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

Overview of financial resources to be shifted into primary/community setting
Table 15

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

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

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

4.3.2 Monitoring the Delivery of Financial Shift Left

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

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

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

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

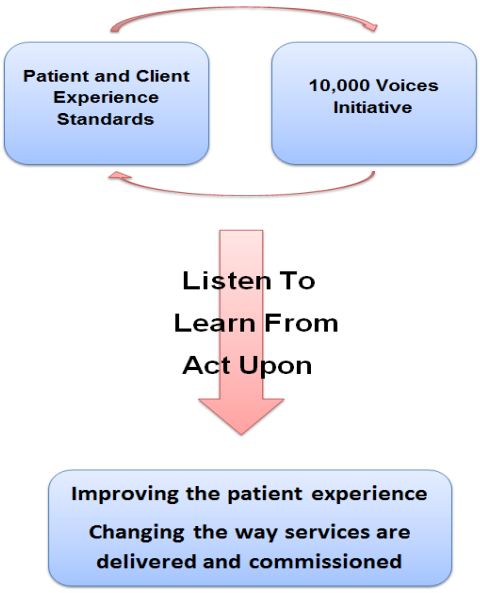
5.0 Listening to Patient and Client experience and learning from Personal and Public Involvement

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

5.1 Patient Client Experience Standards & 10,000 Voices

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

Figure 3



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

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

5.2 Patient Client Council (PCC) Peoples' Priorities 2014

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

Table 16

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

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

5.3 Personal and Public Involvement

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

Standards for PPI

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

Involving Patients and Clients in the Commissioning of Services

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

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

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

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

ICPs are another vehicle for effective involvement of service users and carers. Each ICP has a service user and a carer representative who fulfil a vital role in helping to ensure that ICPs plans for greater integration of services are person centred and meet the needs of those who use services.

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

The HSCB has:

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

6.0 Regional Commissioning – Overarching Themes

6.1 Improving & Protecting Population Health & Reducing Inequalities

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

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

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

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

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

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

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

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

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

6.1.1 Giving every child the best start

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

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

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

6.1.2 Tackling poverty

Specific Commissioning Intentions for 2015/16 will include:

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

6.1.3 Sustainable communities

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

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

6.1.4 Supporting healthier choices

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

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

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

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

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

6.1.5 Screening & Health Protection

Screening

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

During 2015/2016 the key deliverables will include:

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

Health Protection

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

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

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

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

Commissioning priorities for 2015/16 include:

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

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

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

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

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

6.2 Providing care closer to home

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

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

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

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

6.2.1 Commission acute care closer to home

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

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

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

6.2.2 Ensure effective community nursing and AHP interventions

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

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

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

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

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

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

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

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

6.2.3 More appropriate targeting of domiciliary care services

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

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

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

Key actions during 2015/16 will include:

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

The funding position in 2015/16 will impact on the ability of commissioners to maintain effective domiciliary services for older people with providers expressing concern regarding the increasing costs and their ability to provide these services within existing funding. It is becoming an increasing challenge to source independent provision in some parts of Northern Ireland, particularly in the remoter rural areas. Some providers are also finding it increasingly difficult to attract workers at the rates per hour currently being paid. Depending on the outcome of forthcoming Trust tendering processes, the funding available for demographic increases this year may not be sufficient to cover both the needs of an increasing number of older people as well as an increase in the cost per hour.

6.2.4 Statutory Residential Homes

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

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

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

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

6.3 High quality, safe & effective care

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

and carers are shared, understood and acted upon, appropriately influencing commissioning.

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

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

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

6.3.1 Quality Improvement Plans (QIPs)

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

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

- Falls: - Trusts will continue to improve compliance with Part B of the 'Fallsafe' Bundle. Trusts will spread Part A of the 'Fallsafe' bundle and demonstrate an increase each quarter in the % of adult inpatient ward/areas in which 'Fallsafe' bundle has been implemented.

- Pressure Ulcers: 'From April 2015 establish a baseline for the Incidents of pressure ulcers (grade 3 & 4) occurring in all adult inpatient wards & the number of those which were unavoidable.'
- Venous Thrombosis Embolism: Trusts will sustain 95% compliance with VTE risk assessment across all inpatient hospital wards throughout 2015/2016.
- Sepsis6: The HSC Safety Forum will monitor the Sepsis6 bundle compliance in the pilot areas and establish a spread plan.
- The 'Malnutrition Universal Screening Tool' (MUST) tool: % compliance of the completed MUST tool within 24 hours admission to hospital in all Adult Inpatient Wards by March 2016.
- Early Warning Scores (EWS): % compliance with accurately completed EWS charts.

6.3.2 Unscheduled Care Services

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

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

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

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

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

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

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

- Establishment of radiology services seven days a week to support same day/next morning investigation and reporting (to include CT, MRI and non-obstetric ultrasound scans).
- Establishment of dedicated minor injury stream in EDs (9am to 9pm, 7 days a week).
- Embedding of physiotherapy, occupational therapy, pharmacy and social work support within EDs and short-stay wards (9am to 5pm, 7 days a week).

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

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

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

and improve patient flow, and will consider any other opportunities to provide additional funding in-year.

6.3.3 Acute reform

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

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

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

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

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

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

6.3.4 Delivering Care

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

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

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

6.3.5 Managing Long-Term Conditions

The prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation. Across N Ireland the most

prevalent LTCs are hypertension (131 per 1000 patients; 250,000 people), asthma (60 per 1000 patients) and diabetes (54 per 1000 patients; 82,000 people).

Emergency Admissions to hospital for Long Term Conditions

In each of the years from 2010/11 to 2014/15 (Full Year Effect projected based on activity between April and September) the number of emergency admissions to hospital ranged from approximately 11,500 to 12,900 for those aged 18 years and over (see Table 17). COPD accounts for the majority of these admissions at approximately 40% of the total, with Asthma having the lowest percentage of admissions at approximately 8%.

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

Table 17

Emergency Admissions	Asthma		Diabetes		Heart Failure		COPD		Stroke	
	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000	No. of Emergency Admissions	Rate per 100,000
2010/11	886	64	1017	74	2341	170	4716	343	2537	185
2011/12	834	60	1010	73	2373	172	4700	340	2848	206
2012/13	995	71	1098	79	2600	187	5404	388	2820	203
2013/14	960	69	1076	77	2630	188	5355	383	2833	203
2014/15 FYE	868	62	1038	74	2652	190	4756	340	2532	181

Source: PAS Data Warehouse

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

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

6.3.6 Addressing known shortfalls in capacity/quality concerns

Improving Cancer Services

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

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

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

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

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

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

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

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

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

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

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

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

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

Improving Fracture Services

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

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

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

Improving Imaging Services

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

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

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

Each HSC Trust manages the reporting of the scans undertaken for their patients. In addition, work may be either outsourced to the Independent Sector or undertaken as in-house additionality. There are number of hidden drawbacks to the outsourcing model which are increasingly apparent with greater use. Most

work is reported in-hours, but the level of reporting undertaken out of hours has increased significantly, not least because there are approximately 21 vacant radiologist posts across the region.

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

6.4 Promoting independence and choice

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

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

6.4.1 Reablement

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

The Regional Reablement Model was originally issued in 2012/13 as a guide for Trusts in their work to establish the Reablement service model, with the intention

to review in the light of Trusts' experiences of embedding the key components of the model. To determine the progress and effectiveness of the Reablement service across the Health and Social Care Trusts, the Reablement Project Board approved a Regional Audit in 2014 which was conducted by the HSCB. This Audit demonstrated that there was a divergence in how the Trusts interpreted the model and its roll-out. However, it also clearly highlighted the essential components which should be considered for adoption within a Northern Ireland model. Therefore, to ensure a convergence across the region the HSCB has revised the model to reflect key essential elements which will underpin a consistent and effective model which will allow more effective measurement of outcomes, planning investment and will set out a "road map" for further improvement.

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

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

6.4.2 *Promotion of direct payments / self-directed support*

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

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

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

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

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

6.4.3 *Carer support*

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

carers and have been doing this for some time. HSC has been prioritising support to this group.

Key priorities for 2015/16 include:

- *Increasing uptake of carer's assessments* - In any quarter, trusts identify approximately 2500 "new" carers and offered them their legal entitlement of a carers assessment. (In accordance with Ministerial Target 7, appendix 2) But there are numbers who are not recognised and we need to improve performance here. This will include better information directly available to all who might be carers; and working with GP Practices who increase numbers referred at the point of GP consultation.
- *Improving the carer experience of the carer assessment* - Carer feedback has sometimes been that carers assessments experienced as a test of their eligibility rather than an opportunity to acknowledge their contribution and the emotional pressures on them. As part of the updating of NISAT carers assessment, Trusts should participate in the HSCB service improvement focus on carer experience. Trusts should also adhere to the carer support parts of the Service Framework for Older People.
- *Creating more community-based short break options* - Trust provision of short break support is now more than one million hours in each quarter; but more than half of this is in an institutional setting and we need to offer carers home-based alternatives where that is feasible or by offering more carers some form of self-directed support so that they can arrange their own support. HSCB also expects trusts to respond to the findings of the TYC report on short break pilot projects and cooperate with the HSCB review of home-based short break support currently underway and implement service improvement measures which emerge.

6.4.4 Implementation of Learning Disabilities Day Opportunities Model

Following the endorsement of the Learning Disability Day Opportunities Model in 2014, implementation has now begun. The number of young people leaving school with a learning disability who require either a buildings-based or community based day support service has been identified. The appropriate additional services required to meet these needs will be delivered by HSC

alongside other statutory providers with responsibility for further education, vocational training, supported employment, travel and leisure.

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

6.5 Safeguarding the most vulnerable

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

6.5.1 Dementia strategy

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

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

- Implementation of a Public Awareness campaign to improve early diagnosis and information support
- Work with training and care providers and informal carers to complete a training needs analysis and knowledge skills framework in order to drive up workforce skills base and support carers to continue to care.
- Implement a delirium pathway to optimise patient experience
- Development of short breaks offered to people with dementia and their carers.

- A review of outpatient memory services to analyse the barriers to practice, functional and structural integration, identify and reduce all unwarranted service and practice variations.
- Profiling service demand, including an analysis of existing follow up / review models. This will include exploring the opportunities to develop a new risk / need stratified care model for follow on care.
- Benchmark current service capacity including an analysis of how current clinics operate, their respective capacity, the workforce, resources and skills.
- An audit of dementia care in acute hospitals has just finished across NI and recommendations from this audit will be factored into commissioning decisions during 15/16.

6.5.2 Investing in mental health/learning disability community infrastructure

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

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

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

The HSCB will continuously review commitments to ensure best use of all available resources. The HSCB has also supported the DHSSPS in making a bid

through June monitoring for additional in-year resources to allow many of these priority service developments to be taken forward.

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

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

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

6.5.3 Safeguarding services

Safeguarding children

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

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

The PSNI have recently restructured the Public Protection Units which are aligned with Trust boundaries to enhance closer working relationships between HSC and the PSNI. Issues around abuse of alcohol use of legal highs and illegal drugs continue to present as difficulties. The HSCB identified additional investment to

help address issues around CSE and other concerns within both the statutory and voluntary sectors.

A further pressure identified by Trusts relates to children with complex healthcare needs and those children with additional needs and challenging behaviours, some of these children will be in the looked after system. The HSCB is leading on a reform agenda within LAC service provision and Trusts submitted plans to address the commissioning proposals. During 2015/16:

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

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

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

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

As referenced above, there is a cohort of young people who are in contact with a range of services, including the regional acute CAMHS facility, Secure Care which are supported by other statutory services such as Youth Justice. On occasion the demand for secure care will exceed supply for short durations and Trusts put in

place suitable alternative arrangements to manage the presenting risks. Work is progressing on a regional basis to consider the interdependencies across the LAC continuum and with other services to determine how the service can best respond to these complex situations.

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

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

Adult Safeguarding

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

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

- Work with providers to develop innovative ways to prevent abuse and promote a safe environment for the delivery of care. This will include consideration of the use of new or alternative technologies (PoC 4-7)
- Complete move to Gateway approach to respond to all adult safeguarding referrals across all Programmes of Care. This will improve the quality of decision-making, ensure a standard response to all referrals and improve working arrangements with other partner agencies (PoC 4-7)

- Implement generic and specialist safeguarding standards contained in all Service frameworks, with specific reference to the Older Person's Health and Wellbeing Service Framework (PoC 4- 7)
- Work with providers to drive up the quality of services to support people living in residential, nursing or supported living environments (PoC 5)

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

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

6.6 Efficiency & Value for Money

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

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

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

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

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

to deliver particular services in a more consolidated fashion, potentially with a single provider for the whole of NI. In this regard, the HSCB will during 2015/16 establish regional arrangements for the delivery of out of hours radiology reporting and stroke lysis advice. Opportunities for regionalisation will also be explored through the outpatient reform initiative referred to above with proposals already being worked up in relation to neurology and urology.

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

6.6.1 Procurement from Alternative Providers

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

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

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

This approach will be adopted across a range of service areas. In each case the over-riding priority will be to identify opportunities for more patient-focused,

sustainable and cost effective delivery while at the same time seeking to maintain the integrity of other related services commissioned from existing providers.

GP Federations

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

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

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

6.6.2 Delivery of Contracted Volumes

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

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

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

7.0 Regional Commissioning

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

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

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

7.1 Family & Childcare Services

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

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

Family and Childcare– Key Commissioning Priorities 2015/16

Needs and Assessment

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

Services to be commissioned

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

Securing Service Delivery

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

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

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

Family and Childcare– Values and Volumes

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

Table 18

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

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

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

7.2 Specialist Services

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

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

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

Specialist Services – Key Commissioning Priorities 2015/16

Needs and Assessment

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

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

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

Services to be Commissioned

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

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

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

Securing Service Delivery

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

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

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

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:

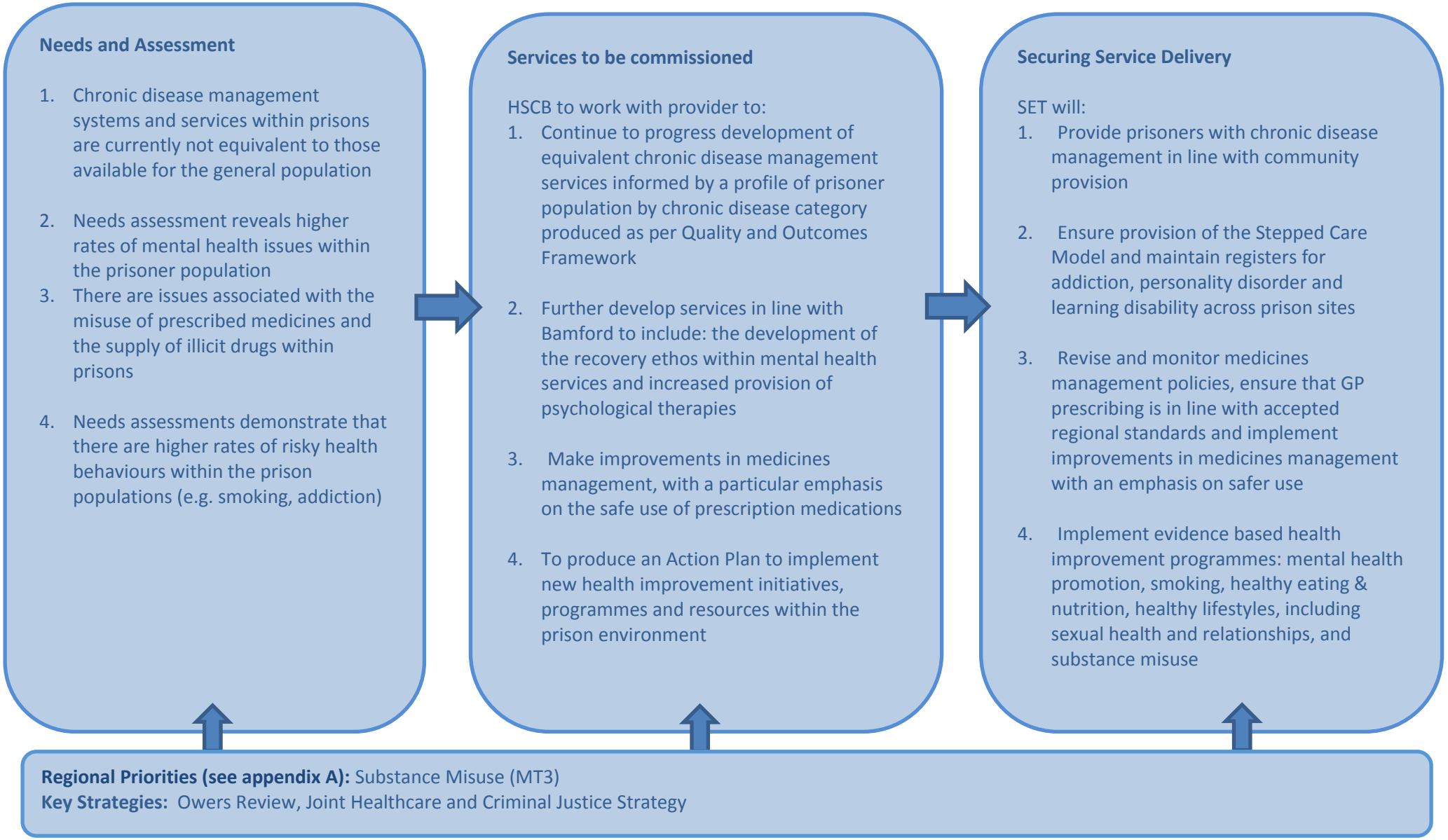
- Prison populations have risen since the transfer of healthcare in 2008 from Department of Justice to Department of Health placing increased pressure on available resources.
- There is a particular need to address the healthcare needs of vulnerable groups such as young persons, women, older people and 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 longer to handover patients to Emergency Departments).

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

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

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

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

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

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

NIAS– Key Commissioning Priorities 2015/16

Needs and Assessment

1. NIAS reports increasing volumes of 999 calls and reducing ability to achieve 8 minute category response times.

2. NIAS have been working in the past year to introduce appropriate care pathways to prevent unnecessary hospital attendances. Several pathways are now in place which 'hear and advise', 'see and treat/refer' or transport patient to an alternative to ED, e.g. Minor Injuries Unit.

3. Hospital Ambulance Liaison Officers (HALOs) have been piloted in 4 major acute hospitals across NI. Initial evidence shows improved ambulance turnaround times at ED and better coordination of hospital discharge.

4. In 2013/14, NIAS provided over 212,000 non-emergency (PCS) journeys. 48% of journeys were provided to users described as 'walking' and 83% of journeys were to outpatient appointments. The current provision of non-emergency patient transport services is not sustainable in the longer term.

Services to be Commissioned

1. Commissioner will put in place plans to improve performance against Ministerial emergency ambulance response targets by March 2016.

2. Commissioner will support NIAS to continue to put in place alternative care pathways which avoid unnecessary hospital attendances.

3. Commissioner will mainstream Hospital Ambulance Liaison Officers (HALOs) at the major acute hospitals to support patient flow and ambulance turnaround.

4. Commissioner, in partnership with NIAS, will, by November 2015, complete a public consultation on the future provision of non-urgent patient transport services. This will include the proposed introduction of eligibility criteria for non-emergency transport which seeks to prioritise mobility need in the face of limited capacity.

Securing Service Delivery

1. Commissioner, in collaboration with NIAS, will review demand for an emergency ambulance response against available commissioned capacity and in light of alternative care pathways.

2. Commissioner will seek to evaluate alternative care pathways with a view to maintaining where successful. The introduction of related, NIAS-managed Directory of Services with support from the 5 HSC Trusts will be essential in taking forward the pathways.

3. Commissioner will seek a proposal from NIAS to maintain HALOs at major acute hospitals

4. Commissioner will work with NIAS to take forward recommendations following the review and public consultation of non-urgent patient transport services, including the implementation of eligibility criteria.

Regional Priorities (see appendix A): Unscheduled Care (MT13), Unplanned Admissions (MT5 and MT6), Emergency Re-admissions (MT14)

NIAS – Values and Volumes

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

Table 21

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

7.5 Family Practitioner Services

Family practitioner Services comprise the following four key areas:

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

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

7.5.1 General Medical Practitioners Services

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

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

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

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

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

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

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

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

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

Enhanced Services uptake by general practice will continue to be challenged to ensure equity of provision to patients. The GP annual reporting requirements

enable the HSCB to evaluate and review all Enhanced Services. This information will be used to improve future services and patient care.

7.5.2 General Ophthalmology Services

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

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

Commissioning Priorities 2015/16

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

- LCGs will commission training and accreditation of community optometrists in line with NICE and Joint College Guidelines to make full use of the available skillset across primary and secondary care.

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

- LCGs will ensure there is adequate access to Level 2 LES practitioners (in terms of both geography and timeliness)

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

7.5.3 General Dental Services

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

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

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

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

HSCB will commission 18 dental practices to provide primary dental care for 50,000 patients for a 12 month period in order to test the new contracting arrangements.

Practices will be selected so that they represent, as far as is possible, the main types of dental practice found in Northern Ireland.

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

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

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

7.5.4 Community Pharmacy and Medicines Management

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

General Pharmaceutical Services

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

Negotiations on the development of revised community pharmacy contractual arrangements have been challenging in 2014/15 not least with the initiation of

Judicial Review proceedings by the community pharmacy contractor representative body, Community Pharmacy NI.

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

Medicines Management

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

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

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

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

Medicines Safety

Medicines are the most commonly utilised intervention in the HSC and the HSCB has a key leadership role in supporting the delivery of safer medicines systems. Electronic Prescribing has been identified as a key issue to be addressed in secondary care.

During 2015/2016 the key deliverables will include:

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

8.0 Achievement of Ministerial Targets

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

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

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

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

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

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

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

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

Progress was made in a number of areas including:

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

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

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

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

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

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

Significant improvement has been made against the 14-day breast cancer standard during the latter half of 2014/15 compared to 2013/14. While performance has deteriorated slightly in the latter part of 2014/15 this is primarily in one HSC Trust (regionally during quarter three, 98% of urgent referrals were seen within 14 days). Actions to address this have been agreed and performance is expected to improve during quarter one of 2015/16 and be sustained thereafter. Performance against the 31-day standard has been consistently strong regionally, ranging from 95.1% - 97.4% for the period April December 2014 and it is the expectation this too will continue. However for the same period Trust level performance has ranged from 90.6% - 100%.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.0 Belfast Local Commissioning Plan

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

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

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

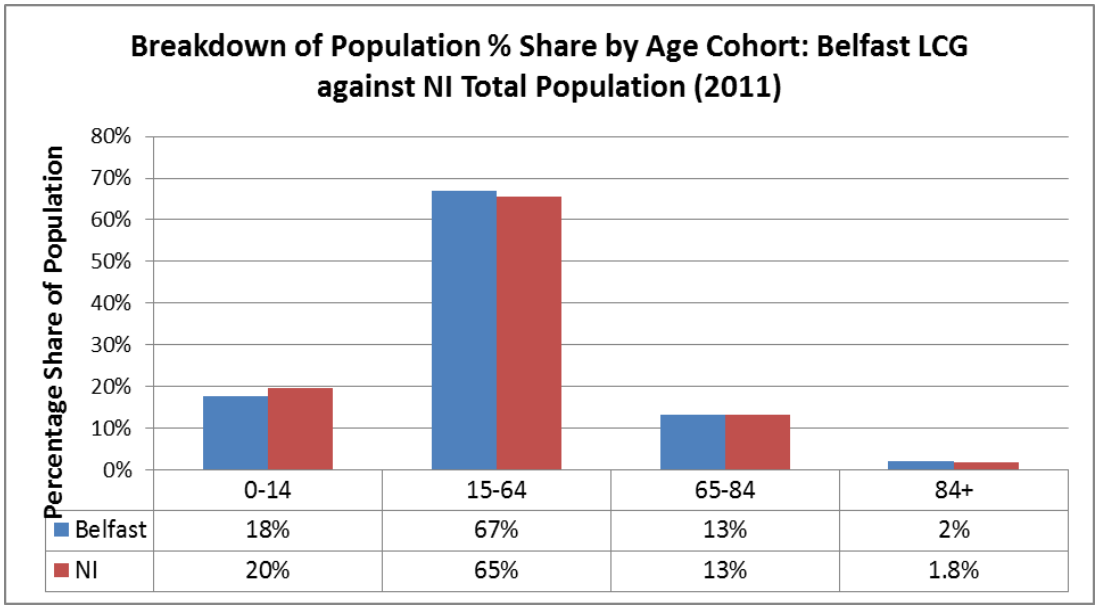
9.1 Overarching assessment of need and inequalities for LCG population

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

9.1.1 Demographic changes / pressures

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

Figure 4



Source: NISRA 2012

Demography

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

Belfast LCG population changes

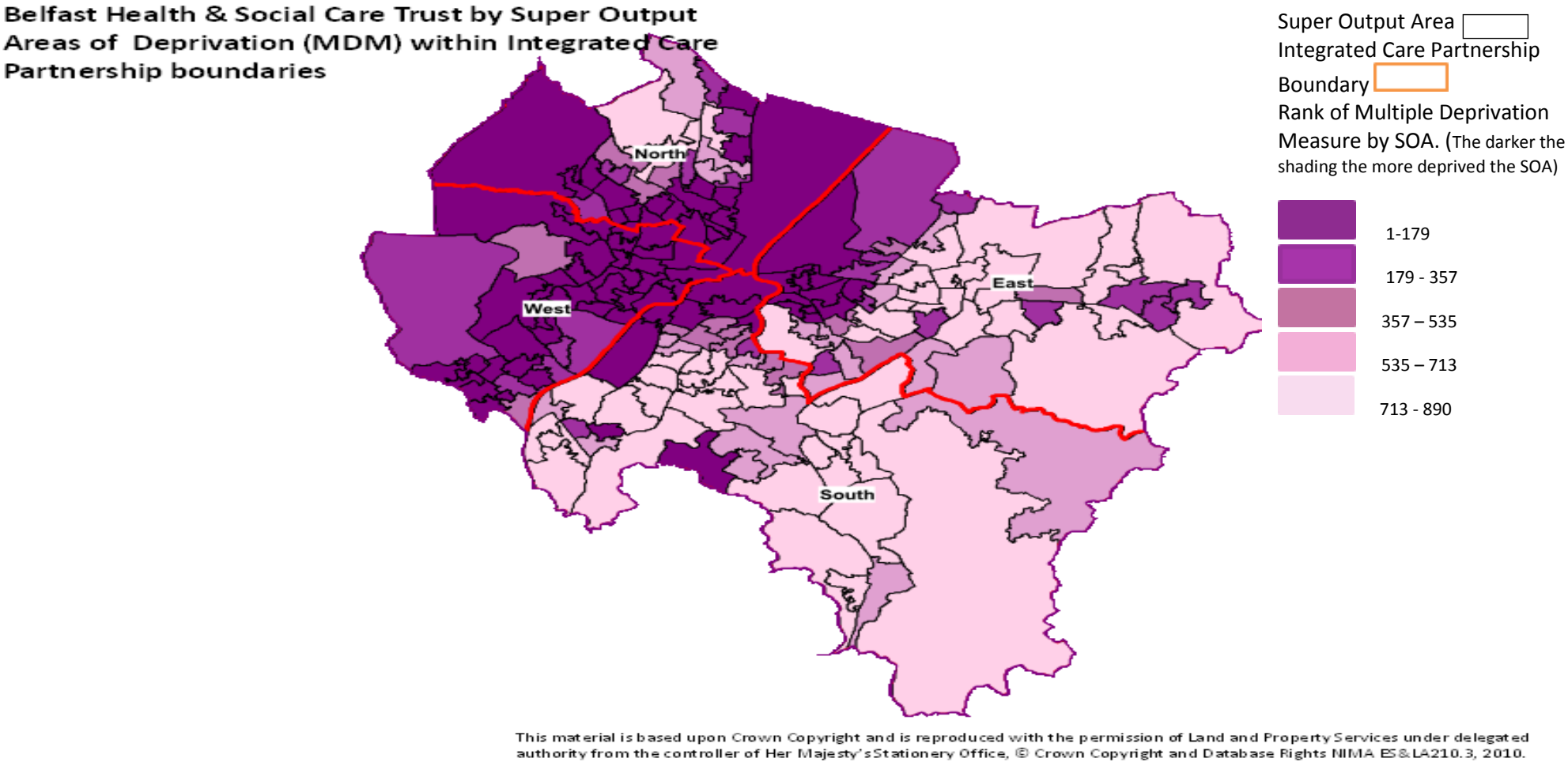
Table 22

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

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

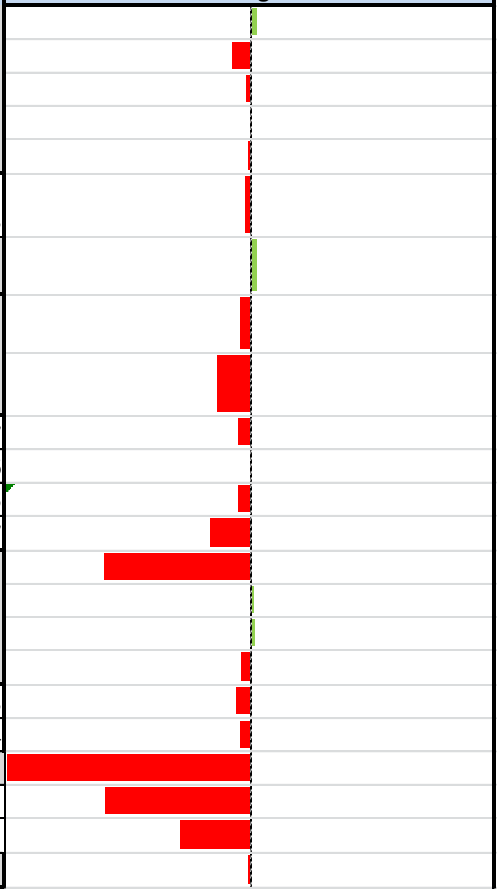


Health Summary

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		



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

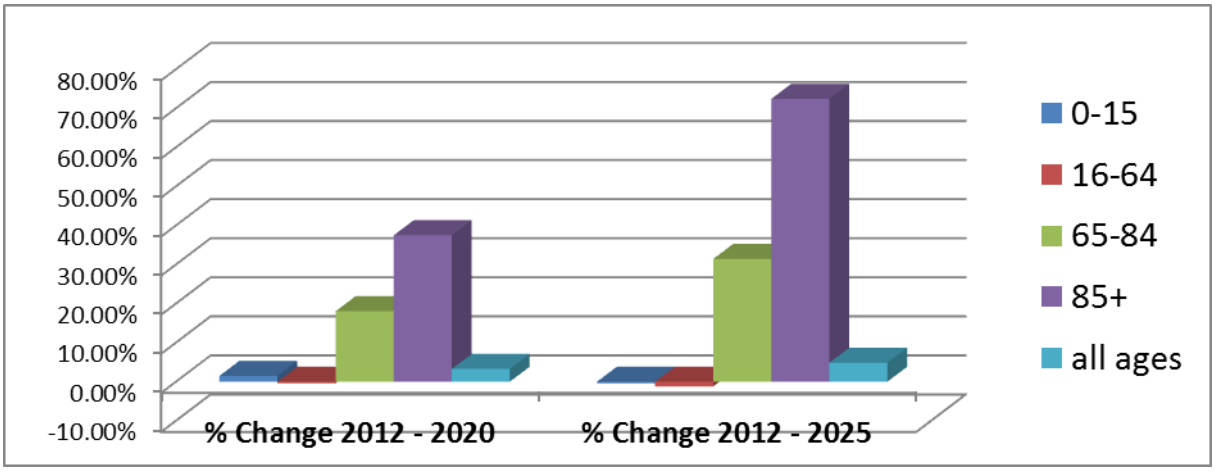
This section provides an overview of the assessed needs of the populations of the Northern Local Commissioning Group (NLCG). A range of information and analyses have been used to identify the challenges facing the NLCG in 2015/16 and beyond.

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

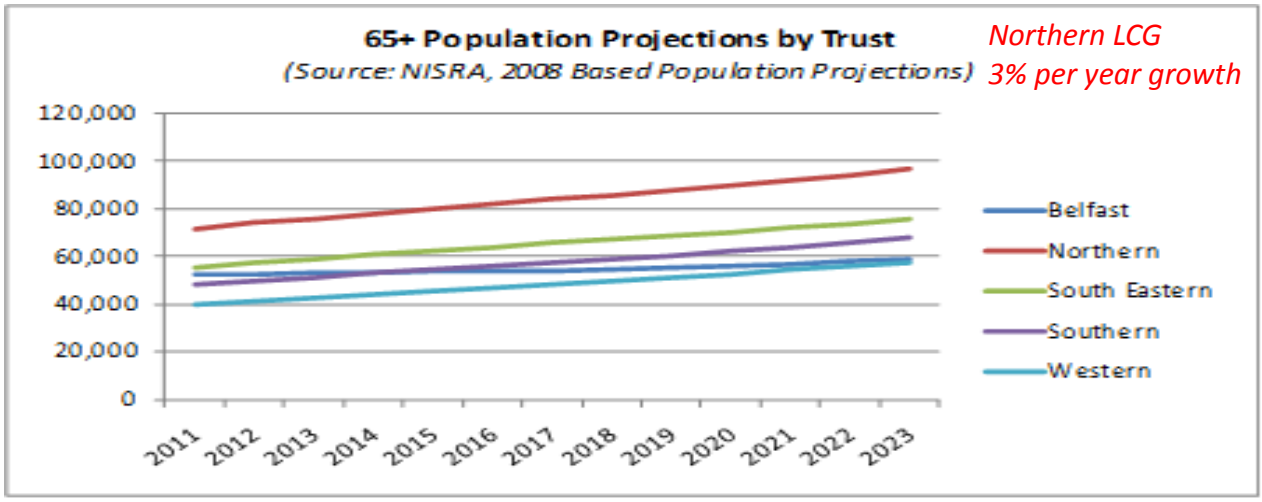
LGD	65-74	75-84	85+	Total 65+
Antrim	4,549	2,347	798	7,694
Ballymena	6,117	3,707	1,393	11,217
Ballymoney	2,751	1,570	570	4,891

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

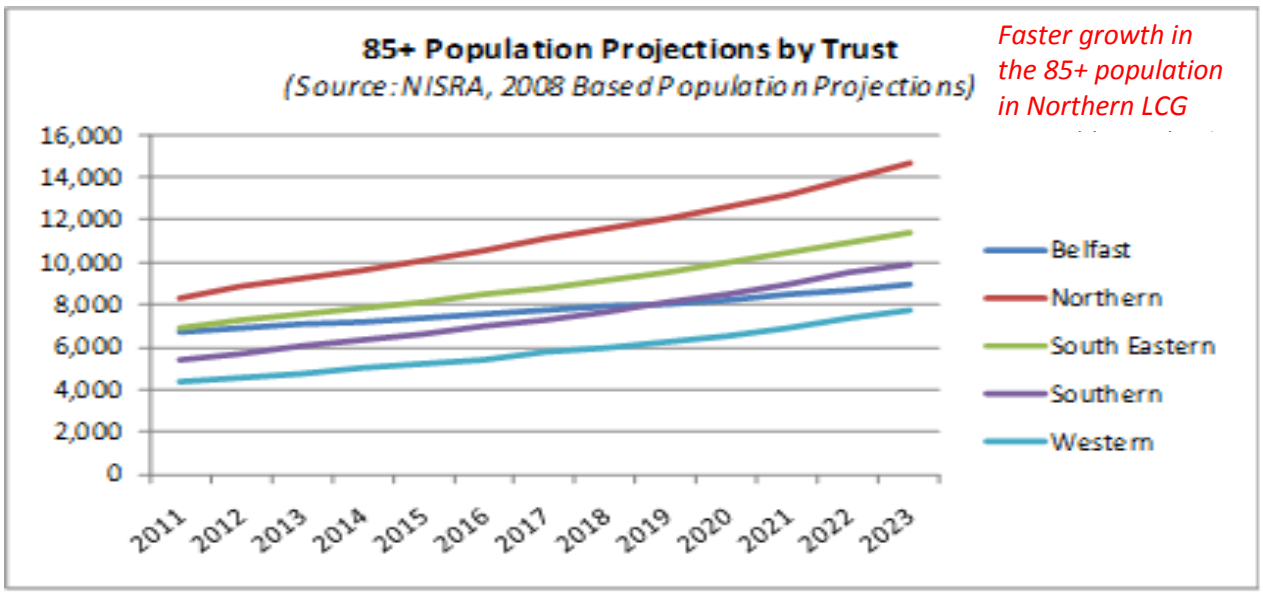


Year:	2011	2012	2013	2014	2015	2016	2017
65+ Pop	71,527	73,876	75,912	77,834	79,785	81,725	83,706
	2018	**2019**	**2020**	**2021**	**2022**	**2023**	
65+ Pop	85,693	87,661	89,630	91,777	94,024	96,386	

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

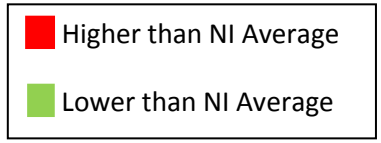
The table below highlights the greater prevalence of certain conditions in the Northern LCG area namely: cancer, stroke, atrial fibrillation, coronary heart disease, hypertension and diabetes.

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	36,645	2000	38,645
		ED Attendances	133,088	250	133,338
		Planned investment in 2015-16		£1.5m	

10.3.3 POC 2: Maternity and Child Health Services

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

Local Needs and Assessment

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

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

Services to be commissioned

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

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

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

Securing Service Delivery

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

Progress of the APNP will be monitored.

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

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

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

POC2 Values and Volumes

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

Table 37

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,069		4,069
	Health Visiting	Contacts	68,046		68,046
		Planned investment in 2015-16		Nil	

10.3.4 POC 4: Older People

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

Local Needs and Assessment

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

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

Services to be Commissioned

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

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

Securing Service Delivery

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

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

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

POC4 Values and Volumes

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

Table 38

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

10.3.5 POC 5: Mental Health Services

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

Local Needs and assessment

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

Services to be Commissioned

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

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

Securing Service Delivery

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

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

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

POC5 Values and Volumes

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

Table 39

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	37,280		37,280
	Residential and Nursing Home Care	Occupied Bed days	50,100		50,100
	Domiciliary Care	Hours	108,150	2,000	110,150
		Planned investment in 2015-16		£0.4m	

10.3.6 POC 6: Learning Disability Services

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

Local Needs and Assessment

1. People with a learning disability who experience crisis out of hours are more likely to be admitted to hospital.
2. Service users with learning disabilities are now living longer thanks to the medical advancements in their care. There is therefore an increase in numbers and complexity.
3. Carers provide a valuable service in the day to day care of people with a learning disability. Support needs to be provided to these carers in the form of breaks from the caring responsibility.
4. The number of long-stay patients in hospital must be reduced by 9 by 31st March 2016.

Services to be Commissioned

1. NLCG will commission an Out of Hours (OoH) crisis response service for service users with a learning disability.
2. In light of the increasing complexity and numbers of young people with a learning disability, the NLCG will commission additional day care places.
3. NLCG will commission additional packages of care for carers of people with a learning disability in the Northern area.
4. NLCG will support the HSCB to commission resettlement packages of care for 9 long stay patients. NLCG will commission additional domiciliary care to support service users with Learning Disabilities to live in the community.

Securing Service Delivery

1. NHSCT should commence development of a similar service as to that provided for mental health.
2. NHSCT will provide an additional 15 daycare places for school leavers.
3. NHSCT will provide an additional 20 short breaks including overnight stays.
4. NHSCT will provide resettlement packages for 9 long stay patients by 31st March 2016, reducing the total number of their long stay patients to 0.

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

POC6 Values and Volumes

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

Table 40

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

10.3.7 POC 7: Physical Disability and Sensory Impairment Services

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

Local Needs and Assessment

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

Services to be Commissioned

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

Securing Service Delivery

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

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

POC7 Values and Volumes

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

Table 41

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

10.3.8 POC 8: Health Promotion

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

Local Needs and Assessment

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

Services to be commissioned

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

Securing Service Delivery

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

   NHSCT should be smoke free by No Smoking Day 2016.

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

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

10.3.9 POC 9: Primary Health and Adult Community

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

Local Needs and Assessment

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

Services to be Commissioned

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

Securing Service Delivery

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

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

11.0 South Eastern Local Commissioning Plan

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

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

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

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

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

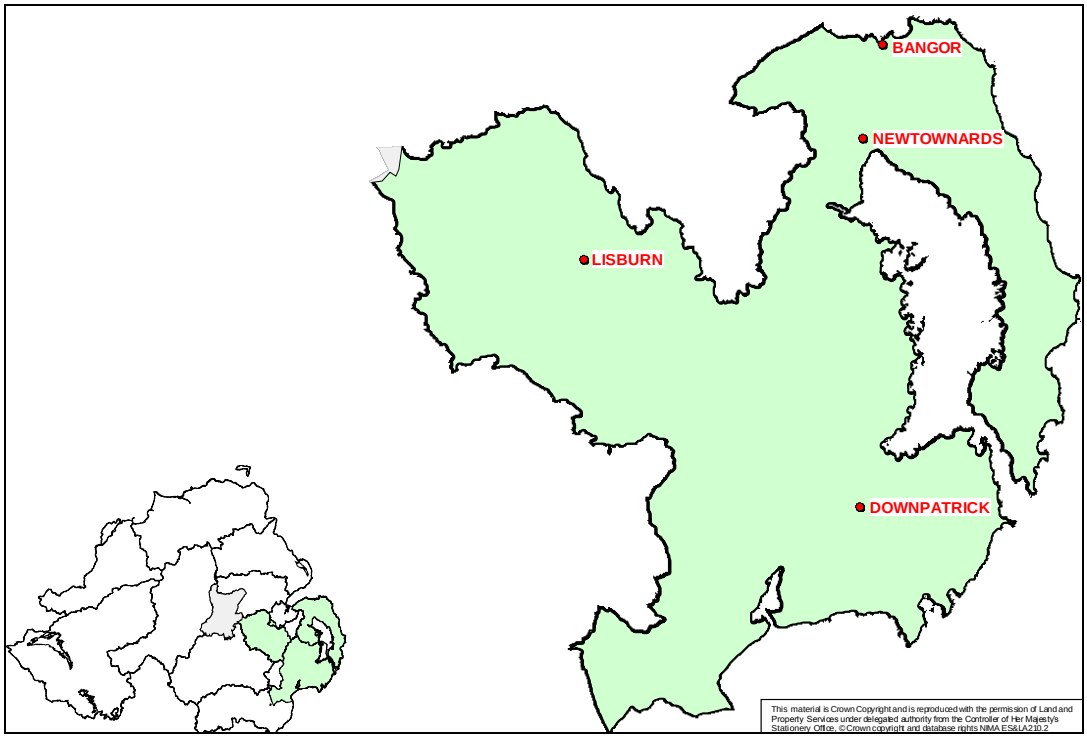
11.1 Overarching assessment of need and inequalities for LCG population

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

Geography and Communities

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

Figure 9: Population Centres in SELCG area



11.1.1 Demographic changes / pressures

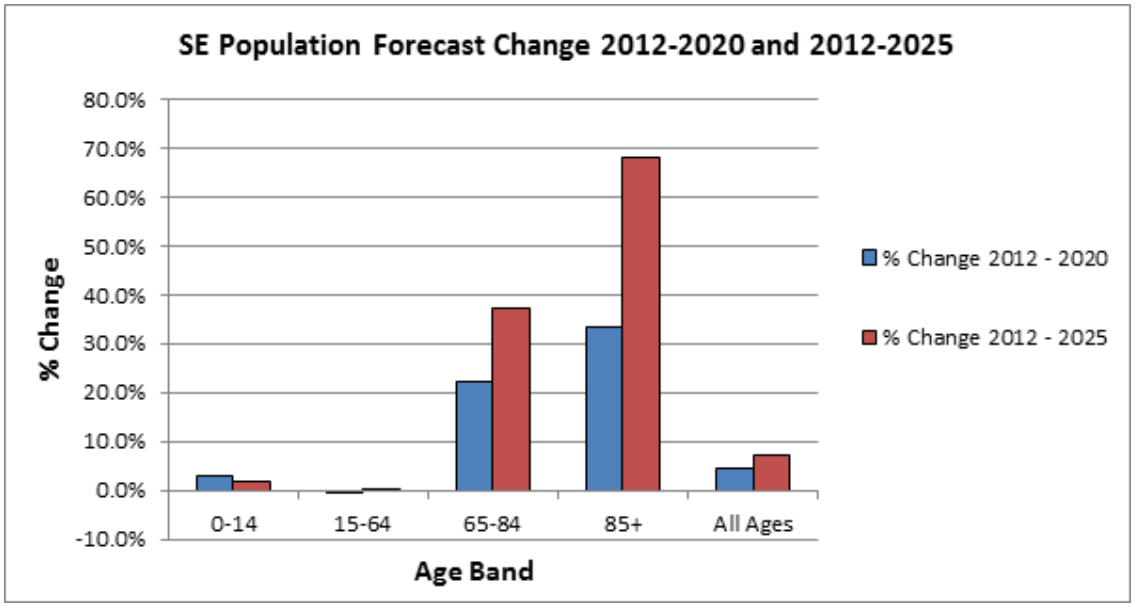
This section gives a general overview of the population within the LCG area, describing the age structure, general health and income of the resident population.

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.

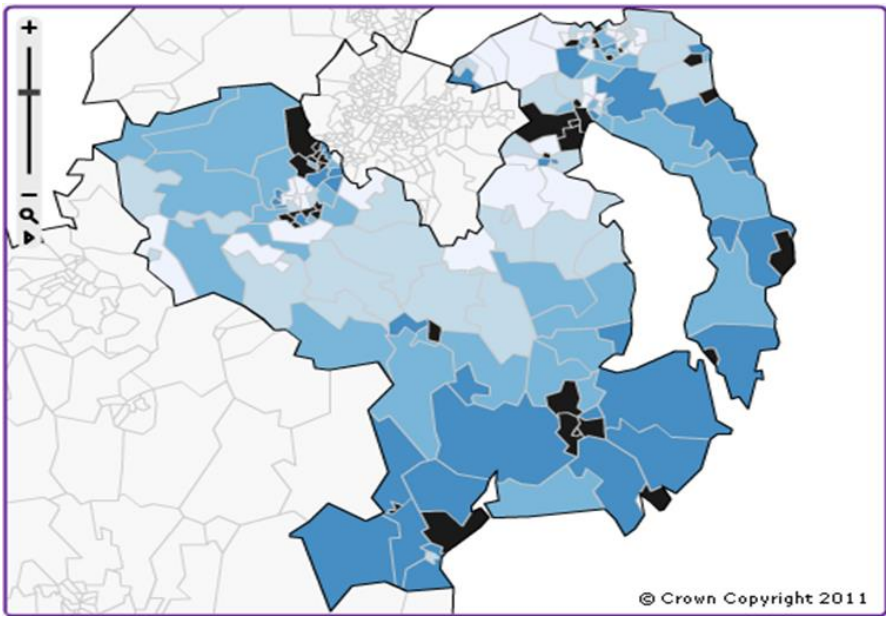
Deprivation

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.Ireland as a whole.

Deprivation Mapping

Figure 11



One in ten people residing within the SELCG area in 2013 were living within the most deprived of the N. Ireland deprivation quintiles. Across N. Ireland 18.8% of the population live in the most deprived quintile. This is represented in the figure below.

Percentage of Population in NI Deprivation Quintiles
Figure 12

Source: PMSI South East Local Area Health Profile

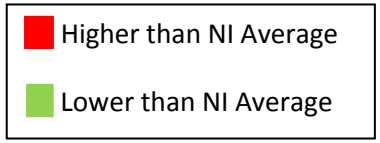
Work produced by the N. Ireland Health and Social Care Inequalities Monitoring System (HSCIMS) sub regional inequalities (2015) has been helpful in identifying, across a range of domains, inequalities across the south east in comparison to the N. Ireland average. The general picture shows that within the LCG area there is an overall trend of reducing deprivation, however the reduction in gap between the deprived and most deprived is variable. In comparison to the N. Ireland averages the LCG population is under these figures with the following exceptions; drug related mental health disorders, admissions due to self-harm and ambulance response times.

Health Summary

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

Table 43

Domain	Indicator	Descriptor	SELCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	20.96	19.12	
	COPD	Prevalance per 1000	15.94	18.56	
	Stroke	Prevalance per 1000	19.55	17.94	
	Atrial Fibrillation	Prevalance per 1000	16.36	15.12	
	Coronary Heart Disease	Prevalance per 1000	41.48	38.81	
	Hypertension	Prevalance per 1000	136.76	130.5	
	Diabetes	Prevalance per 1000	44.4	42.61	
	Diabetes Prescriptions	Stdised Prescription Rate	37	39	
	Asthma	Prevalance per 1000	63.95	60.48	
	Dementia	Prevalance per 1000	8.39	6.67	
	Learning Disability	Prevalance per 1000	5.48	5.33	
	Bowel Cancer Screening	Programme Uptake	55.19	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.49	8.54	
	Crude Suicide Rates	All Persons	13.5	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score 2013	45.75	46.23	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	67	62	
	Meeting Physical activity levels	% of population (2012 -2013)	56	53	
	Pain or Discomfort	% of population (2012-2013)	35	35	
	Anxious Depressed	% of population (2012 -2013)	26	26	
Maternal and Child Health	Children in Need	Rate per 100,000	47.52	60.18	
	Births to Teenage Mothers	Percentage 2013	4.04	3.86	
	Births to unmarried mothers	Percentage 2013	41.13	42.46	
	Births to Mothers from outside NI	Percentage 2013	16.12	17.88	
Life Expectancy	Male	Age (2009-11)	78.36	77.5	
	Female	Age (2009-11)	82.4	82	
	Neonatal	Death Rate (2013)	0.4	0.3	
	Infant Mortality	Death Rate (2013)	5.3	4.6	
	Lung Cancer	STD Death Rate(2008-2012)	54.7	66.5	
	Female Breast Cancer	STD Death Rate (2008-2012)	38.8	38.1	
Carers	Unpaid Care	50+ Hours provided (2011)	3.2	3.1	



11.1.2 Personal and Public Involvement

Across the south eastern locality there is a strong and vibrant community development culture and infrastructure in the form of many voluntary and community networks.

The SELCG has been proactive in engaging with communities to ensure that local patients and carers have an opportunity to influence and shape what services might be commissioned in the future.

The SELCG has maintained its policy of initiating engagement with political representatives at local Council level and through locality meetings with MLAs and MPs. LCG Board Meetings are in public and time within these meetings is set aside for discussion with the public. The LCG also participates in workshops undertaken by voluntary organisations. A full list of LCG Personal and Public Involvement (PPI) activity can be viewed on the LCG web page www.hscboard.hscni.net

11.1.3 Summary of Key Challenges

From the needs assessment analysis undertaken, our engagement with communities and our ongoing work with providers the LCG has identified the following summary of key challenges for 2015/16:

- The increasing levels of overweight and obese adults, with few people meeting the recommended national guidelines in physical activity. There are higher prevalence of heart disease, stroke, hypertension, asthma and diabetes in the south east compared to the N.Ireland average.
- With a significant rural geography, access to services has been identified as a concern for those communities highlighted in the *Regional Health Inequalities Report (March 2015)* e.g., emergency care requiring a 999 ambulance or specialist/urgent services located in Belfast.
- An over-relevance on hospital services with current demand causing pressure on the system and the need to address improving patient flow at the Ulster Hospital.

- A growing older population with increasing health and social care needs.
- The increasingly complex health needs of some children and adults with disabilities living longer.
- Promoting the Transformation agenda in working with ICPs in the designated Clinical Priority Areas.
- Ensuring close working with Primary Care specifically in regard to the quality of referrals to secondary care and opportunities to improve prescribing in General Practice.
- Continuing to push to address inequality gaps within our population.
- Supporting the capital infrastructure programme in the south east to ensure the modernisation of services in respect of the Ulster Hospital (Phase B), the Primary and Community Care Centre planned for at the Lagan Valley Hospital site.

Equality and Human Rights

The SELCG is mindful that the changing make-up of the south eastern population brings challenges in ensuring that identified groups within communities have equity of access to services and that individuals' human rights are upheld. In this regard the LCG has carried out an equality screening of the proposals set out in the section below and the findings and the mitigating actions are available for review.

11.2 LCG Finance

Use of Resources

The SELCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £531.6m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 44

Programme of Care	£	%
Acute Services	192.9	36.25%
Maternity & Child Health	28.2	5.30%
Family & Child Care	39.4	7.39%
Older People	127.0	23.85%
Mental Health	39.4	7.39%
Learning Disability	52.2	9.80%
Physical and Sensory Disability	17.1	3.21%
Health Promotion	15.2	2.86%
Primary Health & Adult Community	20.2	3.96%
POC Total	**531.6**	**100%**

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

Table 45

Provider	£	%
BHSCT	116.8	21.97%
NHSCT	0.4	0.07%
SEHSCT	371.9	69.78%
SHSCT	5.9	1.12%
WHSCT	0.2	0.05%
Non-Trust	36.4	7.02%
Provider Total	**531.6**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the Family Health Services (FHS).

Whilst Emergency Department (ED) services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of emergency care by the South Eastern Trust is in the region of £27.8m.

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

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

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

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

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

Trust Savings Plan

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

Community Information Exercise

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

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

11.3.1 POC 1: Acute (Elective)

Strategic Context: The LCG, with stakeholders, will consider the demand on elective services to ensure standards and response times are further improved. Key to this approach will be to explore optimising the opportunities through GP Federations and community service for safe and viable services to closer to home.

Local Needs and Assessment

1. Demand for diagnostic services across a range of modalities has increased.
2. Elective capacity for outpatients and treatments across many specialties remains insufficient to meet demand. The number of patients waiting up to and over a year to be seen is increasing.
3. SET has the lowest number of surgical patients in NI admitted for treatment on the day of surgery which impacts length of stay.
4. The Cardiology model in the SE area needs reformed to address increasing demand and advances in treatment.
5. The number of referrals for suspected cancer in the SE area continues to increase.

Commissioning Requirements

1. LCG will commission additional capacity to meet projected increases in demand in MRI, CT, Non-Obstetric Ultrasounds and Plain film X-rays.
2. The LCG will invest in a number of specialties to increase capacity through provision of new outpatient clinics, as well as inpatient and day case treatments are required.
3. The LCG will seek a proposal from SET to pilot a surgical admissions Unit at Ulster Hospital to provide dedicated beds.
4. The LCG will reshape the cardiology service in SET by putting in place a rapid assessment and diagnostic model to support elective and non–elective care and enhance communication with primary care.
5. The LCG will work with the Trust to identify improvements in cancer care within the SE area.

Securing Service Delivery

1. SET will deliver additional diagnostic capacity and reporting as commissioned
2. To ensure demand is met, the LCG will work with the Trust/ICP/GP Federations to ensure there is sufficient capacity and to provide care out of hospital and closer to home.
3. LCG will support agreed plans to establish a surgical admissions unit to increase capacity by reducing patient lengths of stay.
4. SET will implement the new cardiology model in line with the commissioner specification.
5. SET to implement approved service developments.

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

11.3.2 POC 1: Acute (Non-Elective)

Strategic Context: The SELCG, with stakeholders, will address the demand non-elective services to ensure standards and response times are further improved. Key to this approach will be to explore commissioning opportunities from GP Federations/ICPs, to provide safe and effective services to complement secondary care and to community services to provide more complex care at home.

Local Needs and Assessment

1. Attendances at the Ulster Hospital have increased by 8,272 since 2011/12 to a projected 86,000 for 2014/15. The demand for unscheduled admissions to the Ulster Hospital since 2011/12 has increased by 3,200 to 30,000.
2. SET is not consistently delivering on unscheduled care targets.
3. The current model of emergency care in SE area remains vulnerable due to pressures in the medical workforce. The local community acknowledges the need for changes in emergency/urgent care services and seek to have in place an appropriate and sustainable model of care which ensures access to emergency /urgent care, particularly for rural communities.
4. The local community has voiced its concern on ambulance response times.

Commissioning Requirements

1. The LCG will commission a Care at Home model to improve care between the acute and community interface.
2. The LCG will commission an increasing range of 7-day services to improve patient flow at the Ulster Hospital.
3. The model of acute care in the SE area needs to further evolve to ensure that communities can access appropriate care in the right place when required. A new urgent care model will require changes to the provision of acute medical care on some sites.
4. The LCG will work with the HSCB to look at opportunities to improve Ambulance response times specifically in the Down and Ards localities.

Securing Service Delivery

1. ICPs to deliver a comprehensive range of care closer to home and specifically to ensure that patients with more complex needs who are currently admitted to hospital can be supported and cared for at home.
2. SET will deliver 7 day working in a range of service areas at the Ulster Hospital
3. The LCG has requested that the SET submits a proposal supporting the continued modernisation of acute and urgent care provision and associated acute medical services in relevant hospitals.
4. SET will work with HSCB/NIAS to support the improvement of response times in the SE area.

Regional Priorities (see appendix A): Unscheduled Care (MT12), Patient Safety (MT25), Excess Bed Days (MT27), Patient Discharge (MT21)

POC 1 Values and Volumes

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

Table 46

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**[6]	Inpatients	5,849		5,849
		Daycases	22,071		22,071
		New Outpatients	77,570		77,570
		Review Outpatients	128,511		128,511
	Unscheduled[7]	Non Elective admissions[8]	33,214	3,086	36,300
		ED Attendances[9]	125,255	11,926	137,181
		Planned investment in 2015-16		£1.5m	

[6] Baseline elective volumes include FYE of 14/15 in-year investments.

[7] Baseline unscheduled volumes based in 2014/15 SBA

[8] UHD, Downe, LVH sites only

[9] UHD, Downe, LVH sites only

11.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The LCG will continue to work with the Regional Maternity and Pregnancy Related Gynae, Fertility, Paediatric and Child Health Commissioning Service Team, the SET and other key stakeholders (including the ICP) to develop services that are in line with the DHSSPS Strategy for Maternity Care in N.Ireland 2012 -2018, relevant NICE Guidelines, the regional Neonatal Network Review and the DHSSPS Paediatric Strategy for N.Ireland (anticipated to be published during 2015).

Local Needs and Assessment

1. There has been an increase in births above the commissioned capacity (4,941 in 14/15). In particular, there has been an increase in births at the Ulster Hospital (UH). This has put pressure on both inpatient and outpatient provision.

   The prevalence of mothers with higher BMIs and births where diabetes was identified as a maternal risk factor is increasing.

2. The incidence of asthma and allergies among children has increased in recent years and there is currently no paediatric consultant in place in the SE with an interest in Epilepsy.

   Medical cover in paediatrics – there are fewer consultant paediatricians serving the locality than in other LCG areas despite having the second largest childhood population.

3. There are a small number of children with complex needs requiring specialised, high cost care.

Services to be Commissioned

1. Core baseline funding will be reviewed due to sustained increase in births above commissioned capacity. The LCG will commission additional resource to make labour rooms 6 and 7 operational at the UH.

   The LCG will also seek to address capacity issues within the UH's maternity outpatient area to deal with the volume of Gynae, fertility and other maternity clinics, to include diabetes clinics. The LCG will also review neonatal services at the Ulster Hospital following the publication of the Neonatal Review.

2. The LCG will explore with the SET, a new paediatric model, to include a consultant with an interest in epilepsy and will work with the SET to support improved access to paediatric services at the Ulster Hospital.

3. The LCG will continue to work with SET to address pressures associated with complex care packages at home.

Securing Service Delivery

1. The LCG will seek to commission an evaluation of Downe and Lagan Valley Midwifery Led Units in conjunction with the Leadership Centre.

   SET should continue to ensure that the model of care in place is in line with the Maternity Strategy and participate in projects led by the HSCB/PHA to implement other key priorities.

   SET should relocate gynae and speciality outpatient clinics from the UH maternity unit to community hubs (or other appropriate sites) where it is safe to do so.

   SET should ensure that all eligible pregnant women, aged 18 years or over, with a BMI of 40 or more at booking are offered the 'Weight to a Healthy Pregnancy Programme', with an uptake of at least 65% of those invited.

2. SET to provide a paediatric epilepsy service subject to funding.

3. SET to increase access to paediatric services by extending the opening hours of the paediatric short stay assessment unit at the UH.

Regional Priorities (see appendix A): Tackling Obesity (MT2), Patient Safety (MT25)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC 2 Values and Volumes

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

Table 47:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,941		4,941
	Health Visiting	Contacts	24,430		24,430
		Planned investment in 2015-16		Nil	

11.3.5 POC 4: Older People

Strategic Context: The elderly population (65+) of the south eastern locality is growing faster than any other age group. With an ageing population, gains in life expectancy often present challenges in the context of higher prevalence rates of long term conditions such as COPD, diabetes, heart failure and stroke. Population ageing means that overall health and social care need has risen. This holds new responsibilities and challenges for us to commission services that help older people to stay healthy, independent and active for as long as possible

Local Needs and Assessment

1. SE LCG locality has, and into the future is projected to have, the highest number of 65+ older people in NI as a % of its population (18.3% of SELCG population by 2017). By 2023, 11,418 people will be 85+, a rise of 57.8%.

   This is leading to increased demand on both acute and community services including, unscheduled care, domiciliary care, dementia care, psychiatry of old age, safeguarding and provision of end of life care.
2. SE LCG the highest prevalence of Stroke and TIA in Northern Ireland and it continues to rise. (Source GP QoF)
3. As the population ages, the LCG area has an increased number of people providing unpaid care. Evidence shows that caring impacts negatively on both the mental and physical wellbeing of the carer.

Services to be Commissioned

1. To meet the increasing demands the LCG will commission:
   - additional domiciliary care hours
   - additional community equipment
   - appropriate care at home as an alternative to ED and acute hospital admission where clinically appropriate for elderly patients.
   - a 'Safe and Well 'model of community support.

   The SELCG will also work with PHA to develop and commission preventive services to include falls prevention, social inclusion and the promotion of active and healthy lifestyles
2. A new stroke model for the SE will be designed.
3. The LCG will commission additional short break provision for carers of older people.

Securing Service Delivery

1. SET will provide additional hours of domiciliary care for older people through a mix of statutory and independent domiciliary care provision and implement a 'Safe and Well' model.

   The ICP will:
   - implement a Care at Home initiative in North Down in 15/16.
   - develop initiatives to support older people to remain at home e.g. Falls programme.
   - progress actions coming from the Transforming Your Palliative and End of Life Care initiative to support people to die in their preferred place of death.
2. A new stroke model will be delivered by the ICP.
3. SET will provide additional short break provision for carers of older people.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC 4 Values & Volumes

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

Table 48

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,048	58,700	2,316,748
	Residential and Nursing Home Care	Occupied bed days	730,804		730,804
	Community Nursing	Contacts	206,704	6,400	213,104
		Planned investment in 2015-16		£4.2m	

11.3.6 POC 5: Mental Health Services

Strategic Context: The LCG will continue to work with the Regional Bamford Team to develop services for those with mild, moderate or severe mental illness, placing an emphasis on recovery through the Stepped Care Model which supports people to live as independently as possible. Focus should also be on people who have significant life events and/or stressors that increase the threshold of harm. The LCG will also work to develop access as appropriate to community voluntary or specialist support by targeting clients at an earlier stage to prevent crisis intervention.

Local Needs and Assessment

1. Clients are waiting longer than 13 weeks for psychological therapy within the secondary care service.

   There is an over dependency in the SE area on prescription drugs for those with mental health issues.
2. Current hospital admissions and length of stay for acute patients are currently higher in NI compared to England and could be further reduced with greater use of Crisis Response/Home Treatment and a new acute MH in-patient model.
3. Carers continue to provide vital support to family members with mental health issues. Carers have reported to the LCG poorer mental and physical health as a consequence of their caring role.

Services to be Commissioned

1. The LCG will commission additional psychological therapies within primary care at levels 1 and 2 of the Stepped Care Model; and within secondary care at Level 3.
2. The LCG will commission a reprofiling of Crisis Response Home Treatment with the inclusion of a skill mix based staffing complement and the opportunity to develop a new MH centre of excellence.
3. The LCG will commission additional carers assessments and support to include short breaks in addition to uplifting nursing and residential home places.

Securing Service Delivery

1. SET will establish a Primary Care Mental Health and Well-Being Hub pilot site in Dunmurry. The evaluation of this pilot will influence further commissioning intent in other sectors.

   SET will also deliver the additional commissioned capacity within secondary care for psychological therapies.
2. SET will further develop and extend access to the Crisis Response Home Treatment service in accordance with the commissioner specification.
3. LCG will monitor provision of short breaks.

Regional Priorities (see appendix A): Unplanned Admissions (MT6), Carers' Assessments (MT7), Mental Health Services (MT22), Excess Bed days (MT27)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC 5 Values and Volumes

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

Table 49:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	39,273	0	39,273
	Residential and Nursing Home Care	Occupied Bed days	41,808	720	42,528
	Domiciliary Care	Hours	13,042	2,612	15,654
		Planned investment in 2015-16		£0.43m	

11.3.7 POC 6: Learning Disability Services

Strategic Context: The key aims of Learning Disability services are to promote independence for people with a learning disability in inclusive community environments which promote their health and wellbeing and provide appropriate support for their families who care for children and adults with learning disabilities.

Local Needs and Assessment

1. A small number of LD clients remain to be resettled from Muckamore Abbey Hospital.
2. There is a need to reduce the number of LD clients presenting at EDs.
3. There is also a need to extend supported living schemes for LD clients.
4. A number of children with learning disability and complex health needs are transitioning to adult services in 2015/16.
5. There is a need to continue the delivery of Day Services in line with the Regional Day Opportunities model.

Services to be Commissioned

1. The LCG will respond to plans for resettlement to finalise the arrangements for the remaining LD clients in Muckamore Abbey.
2. The LCG will commission a pilot Crisis Response Home Treatment service for people with LD.
3. The LCG will continue to develop supported living schemes under South Eastern Area Supporting People Partnership.
4. The LCG will commission services for those young people with LD and complex health needs who are transitioning to adult services.
5. The LCG will commission the delivery of additional Day Services subject to budgetary constraints.

Securing Service Delivery

1. SET will be required to report on the progress of the remaining LD clients. If needed, appropriate funding will be made available to facilitate this process.
2. SET will pilot the Crisis Response Home Treatment service.
3. LCG will monitor provision of supported living places in line with need.
4. SET will be commissioned to provide a number of services for those young people with LD and complex health needs who are transitioning to adult services.
5. SET will provide additional Day Services for LD clients.

Regional Priorities (see appendix A): Delivering Transformation (MT29)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 - Values and Volumes

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

Table 50

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	108,582	4,000	112,582
	Residential & Nursing Home Care	Occupied bed days	116,456		116,456
		Planned investment in 2015-16		£0.13m	

11.3.8 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: SELCG will continue to the implementation of the Physical and Sensory Disability (P&SD) Action Plan and Transforming Your Care (TYC) recommendations to support people to live independently in their own homes as long as possible. We will continue to invest in additional neuro-rehabilitation services to support the increasing number of people being discharged from hospital with complex care needs.

Local Needs and Assessment

1. As of September 2014 there were 489 physical and sensory disabled clients in receipt of a domiciliary care package. Of these, 193 are receiving intensive domiciliary care. The number of people with complex needs is increasing and these people require significant packages of care.
2. Wait times for access to audiology services do not meet with regional guidelines
3. Over 5% of the SELCG population provide 20 hours or more of unpaid care per week.
4. It is anticipated that there will be increased pressure to discharge from secondary care those patients who suffer from brain injury and who are clinically appropriate for discharge to an alternative facility best placed to meet their longer term needs.

Services to be Commissioned

1. The LCG will commission an appropriate mix of domiciliary care and direct payments via a mix of statutory and Independent providers and additional Nursing Homes for P&SD clients.
2. The LCG will commission additional audiology capacity for those with a hearing impairment.
3. The LCG will commission short break provision for Carers of People with Physical and Sensory Disabilities.
4. The HSCB will commission additional bed days in Thompson House to support the brain injury pathway.

Securing Service Delivery

1. SET will ensure delivery of additional domiciliary hours and nursing home beds.
2. SET to appoint an additional audiologist and ensure improvements in audiology access.
3. SET will provide the required number of short breaks.
4. SET will ensure provision of the neuro-rehabilitation additional bed days and consultant sessions.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Direct Payments (MT8), Allied Health (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC 7 Values and Volumes

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

Table 51

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	342,870	500	343,370
	Residential & Nursing Home Care	Occupied bed days	27,192	80	27,272
		Planned investment in 2015-16		£0.08m	

11.3.9 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing health inequalities are key priorities for the SELCG and the PHA. In line with the new public health strategy 'Making Life Better' and the Marmot Review 2010 and 2012, action will focus on strengthening coordination and collaboration across organisations and communities, and with the community planning function of the new councils, to ensure children and young people get the best start in life, people are supported to make healthy choices and together with partners we seek to ensure structural, economic, environmental and social conditions are conducive to health.

Local Needs and Assessment

1. In the SE area 20% of the population continue to smoke (NI 22%), 37% of adults are overweight (NI 37%), 26% are obese (NI 25%) and 18% of adults drink above recommended weekly limits (NI 16%).
2. Communities experiencing higher levels of deprivation continue to experience lower levels of life expectancy and higher levels of disability and poor health.
3. There is a high rate of suicides and self-harm among the south east population.
4. Local Councils now have a lead role in developing Community Plans which include Health and Wellbeing.

Services to be Commissioned

1. The LCG/PHA will commission programmes to encourage changes in behaviour related to physical activity, healthy eating, alcohol and drug use, cancer prevention, sexual health and smoking.
2. The LCG/PHA will commission evidence based parenting programmes to ensure accessible and equitable family support services & programmes across the area.
3. The LCG/PHA will commission programmes to promote mental and emotional wellbeing and prevent suicides and self-harm.
4. The LCG/PHA will engage with the new Councils in the development of Community Plans.

Securing Service Delivery

1. The LCG with PHA will continue to invest in the work of the SET Health Improvement Service to provide effective operational leadership, coordination and support across all communities and organisations contributing to health and wellbeing improvement.
2. Early Years Intervention communities to deliver programmes in Colin, Lisburn, Downpatrick, Ards/North Down .
3. ICPs, Primary Care Teams & SET to deliver commissioned mental health support programmes.
4. New Partnerships through Local Councils should deliver and support improved health outcomes.

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

12.3.10 POC 9: Primary Health and Adult Community

Strategic Context: This programme of care includes all work, except screening, carried out by General Medical Practitioners, Out of Hours, General Ophthalmic, Dental, and Pharmacists as well as community based AHPs and nursing services. The GP practice population for the SELCG is 315,664 (overall population is circa 350,000). The SELCG will continue to commission primary care led services for the frail elderly and people with long term conditions, such as coronary heart disease, diabetes, respiratory conditions and TIAs/strokes.

Local Needs and Assessment

1. There are increasing numbers of adults being referred to ED and admitted to hospital. Many of these people could be alternatively treated at home or in the community.
2. SELCG population has higher than average prevalence of cancer, stroke, coronary heart disease, hypertension, asthma, diabetes and chronic pain.
3. Along with the rest of N.Ireland, reliance on prescription medication remains high within the population.
4. Prevalence rates of sexually transmitted infections are higher than the NI average.

Services to be Commissioned

1. LCG will continue to commission services in relation to the 'Care at Home' model of care and Frail Elderly LES.
2. LCG will invest in ICP developed care pathways. Subject to funding, Arthritis Care NI will be commissioned to provide a Peer Education Pain Management Programme for patients with chronic pain.
3. LCG will continue to invest in Practice Based Pharmacists to facilitate efficient medicines management and further reduction of prescribed medication costs.
4. LCG will commission the roll out of Asymptomatic STI testing in Primary Care to the Down and Ards localities with a view to developing a fully integrated sexual and reproductive (family planning) service.

Securing Service Delivery

1. SE ICP will implement the Care at Home initiative in the North Down locality in 2015/16.
2. ICPs will implement new care pathways for respiratory disease and diabetes.
3. The SELCG will continue to monitor prescribing practice and costs within south east locality.
4. SET Sexual Health service will build the Primary Care Asymptomatic STI testing service LCG wide and will seek to redesign and integrate the FP service.

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

12.0 Southern Local Commissioning Plan

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

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

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

12.1 Overarching assessment of need and inequalities for LCG population

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

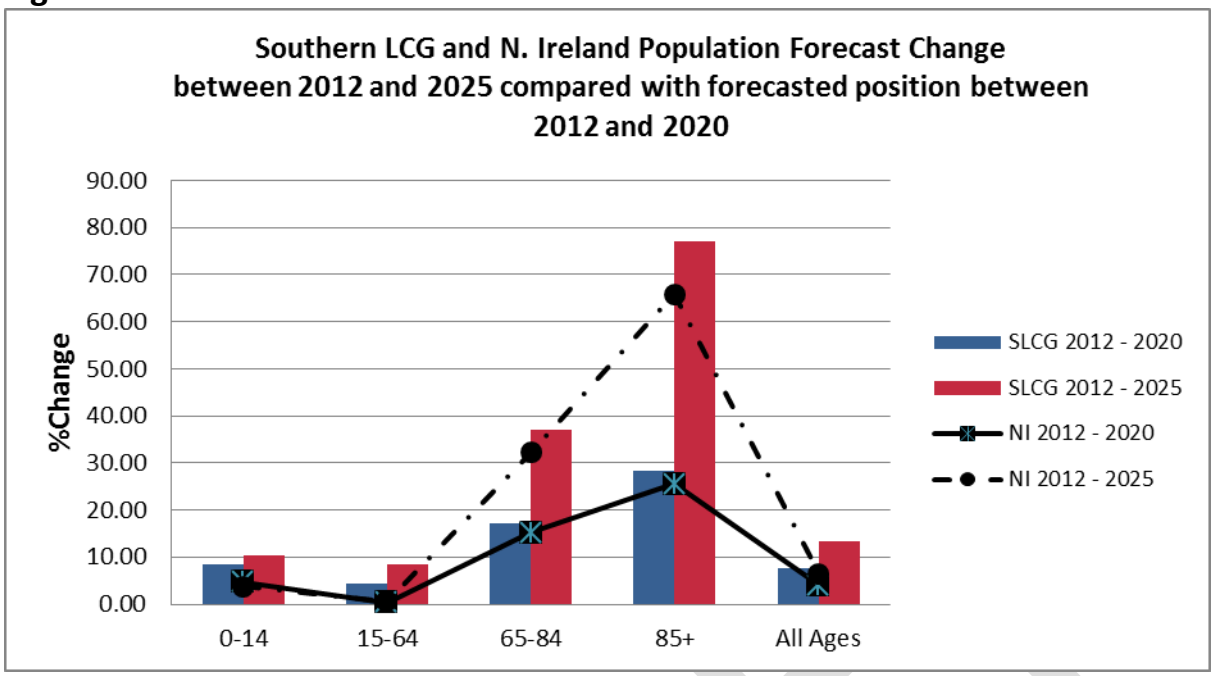
12.1.1 Demographic changes / pressures

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

Demography

The Southern LCG currently has a population of 365,712, representing 20.0% of the overall N. Ireland population. 93,595 SLCG residents aged 0-17 years account for 25.5% of the total SLCG population. 60.5% are aged 18-64 years, and 14% make up 65 years and over SLCG population.

Figure 13



The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five to ten years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group. Investment in the "Acute Care at Home" model and District Nursing will be pivotal in meeting this need.

Migration

The Southern LCG area has experienced a high influx of foreign nationals, between July 2004 and June 2013 the 5 Local Government Districts within the Southern LCG area experienced a net international migration population of 20,233 which accounts for 68% of the overall N. Ireland total. In addition, 4 of the 5 SLCG LGDs fell within the highest net figures across N. Ireland, with Dungannon LGD accounting for 22% of the NI total.[10]

[10] NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 52

NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 4.3: Estimated Net International Migration, by Age and Gender (July 2012 - June 2013) - N. Ireland, Trust and SLCG LGD

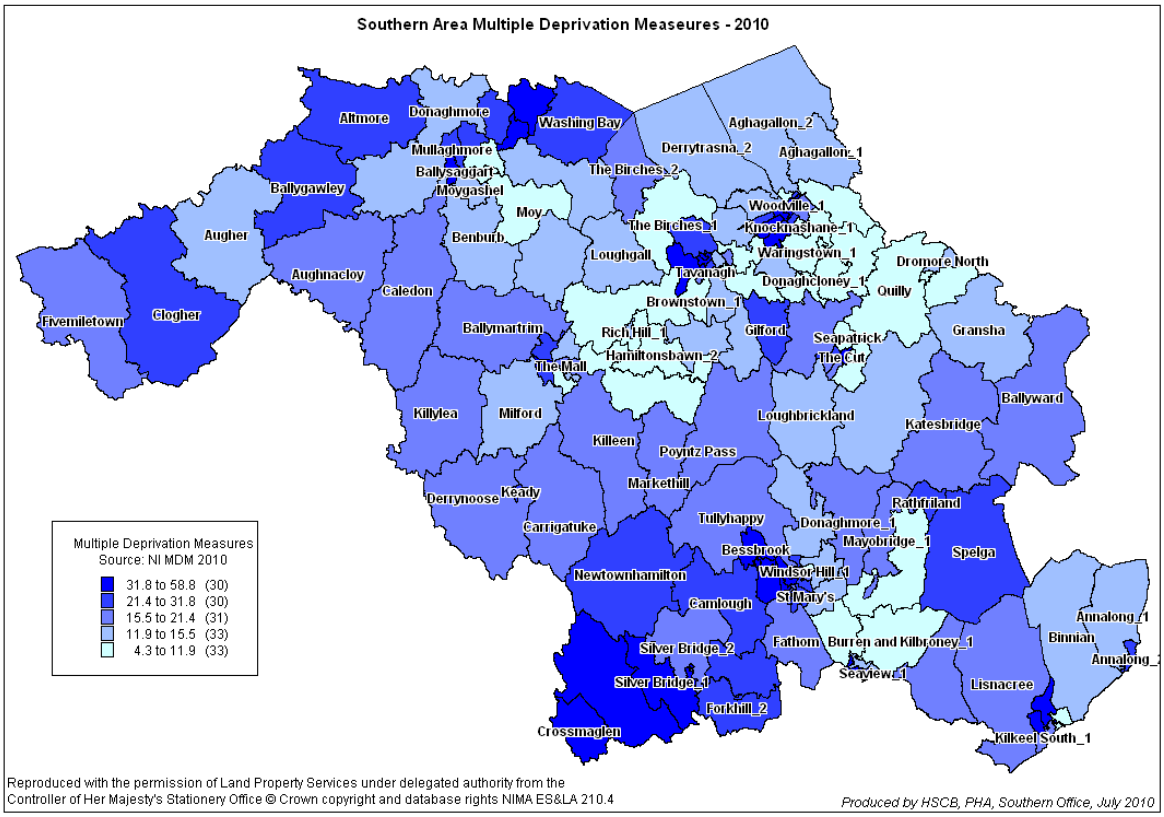
Gender / Age	Estimated Net International Migration	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Armagh	Banbridge	Craigavon	Dungannon	Newry and Mourne
Male	**-547**	**-756**	**-89**	**-124**	**527**	**-105**	**86**	**-9**	**207**	**156**	**87**
Less than 18 years	263	52	49	-20	158	24	27	0	44	60	27
18-24	216	-168	51	28	314	-9	28	-2	113	109	66
25-34	-529	-386	-125	-17	23	-24	21	-5	40	-19	-14
35-44	-331	-182	-61	-59	34	-63	12	1	6	0	15
45-54	-32	-12	8	-33	15	-10	6	-2	10	-3	4
55-64	-69	-29	-10	-10	-9	-11	-2	3	-3	1	-8
65 years and over	-65	-31	-1	-13	-8	-12	-6	-4	-3	8	-3
Female	**-340**	**-367**	**-202**	**-56**	**493**	**-208**	**55**	**7**	**205**	**126**	**100**
Less than 18 years	421	132	42	27	178	42	18	8	42	58	52
18-24	225	-22	-19	32	236	-2	19	9	77	73	58
25-34	-652	-322	-173	-54	25	-128	6	1	33	-3	-12
35-44	-254	-125	-44	-39	-6	-40	-1	-14	24	0	-15
45-54	-44	-24	-15	-17	35	-23	6	2	20	-2	9
55-64	-1	15	-1	0	9	-24	-1	-1	1	1	9
65 years and over	-35	-21	8	-5	16	-33	8	2	8	-1	-1
Total	**-887**	**-1,123**	**-291**	**-180**	**1,020**	**-313**	**141**	**-2**	**412**	**282**	**187**

Source: NISRA (June 2014)

Deprivation

- Using the Multiple Deprivation Measure, the most deprived Super Output Area across the Southern area is Drumnamoe_1 (Craigavon LGD) whilst the least deprived is Waringstown_2, (Craigavon LGD).
- Using Multiple Deprivation, Drumnamoe_1 is ranked 16 out of 890 and Waringstown_2 is ranked 830 out of 890 across Northern Ireland.
- *Summary Measures* - using the Extent score (% of an area's population living in the most deprived SOAs in NI); the highest % in the Southern area is within Craigavon LGD, 21%. This LGD ranks 4th across NI using this score.
- The summary measures also indicate that almost 30,000 people or 29% of the total population in Newry/Mourne LGD are considered income deprived (ranked 3rd in NI).

Southern Area Multiple Deprivation Measures (2010)
Figure 14

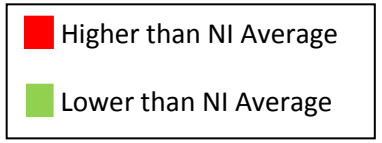


Health Summary

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

Table 53

Domain	Indicator	Descriptor	SLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.61	19.12	
	COPD	Prevalance per 1000	15.82	18.56	
	Stroke	Prevalance per 1000	15.86	17.94	
	Atrial Fibrillation	Prevalance per 1000	13.45	15.12	
	Coronary Heart Disease	Prevalance per 1000	35.59	38.81	
	Hypertension	Prevalance per 1000	124.32	130.5	
	Diabetes	Prevalance per 1000	38.47	42.61	
	Asthma	Prevalance per 1000	55.35	60.48	
	Dementia	Prevalance per 1000	5.8	6.67	
	Learning Disability	Prevalance per 1000	5.35	5.33	
	Bowel Cancer Screening	Programme Uptake	47.76	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.66	8.54	
	Crude Suicide Rates	All Persons	15.2	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	61	62	
	Meeting Physical activity levels	% of population (2012-2013)	51	53	
	Pain or Discomfort	% of population (2012-2013)	34	35	
	Anxious Depressed	% of population (2012-2013)	23	26	
Maternal and Child Health	Children in Need	Rate per 100,000	45.64	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	2.57	3.86	
	Births to unmarried mothers	Percentage 2013	53.44	42.46	
	Births to Mothers from outside NI	Percentage 2013	20.98	17.88	
Life Expectancy	Male	Age (2009-11)	77.5	77.5	
	Female	Age (2009-11)	82.11	82	
	Neonatal	Death Rate (2013)	0.2	0.3	
	Infant Mortality	Death Rate (2013)	3.5	4.6	
	Lung Cancer	STD Death Rate	58.8	66.5	
	Female Breast Cancer	STD Death Rate	42.2	38.1	
Carers	Unpaid Care (2011)	50+ Hours provided	3	3.1	



12.1.2 Personal and Public Involvement

The Southern LCG has over the past year initiated, faciliated and supported a range of opportunities to engage directly with patients, service users and the public on both their experiences of using health and social care services in the southern area and their views on how these could be commissioned and provided in the future to improve outcomes for patients. Specific engagement events[11] have been held on:

- Integrated Care Partnerships and their role in the delivery of health and social care at a local level
- The views of carers and carers representatives on the provision of short breaks
- Urgent Care, as provided by emergency departments, minor injuries units and the GP Out of Hours services

In addition and as a consequence of the second event above, the LCG has established a carers group of 10 local carers who will work directly with the LCG to contribute to and support its commission decisions. Already and in response to carers input, the LCG has invested in support for carers in a number of programmes of care and intends to continue this support in year.

The LCG has also recognised that the voice of adults with a physical disability and /or sensory impairment is often not heard and so has set up a User Panel to seek the views of individuals who have experienced these services to improve the outcomes for service users.

The LCG has also extensively engaged with public representatives on a range of issues and has and will continue to offer community and voluntary groups the opportunity to come to meet LCG members. Groups have used these opportunities to share what they are doing to improve outcomes for individuals, families and communities at both a service and / or geographical level.

[11] Full reports on the events can be found at www.hscboard.hscni.net in the Southern LCG section

Following all these events and processes, a number of key themes have emerged which the SLCG is committed to taking forward, namely:

- **Improved communication with service users**: The SLCG will continue to hold 3-4 engagement events annually.
- **Continued support for carers**: The SLCG has identified this as a commissioning priority in Programmes 4, 6 and 7.
- **Need for more flexible services which respond to real life situations, especially at weekends**: The SLCG is committed to working toward extended day and /or 7 day services where possible

12.1.3 Summary of key challenges:

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

12.2 LCG Finance

Use of Resources

The Southern LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £562m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 54

Programme of Care	£m	%
Acute Services	205.6	36.50%
Maternity & Child Health	27.3	4.85%
Family & Child Care	38.8	6.89%
Older People	128.2	22.79%
Mental Health	48.4	8.60%
Learning Disability	54.3	9.65%
Physical and Sensory Disability	18.8	3.34%
Health Promotion	19.5	3.46%
Primary Health & Adult Community	21.1	3.93%
POC Total	**562.0**	**100%**

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

Table 55

Provider	£m	%
BHSCT	49.1	8.69%
NHSCT	0.1	0.02%
SEHSCT	5.3	0.93%
SHSCT	463.1	82.32%
WHSCT	3.7	0.65%
Non-Trust	40.7	7.39%
Provider Total	**562.0**	**100.00%**

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

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Southern Trust is in the region of £15.7m.

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

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

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

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

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

Trust Savings Plan

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

Community Information Exercise

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

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

12.3.1 POC 1: Non Specialist Acute – Elective Care

Strategic Context: The LCG, working with key providers, will address the demand on elective and non-elective services to ensure Ministerial targets, extant standards and response times are improved, as per priorities below. Key to this approach will, in 15/16, be exploring opportunities to commission from Integrated Care Partnership, GP Federations and other new providers, for safe and viable services to complement secondary care.

Local Needs and Assessment

1. Demand for imaging exceeds capacity and it is recognised that this needs to be addressed.
2. Demand for Endoscopies exceeds commissioned capacity by 3352 per year.
3. Demand exceeds service capacity by 11,820 outpatient consultations, 972 inpatient and 1,046 day case treatments
4. There is no longer a local Consultant Ophthalmology service in the Southern area and this gap needs to be addressed.

Services to be Commissioned

1. The LCG will commission an additional 1324 MRI Scans, 7364 CTs, 10,545 Non-Obstetric Ultrasounds and 37,675 plain film
2. Referrals for endoscopy will be scored on a JAG accredited points system to ensure more effective use of clinical capacity.
3. The LCG will support initiatives in Primary care to manage demand for Neurology, Dermatology, ENT, General Surgery, Urology and Gynaecology.
4. The LCG will work with the Trust to agree the future configuration of BHSCT Ophthalmology outreach clinics and the possible provision of clinics in the WHSCT in order to meet demand

Securing Service Delivery

1. The Trust should fully develop the potential for Nurse-led Endoscopy and introduce an agreed points system to increase capacity.
2. Demand management will be sought from primary care contractors where these can be shown to reduce the need to refer to Trust Consultant-led services.
3. The Trust should seek to recruit to funded capacity particularly where recent investments have been made to further enhance the service. This is particularly relevant to T&O, Rheumatology, Obs & Gynae and to ENT
4. BHSCT and WHSCT to deliver the agreed service model.

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Cancer services (MT11), Elective Care (MT15, 16, 17),

12.3.2 POC 1: Non Specialist Acute – Unscheduled Care

Strategic Context: The SLCG aim is to ensure that there is a fully integrated care system in place in the Southern area where patients know who to contact in an urgent care situation, receive appropriate care and treatment as close to home as possible, move through the patient pathway in a seamless manner and where outcomes, as per the regional priorities identified below.

Local Needs and Assessment

1. The number of new and unplanned ED attendances at all SHSCT emergency departments is expected to increase by 8% this year compared to last

   Performance against the 4 hour target has reduced in recent years, currently averaging 85%

   Conversion from attendance to admission is low, (24%) with discharges spread evenly Monday to Friday but less at weekends

2. Baseline position for the Regional Unscheduled Care Task Force's 5 identified key tasks has identified gaps in AHP, Social Care, Nursing and Pharmacy input to EDs and wards

Services to be Commissioned

1. Subject to a satisfactory evaluation of the current Phase 1 of the Acute Care at Home model, the LCG will consider further roll out of this to support and manage patient flow within the Trust.

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

2. The LCG will take forward the implementation of the recommendations in the unscheduled care plan to address 5 identified key tasks including additional capacity for CAH ED

Securing Service Delivery

1. The Trust should provide evidence of improved discharges at weekend, reducing transfers after 7pm and increased use of minor injury streams at CAH

2. The Trust will implement the agreed recommendations of the Unscheduled Care Plan with defined activity agreed in SBA

Regional Priorities (see appendix A): Unscheduled Care (MT12), Excess Bed Days (MT27)

POC1 Values and Volumes

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

Table 56

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	6,947		6,947
		Daycases	23,573		23,573
		New Outpatients	78,976		78,976
		Review Outpatients	132,485		132,485
	Unscheduled	Non Elective admissions	33,108	1,236	34,653
		ED Attendances	129,961	4,548	134,509
		Planned investment in 2015-16		£1.9m	

12.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The SLCG is committed to commissioning high quality, safe, effective and sustainable maternity services for women and babies in line with the objectives of the "Strategy for Maternity Care in Northern Ireland 2012 -2018". The forthcoming Departmental Paediatric Review, NICE guidance and the recommendations arising from the regional Review of Neonatal Services will focus the SLCG in its commissioning of efficient and value for money networked neonatal and paediatric acute services at both CAH and DHH and the supporting primary and community services to give the best outcomes for mothers, babies and children.

Local Needs and Assessment

1. Projected number of increased births until 2017 /2018 (circa total 6000 births per annum)

   Increased number of complex pregnancies are circa 105 multiple births annually, 20% mothers present with a BMI over 30 and 4% of mothers present with Diabetes, all of whom require more frequent clinic visits in an ambulatory care setting

   Caesarean sections rates are significantly higher than NI average (34%v29%)

2. A 29% increase in birth rate in the decade from 2002, has resulted in a growing child population in SLCG with associated rising demand for child health services, including universal services provided by Health Visitors i.e. Healthy Child Healthy Futures.

Services to be commissioned

1. The LCG will work with the Trust to achieve an increase in midwife led births and promoting midwife as first point of contact, particularly in DHH. Commissioning requirements for the neonatal services at both CAH and DHH will be clarified following the publication of the Neonatal Review recommendations

   The Treating Obesity in Pregnancy programme will be commissioned by the PHA

2. The LCG will issue a commissioner specification for paediatric ambulatory care will be issued in 2015/2016 outlining required performance and monitoring standards to be delivered.

   In paediatric care, a planned programme of investments will continue in 2015 / 2016 to ensure that appropriate paediatric medical and nursing capacity is provided and that ambulatory paediatric care is available to the standard outlined in the commissioner specification

Securing Service Delivery

1. Monitoring of consultant and midwife births along with intervention rates will continue, including full implementation of the Trust's normalisation of birth action plan on both sites

   The Trust should put in place additional consultant obstetric capacity to monitor and support mothers with identified risk factors, including multiple pregnancies and complex risk factors in line with NICE and other relevant guidance

   Midwifery and Health Visiting capacity will continue to be monitored.

   The Trust will implement the Treating Obesity in Pregnancy Programme. At least 139 women per year will receive this additional support.

2. Universal child health programmes will provide data on the state of health of children in the SLCG area informing targeting of initiatives, such as FNP, at those sub-populations with poorer health outcomes

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

POC2 Values and Volumes

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

Table 57

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	5995		5995
	Health Visiting	Contacts	116,073		116,073
		Planned investment in 2015-16		Nil	

12.3.4 POC 4: Older People

Strategic Context: The SLCG is committed to promoting independence and choice and securing care closer to home, with an appropriate range of inpatient services for those who require it. We will work with providers including Integrated Care Partnerships to commission a range of services to meet the needs of our frail elderly population. Our commissioning intent will underpin the principles of TYC, the Regional Dementia Strategy and the Older People's Service Framework.

Local Needs and Assessment

1. 2012 Population Estimates would suggest that there are 48,922 people aged 65 and over living in the Southern LCG area, over 5,500 of these are aged 85 and over. Every year our older population increases by 3% (almost 1,500 persons).

2. Alzheimer's Society suggests that 1 in 14 people over the age of 65 have dementia. This number rises to 1 in 6 over the age of 80. Currently 2,234 patients are registered with the Southern Trust as living with dementia. Application of prevalence rates would indicate that there could up to 3,490 people in the SLCG area currently living with dementia, rising to as many as 4,435 people by 2020.

3. Demand for nursing home beds has increased Currently 1,360 beds are used by older people in the SLCG area.

Services to be Commissioned

1. The LCG will continue to commission phase 1 of the Acute Care at Home model and will conduct a detailed evaluation of the service during 2015/16, the outcome of which will inform its further development. The LCG will continue to support the ICP through commissioning extended hours and pharmacy input to this service.

   The SLCG will explore the potential to implement a crisis response model to address the urgent needs of people with dementia and their carers. An OT-led cognitive model will also be considered.

2. The LCG will commission additional care packages in line with assessed need and demographic growth. The reablement model will be extended to the full LCG area during 2015/16.

3. The LCG will work with the Southern Trust to assess the demand and capacity within district nursing services. This may require additional investment to ensure a 24/7 DN service which is GP aligned

Securing Service Delivery

1. The SHSCT should report against agreed KPIs to demonstrate the activity of the Acute Care at Home team, taking account of patient outcomes impact on unscheduled/urgent care services and stakeholder feedback.
   Investments in dementia should be implemented and the SHSCT should report on demand/capacity of the memory service which commenced in 2014/15.

2. The LCG will continue monitoring of domiciliary care provision against SBA volumes. This will include assessment of the impact of extended reablement services.

3. The SHSCT will comply with data requests on community nursing activity through community indicators, ensuring consistent ECAT's implementation across the Trust.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7), Emergency readmissions (MT14)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

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

Table 58:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,781	35,000	2,293,781
	Residential and Nursing Home Care	Occupied bed days	662,160	17,549	679,709
	Community Nursing	Contacts	207,073	6,187	213,260
		Planned investment in 2015-16		£4m	

12.3.5 POC 5: Mental Health Services

Strategic Context: Bamford Strategy, Regional Psychological Therapies Strategy, Mental Health Services Framework and NICE guidance, all outline the need for a focus on improving access to psychological therapies. The SLCG is committed to securing local services which focus on prevention and early intervention to improve and protect the mental health and wellbeing of our population. We believe that through this we can reduce unnecessary demand for secondary care services, protecting access to more specialist services for those most in need.

Local Needs and Assessment

1. During 2012/13, within the SLCG there were 308 mental health compulsory admissions which represented the highest number across NI accounting for 28.7% of the NI total for 2012/13
2. SLCG GP registers indicate that 3,040 patients are registered as having schizophrenia, bipolar affective disorder and other psychoses or are on lithium therapy
3. During 2009/10, the Southern Trust received 2,460 referrals to the community addictions service (686 per 100,000 people against the NI average of 665 per 100,000 people). There has been a significant increase in the gap between the least and most deprived areas in the SLCG in terms of the standardised death rate relating to, alcohol and standardised admission rates relating to drugs, alcohol and self-harm (DHSSPSNI Sub Regional Health Inequalities).

Services to be Commissioned

1. The SLCG will seek assurance that there are adequate levels of staff to support complex patients in local inpatient units. The SLCG will monitor use of the regional addiction beds by Southern residents during 2015/16 to ensure fair access.

   The LCG will commission the first talking therapies hub in the Southern area to support people with low level mental health needs resident in the Armagh and Dungannon locality.
2. The LCG will seek to invest in additional staff to support community addictions services during 2015/16.
3. The SLCG will consider local capacity to support the diagnosis of adults with ASD.

Securing Service Delivery

1. SHSCT should ensure that local addictions staffing is in line with regionally recommended levels.
2. The Trust should progress against the action plan for implementation of psychological therapies primary care hubs.
3. The Trust will closely monitor short breaks and day opportunities investment in 2014/15 will be measured during 2015/16.

   SHSCT to implement the alcohol liaison 7 day service during 2015/16.

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

POC5 Values and Volumes

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

Table 59

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	34,230		34,230
	Residential and Nursing Home Care	Occupied Bed days	64,119		64,119
	Domiciliary Care	Hours	120,505	2000	122,505
		Planned investment in 2015-16		£0.66m	

12.3.6 POC 6: Learning Disability Services

Strategic Context: People with learning disabilities have a variable range of health and social care needs and often experience greater health and wellbeing inequalities than the general population and can experience difficulty in accessing services. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. Both TYC and the DHSSPS Learning Disability Service Framework highlight the needs of the increasing numbers of young people with complex needs surviving into adulthood and the importance of the right support at transition stage.

Local Needs and Assessment

1. In 2013/14 there were 2,123 people identified on Southern LCG GP Practice registers for learning disability. Uptake of day opportunities has increased in line with the regional direction - an increase from 274 persons in 2012 to 359 by 2014.
2. It is expected that there will be at least 50 young people who will transition into adult learning disability services during 2015/16.
3. The regional caseload review audit as part of the learning disability service framework suggests a need for an increased focus on carer's assessments, recording of service user satisfaction levels and the documentation of person centred plans.
4. There are 536 adult carers known to the learning disability programme in the Southern area, representing 23% of the NI total for this programme.

Services to be Commissioned

1. The SLCG will commission the development of additional day opportunities for people with learning disabilities.
2. The SLCG will invest further to support the additional needs of young people transitioning into adult services, including enhancement of the transitions team.
3. Following on from investment in 2014/15, the LCG will provide further support to carers, particularly older carers
4. The SHSCT will be required to produce health action plans for people with learning disabilities.

Securing Service Delivery

1. The Trust should develop a menu of day opportunities across a range of sectors, continuing to engage with service users/carers and monitor uptake and change in demand patterns for day care.

2. The LCG will develop and implement a monitoring proforma for high cost packages in transition to adult services.

3. The Trust should continue to deliver the required complex caseloads and conduct ensure following on from the caseload review audit improved outcomes

4. The LCG will monitor the use of health action plans to ensure equity of outcomes for people with a learning disability.

Regional Priorities (see appendix A): Carers' Assessments (MT7),
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

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

Table 60:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	276,991	2100	279,091
	Residential & Nursing Home Care	Occupied bed days	113,740	800	114,540
		Planned investment in 2015-16		£0.36m	

12.3.7 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: In support of the strategic direction to provide as much support and care close to home as possible, the SLCG are aware of a sharp increase in the number of people with complex disabilities being cared for in hospital settings who require discharge. In addition, demand for services to support people with a brain injury is increasing. The LCG will work within the Physical and Sensory Disability Strategy to ensure the provision of safe, high quality and effective services which are person-centred, promoting independence, choice and control.

Local Needs and Assessment

1. The Physical Disability Strategy estimates that 21% of adults in Northern Ireland live with a physical or sensory disability. In terms of the adult population of the Southern area, this would equate to around 54,781 people (based on an adult population of 260,860 people - 2011 Census persons aged 19+).
2. The SHSCT provided details on 25 complex hospital discharges requiring significant care packages.
3. Population growth in the Southern LCG area, including a significant growth in the child population, has resulted in increased demand for hearing aids.
4. Headway UK state that 661 persons per 100,000 sustained an acquired brain injury in 2011-12 in NI, the highest rate in the UK. Pro rata to the Southern area, this would equate to 2,379 persons. There were 6,943 finished episodes in NI hospitals relating to head

Services to be Commissioned

1. The SLCG will commission an appropriate mix of care to meet the needs of persons with complex disability upon discharge from hospital. This will require investment across a range of community service such as domiciliary care, short breaks and care homes.
2. A monitoring template will be developed to enable to LCG to capture information on the ongoing care needs of complex hospital discharges.
3. The LCG will invest further in equipment to support both children and adults with sensory disabilities, including audiology services and hearing aids.
4. The existing service agreements with community and voluntary sector organisations should be reviewed to ensure that people with a brain injury across the southern area are able to avail of a range of supports to meet their needs.

Securing Service Delivery

1. The Trust should continue to move towards increased uptake of direct payments and self-directed support.
2. Trust to put in place arrangements to address the outcomes of the LCG monitoring process
3. The Trust should ensure that there is appropriate access to audiology services including hearing aids.
4. The SHSCT should report to the LCG on plans to re-procure community and voluntary sector supports for people with a brain injury.

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

POC7 Values and Volumes

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

Table 61

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	365,130	5200	370,330
	Residential & Nursing Home Care	Occupied bed days	20,805	259	21,064
		Planned investment in 2015-16		£0.22m	

12.3.8 POC 8: Health Promotion

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

Local Needs and Assessment - SLCG

1. 17% of babies born are to mothers who themselves were born outside of the UK or ROI. Approximately one fifth of the population live in relative poverty, including 22% of children.
2. 20% of adults smoke cigarettes and 13% drink in excess of weekly recommended alcohol limits. 57% of adults and 17% of boys and 24% of girls in P1 are overweight or obese. In 2012 an estimated 656 people died prematurely of potentially avoidable causes
3. Uptake for screening programmes in 13/14 was 78% cervical; 76% breast; 49% bowel; 82% AAA and 79% diabetic retinopathy.

Services to be Commissioned

1. Family Nurse Partnership, Roots of Empathy and a suite of evidenced based parenting programmes will be made available.
2. The LCG will commission a range of health promotion services will be available on smoking; healthy eating; physical activity; alcohol; drugs; mental health and suicide prevention.
3. The LCG will commission a range of screening programmes including the Be Cancer Aware Programme

Securing Service Delivery

1. The Early Years/Early Interventions Officer will support this work. These services will link with the existing Family Support Hubs and the EITP.
2. Trusts should ensure that services commissioned meet specified quality standards which are monitored i.e. Stop Smoking Services; Drugs and Alcohol; Mental Health and Emotional Wellbeing
3. Performance targets for all programmes commissioned are specified and monitored quarterly.

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

12.3.9 *POC 9: Primary Health and Adult Community*

Strategic Context: Enabling people to maintain their independence, live at home and receive care at or as close to home as possible remains a key strategic and local commissioning priority. Ensuring effective community nursing and therapeutic interventions, 7 day working and developing work with Integrated Care Partnerships and the emerging GP Federations will assist in addressing known shortfalls in capacity and quality concern of service users.

Local Needs and Assessment

1. NI Quality and Outcomes Framework (QOF) 2013 registers indicate that there are 6,012 patients registered in Southern LCG GP practices as having Chronic Obstructive Pulmonary Disease (COPD) and 6,068 registered as having survived a stroke. During 2012/13, there were 528 people admitted to hospital in the Southern area following a stroke.

2. In the NI Diabetes Inpatient Audit (2013 Draft Report), the Southern Trust performance was below that of other NI hospitals and also suggested there were lower levels of specialist nursing investment in NI compared to the rest of UK.

3. The LCG has seen a higher increase than the NI average in both cost 2.5% compared to 1.9%) and volume of prescribed drugs (1.7% to 1.5%).

Services to be Commissioned

1. The LCG will work with the SHSCT to assess the demand and capacity within district nursing services which may require additional investment to ensure a 24/7 DN service which is GP aligned

The LCG will consider enhanced specialist nursing input to diabetes services to improve patient care, specifically inpatients.

2. Through the Southern ICPs, the LCG will continue to develop pathways and commission services to deliver on ICP specifications

3. The LCG will work closely with primary and secondary care to ensure efficient and effective prescribing in line with the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Proposals for the allocation of the SLCG prescribing budget will be brought forward in early 2015/16.

Securing Service Delivery

1. The Southern Trust should contribute to community indicators data to monitor activities of community nurses. The Trust should also ensure eCAT is implemented consistently throughout the Trust.

2. The SLCG will continue to monitor the progress of the Southern ICPs in delivering on the agreed specifications for priority groups – frail elderly, diabetes, respiratory and stroke.

3. Primary and Secondary Care should ensure that the prescribing budget is brought into line with the requirements of the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Regional Priorities (see appendix A): Pharmaceutical Clinical Effectiveness Programme (MT30)

13.0 Western Local Commissioning Plan

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

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

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

13.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Western LCG, covering the council areas of Derry and Strabane District; Fermanagh and Omagh District; and the former Limavady Borough now within Causeway Coast and Glens.

13.1.1 Demographic changes / pressures

On Census Day (27 March 2011), the resident population of the Western LCG area was 294,417 persons accounting for 16.26% of the NI total. Mid-Year Estimates (2013) show projected increase in population to 296,883 persons.

The age profile on Census Day includes:

- 22.1% were aged under 16 years and 13.1% were aged 65 and over;
- 49.6% of the usually resident population were male and 50.4% were female; and

- 36 years was the average (median) age of the population

The older people population is lower proportionately than the NI average (13.1% and 14.6% respectively) although the Western area is projected to see the greatest increase in 65+ persons in the next ten years, i.e. 40.1% increase compared to 29.7% for NI as a whole. There were 3,951 births to Western families during 2013/14.

Deprivation

One in four people (25.3%) residing within the Western area in 2013 were living within the most deprived of the Northern Ireland deprivation quintiles. Across Northern Ireland, 18.8% of the population live in the most deprived quintile.

Key Indicators of Health and Wellbeing

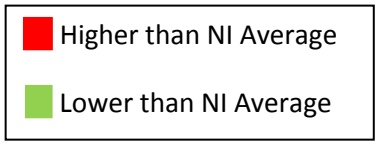
Table 74 below provides an overview of key indicators of health and wellbeing. Despite high levels of deprivation, Western population shows better health outcomes than the NI average, apart from for respiratory conditions, i.e. asthma and chronic obstructive pulmonary disease (COPD). Mental health however is considerable worse, particularly due to anxiety and depression. There is higher rate of children in need.

Health Summary

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

Table 62

Domain	Indicator	Descriptor	WLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.49	19.12	
	COPD	Prevalance per 1000	20.36	18.56	
	Stroke	Prevalance per 1000	17.33	17.94	
	Atrial Fibrillation	Prevalance per 1000	15.11	15.12	
	Coronary Heart Disease	Prevalance per 1000	36.08	38.81	
	Hypertension	Prevalance per 1000	128.91	130.5	
	Diabetes	Prevalance per 1000	41.45	42.61	
	Asthma	Prevalance per 1000	61.62	60.48	
	Dementia	Prevalance per 1000	6.02	6.67	
	Learning Disability	Prevalance per 1000	6.34	5.33	
	Bowel Cancer Screening	Prevalance per 1000	50.22	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	9.12	8.54	
	Crude Suicide Rates	All Persons	16.7	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012 - 13)	28	24	
	Obese or overweight	% of population (2012-13)	60	62	
	Meeting Physical activity levels	% of population (2012-13)	51	53	
	Pain or discomfort	% of population (2012-13)	39	35	
	Anxious Depressed	% of population (2012-13)	28	26	
Maternal and Child Health	Children in Need	Rate per 100,000	85.51	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	3.34	3.86	
	Births to unmarried mothers	Percentage 2013	43.79	42.46	
	Births to Mothers from outside NI	Percentage 2013	15.58	17.88	
Life Expectancy	Male	Age (2009-11)	77.23	77.5	
	Female	Age (2009-11)	81.84	82	
	Neonatal	Death Rate (2013)	0.4	0.3	
	Infant Mortality	Death Rate (2013)	4.9	4.6	
	Lung Cancer	STD Death Rate	67.9	66.5	
	Female Breast Cancer	STD Death Rate	37.4	38.1	
Carers	Unpaid Care	% of population 50+ Hours provided	3.1	3.1	



13.1.2 Personal and Public Involvement

In 2014, Western LCG undertook a flagship engagement programme, *Voice of Older People*, which engaged with 1,050 older people between January and March. The LCG worked with a range of Community Networks who undertook semi-structured interviews in line with an LCG brief to ascertain the views of older people from across the West on using Primary Care, Secondary Care and Community Care; on Transforming Your Care; and their expectations of future services.

The Networks engaged with older people in places which they routinely used, such as Luncheon clubs, Community Centres, Healthy Living Centres Community Theatre, Art Groups, Drop in Clubs, Exercise Classes, Singing Groups, Smoking Cessation Groups, Diabetes and Podiatry clinics in Healthy Living Centres to ascertain their views on the services they receive and use through the health service. The views of older people who did not attend community activities/centres or did not access local Voluntary and Community groups, and who are harder to reach were also sought through the Networks contacts and member organisations. Participants ranged from 65 to 90 years. Each participant completed.

Providers nominated one "Champion", an older person who had participated in the exercise, from each area who attended the Local Commissioning Group meeting in May 2014. There was an opportunity for LCG members to hear initial findings and to engage directly with the Champions on issues of interest and concern. The LCG gave an undertaking to convene feedback sessions to inform and discuss with participants the outcomes and findings of the engagement process. The undertaking to feedback to stakeholders is a crucial element in getting the Networks to agree to accept the commission as it showed the HSCB's commitment.

Key issues from the engagement initiatives:

- Need for more joined up approach in tackling health inequalities;

- Need for greater communication with older people regarding the services available;
- Need to tackle anxiety experienced by older people when attending the Emergency Department;
- Importance of transport in accessing health and social care services and alignment of appointments to transport schedules;
- Need for more support to carers; and
- More services delivered in local health centres, such as Physiotherapy, Minor injuries

LCG has committed to feedback sessions in response to issues raised and has published a report on the engagement programme.

The LCG also held a conference on health and social care in rural communities, in partnership with five local Community Networks, in Enniskillen on 3rd April 2014. The conference focused on:

- Rural issues of poverty, isolation, transport and access to services;
- Mental Health Services, promoting positive mental health; and
- Community planning, access and influencing key agencies

82 participants attended this event, largely comprising service users and carers living in rural areas across the Western area. Representatives from Rural Community Network, community and voluntary sector organisations, local Government, HSCB, WHSCT, NIAS and PHA also attended to hear participant views on services and related issues.

13.1.3 Summary of Key Challenges

Key challenges for the LCG in 2015/16 include:

- Fulfilling the potential of Western Integrated Care Partnerships in driving the *Transforming Your Care* agenda through integrated care pathways;
- Extending Pain Management programmes;

- Delivering the proposed Primary Care Infrastructure programme for the Western area, in line with agreed priorities;
- Further enhancing carers support and short breaks opportunities;
- Progressing plans towards having in place appropriate 24-hour community nursing services, including Acute Care at Home;
- Meeting domiciliary long-term care demand supported by the roll-out of reablement model;
- Tackling impact of alcohol on HSC services, particularly Emergency Services;
- Ensuring provision of Older People's Mental Health Services;
- Putting in place across key acute specialties processes to allow GPs to gain consultant and specialist professional advice which might prevent the need for referrals and improve management of patients in primary care;
- Maximising utilisation of hospital theatres and in-patient beds; and
- Identification of opportunities to consolidate the provision of intermediate and acute beds and/or sites.

13.2 LCG Finance

Use of Resources

The WLCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £519.1m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Table 63

Programme of Care	£m	%
Acute Services	196.8	37.85%
Maternity & Child Health	25.2	4.84%
Family & Child Care	42.1	8.09%
Older People	114.9	22.10%
Mental Health	47.3	9.10%
Learning Disability	39.2	7.53%
Physical and Sensory Disability	15.5	2.98%
Health Promotion	17.0	3.28%
Primary Health & Adult Community	21.1	4.22%
POC Total	**519.1**	**100%**

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

Table 64

Provider	£m	%
BHSCT	26.2	5.05%
NHSCT	1.1	0.21%
SEHSCT	0.2	0.03%
SHSCT	1.9	0.38%
WHSCT	450.4	86.60%
Non-Trust	39.3	7.73%
Provider Total	**519.1**	**100%**

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

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Western Trust is in the region of £12.7m.

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

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

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

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

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

Trust Savings Plan

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

Community Information Exercise

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

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

13.3.1 POC 1: Non-Specialist Acute Services

Strategic Context: Growing demand for hospital care, coupled with challenges recruiting and retaining medical and other staff, remain a key feature for Western services. Alternative pathways, designed to reduce demand, have been championed by LCG and ICPs and further opportunities exist in light of emerging GP Federations. The prerogative to extend Acute Care at Home, building on enhanced community nursing services adds an important dimension to transformation of care.

Local Needs and Assessment

1. Demand for OP assessment in the West currently outstrips capacity by around 6,000 patients per year, with referral rates continuing to rise annually.
2. Unscheduled care patient flow at Altnagelvin Hospital remains challenging. In 14/15, there were 25 12-hours breaches of Emergency Dept standards across WHSCT; 4-hour performance fell below 95%; and delayed discharges were a feature of pressures through the winter months.
3. Older Persons Assessment and Liaison Services in Altnagelvin demonstrated that through comprehensive geriatric assessment that a 4-day reduction in length of stay was achievable
4. Demand for neurology services exceeds commissioned capacity by 750 outpatients per year and demand for Orthopaedics exceeds commissioned capacity by 1,100 outpatients and resulting conversions.

Services to be Commissioned

1. The LCG, working with ICPs, will seek the introduction of GP request for advice across acute specialities, including extension of virtual clinics and direct GP access to hospital diagnostics
2. The HSCB approved 5 key commissioning priorities to improve patient flow. The LCG, supported by the Unscheduled Care Team, will prepare costed proposals for Altnagelvin Hospital for implementation.
3. The LCG will ensure the introduction of the commissioned Older People's Assessment and Liaison Services at South-West Acute Hospital with the provision of a multi-disciplinary assessment for all patients admitted to hospital, leading to reduced length of stay of 4 days for over 75 year olds
4. LCG will commission additional capacity in neurology and orthopaedics services to meet demand

Securing Service Delivery

1. Demand management initiatives will be sought from Integrated Care Partnerships where these can be shown to reduce the need to refer to Trust Consultant-led services.

2. The Trust will take forward the 5 key commissioning priorities, including delivering additional multi-disciplinary access and activity 7 / 7; extended senior clinical decision making; and a seven day dedicated minor injury stream in ED.

3. The Trust should implement Older Persons Assessment and Liaison Services in the South West Acute Hospital.

4. The Trust should bring forward proposals to close the elective gaps for neurology and orthopaedics.

14.3.1 POC 1: Non-Specialist Acute Services (continued)

Local Needs and Assessment

5. Increased annual demand on elective surgery, unscheduled admissions and GP surgical assessments.
6. Acute Care at Home (POC 1&4) can provide active treatment by health care professionals in the patients home avoiding unnecessary inpatient care.
7. The Western area has the largest increase in prevalence rates for stroke between 2007 (13.8/1000 population) and 2014 (17.3/1000 population) at 25%. RQIA recommends clear definition of a stroke unit, accessible thrombolysis service and TIA assessment and treatment at weekends for high risk cases.
8. In Western hospitals, there were 25,024 hospital cancelled outpatient appointments in 2014/15

Services to be Commissioned

5. The LCG will review the Elective Day of Surgery Unit and Surgical Assessment Area pilot with a view to mainstreaming if successful in reducing length of stay and admissions.
6. The LCG will commission a proportionate 24-hour community nursing service, building on district nursing, Rapid Response nursing and Treatment Room services which prevents unnecessary hospital admissions and supports the introduction of Acute Care at Home.
7. The LCG will consider the redesign of stroke services in line with regional model of care, including creation of a specialist acute unit and appropriate rehabilitation in hospital and at home.
8. The LCG will seek assurances that hospital cancelled appointments are minimised and appropriate and in line with Departmental requirements, i.e. reduced by 20% by March 2016.

Securing Service Delivery

5. The Trust should complete an evaluation of the Elective Day of Surgery Unit and Surgical Assessment Area.
6. The Trust should implement a phased Acute Care at Home model, building on commissioned expansion within Community nursing with Demographics investment in 15/16 focused to enhance the delivery of the 24/7 Community Nursing Model aligned to GPs, pathway development for >65years frail elderly Disease Specialist Nursing and an Acute Care at Home Team.
7. The LCG will work with the Trust to review existing medical, nursing and AHP capacity with a view to agreeing a new stroke service model later 2015.
8. By June 2015, the Trust will provide a plan to reduce cancelled consultant-led hospital appointments by March 2016

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Unscheduled Care (MT12), Elective Care (MT15, 16, 17) Stroke (MT19)

POC1 Values and Volumes

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

Table 65

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	11,302		11,302
		Daycases	31,915		31,915
		New Outpatients	115,379		115,379
		Review Outpatients	150,756		150,756
	Unscheduled	Non Elective admissions	37,053		37,053
		ED Attendances	100,733		100,733
		Planned investment in 2015-16		£1.4m	

13.3.2 POC 2: Maternity and Child Health Services

Strategic Context: Normalisation of birth remains the imperative in line with the Maternity Strategy. There have been fewer births in Western hospitals in recent years although there is some evidence of increased complexity, particularly a marked increase of mothers with a diabetes risk. Medical staffing challenges continue and are exacerbated by moves to extend cover of middle and senior obstetrician and paediatricians at South West Acute Hospital in the face of safety concerns regionally.

Local Needs and Assessment

1. WHSCT SBA outturn in 2013/14 outstripped the legacy SBA volume across a number of POCs with an increase in demand for health visiting 1,446 contacts within maternity & child health.
2. There are typically 3,600 medical admissions to paediatric wards in Altnagelvin, with requirement for escalation beds every year over the winter period.
3. While 27% of births were by caesarean section (elective & non elective), 2.1% below the NI average, caesarean section rates at SWAH have increased steadily and were 0.7% higher than the NI average in 2013/14
4. The pilot weight management programme for pregnancy women, "Weigh to a Healthy Pregnancy" is underway offering a lifestyle intervention to all pregnant women with a

Services to be Commissioned

1. In the context of on-going regional review, LCG will review capacity and demand for health visiting services (across PoCs) with a view to closing any gap and in line with normative nursing levels.
2. The LCG will review the pilot of the Paediatric Assessment Unit (PAU). If successfully evaluated, the LCG will consider commissioning recurrently, leading to reduction of admissions by 20%.
3. The LCG will work with Western Trust to promote normalisation of births in line with Maternity Strategy 2012-18.
4. The LCG, working with PHA, will seek to mainstream "Weigh to a Healthy Pregnancy", drawing on the learning of the pilot programme.

Securing Service Delivery

1. The LCG in collaboration with PHA will realign the WHSCT Health Visiting SBA 15/16 to reflect current service and modernisation reform that has been undertaken in line with normative nursing.
2. The Trust will carry out an evaluation of the PAU by July 2015 and LCG will consider the findings in due course.
3. The Trust will take steps to reduce Caesarean section rates to NI average within 12 months.
4. The Trust will bring forward proposals to continue "Weigh to a Healthy Pregnancy" programme.

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

POC 2 Values and Volumes

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

Table 66:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,009		4,009
	Health Visiting	Contacts	67,633		67,633
		Planned investment in 2015-16		Nil	

13.3.3 POC 4: Older People's Services

Strategic Context: In the face of rapid growth of the older population and in light of *Transforming Your Care*, it is imperative that services for older people change and grow. The priority will be to provide support to enable all older people to remain independent and living in their own home for as long as possible.

Local Needs and Assessment

1. The number of over 65 years continues to grow in the LCG area; increasing demand on domiciliary care and among people with mental health difficulties and those with disabilities.
2. The demand for domiciliary care service has increased by 23% (2010-2014 estimated contact hours). Reablement services provide considerable benefit to patients with reduction in care requirements following period of intervention.
3. Older people with mental health challenges, particularly dementia continue to increase.
4. From April to September 2014, 1,168 people over 65 years attended Altnagelvin ED due to a fall. 82% of these falls were at the home.

Services to be Commissioned

1. The LCG will seek to increase the number of Domiciliary Care hours although this may be reduced by initiatives, such as the roll-out of Reablement.
2. The LCG will commission the further roll-out of Reablement across the Western area with a view to realising 45% reduction in referral rates to long term caseloads during 2015/16.
3. The LCG will review older people's mental health services, including dementia care, to ensure recent investments have proven successful and need is appropriately met.
4. The LCG will support ICP initiative to coordinate falls prevention through integrated care pathways supported by GPs, Western Trust, NIAS and voluntary sector agencies.

Securing Service Delivery

1. The Trust will deliver the required domiciliary care hours and other initiatives as specified by the commissioner.
2. The Trust should complete the roll-out of Reablement to the Southern sector to include an OT led Reablement Team and Contact and Information Centre covering the whole Western area, leading to 45% of discharges requiring no on-going care.
3. In collaboration with the Trust, LCG will produce a needs assessment of older people's mental health by October 2015, taking into account ICP plans to develop an integrated dementia care pathway.
4. ICPs will lead in building on GP pathway to Stepping On programmes and developing a Western wide falls prevention service.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

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

Table 67

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	1,606,351	38,624	1,644,975
	Residential and Nursing Home Care	Occupied bed days	511,947		511,947
	Community Nursing	Contacts	162,488	7,000	169,488
		Planned investment in 2015-16		£2.8m	

13.3.4 POC 5: Mental Health Services

Strategic Context: In line with *Transforming Your Care* and taking forward the *Bamford Review*, the importance of maintaining mental health and intervening early in Primary Care remains the priority. A focus on Recovery Approaches in line with *Transforming Your Care* which states that "At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives."

Local Needs and Assessment

1. Mental health in NI is poor compared to GB. 25% of those surveyed in the West for NI Health Survey in 13/14 reported being anxious or depressed; higher than the NI average.
2. Patients on the Mental Health Register have risen by almost 10% in the 5 years to 2012.
3. HSCB has reviewed in-patient addiction services which recommends a regional model for detoxification and stabilisation care and rehabilitation.
4. The number of patients waiting longer than 13 weeks for a first appointment with psychological therapies service has increased through 2014.

Services to be Commissioned

1. The LCG will commission the introduction of Primary Care Talking Therapies, with support from ICPs to put in place clear GP referral pathway and appropriate access protocols.
2. The LCG will seek a consistent model of Primary Care Liaison and Crisis Response Home Treatment services across the Western area.
3. The LCG will support regional plans to have in place a 7-day in-patient addiction treatment service, including 8-beds in the Western area.
4. The LCG will review demand and capacity in psychological therapies required to deliver 13 weeks waiting times for first appointment.

Securing Service Delivery

1. The Trust will provide 400 talking therapy sessions through community and voluntary sector providers in 2015/16. The LCG will work with the Trust to ensure roll-out across the entire Western area during 2016.
2. The Trust will ensure consistent access to these services, particularly in the Southern Sector, leading to further reductions of acute mental health beds.
3. The Trust will ensure appropriate staffing levels are in place in line with investment.
4. The Trust will ensure that additional capacity is made available, in line with the commissioner requirements.

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

POC5 Values and Volumes

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

Table 68

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	38,759		38,759
	Residential and Nursing Home Care	Occupied Bed days	30,086	210	30,296
	Domiciliary Care	Hours	29,294	250	29,544
		Planned investment in 2015-16		£0.26m	

13.3.5 POC 6: Learning Disability Services

Strategic Context: The population of people with a learning disability is continuing to rise in line with the very welcome increase in the average lifespan. Consequently, there are greater numbers of people with a learning disability reaching adulthood and requiring day opportunities and appropriate community support. As adults reach old age in greater numbers, planning is required for their future long term care and housing and support for carers, in particular older carers, is crucial.

Local Needs and Assessment

1. The LCG area has the highest prevalence in NI of people with learning disabilities (6.17 per 1,000 people) and the number of people with a severe learning disability has increased by 30% since 2000.
2. For adult carers of LD clients, availability of alternatives to traditional forms of respite (day and residential care) is very limited.
3. Transition from children's to adult services is a challenging time for young adults with a learning disability and their families. Collaborative work between Education and Health sectors seeks to manage smooth transition and ensure individual needs are addressed through a coherent transition plan.

Services to be Commissioned

1. The LCG will seek to keep pace with growing demand for day opportunities to adults with learning disabilities, including providing support to up to 50 school leavers and meeting the needs of older adults.
2. The LCG will extend innovation fund for Adult carer recipients of short break hours in line with SDS approaches. Further short break options will be tested to extend the range of choice and flexibility for carers.
3. Given anticipated transition of up to 50 school leavers in 15/16; continued pressures on adult services and the emphasis on day opportunities, the LCG will seek assurance that the current transition process is effective in supporting individuals.

Securing Service Delivery

1. The LCG will continue to work with Western Trust to extend day opportunities and meet the needs of school leavers in 2015 as a priority, in line with emerging self-directed support model.
2. The Trust will provide additional innovative short breaks hours based on the outcomes of an LCG workshop in April 2015
3. The LCG and Trust will review the transition process and identified needs leading to any gaps in service.

Regional Priorities (see appendix A): Carers' Assessments (MT7)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

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

Table 69

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	92,760		92,670
	Residential & Nursing Home Care	Occupied bed days	135,520		135,520
		Planned investment in 2015-16		Nil	

13.3.6 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: Developments in services for people with Physical and Sensory Disabilities have received a renewed impetus with the recent publication of Departmental and OFMDFM strategies. Implementation has benefited from the involvement of voluntary sector partners and emphasis on the participation of service users.

Local Needs and Assessment

1. In September 2014, 70 adults were awaiting a multi-disciplinary assessment for autistic spectrum disorder, most in excess of 13 weeks. 85 adults with a learning disability also required ASD assessment and support.
2. Western Trust figures show there are 279 deaf service users in the Western area, 127 of whom have no speech. Some have significant mental health and developmental difficulties and at risk behaviours in later life.
3. There is an increasing number of people with physical disabilities which are more complex including service users requiring high cost care packages and young people transitioning to adult services.

Services to be Commissioned

1. The LCG is investing in development of assessment and support service for adults with autism spectrum disorder leading to no one waiting longer than 13 weeks for an assessment by March 2016.
2. The LCG will commission community-based flexible service model of enablement, communication and skills development, providing 7 places in 15/16.
3. The LCG, working with regional colleagues, will consider a review of physical disability services, taking account of Trust reported pressures; the move to self-directed support; and population needs.

Securing Service Delivery

1. The multi-disciplinary Adult ASD service will provide integrated care plans for all young people transitioning to adult services; 30 adults supported by dedicated psychologist; 40 adults supported by dedicated Speech & Language Therapist and 40 adults supported by a dedicated Occupational Therapist.
2. The Trust will provide the commissioned service through Action for Hearing Loss.
3. The LCG will seek the input of Western Trust and relevant voluntary organisations in reviewing current services and evident gaps against regional standards.

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

POC7 Values and Volumes

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

Table 70

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	298,781	1,200	299,981
	Residential & Nursing Home Care	Occupied bed days	24,283		24,283
		Planned investment in 2015-16		£0.06m	

13.3.7 POC 8: Health Promotion

Strategic Context: NI Executive published Making Life Better in 2014, a whole systematic strategic framework for public health which sets out clearly the action required to address the determinants of health alongside a life course approach. The health and social care system will play a full part through embedding health improvement and health inequalities in planning, commissioning and delivery processes.

Local Needs and Assessment

1. Hospital attendances and admissions continue to disproportionately relate to substance misuse and in particular alcohol.

2. 11% of Travellers live in Derry City Council area. The 2009 All Ireland Travellers Health Study has highlighted the huge disparities in life expectancy and other health outcomes for Travellers.

3. The number of older people who rely on HSC services is increasing. Initiatives to build or restore self-confidence and self-reliance among older people, providing practical support to help them achieve their aspirations and reduce dependency are required

Services to be Commissioned

1. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days

2. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days

3. The LCG, in collaboration with ICPs, will pilot the Social Prescribing scheme which seeks to offer alternatives to medicine prescription and overcome social isolation and loss.

Securing Service Delivery

1. The LCG, PHA and Trust will review the progress in the brief intervention and alcohol liaison service relating to both acute hospitals with a view to having in place a development plan by October 2015.

2. The LCG is co-funding support workers who will scope needs and services leading to an Action Plan, including health improvement programmes and improve access to HSC services.

3. ICPs have appointed a voluntary organisation to pilot the Social Prescribing Scheme with a number of GP Practices. Review will be undertaken in Autumn 2015 to inform decisions on mainstreaming in 2016/17.

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

13.3.8 POC 9: Primary Health and Adult Community Services

Strategic Context: Integrating primary and secondary care is central in the drive for Health and Social Care reform. Integrated Care Partnerships are established to be a key driver in this with their emphasis on integrated care pathways focused developing the role of primary care. Challenges in developing the necessary physical infrastructure in terms of primary care hubs and spokes; appropriate hospital accommodation; and IT systems are of critical importance. Engagement with service users and staff to ensure services meet their needs remain the strategic priority.

Local Needs and Assessment

1. An innovative partnership with community networks across the West elicited the views of over 1,000 older people, with older person champions raising their concerns directly with the LCG.
2. Chronic pain is estimated to affect approximately 20% of people in Northern Ireland. 35% of people in the West, surveyed as part of the NI Health Survey 2012/13, reported having pain or discomfort. Demand for pain management service outstrips commissioned capacity.
3. Clinical Interventions centres (CICs) reducing avoidable hospital admissions, facilitates early hospital discharge, reduces ALOS

Services to be Commissioned

1. During 2015, LCG will provide feedback on the issues raised during engagement projects in 2014, highlighting progress in addressing issues raised and will engage with community networks to elicit the views of HSC services from 1,000 adults in the Western area.
2. The LCG will commission a Pain Management Programme in the Northern sector of the Trust to reduce demand on assessment and treatments.
3. The LCG will commission Clinical Intervention Centres at Enniskillen Health Centre and Strabane Health Centre

Securing Service Delivery

1. LCG will engage with 5 local community networks who will each undertake at least 200 semi-structured interviews in a council area, including the involvement of Section 75 groups. LCG will engage with older person champions and network representatives to provide feedback on issues raised during engagement projects in 2014.
2. The Trust should bring forward proposals to expand the Pain Management Programme Trust wide
3. The Trust will provide an ambulatory service for patients in the community in Enniskillen and Strabane CICs in an ambulatory setting when it is safe and effective to do so

POC 9: Primary Health and Adult Community Services (continued)

Local Needs and Assessment

4. There is a need to put in place Primary Care Infrastructure (PCI) capital projects within primary care to support wider system change and the implementation of the recommendations of Transforming Your Care (TYC)

5. Altnagelvin's Emergency Department is not fit for purpose to meet the needs of its annual 58,000 patients. Outpatient demand also continues to rise placing considerable pressure on existing clinic space. There is also anticipated pressure on ICU/HDU.

6. The Transforming Your Palliative and End of Life Care Programme is supporting the redesign and delivery of coordinated services to enable people across Northern Ireland with palliative and end of life care needs to have choice in their preferred place of care.

Services to be Commissioned

4. The LCG will commission the opening of Omagh Local Enhanced Hospital, expansion of Enniskillen Health Centre and Lisnaskea Primary Care Centre as hubs in line with the HSCB's Primary Care Infrastructure programme and continue to progress hubs in Cityside, Limavady and Strabane

5. LCG judges that the completion of Phase 5.1 in 2017 leading to reduction of theatre capacity by 25% means it is imperative that 5.2 progresses as soon as possible. Improved accommodation for the Emergency Department and clinical adjacencies will also considerable improve patient flow and clinical decision-making.

6. LCG, working closely with Western ICPs, will commission 8 initiatives agreed within programme.

Securing Service Delivery

4. LCG in collaboration with WHSCT and Primary Care GPs deliver development of relevant Tranches of PCI programme for Western locality

5. The Trust will bring forward an Outline Business Case for the proposed Altnagelvin Hospital Phase 5.2.

6. The Programme is being delivered by the HSCB/PHA in partnership with Marie Curie working with statutory, voluntary and independent sector providers.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency Readmissions (MT14), Excess bed days (MT27)

Appendix 1 - Programme of Care Definitions

Acute Services (POC 1)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in an acute specialty. It also includes all activity, and resources used, by a hospital consultant in an acute specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

Acute specialties are all hospital specialties with the exception of the following (specialty codes in brackets); Geriatric Medicine (430), Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), GP Maternity (610) and mental health specialties (710 to 715).

Maternity and Child Health (POC 2)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), and GP Maternity (610). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts by any health professional where the primary reason for the contact was maternity or child health reasons. All community contacts to children under 16 are included as long as the contact was not in relation to mental health, learning disability or physical and sensory disability.

Family and Child Care (POC 3)

This programme is mainly concerned with activity and resources relating to the provision of social services support for families and/or children. This includes

Children in Care; Child Protection; Child Abuse; Adoption; Fostering; Day Care; Women's Hostels / Shelters and Family Centres. This is not a definitive list of the type of support which may be offered under this programme. This programme includes community contacts by any health professional where the primary reason for the contact is because of family or child care issues.

Elderly Care (POC 4)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Geriatric Medicine (430), Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts with those aged 65 and over except where the reason for the contact was because of mental illness or learning disability. All community contacts where the reason for the contact was dementia are also included, regardless of the patient's age, as well as all work relating to homes for the elderly, including those for the Elderly Mentally Infirm.

Mental Health (POC 5)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Mental Illness (710), Child & Adolescent Psychiatry (711), Forensic Psychiatry (712) and Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to mental health. If the reason for contact is that the patient has dementia, the activity is allocated to the Elderly Care programme of care.

Learning Disability (POC 6)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in the Learning Disability specialty (710). It also includes all activity, and resources used, by a hospital consultant in this specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to learning disability. All community contacts with Down's Syndrome patients who develop dementia, for any dementia related care or treatment are included as are all contacts in learning disability homes and units.

Physical and Sensory Disability (POC 7)

This programme includes all community contacts by any health professional where the primary reason for the contact is physical and/or sensory disability. All patients and clients aged 65 and over are excluded. These contacts should be allocated to the Elderly Care programme.

Health Promotion and Disease Prevention (POC 8)

This programme includes all community and GP based activity relating to health promotion and disease prevention. This includes all screening, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisation and community dental screening and prevention work.

Primary Health and Adult Community (POC 9)

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

Appendix 2 - Ministerial Priorities & Targets

Ministerial Theme:

To improve and protect population health and wellbeing and reduce health inequalities

Standards and Targets

Bowel cancer screening

1. By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited.

Tackling obesity

2. From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.

Substance misuse

3. During 2015/16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes.

Family Nurse Partnership

4. By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme.

Ministerial Theme:

To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.

Standards and Targets

Unplanned admissions

5. By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas.

6. During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.

Carers' assessments

7. By March 2016, secure a 10% increase in the number of carers' assessments offered.

Direct payments

8. By March 2016, secure a 10% increase in the number of direct payments across all programmes of care.

Allied Health Professionals (AHP)

9. From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.

Hip fractures

10. From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Cancer services

11. From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of

patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Unscheduled care

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

13. By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.

Emergency readmissions

14. By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.

Elective care – outpatients / diagnostics/ inpatients

15. From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks.

16. From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken.

17. From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.

Organ transplants

18. By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.

Stroke patients

19. From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.

Healthcare acquired infections

20. By March 2016 secure a reduction of x% in MRSA and *Clostridium difficile* infections compared to 2014/15. **[x to be available in April/May 2015 following analysis of 2014/15 performance and benchmarking process.]**

Patient discharge

21. From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

Mental health services

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

Children in care

23. From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.

24. By March 2016, ensure a three year time frame for 90% of children who are adopted from care

Patient safety

25. From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.

Normative staffing

26. By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.

Ministerial Theme:

To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

Standards and Targets

Excess bed days

27. By March 2016, reduce the number of excess bed days for the acute programme of care by 10%.

Cancelled appointments

28. By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment.

Delivering transformation

29. By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model.

Pharmaceutical Clinical Effectiveness Programme

30. By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

Appendix 3 - Summary of Unfunded Service Pressures

As indicated within the Commissioning Plan the funding position for 2015/16 means that a range of key service developments cannot be progressed or can only be taken forward at a significantly reduced scale and/or pace. These service areas are listed below along with the location of relevant information.

Service Area	Section	Page
Maternity services	3.10	15
Physical and sensory disability services	3.11	16
Implementation of the regional reform programme	4.3.2	38
Health Protection Services	6.1.5	48
Services for older people	6.2.3	53
Unscheduled care waiting times	6.3.2	58
Services for people with long-term conditions	6.3.5	61
Cancer services	6.3.6	63
Mental Health services	6.5.2	71
Learning Disability services	6.5.2	71
Family & Childcare Services	7.1	82
Specialist acute services	7.2	87
Access to NICE treatments	7.2	87
Ambulance response times	7.4	94
Primary care and adult community services	7.5.1	98
Elective care waiting times	8.0	108

Steps are being taken, where possible, to mitigate risk and HSCB will continuously review commitments to ensure best use of all available resources.

In addition the HSCB have supported the DHSSPS in preparing bids for June Monitoring amounting to £89m –the bids remain subject to approval.

Bid	Amount £m
Learning Disability Resettlement	6.0
Public Health	4.0
Unscheduled care/Patient Flow	6.0
Revenue Consequences of Capital	7.0
Elective Care/Diagnostics	45.0
Specialist Services	7.5
Mental Health and Learning Disability	4.0
Children's Services	2.0
Transforming Your Care	5.0
Other Departmental Priorities	2.5
	89

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the DHSSPS in N Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / longterm conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the HSCB and PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction – A document published by the Minister on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not publicly funded. Also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

Cord blood is blood that remains in the placenta and in the attached umbilical cord after childbirth. Cord blood is collected from the umbilical cord because it contains cells called stem cells, which can be used to treat some blood and genetic disorders.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Directed cord blood donations - These are collected from the umbilical cord of new born siblings of children with a condition such as acute leukaemia (sometimes referred to as saviour sibling donations). They are arranged with the haematologist treating the affected child.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a

range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, pharmacists, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector as well as service users and carers.

Lesbian, Gay, Bisexual & Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the HSCB arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Neoplasm – Any new and abnormal growth of tissue. Usually a cancer.

Palliative Care – The active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of N Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) – these pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Reablement - range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Service Framework - a document which contains explicit standards underpinned by evidence and legislative requirements. Service Frameworks set standards, specific timeframes and expected outcomes

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Transforming Your Care – Published in 2011 the Review of Health and Social Care in Northern Ireland "Transforming Your Care", sets out a model of care for health and social care which makes recommendations about how we change our services to enhance prevention, early intervention, care closer to home, and greater choice and access. The HSCB is taking forward the implementation of around 70 of the 99 proposals sets out in the TYC Report.

Trust Delivery Plans – In response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Ministerial targets, key themes and objectives outlined for the year ahead.

Unrelated cord blood donations - Also known as undirected or public donations, these are altruistic donations of blood taken from volunteers' umbilical cords at the time of delivery. They are processed and typed for storage in a public cord bank. Registers of public cord banks can be searched internationally to provide the best match for a stem cell transplant.