Belfast Local Commissioning Plan 2013/14

14 March 2013

Contents

1. Belfast LCG Population & Need

Demography

The total resident population of the LCG area is 348,204 (2011). However, the population using health and social services in Belfast is much larger than this, extending to parts of Northern and South Eastern LCG areas for local services and the whole of Northern Ireland for regional services.

The age breakdown of the LCG population is shown in Table 1. There is a smaller proportion of children than in Northern Ireland as a whole but a higher proportion over 75. 3.5% of the population are from an ethnic minority population (NINIS 2013). The number of births is expected to continue to fall over the next few years although the LCG population is expected to increase slightly, due to longer life expectancy and migration.

Table 1 - Age Breakdown of Belfast LCG Population

Area	Age Band	**Total Population**
NI	0 < 16 yrs	**20.9%**
	16 < 65 yrs	**64.5%**
	65 < 75yrs	**8.0%**
	75 < 85 yrs	**4.8%**
	85+ yrs	**1.7%**
NI Total		**1810863**
Belfast LCG	0 < 16 yrs	**18.7%**
	16 < 65 yrs	**66.2%**
	65 < 75yrs	**7.7%**
	75 < 85 yrs	**5.4%**
	85+ yrs	**2.1%**
Belfast LCG Total		**348204**

Source: NISRA Census 2011

The numbers of people aged over 75 will increase by 4.9% between 2012 and 2018 although this is a much slower rate of increase than in Northern Ireland as a whole, as shown in Table 2.

Table 2 - Projected changes to age profile of Belfast LCG

		Projected % change		
		2012 - 2018	2018 - 2023	2012 - 2023
NI	**Total**	**+3.7%**	**+2.6%**	**+6.5%**
	0 < 16	+2.4%	+1.2%	+3.6%
	65+	+15.1%	+12.7%	+29.7%
	75+	+18.9%	+19.5%	+42.1%
	85+	+27.0%	+24.6%	+58.3%
Belfast LCG	**Total**	**+1.0%**	**+0.7%**	**+1.8%**
	0 < 16	+0.1%	-0.4%	-0.3%
	65+	+3.9%	+7.4%	+11.6%
	75+	+4.9%	+8.1%	+13.4%
	85+	+15.2%	+13.0%	+30.2%

Source: NISRA Census 2011

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. Two key measures within the multiple deprivation index are income and employment as these affect many other aspects of people's lives, including their general health. Table 3 shows the proportions of young people gaining basic qualifications and apprenticeships to be lower than the average for Northern Ireland. 6.12% of people in the LCG area aged 16-74 have never worked, compared with 4.9% in Northern Ireland as a whole. 69.5% of school leavers in the LCG area in 2010/11 gained 5 or more GCSEs at Grade C or above compared with 73,2% for Northern Ireland. These statistics for the LCG as a whole mask areas within the LCG where the scale of deprivation is much greater.

Table 3 - Young people gaining basic qualifications and apprenticeships

	No qualifications: Aged 16+ years (%)	Highest level of qualification: Level 1 qualifications: Aged 16+ years (%)	Highest level of qualification: Level 2 qualifications: Aged 16+ years (%)	Highest level of qualification: Apprenticeship: Aged 16+ years (%)
HSCT	16+ years	16+ years	16+ years	16+ years
N Ireland	29.12	11.51	14.92	4.22
Belfast	29.11	10.83	12.99	3.53

Source: NISRA Census 2011

Health Risk Factors

The risk of ill health is known to be greater where there is multiple deprivation as key risk factors for poor health outcomes are more prevalent, including obesity, smoking, drug and alcohol abuse, common mental health conditions, suicide and self harm and births to teenage mothers.

Raw prevalence of patients (per 1,000) on the Obesity register aged 16 and over (QOF 2012) indicates the Belfast LCG population as having a lower obesity rate (101.6) than Northern Ireland as a whole (110.3) though the rate is likely to be higher in areas of deprivation.

Smoking is known to be an important factor in a wide range of diseases including respiratory disease, heart disease, stroke and cancer. Figure 1 shows the higher death rates from smoking in Belfast.

Figure 1 - Standardised Death Rates from Smoking by LCG Area

LCG/ Trust Area of Residence	Deaths per 100,000 00/01-02/03	Deaths per 100,000 08/09-10/11
Belfast	161	164
Northern	129	119
S-Eastern	122	115
Southern	134	127
Western	148	141
N. Ireland	134	122

Alcohol related standardised admission rates and death rates for Belfast LCG residents are significantly higher than all other LCGs. Within Belfast LCG, alcohol related hospital admission rate was 120% higher in the most deprived areas than in the LCG area as a whole (DHSSPS, 2012). Drug and alcohol related deaths are also higher in areas of deprivation.

In 2010 (DHSSPS), Belfast West had the highest proportion of individuals of any constituency in Northern Ireland (246 per 1000) using prescribed medication for mood and anxiety disorders, followed by Belfast North (220 per 1000).

The deaths from suicide (Table 4) in Belfast are higher than the Northern Ireland average and have increased since 1997, as they have for Northern Ireland as a whole. The number is higher in North and West Belfast (Table 5) associated with the greater extent of deprivation.

Table 4 - Suicide Deaths 1997-2011

	Registration Year	
Area	1997	2011
Belfast HSCT	32	80
Northern Ireland	**138**	**289**

Table 5 - Suicide Deaths by Parliamentary Constituency, 1997-2011

Area	Registration Year	
	1997	2011
Belfast East	9	14
Belfast North	7	31
Belfast South	14	21
Belfast West	11	29

From 2006-2010 the age standardised rate of admission due to self-harm for the Belfast LCG area was 242 admissions per 100,000 population, with Northern Ireland at 263 admissions per 100,000 population. Belfast North and Belfast West had the highest rates for hospital admissions due to self harm and were nearly twice as likely to present to hospital than the Northern Ireland average.

Children born to teenage mothers (13-19 years) can be at higher risk of poor health. In 2010, Belfast West was 23.8 per 1,000 females and Belfast North 28.9 per 1,000 females. There can also be a greater risk of ill health for lone parents bringing up children on low incomes. Table 6 shows a higher proportion of single mothers not in employment in Belfast.

Table 6 - Lone Parent Unemployment Rate, 2010

	Lone parent households with dependent children: Lone parent aged 16-74 years not in employment (Female) (%)
HSCT	Female
Northern Ireland	47.16
Belfast	49.48

Source: NISRA Census 2011

Demand

The needs identified above are expressed as demand for services for hospital services, community care and primary care.

Hospital services

GP referral rates for planned appointments with Consultants for elective conditions tend to be lower in Belfast than elsewhere. The standardised admission rate for elective admissions in 2010/11was also below average at 88.8 (Northern Ireland = 100.0). Table 7 shows the overall referral rate. There are no specialties where the referral rate in Belfast is significantly higher. However, there are some specialties where there is insufficient capacity to meet this demand.

Table 7 - Referral Rate per 10,000 Population

NI Referral Rate 11/12	LCG Referal Rate 11/12	Variance	NI Referral Rate 12/13*	LCG Referal Rate 12/13*	Variance
2146	**1881**	**-265**	**2278**	**1968**	**-310**

Referral Source GP and other

**projected*

A relatively large proportion of attendances at Emergency Departments could be managed within primary care. An analysis of data by the PHA for the LCG showed that a large proportion of attendances were for minor illnesses, many of which could have been treated within primary care or by self care. The temporary closure of the Emergency Department at the Belfast City Hospital led to a net decrease in attendances in the Greater Belfast area of over 15,000 attenders without a matching increase in the usage of primary care, indicating that there is significant over-use of EDs for minor conditions.

As indicated above, Belfast LCG population has a significantly higher mortality rate from major disease groups and a higher prevalence of some conditions such as Stroke and COPD than for Northern Ireland as a whole. However, the

standardised emergency admission rate in 2010/11 for all specialities was 6% lower than the NI average and was 13% lower in 2008/09-2010/11 for admissions due to circulatory disease.

Community Care

Table 8 shows that the Belfast LCG commissions a greater number of domiciliary care hours per person than other LCGs for the equivalent need. However, it also commissions a relatively greater number of residential and nursing home bed days than some other LCGs.

Table 8 – Community Care, Belfast LCG Area

Trust	Domiciliary Care Hrs Per Person Per Year (weighted)*	RH Bed Days per person (weighted)	Nursing Home Bed Days per person (weighted)
Belfast	43.25	3.10	10.79
Northern	33.03	4.73	6.76
South Eastern	39.65	3.83	11.77
Southern	41.86	2.74	9.88
Western	40.81	4.54	11.35

Source: HSCB

**Population 65 and over has been "weighted" for a range of needs factors*

Despite this greater provision of community care, over half of all deaths in Belfast LCG area occur in hospital as shown in Table 9. Many of these people are in receipt of a community care which could avoid their having to spend their final days in a hospital environment.

Table 9 - All Deaths, 2011

	NHS Hospital		Nursing Home	
LCG Area	Number	%	Number	%
Belfast	1639	*51*	528	*16*
Northern	1903	*53*	599	*17*
South Eastern	1315	*46*	634	*22*
Southern	1106	*45*	418	*17*
Western	1017	*50*	317	*16*

Source: GRO

In addition to the greater provision of community care in Belfast LCG area, the amount of informal care provided by families and others in Belfast LCG area is higher than elsewhere as can be seen from Table 10.

Table 10 – Informal Care

	Provision of unpaid care: Provides no unpaid care (%)	Provision of unpaid care: Provides 1-19 hours unpaid care per week (%)	Provision of unpaid care: Provides 20-49 hours unpaid care per week (%)	Provision of unpaid care: Provides 50+ hours unpaid care per week (%)
HSCT	All	All	All	All
Belfast	87.68	6.80	2.12	3.41
Northern	88.45	6.79	1.81	2.95
South Eastern	87.18	7.72	1.93	3.17
Southern	88.66	6.38	1.98	2.98
Western	88.96	5.96	1.99	3.09

Demand for services by those suffering from common mental health conditions represents a major challenge for the LCG. A survey by the HSCB in 2010 found that there were 425 referrals per month to the Belfast Trust's single point of access from GPs and other community based services. Of these, 140 were assessed as not meeting the criteria for Trust services or could be dealt with by non-statutory services and were returned to the referrers. Of those referrals which were accepted almost one quarter (23%) did not respond to their offer of appointment and almost one fifth (19%) did respond but did not attend for the appointment. A more recent audit by GPs and Trust clinicians found lower but still significant rates in each of these categories.

Primary Care

The average cost of prescriptions in Northern Ireland is higher than in the rest of the UK. Belfast LCG currently has the lowest average cost per NIPU but is working to reduce this further. The LCG established a Drugs and Therapeutics group to develop and implement a Prescribing Plan. This identified a range of measures which it is implementing in line with regional policy.

Outcomes

The risk factors described above can lead to poor health outcomes. Table 11 below shows a greater proportion of adults aged 16-74 living in the Belfast LCG with very limiting health problems or disabilities or in bad or very bad health. Table 12 shows that for a wide range of conditions, adults in Belfast LCG area represent a greater proportion of the population than in Northern Ireland as a whole. Belfast West (24.0%) has the highest percentage of disability benefit recipients of any constituency in Northern Ireland, followed by Belfast North (20.9%)

Table 11 – General Health percentages Belfast LCG Area, 2011

	Long-term health problem or disability: Day-to-day activities limited a lot: Aged 16-64 years (%)	**General health: Good health (%)**	**General health: Bad health (%)**	**General health: Very bad health (%)**
HSCT	16-64 years	All	All	All
Northern Ireland	9.55	31.79	4.45	1.19
Belfast	10.96	30.80	5.84	1.70

Source: NISRA Census 2011

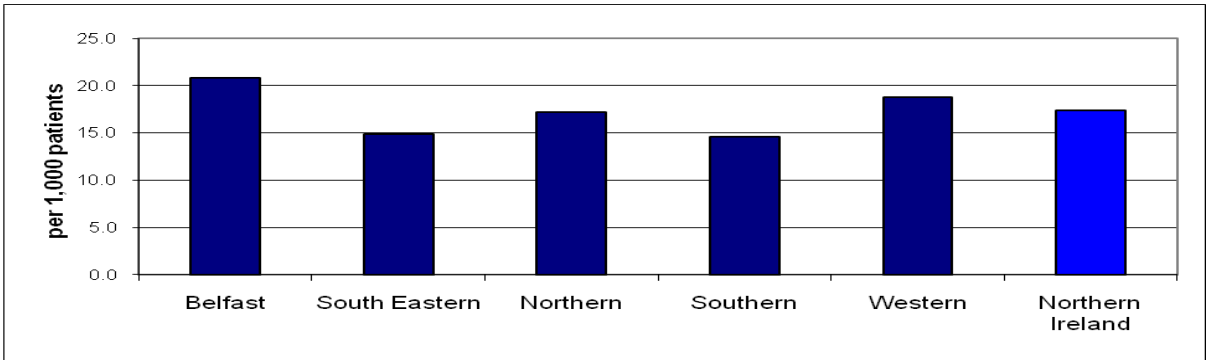
Table 12 - Long Term Conditions percentages in Belfast Area LCG (by type)

	HSCT	
Type of Long Term Condition	**Northern Ireland**	**Belfast**
Deafness or partial hearing loss (%)	5.14	5.59
Blindness or partial sight loss (%)	1.70	2.02
Communication difficulty (%)	1.65	1.87
A mobility or dexterity difficulty (%)	11.44	13.05
A learning, intellectual, social or behavioural difficulty (%)	2.22	2.55
An emotional, psychological or mental health condition (%)	5.83	7.41
Long-term pain or discomfort (%)	10.10	11.39
Shortness of breath or difficulty breathing (%)	8.72	10.25
Frequent periods of confusion or memory loss (%)	1.97	2.53
A chronic illness (%)	6.55	7.18
Other condition (%)	5.22	5.62
No condition (%)	68.57	66.00

Source: NISRA Census 2011

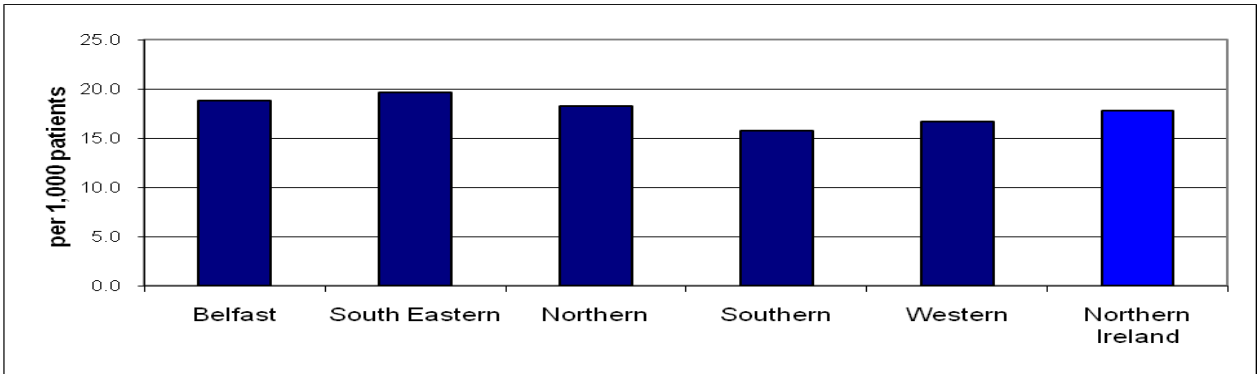
The prevalence of disease is greater for COPD (Table 13) and Stroke (Table 14) in Belfast than in Northern Ireland as a whole, reflecting the health risks noted above, particularly rates of smoking.

Table 13 - Raw Prevalence: COPD



Source: www.dhsspsni.gov.uk

Table 14 - Raw Prevalence: STROKE



Source: www.dhsspsni.gov.uk

Potential Years of Life Lost (PYLL) is a measure of premature death, measured as the number of years of life 'lost' from a death when a person dies before the age of 75. A death at age 25, for example, has lost 50 potential years of life. In the Belfast HSCT the PYLL per 100 persons for 2008-10' was 9.0 years for males and 5.0 years for females.

Table 15 shows Life Expectancy for males living in Belfast is significantly lower than for Northern Ireland in general, though this average masks a much greater differential between the most deprived and least deprived parts of Belfast. Statistics available from the Subregional HSCIMS which show that the difference in life expectancy for the most deprived Belfast Trust areas compared with the Trust as a whole were 6.7 years for males and 3.9 years for females (reference PSAB, DHSSPS).

Table 15 - Life Expectancy at Birth and at Age 65 by Health & Social Care Trust 2008/10

	Males		Females	
	Life expectancy at birth	**Life expectancy at age 65**	**Life expectancy at birth**	**Life expectancy at age 65**
	Years	**Years**	**Years**	**Years**
Belfast HSCT	74.7	16.4	80.4	19.6
N I	**77.1**	**17.4**	**81.5**	**20.2**

Table 16 indicates that standardised mortality ratios for cancers, heart diseases and respiratory diseases in Belfast LCG area are all above average for Northern Ireland.

Table 16 - Standard mortality ratios for selected causes by LCG HSCT 2011

		Malignant Neoplasms (i.e. : Cancers)			Circulatory			Respiratory	
	All deaths	All sites	Trachea, bronchus and lung	Breast (female)	All	Ischaemic Heart Disease	Cere-brovascular disease	All	Pneu-monia
Belfast LCG	112	116	146	106	100	104	125	117	100
NI	100	100	100	100	100	100	100	100	100

Source: NISRA www.nisra.gov.uk

Issues raised during Public and Personal Involvement

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

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

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

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

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

In 2012-13 the LCG commissioned a survey of 200 attenders at RBHSC and RVH and held focus groups within communities where use of the EDs was particularly high. This was done in conjunction with the BHSCT and the West Belfast Area Partnership and will inform action planning to promote alternatives to ED attendance. The main findings were:

- Many people attending ED with minor illnesses could have been seen by GP
- People are aware ED isn't necessarily the place they should be going
- Parents with young children much more likely to attend ED
- Not all ethnic minorities registered with GP so as a result go to ED for healthcare
- Difficulties getting appointments with GP if people want to see a particular GP
- Some GPs sending people to ED without seeing them
- Real or perceived lack of GP open surgeries
- Delays in results coming back from GP surgery
- People want a quicker diagnosis
- Some people don't know about BELDOC (local Out of Hours)
- Issues for Lone Parents/ Ethnic Minority Groups
- Difficulties getting through to staff by phone
- Health Visiting difficult to access- hard to contact

These findings are similar to studies elsewhere.

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

The LCG has closely involved the Stroke Users and Carers Forum, Stroke Association and CHS, Diabetes UK, RNIB, Guide Dogs for the Blind and Arthritis UK and minority ethnic groups in the development of new care pathways.

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

Some broad themes have emerged from this engagement:

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

2. Key successes in 2012/13

In 2012/13 the LCG took action across a broad front. The following have been of particular note:

In November 2012 a new care pathway for Type 2 Diabetes was launched in South Belfast. This had been developed by a multi-stakeholder group including GP and Community Pharmacy practitioners, secondary care Consultants, Structured Patient Education team, podiatry, dietetics and nursing, Diabetes UK, community providers of physical activity and minority ethnic groups. The multi-stakeholder group will form the core of an ICP group and are now developing proposals for primary-secondary shared care clinics and will bring forward proposals to the LCG.

Agreement was reached between primary care, secondary care and the Stroke Users and Carers Forum on a new evidenced-based Stroke Pathway which is now being implemented, including the development of integrated working between primary and secondary physicians, the consolidation of two stroke units into one, enhanced access to TIA clinics, 24-hour specialist medical cover, intensive rehabilitation, Early Supported Discharge and psycho-social support for stroke survivors and carers living with stroke involving the voluntary sector. The LCG and BHSCT hosted a major workshop to launch the development of a comprehensive integrated pathway for urgent care with the aim of having no older person going to an ED unless it was the most appropriate setting for them. The Trust and LCG have worked on the detailed arrangements of this pathway with a range of other stakeholders, including primary care, NIAS and older people's forums and the LCG will commission it in 2013-14. The pathway includes investment in falls prevention and in community nursing to support GP practices and a Trust-wide Community Urgent Care Team to respond to escalation of cases by GPs with a single phone call. This will operate in tandem with the newly introduced arrangements for GP access to assessment in the BCH and will offer advice and assessment by a Consultant Geriatrician. The Community Urgent Care Team will operate a 'Virtual Ward' in the community

and be able to access specialist support and organise social support as necessary to support older people at home. Feedback from consultation on the proposals with older people's forums is very positive. A pilot scheme has been commenced.

Implementation of the LCG Prescribing Plan has been associated with a significant reduction in the costs of prescriptions in primary care. The LCG has promoted methods of standardising prescribing within practices aimed at improving quality and reducing costs. It has recommended adopting a web-based Formulary and a system of screen prompts and has promoted the use of practice-aligned pharmacists to support GP practices in implementing their prescribing plans.

The LCG has gained broad agreement from BHSCT, primary care and voluntary and community providers to its proposals for commissioning wide-ranging changes to the provision of Level 2 therapeutic interventions for common mental health conditions. This is a significant step towards the development of a Primary Mental Health Service integrated across all sectors. A Referral Hub has been commissioned which will test this new way of working between GPs, Trust specialists and the community and voluntary sector.

The LCG has worked closely with the PHA, BHSCT, Belfast Health Development Unit and Belfast Area Partnerships to develop approaches which will address the social determinants of life inequalities. The commissioning of a Diabetes Pathway was noted above and the organisations have also intensively supported the initiative led by the West Belfast Partnership and Community Pharmacists to reduce the risks of heart disease. This has engaged schools, businesses and the media in the area and provided risk-reduction services such as vascular management.

The LCG has continued to work closely with the Trust in taking forward strategic re-configuration of services. Most notable was its decision to support the Trust's proposals for the consolidation of consultant-led obstetric services at the Royal Jubilee Maternity Hospital and the development of a free-standing Midwife-led Unit at the Mater Hospital.

3. Key challenges for the LCG for 2013/14

The following challenges have been identified by the LCG on the basis of the local needs and demands identified above and the implementation of regional priorities including Transforming Your Care.

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

The extent and scale of deprivation presents the most significant risk to poor health outcomes in Belfast. Access to specialist health services in Belfast is inversely proportional to the life expectancy of its population and its general health. This is partly because access to health services alone has a marginal impact on general health outcomes.

The LCG, the Public Health Agency and Belfast Trust are therefore engaging with local communities and other agencies, particularly through the Belfast Strategic Partnership, to address the multiple social determinants of health outcomes. The LCG will develop integrated planning with other agencies within the framework of the Belfast Strategic Partnership, including exploring joint approaches to procurement, governance and pooling of budgets. In this regard, the LCG will continue to lead the development of a multi-agency action plan for an Age Friendly City within the Belfast Strategic Partnership as well as being a partner on the other thematic groups, Active Belfast, Lifelong Learning, Outcomes Group for Children and Young People and the Mental Health Group. The LCG will continue to look for opportunities to support local community capacity building and encourage their leadership in initiatives which target the needs of vulnerable groups and those least able or likely to access services.

Challenge 2: Supporting older people and those with long term conditions or other needs to live at home.

The population in Belfast LCG area is ageing at a slower rate than elsewhere. However, there are higher proportions of over 75s of people living with disabilities or in poor health as well as a higher proportion of people spending more of their time in caring roles. Community care has traditionally been provided through daily home care visits and fixed periods of respite care.

However, the LCG aims to transform the way in which people are supported to live at home, through the Re-ablement approach and personalisation, and to support carers in more innovative ways.

The LCG will commission a Re-ablement approach which will further reduce demand for traditional domiciliary care packages and signpost people towards services within their local communities. The LCG will provide pump-priming investment in Re-ablement teams following agreement on the Trust's business case. It has committed to invest in a preventative strategy to enable older people and those with physical disabilities to access support from the community and voluntary sector where this can be shown to reduce their need for domiciliary care.

Transforming Your Care highlighted the need to modernise housing options for older people and in particular to reduce substantially the provision of residential homes, and instead provide more support for independent living. The LCG has supported Belfast Trust plans to re-provide accommodation at Shankill House in a new supported living scheme. Opportunities for further re-provision will be continue to be explored.

The critical role played by family and other carers in maintaining the independence of older people, those with long term conditions and those with physical disabilities, has been prioritised by the LCG. The LCG has committed to further investment in innovative approaches to supporting carers in line with the Carers Strategy and will fully involve carers' advocates in this process.

Challenge 3: Commissioning new pathways of care for common health conditions which promote good health and self care, reduce the risk of ill health and unnecessary attendance at an Emergency Department or hospital admission and support patients to return home as soon as clinically appropriate.

The standardised emergency admission rate in 2010/11 for all specialties was lower than average. However, the Belfast LCG is committed to reducing unnecessary emergency admissions wherever possible, focused on the Ministerial priorities of Frail Elderly, Respiratory disease, End of Life Care,

Diabetes and Stroke. Integrated Care Partnerships would ensure the delivery of the pathways in each of these five priority areas through:

1. **Risk stratification** – identify patients with long term health conditions who are at risk of requiring an unplanned hospital admission
2. **Information** – intelligence gathering from primary and secondary care information systems and knowledge within the primary care team about the patients who have been identified
3. **Care Planning** – joint multi-disciplinary meetings to consider interventions for those patients which would support their living at home for longer – including psycho-social support, practical help and promotion of good health and self care utilising local community and voluntary sector resources where appropriate.
4. **Evaluation** – to review the interventions and adjust the care plans as appropriate

The LCG will commission from ICPs a two-tiered approach to the management of urgent conditions for older people in the community. It will commission integrated primary and community teams in each of 8 localities across the LCG area which will have community nursing, social worker and AHP staffing levels commensurate with the needs of the area and close links with GP practices in the area. This will facilitate population health management at local level and enable the risk stratification and care planning outlines above.

Supporting these teams will be a single Trust-wide Community Urgent Care Team led by Community Geriatricians which will respond to urgent referrals escalated by the eight integrated teams or by Out of Hours or NIAS. This Team will be able to access specialist community nursing teams for specific conditions as well as domiciliary care, step-up beds or hospital assessment and admission as necessary. GPs will also be able to access immediate advice from a senior doctor through a single number. These escalation routes will avoid the need for urgent patients to go to an ED and will provide appropriate access to acute care at home or other care setting.

Challenge 4: Commissioning a Stepped Care Model of recovery for common mental health conditions.

The LCG has been working closely with the Bamford Task Force and the Mental Health Thematic Group of the Belfast Strategic Partnership in developing its commissioning of the Stepped Care Model. A Mapping Exercise commissioned by the LCG and Belfast Health Development Unit identified the potential for GPs to refer directly to providers of Level 2 therapeutic interventions and avoid the need for referral via the Trust, helping to reduce missed appointments by providing greater access at local level. The recommendations of the mapping exercise included a common care pathway, sustainable procurement arrangements with providers, common standards, joint planning by funders. A pilot Referral Hub and Primary Care Coordinator has been commissioned by the LCG from BHSCT and will operate with 5 GP practices for six months and will inform future commissioning at regional level.

Challenge 5: Reducing waiting times for planned appointments, tests, reviews and elective admissions to hospital, providing locally-based services where appropriate.

The LCG agreed a new SBA with BHSCT in 2012-13 which set a capacity level for the delivery of new outpatient appointments and diagnostic tests as well as inpatient and day case treatments. Although referral rates from GPs in Belfast LCG are lower than for Northern Ireland in general, in some cases additional capacity needs to be commissioned by the LCG. Sustainable reductions in waiting times will require that BHSCT fulfils the activity targets in the SBA and the commissioning of additional capacity.

Where appropriate, additional capacity for outpatients will be delivered in local settings outside hospital and by primary care practitioners. The evaluation of the PCP Pathfinder projects in east and south Belfast provided valuable learning for future developments in ICPs.

Challenge 6: Commissioning safe and sustainable hospital services and a community infrastructure which facilitates the implementation of Transforming Your Care.

Following public consultation on New Directions in 2008, the Belfast Trust has been developing a networked approach to the provision of hospital services. This has made hospital services more sustainable as standards of hospital care become more demanding and the nature of the workforce changes. However, hospital services must continue to adapt to changing circumstances.

The HSCB, in collaboration with the Belfast Trust, will undertake a public consultation on the future configuration of Emergency Departments in Belfast. The Paediatric Review being led by the DHSSPS will set a framework for the future development of inpatient services which are safe and sustainable. The LCG will develop a needs assessment for the new Children's Hospital proposed by the Minister, taking account of the Paediatric Review. This will enable the Belfast Trust to develop an Outline Business Case for the hospital.

Transforming Your Care envisages a shift of services from hospitals to local community facilities. Belfast Trust has had a process of transferring services to Well Being and Treatment Centres and this process could be further extended with benefits for patients. The LCG will develop a strategic infrastructure plan for its population which takes account of the outcome of the consultation on Transforming Your Care, its population plan, priorities for Integrated Care Partnerships and how these will determine the configuration of the primary care infrastructure and local hospital provision.

Challenge 7: Cost-effective prescribing

Prescribing rates per NIPU in Belfast LCG are lower than in other LCGs but Northern Ireland as a whole has higher prescribing costs than the rest of the UK. A proportion of savings made against a target spend can be re-invested in commissioning new services. The LCG approved a Prescribing Plan and established a Drugs and Therapeutics sub-committee to implement the plan. Actions continue to be focused on:

- Promotion of the NI Formulary and improving the quality of prescribing

- Investment in practice-aligned Pharmacists, subject to evaluation of the current scheme, to support practices in implementing their practice prescribing plans agreed with the HSCB
- Investment in reducing the use of Oral Nutrition Supplements
- Co-operation between primary and secondary care prescribers
- Managed entry of new drugs

4. Commissioning Priorities

The table below sets out the Commissioning Plan priorities and the local commissioning context. BHSCT will be expected to address each of the regional priorities and Commissioning Plan Direction targets in its Trust Delivery Plan, paying particular attention to the local commissioning context where this is stated.

HSCB/PHA Commissioning Plan Priorities	Local commissioning context
4.1 Cancer Services	
Ministerial Priority: From April 2013, ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days. During 2013/14 all Trusts will continue to address longest waits and improve the headline percentage to ensure that 95% of patients receive their first definitive treatment within 62 days to include: maintaining mechanisms for patient tracking; breach analysis; and action planning and follow up with HSCB personnel In addition, Belfast Trust will progress developments to include: improved access to Brachytherapy; provision of enhanced thoracic surgical capacity and the centralisation of upper GI surgery in order to address pathway issues which contribute to delays.	

Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery. ▪ Minimum of 30% of Breast Cancer Patients on self-directed aftercare pathway by Jan 2013- rising to 40% from Jan 2014 ▪ All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services ▪ All Trusts should develop clear project plans and begin to introduce a risk stratified model of follow up across all other cancer groupings, which will clear and prevent review backlog ▪ Findings of external evaluation to be incorporated into Trust Transforming Follow Up action plans	The LCG will commission pathways for transformed cancer follow up for priorities agreed with the Regional Steering Group and included within BHSCT's TCFU Action Plan. The LCG will continue to work with the BHSCT Macmillan Information Centre, Trust Psychology Service and the community and voluntary sectors to commission a stepped model of care for psycho-social support for those who are living with cancer. This will be informed by the mapping exercise being undertaken by BHSCT which will identify statutory, community and voluntary sector resources available across Belfast LCG area.
All Trusts should work with HSCB to implement the recommendations of the 2010 NI Chemotherapy Service Review. This should include: ▪ Establishment of an Acute Oncology Service (activity to be monitored as agreed with the HSCB). ▪ All Trusts to work with HSCB to agree regional model that provides appropriate oncology presence across centre and units ▪ All Trusts to monitor compliance with NICE	

guidance on neutropenic sepsis and to report to the HSCB on a monthly basis via the performance management information returns ▪ All Trusts to work closely with HSCB to modernise oncology services including staff levels and skills mix. ▪ All Trusts to implement C-PORT ▪ All Trusts to continue to ensure involvement of relevant personnel / stakeholders in the development of RISOH	
Effective Multidisciplinary Teams All Trusts should ensure that cancer MDTs undertake the NICaN Peer Review process and develop action improvement plans which will be shared with HSCB. ▪ All Trusts should participate in peer review of, Lung, Gynae, Colorectal, Urology and Haematology ▪ All Trusts will participate in peer review of Skin, Head and Neck, Upper GI/HPB and Breast ,MDTs ▪ BHSCT to participate in peer review of Sarcoma, Brain& CNS MDT ▪ All Trusts to participate in national Lung, e.g Bowel, UGI and Head and Neck audits ▪ All Trusts to share with HSCB on an annual basis findings from national and other relevant audits (including M&M Meetings) and subsequent action	

plans. ▪ All Trusts will audit the Protocol for Amending the Status of a Red Flag Referral including the implementation of the NICE Guidance for Suspected Cancer	
All Trusts will work with the Regional NICaN TYA postholder to scope out current practice (including pathways and referral patterns) and will encourage staff involvement in education and training on the needs of this cohort of patients. ▪ All Trusts to participate actively in the development of streamlined pathways for teenagers and young adults with cancer ▪ Trusts to participate in multiprofessional multidisciplinary working e.g virtual MDMs	
Haematology Services ▪ All Trusts should formally establish & implement virtual clinic arrangements and support the agreed MDM configuration as determined by the HSCB regional working Group. ▪ Trusts working with HSCB should ensure recommendations from NICR Haematological Malignancy Audits are implemented ▪ All Trusts should ensure maximisation of skills mix initiatives as determined by the HSCB working	

group ▪ All Trusts should ensure that clinical teams commence work on implementing a risk stratified model of follow up for patients with a haematological cancer ▪ All Trusts should apply the agreed regional commissioning planning assumptions for Haematology and ensure the delivery of the core volumes in the Haematology SBA, including the agreed Clinical Nurse Specialist Job Planning	
Ovarian Cancer • Trusts should link with Primary Care to raise awareness of the signs and symptoms of cancer, working with GPs within their area to provide Training and Awareness events. An initial focus will be on the introduction of specific referral and diagnostic pathways for suspected ovarian cancer in line with NICE Clinical Guidance.	
4.2 Children and Families	
Ministerial Priority: From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%.	
Ministerial Priority: From April 2013 ensure a 3 year	

time-frame for 90% of all children to be adopted from care.	
Ministerial Priority: By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%	
All Trusts should ensure that a child becomes looked after where that child's long term outcomes will be improved or there is a need for the child to be removed as a safety measure. Trusts should ensure that there is an adequate range of placements available to meet the assessed needs of Looked after Children / Care Leavers.	BHSCT should contribute to the regional processes in place which are leading on the developments for LAC, particularly regarding those young people who are suitable for community intensive support and other diversionary services. In addition all Trusts are participating in the Review of Residential child Care and work being progressed within the Regional Adoption and Fostering Taskforce which will consider placement availability.
Working within the Children and Young Peoples Strategic Partnership the Trust led Outcomes Group should progress the development of local integrated delivery arrangements with the establishment of more Family Support Hubs. This should ensure that interventions are needs led and strive for the minimum intervention required.	The CYPSP's Outcomes Group, which the Trust chairs, is to finalise the number of Family Support Hubs required across the Trust and progress their establishment and development.
All Trusts should ensure that a robust needs assessment and a localised service is provided for children with complex healthcare needs and for children with a learning disability and challenging behaviour.	BHSCT should participate in the regional process under the Children Services Improvement Board Regional Group for Children with a Disability to address the needs of these children.

All Trusts are required to implement the actions arising from the review of AHP services for children with special needs within Special Schools and mainstream education will be concluded and Trusts will require to progress the Implementation Plan arising	BHSCT should implement the actions arising from the review of AHP services for children with special needs within Special Schools and mainstream education will be concluded and Trusts will require to progress the Implementation Plan arising.
All Trusts to increase the percentage of women who receive the recommended antenatal visit by a Health Visitor	
All Trusts should fully implement the recommendations of the RQIA CAMHS Review and implement the DHSSPS Stepped Care Model.	BHSCT should consolidate implementation of CAMHS crisis resolution and home treatment, in particular the developments in home treatment provision with a view to reduction in the number of inpatient admissions and to support discharges. The LCG will commission Primary Mental Health Teams that will support implementation of the DHSSPS guidance and the Stepped Care Model as the service model for CAMHS applicable regionally. The new monies invested should deliver no breaches of the 9 week target throughout 13/14 and some reconfiguration of the existing workforce currently in Step 3 (Tier 3) to activity in Step 2
4.3 Community Care & Older People's Services	
Ministerial Priority: From April 2013, people with continuing care needs wait no longer than 5 weeks for assessment to be completed, and have the main components of their care needs met within a further 8 weeks.	The LCG expects BHSCT to ensure that no clients wait longer than the Ministerial targets for their care and to manage any increase in demand by improving productivity.

Ministerial Priority: By March 2014, deliver 720,000 telecare monitored patient days (equivalent to approximately 2,100 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI Contract.	
Trusts will review existing residential care provision and develop proposals for a phased reduction in capacity which is coordinated with the provision of alternative community based models of care.	BHSCT should provide the LCG, by 30 September, with a Review and Action Plan for residential care provision which: • Provides baseline information on for current levels of statutory residential home care provision and the costs of provision; • Identifies those statutory homes suitable for closure or re-configuration • Ensures appropriate consultation, community engagement and EQIA processes are undertaken and a Trust communication strategy is in place. Quantifies and costs alternatives to statutory home care to ensure projected need continues to be met through community alternatives to statutory residential care including the use of re-ablement approaches to care, domiciliary care, community rehabilitation services and development of a range of accommodation solutions.
Trusts and HSCB will work with independent sector providers to identify practice, training and contractual implications of preventing unnecessary admissions to acute care from nursing homes.	BHSCT should: • Contribute to all relevant HSCB Social Care Procurement groups. • Consolidate and enhance their existing internal arrangements

	for engagement with Independent Sector providers. • Keep contractual arrangements under review, monitoring specific contract compliance and practice issues and respond as required.
Trusts will review current respite care provision to identify the potential for increased support for carers through service remodelling/re-investment in the independent sector.	BHSCT should undertake service re-modelling/re-investment to: • Increase the numbers of carer assessments offered and accepted. • Increase the number of carers receiving direct payments or cash payments in lieu of services. • Develop a range of short break alternatives to traditional respite care. • Increase the use of the Private/ Community Voluntary sector alternative short break/ respite options.
Trusts will work collaboratively with HSCB/PHA/LCG's to scope and develop a regional network for Memory Services.	BHSCT should contribute to the work of the Regional Memory Service Group and work to implement the recommendations agreed.
Trusts will progress a comprehensive range of targeted health and wellbeing programmes in all localities to address the changing health and well- being needs of older people. They should ensure that arrangements are in place:- • To improve provision of advice information and signposting on all aspects of health and wellbeing improvement; • Deliver a co-ordinated, multi-faceted falls	The LCG will commission a community facing falls team that will focus on prevention agenda for falls and bone health and create a seamless pathway between voluntary and community services and Trust falls teams BHSCT should fully implement the "Promoting Good Nutrition Guidelines for Older people across all settings The LCG, PHA and BHSCT will work with other agencies and the 'age sector' voluntary organisations in the Belfast Healthy Ageing Strategic Partnership (part of Belfast Strategic Partnership) and

prevention service • To ensure older people have access to evidence based Falls Prevention Services; • To fully implement the "Promoting Good Nutrition Guidelines for Older people across all settings; • Develop and co-ordinate a shared service model to reduce the risk of social isolation and poor mental well-being amongst vulnerable older people • With relevant partners to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people. • Deliver a co-ordinated range of Targeted Physical Activity and Health programmes to address the CMO Guidelines for Physical Activity	commission additional services to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people. The LCG, PHA and BHSCT will work with Active Belfast (part of Belfast Strategic Partnership) to promote Targeted Physical Activity and Health programmes to address the CMO Guidelines.
Trusts will implement eNISAT, the ICT for the Northern Ireland Single Assessment Tool within older people's services in line with agreed Project Structures, processes and deadlines.	BHSCT should meet the agreed project deadlines for implementation and, in particular, review current ICT network to assess state of readiness for eNiSAT implementation.
Trusts will establish single point of entry arrangements; enhance the role of the community and voluntary sector and develop a Re-ablement service which maximises the independence of the service user.	The LCG will commission a Re-ablement Service from the BHSCT in line with the agreed regional model. BHSCT should, by September 2013 have fully implemented all main components of the Re-ablement Model across the Trust area and provide agreed regular monitoring information.

	The LCG and BHSCT will work with the Belfast Re-ablement Stakeholder Network (including a wide range of voluntary and community organisations) to commission a Preventative Strategy and sign-posting arrangements to additional support services for older people who contact the access point for Re-ablement. BHSCT will review its current contracts with the voluntary sector and re-align these with support needs identified through Re-ablement
Trusts will develop a Gateway Model and single point of referral for the receipt and screening of all referrals to adult safeguarding.	The BHSCT will participate in regional NIASP structure and workplan and develop a Gateway Model or single point of entry to adult safeguarding, including awareness raising of the model for community teams and others. The Trust should use the £93,000 recurrent investment received from the HSCB, appoint a 1.0 WTE Band 7 Social Worker to act as Designated Officer within Trust adult Programmes of Care; appoint 1.0 WTE Band 6 member of staff to assist in complex investigations; appoint 0.5 WTE Band 3 Minute Taker to support the Designated Officer role with Case Conferences and Case discussions.
4.4 Diagnostics	
Ministerial Priority: From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.	

All Trusts should ensure that the RQIA radiology recommendations are fully implemented during 2013/14. [1] As a minimum this requires all Trusts to: • Put in place written escalation procedures to reduce the risk of delays in plain X-ray reporting during 2013/14. • Ensure that all images are accounted for on the PACs system from March 2013 and they have processes in place to ensure that all images are reported on within the required target times from March 2014	
All Trusts should provide Ultrasound as part of the neonatal hip screening programme from 2013/14.	
All Trusts should ensure that the requirements for 7 day access to the MRI imaging requirements for Stroke and MSSC are delivered by March 2014. Going forward, all Trusts should ensure that, where additional imaging capacity is commissioned, that this will in the first instance be achieved through a longer working day to improve patient access.	
All Trusts and should implement NICE CG on	

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

Management of Dyspepsia, supported by pre-referral testing as indicated by the Guidance	
All Trusts should have implemented a direct access pathway for ECHO for patients considered for left ventricular failure (LVF) *as defined by NICE Guidance CG for chronic heart failure,* by September 2013 with the aim to have reduced referrals to cardiology outpatients by 10 % by March 2014.	
From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.	
4.5 Elective Care	
Ministerial Priority: From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures	
Ministerial Priority: From April 2013, at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014 and no patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014.	
Ministerial Priority: From April 2013, at least 70% of inpatients and daycases are treated within 13 weeks,	

increasing to 80% by March 2014, and no patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014.	
Ministerial Priority: From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.	
All Trusts should ensure they have robust and effective booking, scheduling, POA processes to ensure the full utilisation of available elective capacity The HSCB will expect the following and will monitor these indicators to ensure this objective is achieved: • All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more that 8% by March 2014 Trusts should demonstrate a measurable improvement in shift of procedures from day surgery to outpatients with procedure (OPP) by April 2014. (this will be based on the day surgery rates at April 2012) • All Trusts should reduce Theatre DNA/Cancellation rates to 5% by 31 March 2014. • All Trusts should ensure theatre utilisation rates of 83% (as a minimum and in line with Audit Commission recommendations) from March 2014. • All Trusts should work to improve endoscopy throughput per session from an average of 6.2	The LCG will commission from BHSCT the productivity improvements opposite to a minimum value of £1.670m.

patients per session in 2012/13 to 6.5 patients per session by December 2013, 6.7 by March 2014 and 7.1 by March 2014. • Trusts will ensure that they are delivering the recommended day surgery rates for the trolley of procedures identified by The British Association of Day Surgery from March 2015/16. • As a minimum Trusts should ensure that they are delivering the day surgery rate for the basket of 24 procedures identified by the Audit Commission (excluding Termination of Pregnancy). • The commissioner will fund additional activity at the BADS recommended best practice day surgery levels. In addition, the Trusts should utilise the electronic referral system, to support effective patient pathways and triage processes from March 2013. For example in the use of photo images to support dermatology referrals and other means which will support the implementation of the EUR policy	
All Trusts should implement an enhanced recovery model across an agreed range of surgical specialties to improve outcomes, reduce lengths of stay and increase productivity by 2014/14.The initial focus should be on the best practice pathways. This may include the pathways associated with the following 8 procedures:	In addition to the regional priorities opposite, the LCG will work with the BHSCT to commission the following locally: The LCG has agreed a new SBA across local specialties.16 of these specialties have increased their capacity for new assessments by 7230 per annum. The Trust must ensure that the new SBA is fully in

colectomy; excision of rectum; prostectomy; cystectomy; hysterectomy (vaginal and abdominal); and hip and knee replacement.[2]	place by 1st April 2013. This was made possible by using benchmarked new to review standards. The LCG will commission from Belfast Trust a range of services in key specialties to assist with meeting the elective access standard of 15 weeks for outpatient assessment. • The expansion of Orthopaedic ICATS will deliver an additional 2500 new assessments. This will ensure that all Belfast patients who can benefit from orthopaedic community care will do so within 9 weeks. Closely linked with this service will be the development of Rheumatology community clinics which will help to deliver around 750 new assessments and ensure Rheumatology can meet its annual demand. • A Musculoskeletal Integrated Care Pathway including Orthopaedics, Rheumatology and Pain Management. This is in line with the regional objective incorporating self-management and education. It will present challenges in regard to implementation and how the three services are managed but the LCG will work with the Trust to ensure this model of care is delivered. • The LCG will also commission community care orientated service developments for Dermatology and Ophthalmology. These will provide capacity for an additional 1200 dermatology and 2300 ophthalmology patients.
Once established as a regional service, all Trusts will utilise the podiatric surgery service for foot and ankle surgery from 2014/15	
In line with the NICE guidance for Glaucoma, Trusts will work with primary care in the referral refinement programme for glaucoma during 2013/14. This will reduce the false positives and ensure only those patients who require evaluation, monitoring and treatment are referred to secondary care.	
• All Trusts should provide an ultrasound service for infants at risk of or with suspected developmental dysplasia of the hip in line with the standards and guidance of the UK National Screening Committee, the Royal College of Radiologists and the College of Radiographers	
All Trusts will work towards the development of pathways to support. • All Trusts will achieve 90% of vasectomy procedures provided within primary care or as a minimum all moved off main acute hospital sites from April 2014. • All Trusts will move all low risk skin lesions off main	

[2] Further discussion required between Commissioner and provider(s) and / or DHSSPS

acute sites from April 2013 and from April 2014 90% of low risk skin lesions are moved to a primary care setting. • All Trusts to work towards the introduction of a regional pathway for varicose veins which is in line with NICE guidance (CG the diagnosis and management of varicose veins) and includes the provision of minimally invasive surgery for 90% of varicose veins from April 2014. • All Trusts should support the implementation of an MSK / Pain pathway. This service will support the delivery of a primary/community care facing service, with MDT pathways developed to include lower back, knee, shoulder etc., by the end of March 2014. All service models should include self-management/education at the core of service design.	Overall these developments will have the capacity to see 6750 new patients and around 10000 follow up appointments. The LCG will wish to place as many of these clinics across a number of community facilities such as in the seven Wellbeing & Treatment Centres. The LCG will also commission additional capacity in following secondary care services: • Breast Surgery - for 174 inpatients to ensure annual demand is met • MRI – additional scans with general anaesthetic (GA) support will be commissioned to ensure children requiring GA are scanned within 13 weeks • Orthopaedics – a multi-million pound investment has been made to recruit three new consultants and their teams to deliver 2500 new assessments and over 1000 procedures. BHSCT should improve how follow up appointments are ordered and managed to ensure patients are seen within their clinically indicated time. LCG will commission a new pathway for hospital dental services, taking account of the recommendations of the DHSSPS Review of Consultant-led Dental Services (when issued) and an evaluation of the pilot primary care based demand management initiative in Southern area.

	The LCG has invested £465,000 across a range of Allied Health Professional services, particularly OT and Speech & Language Therapy, to ensure 9 week access times are delivered by BHSCT. Demand for these services will be kept under review to ensure the access time is maintained.
All Trust will support improved outcomes measurements to support service improvement and evidence based commissioning • All Trusts should participate in the national hip fracture database during 2013/14 and ensure 100% compliance from 2014/15. • All Trusts providing elective orthopaedic procedures will participate and provide data into the National Joint register from 2013/14 and ensure 100% compliance from 2014/15. • All Trusts providing vascular services should ensure the full participation in the National Vascular Database from 2013/14. • Support the Patient reported outcome measures (PROMS) pilot for varicose veins	
One Trust to work with the commissioner to undertake a pilot service of self-referral for Musculoskeletal Physiotherapy. Pilot to be evaluated for local learning moving towards implementation in 2014/15	

4.6 Health and Social Wellbeing Improvement	
Ministerial Priority: By March 2014, improve long-term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site.	
All Trusts are expected to deliver on the implementation of 'Fitter Futures for All' framework including: • Pilot pregnancy programmes; • Achieving UNICEF Baby Friendly Standards and peer support initiatives to support breast feeding; • Pilot weight loss programmes for adults and children; • Provision of healthy food choices in all HSC facilities.	In addition to supporting Fitter Futures for All, the LCG, PHA and BHSCT will continue to support the West Belfast Area Partnership, Healthy Living Centres and Community Pharmacists in delivering the Healthy Hearts West initiative to reduce the risk of cardiovascular disease through promoting healthy choices in workplaces and schools and a vascular management programme.
All Trusts will ensure delivery of a range of evidence based early years intervention programmes including: • Roots of Empathy • Family Nurse Partnership • Infant Mental Health Training • Parenting support.	
All Trusts will ensure that they support the implementation of key public health strategies including: • tobacco cessation services and BIT in particular for pregnant women and other vulnerable groups;	

• work toward smoke free campuses; • services within hospital settings (including emergency departments) which can respond to alcohol and drug misuse, self harm and associated mental health issues; • Continue to collect data for the Deliberate Self Harm Registry on attendances at ED that are related to self-harm, report on trends and emerging issues and influence the maintenance and/or re-design of appropriate services.	
All Trusts should provide specialist sexual health services in line with the findings of the RQIA Review.	
All Trusts should ensure that existing service provision is tailored to meet the needs of vulnerable groups including: • Looked After Children; • Homeless people • LGBT • Travellers • Migrant groups	The BHSCT should submit an action plan to the LCG by June 2013 showing how it will improve the accessibility and uptake of services by vulnerable groups.

All Trusts should support social economy businesses and community skills development through public procurement, expanding capacity incrementally over the following 3 years.	The LCG will commission, through the BHSCT, additional capacity from the community and voluntary sectors in services for: • Older people • Long term conditions • Mental health • Learning disability • Physical disability including additional support for carers. Commissioning will focus on services which can demonstrably reduce demand for more specialist services or prescribing and therefore contribute to the objectives of Transforming Your Care. The LCG will work closely with BHSCT, PHA and other funders within the Belfast Strategic Partnership to align procurement processes and pool funding where this can better meet shared objectives and provide a more sustainable basis for the community and voluntary sector. The LCG and BHSCT will encourage community and voluntary organisations to develop networks around the holistic needs of individuals and to share administration resources for greater efficiency. The BHSCT should provide training support to volunteers to assist then in meeting governance standards.
4.7 Health Protection	
Ministerial Priority: By March 2014, secure a further	

reduction of X% in MRSA and Clostridium difficile infections compared to 2012/13. [X to be available in March 2013]	
All Trusts should test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption potentially associated with specific major events including the G8 Summit; the World Police & Fire Games 2013 and the All Ireland Fleadh in August as part of the City of Culture in Derry/Londonderry	
All Trusts will ensure that they support the implementation of key health protection initiatives including maintaining Northern Ireland's excellent vaccination rates in respect of influenza and childhood immunisations and the introduction of two new childhood vaccination programmes (Flu and Rotavirus)	
All Trusts will continue to monitor and review the occurrence of Health care Associated Infections (HCAI) and implement appropriate and agreed infection control measures with particular reference to Ministerial targets on Clostridium difficile and MRSA.	
The South Eastern Health and Social Care Trust will	

ensure that agreed procedures are in place in respect of infection control in the prison population including protocols for control of an outbreak of a communicable disease in a prison setting and access of prisoners to appropriate vaccinations.	
4.8 Learning Disability	
Ministerial Priority: From April 2013, ensure that 99% of all learning and disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.	
Ministerial Priority: By March 2014, 75 of the remaining long-stay patients in learning disability hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015. [x to be confirmed]	BHSCT should resettle 25 Learning Disability long stay patients from hospital into community placements with suitable social care and community services infrastructure to support them.

All Trusts should start to deliver Day Services in line with the Regional Model 2013 currently being developed.	Belfast Trust should deliver Day Services in line with the regionally agreed Day Opportunities model currently being developed.
All Trusts should develop their specialist community services to respond to the needs of people whose behaviours challenge services and those with offending behaviours including a 24 hour response 7 days per week and high support beds in the community.	BHSCT should continue to develop its Learning Disability community infrastructure to provide 24/7 support in the community for people whose behaviours challenge and those with offending behaviours.
All Trusts should deliver additional support for Carers through enhanced short break and respite services.	The LCG will continue to commission additional support for carers as the numbers of older people with learning disabilities grows and their carers also grow older. The BHSCT should also review how it can deliver additional, more flexible support for carers from within existing resources including short break and respite services.
All Trusts should work with primary care to further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation.	BHSCT should work with primary care to further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation.
All Trusts should deliver the targets of the Learning Disability Bamford Action Plan 2012-2015 DHSSPS.	Belfast Trust should deliver the outcomes identified for health and social care in the Draft Bamford Action Plan 2012 – 2015 when it is issued.
All trusts should develop action plans to promote the health of people with a learning disability, in line with the priorities identified in the Public Health Strategic Framework: Fit and Well Changing Lives 2012-22.	

4.9 Long Term Conditions	
Ministerial Priority: By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.	
By March 2014, all Trusts should ensure that integrated community teams are available to meet the needs of patients with long term conditions including: • a named nurse for patients on disease registers, with clear arrangements for dealing with multi-morbidity and complex medication regimes • access to specialist medical or nursing advice • Development of admissions/escalation protocols between community teams and secondary care	The LCG will commission from ICPs an integrated primary and community team (IPACT) in each of 8 localities based on a 'hub and spoke' model. Community nursing, social work and AHP staff in each hub will support designated practices with named staff dealing with a caseload of patients with multi-morbidities at risk of admission to hospital. Each team will be able to access specialist advice urgently via a single phone number, including assessment by a senior doctor in an Acute Assessment Unit, or by a Consultant Geriatrician in the patient's home or in a community-based assessment bed. Support will be immediately available from a Trust-wide Community Urgent Care team with access to specialist support as required.
Respiratory • Northern & Western Trusts should ensure that arrangements are in place for all TB patients to be managed by a specialist TB Service (Clinician who is a respiratory physician or appropriately trained infectious disease physician/paediatrician and specialist TB nurse)	The LCG will commission an enhancement of the TB Specialist Nurse service in 2013/14 which will also support SE LCG area. The LCG will commission nursing and dietetics resources for the integrated respiratory, allergy and anaphylaxis service, based on the

• All Trusts should have in place integrated paediatric respiratory and allergy and anaphylaxis teams, which can outreach to other parts of the hospital including A&E, outpatients and ambulatory care, and to the community, in cases of difficult asthma. • All Trusts should fully implement the COPD integrated Care Pathway • All Trusts should fully develop Home Oxygen Services Assessment and Review • All Trusts to participate in a six monthly audit of all COPD patient admissions	outcomes of the needs assessment to reduce the numbers of patients attending outpatients, A&E admissions and development of severe allergic reactions. This service will comply with NICE Guidelines and the Respiratory Service Framework standards. The LCG will commission additional components of the integrated COPD Care Pathway in Belfast to ensure its full implementation: effective case finding/spirometry training; Home Oxygen-Assessment and Review Service; 7 Day Respiratory Early Discharge and Community Support Service.

Stroke • Thrombolysis ➢ All Trusts to achieve a door to needle time of 60 minutes on a 24/7 basis • **Ministerial Priority:** From April 2013, ensure that at least 10% the proportion of patients with confirmed ischaemic stroke receive thrombolysis. • Urgent assessment of high risk TIAs ($ABCD^2$ >4) must be available on a 7 day basis • All Trusts should support early supported discharge (ESD) following an acute stroke. This should support shorter LOS and "shift left" where resources will be freed from hospital beds to develop services in the community.	The LCG will commission an integrated care pathway which will improve the outcomes and quality of care for patients and carers. An investment plan will be agreed with the Trust which makes more efficient use of existing resources and provides pump-priming funding to facilitate a comprehensive change management programme, including: • The reorganisation of stroke service in Belfast to deliver a one- site acute stroke model with all acute rehabilitation taking place on the RVH site. • The development of 7 day rehabilitation capacity and an Early Supported Discharge Team and appropriate rehabilitation resources within the one-site stroke unit for Belfast. BHSCT should deliver the specific regional targets for stroke in 2013/14. Investment will be provided for a stroke service improvement post which will facilitate the coordination of the service and the implementation of the integrated pathway in Belfast.
Diabetes • All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes	Adult Diabetes • The LCG will work with ICPs to roll-out the South Belfast Type 2 Diabetes Pathway across all areas

• Subject to satisfactory pilot evaluation, all Trusts should mainstream the CAWT pre pregnancy care and structured patient education program (CHOICE) for children from January 2014 onwards. [3] • All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14.	• The LCG will commission from ICPs an integrated shared care initiative for adult Type 2 Diabetes with the aim of supporting primary care to manage appropriate patients in the community whilst releasing capacity in secondary care to treat more complex Type 2 diabetic patients. • The LCG will commission from ICPs an integrated community based risk assessment and prevention programme aimed at reducing the number of newly diagnosed Type 2 diabetics. • The LCG will commission from ICPs additional diabetic community nursing services to provide additional support for managing Type 2 Diabetics in the community and in their own homes and reducing unplanned admissions to hospital. <u>Paediatric Diabetes</u> • The LCG will invest in a full time Consultant with an interest in diabetes that will lead and develop a high quality secondary level paediatric diabetes service for the Belfast LCG population. • The LCG will invest in additional paediatric Diabetic Nurse Specialist and Dietetics support to enhance paediatric diabetes care and support the insulin pump service. • Belfast Trust should expand the provision of insulin pumps for 13 children and 25 adults with Type 1 Diabetes • Belfast Trust should take account of the evaluation and

[3] Further discussion required between Commissioner and provider(s) and / or DHSSPS

	mainstream the CAWT pre pregnancy care and structured patient education programme (CHOICE) for children from Jan 2014 . Belfast Trust should complete a demand/capacity analysis of hospital based diabetes services in 2013/14.
Cardiovascular • Implement a Familial Hypercholesterolaemia cascade testing service in N. Ireland • All Trusts should implement a model for Emergency Life Support (ELS) training together with an audit process to monitor agreed outcomes.[4]	BHSCT should implement a model and an audit process for Emergency Life Support training.
Prevention **Ministerial Priority:** By March 2014, deliver 500,000 telehealth monitored patient days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI Contract.	
Ministerial Priority: By March 2014, develop and secure a range of quality assured education, information and	The LCG has highlighted in its commissioning statement for the

[4] Further discussion required between Commissioner and provider(s) and / or DHSSPS

support programmes to help people manage their long term conditions effectively[5] • All Trusts should ensure that smoking cessation services are available in all locations where patients with LTCs are seen including hospitals, primary care and community pharmacy • Belfast Trust to undertake pilot of the Triple Aim in North Belfast • Increase the uptake of direct payments by people with neurological conditions	COPD Integrated Care Pathway the need for BHSCT to improve the take up of smoking cessation services. In particular the Trust should focus on the areas of maternity, ante and post natal, and people with long term conditions. BHSCT to continue to cooperate with the Triple Aim pilot collaborative in West Belfast during 2013/14. The LCG and PHA will commission a further year of evaluation of the Healthy Hearts West initiative led by West Belfast Partnership Board and involving BHSCT, Community Pharmacists and community organisations across three community hubs. The LCG will work with BHSCT and the Belfast Health Development Unit to review the effectiveness of Active Belfast Coordinator and Coaching scheme which is aimed at in-reach to GP practices for referrals to bespoke activity programmes. BHSCT should work with the Neurological Conditions Network to increase the uptake of direct payments.
4.10 Maternity Child Health & Sub-fertility	
All Trusts to ensure that all children and young people admitted to an in-patient paediatric unit are seen by an appropriate level of medical staff within 4 hours and a consultant paediatrician within 24 hours of admission. Those units that do not currently meet this standard must ensure in the interim that the risk profile of	BHSCT should ensure that the standards for access to in patient care are met. BHSCT should ensure that patient flow processes within the RBHSC enable all children who need to be admitted from the Emergency Department to be admitted to a bed in the RBHSC. The LCG has commissioned a pilot Consultant of the Week arrangement from January 2013 and will evaluate this after three

[5] Further discussion required between Commissioner and provider(s) and / or DHSSPS

women booked to deliver in the unit is clinically appropriate to the level of staffing available.	months with a view to commissioning a permanent arrangement. The BHSCT will ensure that a senior doctor is available for advice to junior doctors on a 24/7 basis and that medical staffing cover matches demand. The CoW will carry a mobile phone enabling GPs to gain immediate advice and access to the SSPAU if necessary to avoid unnecessary attendance at the RBHSC ED. BHSCT will evaluate the effectiveness of the current GP Minor Illness Stream in RBHSC ED and inform LCG commissioning intentions. The number of Emergency Nurse Practitioners will also be considered. BHSCT will ensure that the complement of middle grade doctors in RBHSC ED is increased to 5.
All Trusts to achieve 16 years as the upper limit for acute paediatric and surgical care. Age appropriate care must be provided in all in-patient and out-patient settings.	BHSCT should provide the LCG with a plan for increasing the age limit for admission to RBHSC to 15 by March 2014 and 16 by March 2015 and ensure that protocols are in place in other hospitals to ensure that where children up to the age of 16 are admitted that the care is age appropriate.
All units with in-patient paediatric services must have a short stay paediatric assessment unit SSPAU on site	The LCG has commissioned a pilot SSPAU from January 2013 and will evaluate it after three months of operation. BHSCT will make arrangements for a permanent unit of an appropriate size to meet demand.
All Trusts should ensure that all parents with a child with a Long Term Condition are given a named contact worker they can liaise with directly to discuss management of their child's condition and who will liaise with education services if required.	

All Trusts to ensure that all children receiving palliative care have an emergency plan agreed with their GP, care team and secondary care services	
All Trusts to ensure that diagnostic imaging services are available on a 7/7 basis to diagnose and manage the acutely ill child including the assessment of acute surgical conditions of childhood.	
All Trusts to implement the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units and NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection	
All Trusts should ensure that the level of resident medical cover for consultant-led obstetric units meets the minimum standard recommended in the DHSSPS Maternity Strategy (ST3 or equivalent for obstetrics, paediatrics, anaesthetics)	BHSCT should continue to implement 'Re-Shaping Maternity Services' which will provide consultant-led obstetric services at RJMS and provide a stand-alone Midwifery-led Unit at the Mater Hospital. BHSCT should ensure that standards for medical cover are met.
All Trusts should ensure implementation of Normalising Birth Action Plans including: • Keeping first pregnancy and birth normal • Increasing vaginal births after previous caesarean section (VBAC) • Benchmarking against comparable units in NI, the rest of the UK and ROI	BHSCT should implement its Normalising Birth Action Plan and reduce in year the level of caesarean sections with priority on keeping first pregnancy and birth normal and increasing the rate of vaginal birth after caesarean section

• Implementation of NICE clinical guideline 132	
All Trusts should ensure that where a consultant-led obstetric unit is provided a midwife-led unit will be available on the same site.	BHSCT should provide a Midwifery-led Unit at the RJMS and ensure that choice is available for those who wish to have midwifery-led care.
All Trusts should ensure that all women are provided with balanced information on the available options for place of birth and benefits and risks, including midwife and consultant led units and home births.	
All Trusts should ensure that antenatal booking clinics will be provided in the community by midwives which will offer: • Direct access for women to their community midwife • Confirmation of pregnancy scan • Access to NIMATS • Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.	BHSCT should confirm to the LCG the location of antenatal booking clinics in the community and provide assurance that they comply with the standards set in the DHSSPS Maternity Strategy and HSCB Maternity service specification
All Trusts should ensure that for women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community and give greater continuity of care	The Belfast Trust should work with the LCG and PHA to agree an action plan to increase the level of ante natal care provided in the Trust and increase continuity of care.
All Trusts should bring forward 3 year plans to develop	

skill mix in the community midwifery service to include a phased increase in the number of maternity support workers in the community to assist with breastfeeding and early interventions commencing from 2013/14[6]	
All Trusts should implement the Royal College of Obstetricians & Gynaecologists green top guideline No. 36 "The Prevention of Early-onset Neonatal Group B Streptococcal Disease"	BHSCT should provide assurance that RCoOG guidelines for GBS are being followed
Belfast Trust should introduce oocyte cryopreservation (egg freezing and storage), and a blastocyst service[1].	
4.11 Medicines Management	
Ministerial Priority: From April 2013, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care	
NI Formulary to be embedded within prescribing practice through active dissemination within electronic prescribing platforms	BHSCT should provide assurance that NI formulary is embedded in their electronic prescribing platforms
Establish the baseline position ensuring 70% compliance by end 13/14 and Trusts attaining target delivery in 2014/2015.	HSCB will establish the baseline position which should develop action plans with practices to achieve/maintain 70% compliance with the NI Formulary by March 2014. The LCG will evaluate the effectiveness of its current Protected Time/Practice Aligned

[6] Further discussion required between Commissioner and provider(s) and / or DHSSPS
[1] Requires further discussion between the Commissioner and the DHSS&PS with regard to funding.

	Pharmacist scheme and review possible alternatives which would increase compliance with the Formulary and support practices in implementing their agreed Practice Action Plans
Arrangements in place to manage regional monthly managed entry recommendations	BHSCT will work with the HSCB on managed entry recommendations.
All Trusts should ensure 100% compliance with local delivery against the Regional Pharmaceutical Clinical Effectiveness Programmes	BHSCT should work to achieve 100% compliance against regional PCE programme The LCG will also work with community and voluntary providers to evaluate the effectiveness of social prescribing alternatives to drug prescribing The LCG will support the implementation of guidelines for the use of Oral Nutrition Supplements
All Trusts should support development of e-prescribing in hospitals	BHSCT should work with primary care to achieve e-prescribing on all Trust sites
All Trusts should ensure that all patients with highest risks (complexity; high risk medicines) have their medicines reconciled on admission and at discharge in line with NICE guidance (http://guidance.nice.org.uk/PSG001) – baseline in 2013/14; delivery 2014/15.	BHSCT should establish their baseline position for reconciling medicines on admission and discharge for all patients with highest risks as per NICE guidance(http://guidance.nice.org.uk/PSG001) by 2013/14; and to demonstrate 100% compliance with the guidance by 2014/15 .
4.12 Mental Health	
Ministerial Priority: From April 2013, ensure that 99% of all learning and disability and mental health discharges	

take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.	
Ministerial Priority: By March 2014, 23 the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.	Belfast Trust is expected to resettle 10 mental health patients from Long Stay Hospital into community placements with suitable social care and community services infrastructure to support them.
All Trusts are required to fully implement the refreshed "Protect Life" strategy. This should include: • contributing to the development of an improved model of support for those who self harm. • specific efforts to help vulnerable groups including bereaved families, the LGBT community, BME communities and Travellers. • supporting the ongoing delivery of the Lifeline Service and implement the regionally agreed Memorandum of Understanding.	The BHSCT should provide an action plan setting out how it will fully implement the refreshed "Protect Life" strategy

All Trusts should establish integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of a Primary Care Psychological Therapy Service beginning with the appointment of Primary Care Coordinators and training in CBT and/or counselling for a minimum of 5 staff in each Trust.	The LCG will commission an integrated care pathway for the care and treatment of patients with common mental health needs including: • continuing to work with the BHSCT, primary care and the community and voluntary sectors to establish a 6-month pilot Referral Hub and Primary Care Coordinator. The pilot will be evaluated by the LCG. • Working with the BHSCT and other funders and stakeholders in the Belfast Strategic Partnership to implement the recommendations of the Belfast-wide Mapping Exercise of providers and supporting the development of a Belfast Emotional Health and Well Being Strategy • working with the Trust to establish a list of accredited providers of CBT and/or Counselling to whom GPs may refer through the Coordinator Belfast Trust should provide training in CBT and / or counselling for a minimum of 5 staff
All Trusts should begin to implement Recovery Approaches and related Integrated Care Pathways by December 2013.	The LCG will commission integrated care pathways from BHSCT following the evaluation of the pilot Referral Hub for common conditions. The LCG and BHSCT will work with the BSP Thematic Group on Mental Health and with other funding agencies to take forward the recommendations of the Mapping Exercise.

	The LCG will work with the Trust and community and voluntary providers to evaluate the pilot Referral Hub it has commissioned for practices in West Belfast The LCG will continue to work with the Bamford Task Force, Belfast Trust and PHA to implement a governance scheme for providers which gives assurance to referrers and provides additional capacity for therapeutic interventions at Level 2 (non-specialist).
Ministerial Priority: From April 2013, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; and 13 weeks to access psychological therapies (any age)	
All Trusts should implement Crisis Response and Home treatment services for CAMHs with associated primary care teams/services including full implementation of the DHSSPSNI strategy for CAMHs.	BHSCT should to consolidate implementation of crisis resolution and home treatment, in particular the developments in home treatment provision with a view to reduction in the number of in-patient admissions and to support discharges. BHSCT should establish Primary Mental Health Teams that will support implementation of the DHSSPS guidance and the Stepped Care Model as the service model for CAMHS applicable regionally. The new monies invested should deliver no breaches of the 9 week target throughout 13/14 and some reconfiguration of the existing workforce currently in Step 3 (Tier 3) to activity in Step 2
All Trusts should further develop Specialist Community Services to include:	Belfast Trust should further develop Specialist Community Services to include:

• Autism Spectrum Disorder (ASD) services for Adult Services • access to dedicated eating disorder beds in mental health and/or general hospitals (All Trusts should reduce eating disorder extra contractual referrals expenditure by 50% (based on the 01/04/2011 baseline)) • a range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual Referrals based on the 1/4/2012 baseline). • the implementation of the regional Tier 4 Substance Misuse Model including the development of agreed supporting community services and enhanced alcohol liaison services within Emergency Departments • the implementation of services to identify, assess and treat first episode psychosis (age 16+)	• Autism Spectrum Disorder (ASD) services for Adult Services • access to dedicated eating disorder beds in mental health and/or general hospitals (All Trusts should reduce eating disorder extra contractual referrals expenditure by 50% (based on the 01/04/2011 baseline)) • a range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual Referrals based on the 1/4/2012 baseline). • the implementation of the regional Tier 4 Substance Misuse Model including the development of agreed supporting community services and enhanced alcohol liaison services within Emergency Departments • the implementation of services to identify, assess and treat first episode psychosis (age 16+)
Northern Trust to provide the regional Sexual Assault Referral Centre (SARC) at the Antrim Area Hospital site	Not applicable to Belfast Trust
All Trusts should achieve the targets of the Mental Health Bamford Action Plan 2012-2015 DHSSPS.	BHSCT will be expected to deliver the outcomes identified for health and social care in the Draft Bamford Action Plan 2012 - 2015 when it has been issued

4.13 Palliative and End of Life Care	
All Trusts and ICPs should ensure that effective arrangements are in place to engage and promote awareness with the general population and professionals regarding issues around palliative care, dying and service delivery around death.	The LCG has commissioned from North Belfast Area Partnership and BHSCT, a programme of awareness raising among community and voluntary groups, primary care practitioners and nursing homes. ICPs should continue to build on this work.
All Trusts should provide evidence that they are working to increase the quality of life for people in the last year of life by ensuring that palliative care measures run alongside acute intervention for people with cancer, cardiovascular and respiratory disease, dementia, frail elderly and those with a physical disability who are at the end of life. This should include: • implementation of the end of life operational systems model, • identification, holistic assessment and referral for carers assessment • offering people the opportunity to have an advance care plan developed within 3 months of admission to a nursing home, in the last year of life and for those who have an anticipated deterioration in their condition (e.g. on diagnosis dementia) • people are supported to die in their preferred place	The LCG will commission implementation of the ELCOS model, advance care planning and development of co-ordinated care planning for those in the last few months/weeks and days of life, including implementation of the key worker function

of care • use coordinated care planning in the last few days of life	
All Trusts and ICPs should have processes in place to ensure that care for individuals identified as being on the possible last year of life is coordinated around the patient and across services and organisational boundaries. This should be supported through continuation of the palliative care coordination posts and should include: • Implementation of the regionally agreed key worker function • The use of multidisciplinary records in the home • Effective out of hours hand over arrangements	
All Trusts and ICPs should provide evidence of how they are working with the independent and voluntary sector to ensure that there is an increased provision of general palliative care services in the community, supporting patients within their own home and nursing homes where that is their choice. This should include: • Access to 24 hour care and support • Equipment • Arrangements to support timely hospital discharge	The LCG will commission generalist services from ICPs which support people to remain at home when that is their preferred place of care. Investment proposals should quantify the 'shift' in care from hospital to community settings and reflect integrated working with the voluntary sector and plans to co-ordinate care at home and supported discharge.

• Support to nursing homes to meet the standards being developed in conjunction with RQIA	
All Trusts and ICPs should provide evidence of how they are working with the voluntary sector to ensure that there is an increased provision of specialist palliative care services in the community, supporting patients dying within their own home and nursing homes where that is their choice. This should include: • Support to generalist palliative care services • Education and training • Development of community multidisciplinary palliative care teams • Development of new models of palliative care day hospice and outpatient services • Access to face to face specialist advice 7 days a week 9am to 5pm • Trusts & ICPs to work with the commissioners to develop access to telephone advice to professionals 7 days per week until 11pm	The LCG will commission specialist services from ICPs which support people to remain at home when that is their preferred place of care. Investment proposals should quantify the 'shift' in care from hospital to community settings and reflect integrated working with the voluntary sector and plans to co-ordinate care at home and supported discharge
All Trusts and ICPs should provide education and training in communication and end of life care for all staff (e.g. GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers etc)	The LCG will review the continuation of the BHSCT palliative care coordination post with clear outcomes to be delivered including education, training and awareness raising

4.14 Physical and Sensory Disability	
Trusts and HSCB will collaborate in producing a needs analysis of people who are Deafblind to improve assessment and access to services.	The BHSCT is expected to contribute to the regional consortium developing and implementing a Single Tender Action exercise in order to commission the needs analysis. The Trust will be represented on regional steering group and will implement learning and action points.
Trusts will participate in a Regional Review of Communication Services in order to improve service access and consistency.	The BHSCT is expected to contribute to the regional consortium to carry out an initial scoping exercise. The Trust will be represented on regional steering group and will implement learning achieved.
Trusts will pilot at least one programme specific Self Directed Support scheme in order to develop a common approach to the use of personalised budgets and promote learning on a cross programme basis.	The BHSCT is expected to contribute to the regional Self Directed Support roll out within nominated programme(s) of care and to share learning from this work with regional group and other Trusts. The Trust will be represented on regional steering group and will implement learning and action points.
Trusts will review their respite capacity by identifying opportunities to reduce reliance on current residential and domiciliary models and developing community-based services offering short break support.	The LCG intends to increase its investment in support for carers and will commission a review of existing respite capacity by BHSCT. It expects the BHSCT to promote innovative approaches to carers support and to seek proposals from independent providers for development of a range of short break alternatives to traditional respite responses to need. The LCG expects the BHSCT to increase in the number of carers receiving direct payments or cash payments in lieu of traditional respite services *[to be quantified]* The LCG will commission an evaluation of the shift in service models.

Trusts will work with the Carers Strategy Implementation Group to address the recommendations of the 2012 Self-Audit Update and RQIA Inspection of NISAT Carers Assessments.	The BHSCT is expected to develop an action plan to address the key issues arising from 2012 Self Audit and RQIA Inspection Reports
4.15 Prisoner Health	
None of the regional priorities require action in Belfast	
4.16 Screening	
Ministerial Priority: The HSC will extend the bowel cancer screening programme to invite in 2013/14 50% of all eligible men and women aged 60-71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014.	BHSCT should deliver bowel cancer screening to extended age range (60-74 yrs) from 1 April 2014.
From April 2014, all Trusts should work with the PHA and the HSCB to increase screening colonoscopy capacity across the region by 25% to facilitate age extension of the bowel cancer screening programme up to 74 years. This should include the provision of at least one more endoscopy unit of JAG standard in Northern Ireland by the end of March 2015 and a further unit by 2015/16.	BHSCT Trust should increase screening colonoscopy capacity to enable it to achieve age extension of the programme to 74 from 1 April 2014. The Trust should consider need for additional JAG accredited unit to improve patient access to screening colonoscopy and facilitate the above extension of the programme
All Trusts should develop and implement action plans to	BHSCT should develop an action plan outlining how it will promote

enhance informed choice for the eligible population for bowel, breast and cervical screening. Work to focus particularly on hard to reach groups to reduce inequalities of access and uptake of cancer screening programmes.	informed choice of cancer screening programmes in hard to reach population groups
PHA, HSCB, Primary Care and BHSCT should work together to ensure robust processes are in place to maintain the screening interval for diabetic retinopathy and to ensure that ICT systems are in place so direct referral of appropriate patients from screening to ophthalmology occurs and the outcome of screening is shared with GPs and Diabetologists.	BHSCT should work with primary care practitioners to ensure robust processes are in place to maintain the screening interval for diabetic retinopathy and to ensure that ICT systems are in place so direct referral of appropriate patients from screening to ophthalmology occurs and the outcome of screening is shared with GPs and Diabetologists.
Trusts who deliver the Breast Screening Programme to implement local action plans, for the replacement of analogue breast imaging equipment with digital equipment to ensure the images taken are stored on NIPACS.	BHSCT should identify, and refer to the Quality Assurance Reference Centre in the PHA, all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer. From 1st April these women will be called by the Northern Ireland Breast Screening Programme for regular breast imaging according to national protocols.
All Trusts to identify all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer. From April 2013, an identified Trust to provide an imaging service for ladies at high risk (x 8) of developing breast cancer in accordance with NHSBSP guidelines	BHSCT should identify all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer. From April 2013, an identified Trust will provide a breast imaging and assessment service for women at high risk (x 8) of developing breast cancer in accordance with NHSBSP guidelines.

4.17 Specialist Services	
Ministerial Priority: By March 2014, 30% of kidneys retrieved in Northern Ireland through DCD are transplanted in Northern Ireland.	
Ministerial Priority: From April 2013, no patient should wait longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis or ankylosing sponylitis, and no patient should wait longer than 9 months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013.	
Belfast and Western Trusts (networking with NIAS and other Trusts as appropriate) should establish 24/7 primary Percutaneous Cardiac Intervention (pPCI) services at the RVH and Altnagelvin Hospitals and increase the scheduled cardiac catheterisation laboratory capacity in NI to circa 105 per week (to include extended day and weekend working) by September 2013 to improve access to diagnostic intervention and treatment as required.	
Belfast Trust should ensure that by March 2014, 30% of kidneys retrieved in all Trusts in Northern Ireland through Donation after Cardiac Death are transplanted in Northern Ireland; and, continue to ensure the delivery of a minimum of 50 live donor transplants	

Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access specialist ophthalmology regimes, such as Wet AMD within a maximum of 9 weeks.	
All Trusts should pilot the regionally agreed patient journey for Duchenne Muscular Dystrophy.	
Belfast Trust should: • Progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast Hospital for Sick Children Network plan. • Put in place additional capacity of 4 paediatric intensive care beds in line with projected demand expand specialist children's transport and retrieval services to support an increase in hours of cover.	
Belfast Trust will lead on the development and establishment of a specialist service model in line with the Strategic Framework for Intestinal Failure and Home Parenteral Nutritional Services for Adults.	
All Trusts should ensure that patients commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and multiple sclerosis in line with the Commissioning Plan Direction.	

4.18 Unscheduled Care	
Ministerial Priority: From April 2013, 95% of patients attending any Type 1, 2 or 3 A&E Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.	
Ministerial Priority: By March 2014, secure a 10% reduction in the number of emergency readmissions within 30 days.	
Ministerial Priority: By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.	
By September 2013, the Ambulance Service will, in collaboration with primary and secondary care clinicians, develop and implement agreed protocols to enable paramedics to assess and treat patients at the scene (including home) without transporting them to hospital, where appropriate.	The LCG will work with the Ambulance Service, BHSCT and primary care to ensure that the agreed protocols for assess and treat are seamlessly linked with the Community Urgent Care Team which the LCG will commission (see below)
By December 2013, Trusts will agree clear protocols on the management of major trauma patients and further	The LCG expects BHSCT to take a lead role in a Trauma Managed Clinical Network.

develop collaboratively these as necessary towards establishing a Trauma Managed Clinical Network.[7]	
By December 2013, Trusts and ICPs will ensure that effective arrangements are in place to prevent unnecessary attendances at Emergency Departments including: • Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage; • GP direct access to appropriate diagnostics to enhance management of conditions in Primary Care; and • rapid outpatient assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion between GP and senior hospital doctor and agreed decision on steps to take in patient management.	The LCG will commission effective arrangements to prevent unnecessary attendances at Emergency Departments including: • a community facing falls team that will focus on prevention agenda for falls and bone health and create a seamless pathway between voluntary and community services and Trust falls teams • a single 24/7 phone number for GPs to call a mobile phone carried by a senior hospital doctor in Belfast City Hospital Acute Assessment Unit and RBHSC, or to call a Consultant Geriatrician, to enable them to arrange an assessment at home, or at a community assessment hub or, via direct access, in hospital leading to an agreed decision on steps to take in patient management. This will be supported by: • a dedicated and specific 24/7 Community Urgent Care Team (including rapid response nursing, AHPs, social work, community geriatrician) which can access, treat and signpost to other services, supported by specialist condition-based teams that are fully integrated with the Community Urgent Care Team including arrangements to provide cover after 6pm and over weekends • home-based acute care in a 'virtual ward' with twice daily ward rounds involving all members of the multi-disciplinary team. • access to urgent (1-2 day) outpatient clinic slots

[7] Further discussion required between Commissioner and provider(s) and / or DHSSPS

	• immediate access to a Medical Admissions Unit if necessary • a Short Stay Paediatric Assessment Unit in RBHSC (to be evaluated) The LCG will commission evidence-based use of telecare and telehealth monitoring to support patients to live in their own homes more safely. The LCG will work with ICPs to identify a range of diagnostic tests which could be directly accessed by GPs to assist their decision-making for patients at risk of hospital admission. A specified range of tests will then be commissioned from BHSCT. The LCG will develop an action plan to follow up the recommendations of the minor illness survey carried out in local communities with high usage of EDs and commission evidence-based approaches to the management of minor illness in conjunction with community groups, community pharmacies, GP practices, Belfast City Council, PHA, BHSCT and others, including: • Raising awareness of how to seek urgent care locally and when to use an Emergency Department • Ensuring accessibility to GPs and other health care professionals locally and making best use of health centres and Well Being and Treatment Centres • A Working with the regional initiative to provide telephone triage and a directory of services

	• Further development of Minor Illness streams within the RVH, Mater and RBHSC EDs (following evaluation of the current GP pilot in RBHSC)
During 2013/14, all Trusts to confirm that the necessary components are in place to deliver 7-day working on acute sites including access to radiology, pharmacy, and senior medical decision-makers with closer liaison with district/community nursing, AHPs and social care in order to prevent an unnecessary emergency admission through appropriate patient handover and earlier discharge.	The LCG will commission: • the necessary components to deliver 7-day working on acute sites including access to radiology, pharmacy, and senior medical decision-makers with closer liaison with district/community nursing, AHPs and social care in order to prevent an unnecessary emergency admission through appropriate patient handover and earlier discharge. • a community-based ambulatory pathway that can be accessed by staff in the Acute Assessment Facility in BCH, Community Urgent Care Team and other inpatient units. • a review of Intermediate Care provision and step up/step down pathways. • pathways which provide rapid diagnostics/equipment to enable community staff to manage and maintain people safely at home and enabling GPs to access the range of diagnostics that will assist them, supported by community teams.

By June 2013, all Trusts and LCGs will have jointly, identified, quantified and agreed the necessary community services required to ensure that Length of Stay (LOS) within hospitals, acute care at home and post-acute care are optimised. Integral to this will be the development, collaboratively among Trusts (including NIAS), by March 2014, of a directory of community services to support timely discharge of patients as well as prevent emergency attendances/admissions.	**Hospital capacity** The LCG, working alongside a HSCB and PHA team will work with BHSCT to assess the demand and capacity for non-elective care and commission a level of hospital capacity which meets the needs of its population, taking account of the Trust's QICR Productivity Plan which should improve the efficient utilisation of existing capacity. **Community capacity** The LCG will commission from ICPs, 8 Integrated Primary and Community Teams with a standard staffing model of community nursing, social work and AHPs for each of 8 localities. Each will: • support the local population and have a staffing level which reflects its needs profile and caseload • provide named staff to support identified local GP practices. • Will be fully involved in 'RICE' functions of ICPs, • work closely with the Community Urgent Care Team and specialist condition-based teams. • be able to access ambulatory assessment and diagnostics as necessary and will in-reach to hospital to optimise discharge arrangements. The LCG will commission acute care at home in a "Virtual Ward" model from ICPs, to be provided by the Community Urgent Care Team, learning lessons from the initial pilot commenced in January

	2013 in support of four GP practices. The LCG will commission ICPs to review the role and function of the current 100 intermediate care beds and outline how these beds are used to contribute to a whole system flow. This will detail proposed reductions of IC Beds and associated funding implications and how this links to any proposals for step up/step down and respite community beds in the community services for older people with urgent and emergency needs. The LCG and ICPs will support the implementation of a regional plan to support agreed recommendations of the consultation on GP Out of Hours Services, including the establishment of a regional telephone triage system with access to a directory of community services to support timely discharge of patients as well as prevent emergency attendances/admissions.

Other Ministerial Targets	
Healthcare Acquired Infections	By March 2014, secure a further reduction of X% in MRSA and Clostridium difficile infections compared to 2012/13. [X to be available in March 2013]
AHPs	From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.
ICPs	During 2013/14, to implement Integrated Care Partnerships across Northern Ireland in support of Transforming Your Care

5. Next Steps

The Belfast Trust will provide a detailed response to this Local Commissioning Plan in a Trust Delivery Plan, setting out how it proposes to implement the commissioning priorities.

The LCG and Trust will work towards an agreement on a shift in the balance of spend between hospital and community services. This will include an investment plan for the enhancement of community services and its impact on hospital services.

The Service and Budget Agreement between the LCG and the Trust will be rolled-forward to include the additional services to be delivered and the additional productivity which can be obtained from existing services.

Where the LCG has prioritised additional investment in the community and voluntary sectors it will work with the Trust to agree specifications for those services which will centre on the needs of patients and clients.

The establishment of Integrated Care Partnerships will enable a multi-provider response to the Local Commissioning Plan, including primary care contractors, community and voluntary organisations and the Trust.