DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

FRAMEWORK DOCUMENT

Index

1. INTRODUCTION

1.1. The Department has produced this Framework Document to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

Background

1.2. The reform of the health and social care system in Northern Ireland has its origins in the Review of Public Administration (RPA) which was initiated by the Northern Ireland Executive in June 2002. The purpose of RPA was to review Northern Ireland's system of public administration with a view to putting in place a modern, citizen-centred, accountable and high quality system of public administration.

1.3. The need to reform the health and social care system at the earliest possible opportunity was widely supported. The new design is more streamlined and accountable and aimed at maximising resources for front-line services and ensuring that people have access to high quality health and social care. Another key feature is that public health and wellbeing is put firmly at the centre of the new system, with a greater emphasis on prevention and support for vulnerable people to live independently in the community for as long as possible.

1.4. The Health and Social Care (Reform) Act (Northern Ireland) 2009 ("the Reform Act") provides the legislative framework within which the new health and social care structures operates. It sets out the high level functions of the various health and social care bodies. It also provides the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the

effective delivery of health and social care in Northern Ireland.

Framework Document

1.5. The Health and Social Care (Reform) Act (NI) 2009, Section 5(1), requires the Department of Health, Social Services & Public Safety ('the Department') to produce a 'Framework Document' setting out, in relation to each health and social care body:

i the main priorities and objectives of the body in carrying out its functions and the process by which it is to determine further priorities and objectives;

ii the matters for which the body is responsible;

iii the manner in which the body is to discharge its functions and conduct its working relationship with the Department and with any other body specified in the document; and

iv the arrangements for providing the Department with information to enable it to carry out its functions in relation to the monitoring and holding to account of HSC bodies.

1.6. Section 1 (5) of the Reform Act defines "health and social care bodies" as:

i Regional Health and Social Care Board (known as Health and Social Care Board);

ii Regional Agency for Public Health and Social Well-being (known as Public Health Agency);

iii Regional Business Services Organisation (known as Business Services Organisation);

iv HSC Trusts;

v Special Agencies (i.e. Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency);

vi Patient and Client Council; and

vii Regulation and Quality Improvement Authority

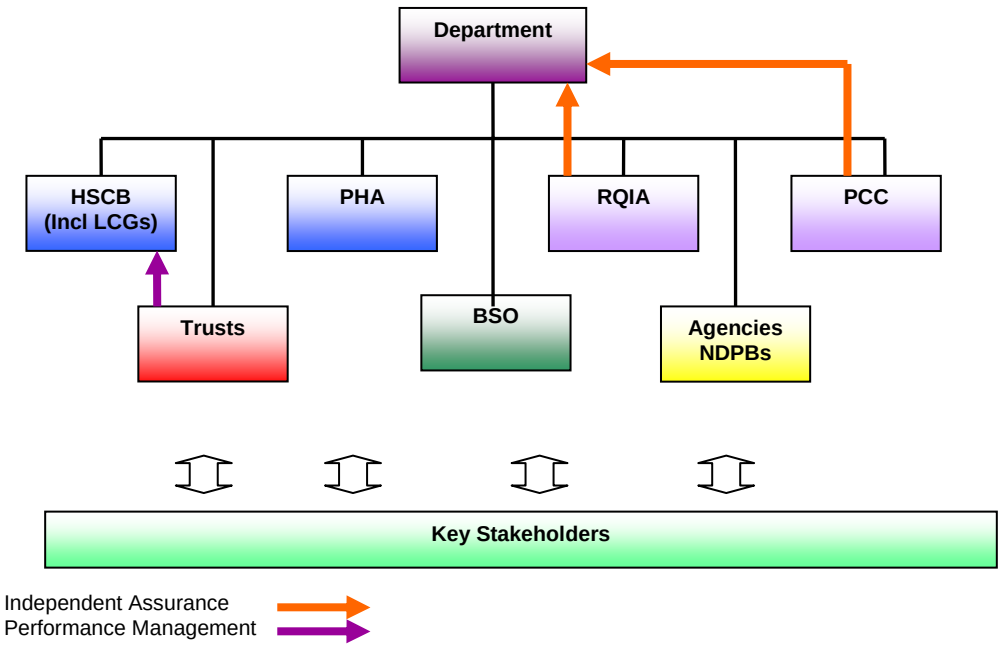
1.7. The focus of the Framework Document is the health and social care system in Northern Ireland and, although not covered by the Reform Act, the Northern Ireland Practice and Education Council and the Northern Ireland Social Care Council are included in the document for completeness. The Northern Ireland Fire and Rescue Service is outside the scope of the Framework Document.

1.8. All of the HSC bodies referred to above remain ultimately accountable to the Department for the discharge of the functions set out in their founding legislation. The changes introduced by the Reform Act augment, but do not detract from, that fundamental accountability.

1.9. Independent family practitioners also play a significant role in the delivery of health and social care. Health and social care objectives can only be achieved with the engagement of a high quality primary care sector that is accessible, accountable and focused on the needs of patients, clients and carers.

2. STRUCTURES, ROLES AND STATUTORY RESPONSIBILITIES

2.1. This section outlines the roles, responsibilities and relationships between the Department and health and social care (HSC) bodies. The diagram below shows the structure of the health and social care system.



Key: HSCB = Health and Social Care Board
LCGs = Local Commissioning Groups
PHA= Public Health Agency
BSO = Business Services Organisation
RQIA = Regulation and Quality Improvement Authority
PCC = Patient and Client Council
Agencies = Special Agencies (Northern Ireland Blood Transfusion Service, Northern Ireland Medical and Dental Training Agency and Northern Ireland Guardian ad Litem Agency)

Department of Health, Social Services & Public Safety

2.2. Section 2 of the Reform Act places on the Department a general duty to promote an integrated system of:

i health care designed to secure improvement:
- in the physical and mental health of people in Northern Ireland, and
- in the prevention, diagnosis and treatment of illness; and

ii social care designed to secure improvement in the social well-being of people in Northern Ireland.

2.3. In terms of service commissioning and provision, the Department discharges this duty primarily by delegating the exercise of its statutory functions to the Health and Social Care Board (HSCB) and the Public Health Agency (PHA) and to a number of other HSC bodies created to exercise specific functions on its behalf. All these HSC bodies are accountable to the Department which in turn is accountable, through the Minister, to the Assembly for the manner in which this duty is performed.

2.4. In addition, the Department retains the normal authority and responsibilities of a parent Department as regards direction and control of an arm's length body. The main principles, procedures etc are set out in the DFP guidance *Managing Public Money Northern Ireland* and are reflected in each body's management statement/financial memorandum (MSFM), in the letter appointing its chief executive as accounting officer for the body, and in the letters appointing its chair and other non-executive board members. The functioning of the bodies covered by this Framework Document is to be viewed in the context of, and without prejudice to, the Department's overriding authority and overall accountability.

Health & Social Care Board

2.5. The HSCB, which is established as the Regional Health & Social Care Board, under Section 7(1) of the Health & Social Care (Reform) Act

(Northern Ireland) 2009, has a range of functions that can be summarised under three broad headings.

2.6. **Commissioning** – this is the process of securing the provision of health and social care and other related interventions that is organised around a "commissioning cycle" from assessment of need, strategic planning, priority setting and resource acquisition, to addressing need by agreeing with providers the delivery of appropriate services, monitoring delivery to ensure that it meets established safety and quality standards, and evaluating the impact and feeding back into a new baseline position in terms of how needs have changed. The discharge of this function and the HSCB's relationship with the PHA are set out in sections three and four.

2.7. **Performance management and service improvement** – this is a process of developing a culture of continuous improvement in the interests of patients, clients and carers by monitoring health and social care performance against relevant objectives, targets and standards, promptly and effectively addressing poor performance through appropriate interventions, service development and, where necessary, the application of sanctions and identifying and promulgating best practice. Working with the PHA, the HSCB has an important role to play in providing professional leadership to the HSC.

2.8. **Resource management** – this is a process of ensuring the best possible use of the resources of the health and social care system, both in terms of quality accessible services for users and value for money for the taxpayer.

2.9. The HSCB is required by the Reform Act to establish five committees, known as Local Commissioning Groups (LCGs), each focusing on the planning and resourcing of health and social care services to meet the needs of its local population. LCGs are co-terminus with the five HSC Trusts.

Public Health Agency

2.10. The PHA, which is established as the Regional Agency for Public Health & Social Well-being under Section 12(1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009 incorporates and builds on the work previously carried out by the Health Promotion Agency, the former Health and Social Services Boards and the Research and Development Office of the former Central Services Agency. Its primary functions can be summarised under three broad headings.

2.11. **Improvement in health and social well-being** – with the aim of influencing wider service commissioning, securing the provision of specific programmes and supporting research and development initiatives designed to secure the improvement of the health and social well-being of, and reduce health inequalities between, people in Northern Ireland;

2.12. **Health protection** – with the aim of protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies;

2.13. **Service development** – working with the HSCB with the aim of providing professional input to the commissioning of health and social care services that meet established safety and quality standards and support innovation. Working with the HSCB, the PHA has an important role to play in providing professional leadership to the HSC.

2.14. In exercise of these functions, the PHA also has a general responsibility for promoting improved partnership between the HSC sector and local government, other public sector organisations and the voluntary and community sectors to bring about improvements in public health and social well-being and for anticipating the new opportunities offered by

community planning.

Health and Social Care Trusts

2.15. HSC Trusts, which are established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991, are the main providers of health and social care services to the public, as commissioned by the HSCB. There are now six HSC Trusts operating in Northern Ireland:

- Belfast Health and Social Care Trust (covering local council areas of Belfast and Castlereagh);
- South Eastern Health and Social Care Trust (covering local council areas of Newtownards, Down, North Down and Lisburn);
- Northern Health and Social Care Trust (covering local council areas of Coleraine, Moyle, Larne, Antrim, Carrickfergus, Newtownabbey, Ballymoney, Ballymena, Magherafelt and Cookstown);
- Southern Health and Social Care Trust (covering local council areas of Dungannon, Armagh, Craigavon, Banbridge and Newry and Mourne);
- Western Health and Social Care Trust (covering local council areas of Derry, Limavady, Strabane, Omagh, and Fermanagh)
- Northern Ireland Ambulance Service Trust (covering all of Northern Ireland)

2.16. The six HSC Trusts are established to provide goods and services for the purposes of health and social care and, with the exception of the Ambulance Trust, are also responsible for exercising on behalf of the HSCB certain statutory functions which are delegated to them by virtue of authorisations made under the Health and Personal Social Services (Northern Ireland) Order 1994. Each HSC Trust also has a statutory obligation to put and keep in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them (Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003).

2.17. Section 21 of the Reform Act places a specific duty on each Trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing the health inequalities between, those for whom it provides, or may provide, health and social care.

Business Services Organisation

2.18. The BSO, which is established as the Regional Business Services Organisation under Section 14 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, contributes to health and social care in Northern Ireland by taking responsibility for the provision of a range of business support and specialist professional services to other health and social care bodies, as directed by the Department in accordance with Section 15 of the Reform Act.

2.19. The BSO incorporates the majority of services previously provided by Central Services Agency. The BSO, however, provides a broader range of support functions for the health and social care service, bringing together services which are common to bodies or persons engaged in providing health or social care. These include: administrative support, advice and assistance; financial services; human resource, personnel and corporate services; training; estates; information technology and

information management; procurement of goods and services; legal services; internal audit and fraud prevention. Such support services may be provided directly by the BSO or through a third party.

Patient and Client Council

2.20. The PCC, which is established under Section 16 (1) of the Health & Social Care (Reform) Act (Northern Ireland) 2009, is a regional body supported by five local offices operating within the same geographical areas covered by the five HSC Trusts and LCGs. The overarching objective of the PCC is to provide a powerful, independent voice for patients, clients, carers, and communities on health and social care issues through the exercise of the following functions:

- to represent the interests of the public by engaging with the public to obtain their views on services and engaging with Health and Social Care (HSC) organisations to ensure that the needs and expectations of the public are addressed in the planning, commissioning and delivery of health and social care services;
- to promote the involvement of patients, clients, carers and the public in the design, planning, commissioning and delivery of health and social care;
- to provide assistance to individuals making or intending to make a complaint relating to health and social care; and
- to promote the provision of advice and information to the public by the HSC about the design, commissioning and delivery of health and social care services.

Regulation and Quality Improvement Authority (RQIA)

2.21. The RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. Although accountable to the Department, it is an independent health and social care regulatory body, whose functions

include:

i Keeping the Department informed about the provision, availability and quality of health and social care services;

ii Promoting improvement in the quality of health and social care services by, for example, disseminating advice on good practice and standards;

iii Reviewing and reporting on clinical and social care governance in the HSC - the RQIA also undertakes a programme of planned thematic and governance reviews across a range of subject areas, reporting to the Department and the Health and Social Care and making recommendations to take account of good practice and service improvements. Such reviews may be instigated by RQIA or commissioned by the Department;

iv Regulating (registering and inspecting) a wide range of health and social care services. Inspections are based on a new set of minimum care standards which ensures that both the public and service providers know what quality of services is expected. Establishments and agencies regulated by the RQIA include nursing and residential care homes; children's homes; independent hospitals; clinics; nursing agencies; day care settings for adults; residential family centres; adult placement agencies and voluntary adoption agencies. The Reform Act also transferred the functions of the former Mental Health Commission to the RQIA with effect from 1 April 2009. The RQIA now has a specific responsibility for keeping under review the care and treatment of patients and clients with a mental disorder or learning disability.

2.22. The RQIA is also the enforcement authority under the Ionising Radiation and Medical Exposure (Amendment) Regulations (N.I.) 2010 [IRMER] and is one of the four designated National Preventive Mechanisms under the United Nations Optional Protocol for the Convention against Torture [OPCAT] with a responsibility to visit individuals in places of detention and to prevent inhumane or degrading treatment. RQIA also conducts a rolling programme of hygiene inspections in HSC hospitals.

2.23. The Department can ask the RQIA to provide advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be specified in the Department's request. The RQIA may also advise the Department about any changes which it considers should be made in the standards set by the Department.

Special Agencies

2.24. Special Agencies are established under the Health and Personal Social Services (Special Agencies) (Northern Ireland) Order 1990 to provide specific functions on behalf of the Department.

2.26. **Northern Ireland Blood Transfusion Service (NIBTS)** - The NIBTS is responsible for the collection, testing and distribution of blood donations each year. The main aim of the NIBTS is to fully supply the needs of all hospitals and clinical units in Northern Ireland with safe and effective blood, blood products and other related services. The discharge of this function includes a commitment to the care and welfare of blood donors.

2.27. **Northern Ireland Medical and Dental Training Agency (NIMDTA)** – The NIMDTA was established to ensure that doctors and dentists are effectively trained to provide the highest standards of patient care. The NIMDTA is responsible for funding, managing and supporting postgraduate medical and dental education. It provides a wide range of functions in the organisation, development and quality assurance of postgraduate medical and dental education and in the delivery and quality assurance of continuing professional development for general, medical and dental practitioners.

2.28. **Northern Ireland Guardian ad Litem Agency (NIGALA)** – The NIGALA is responsible for maintaining a register of Guardians ad Litem who are independent officers of the court experienced in working with

children and families. Under the Children (NI) Order 1995, a Guardian ad Litem is appointed to safeguard the interests of children who are subject to family and adoption court proceedings and to ensure that their feelings and wishes are made clear to the court. The NIGALA also has a pivotal role in ensuring that the Children (Northern Ireland) Order is implemented as intended. The provision of an effective and efficient Guardian ad Litem Service is vital if the Children Order is to operate satisfactorily. It occupies a similar role under the Adoption (Northern Ireland) Order 1987 in that it brings an independence and objectivity to the task of safeguarding the interests of the child.

Non Departmental Public Bodies (NDPBs)

2.29. **The Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) -** The NIPEC was established under the Health and Personal Social Services Act (Northern Ireland) 2002 as a non-departmental public body to support the development of nurses and midwives by promoting high standards of practice, education and professional development. The NIPEC also provides advice and guidance on best practice and matters relating to nursing and midwifery.

2.30. **The Northern Ireland Social Care Council (NISCC)** - The NISCC was established under the Health and Personal Social Services Act (Northern Ireland) 2001 as a non-departmental public body to protect the public, specifically those who use social care services, and to promote confidence and competence in the social care workforce. It achieves this aim by registering and regulating the social care workforce, setting and monitoring the standards for professional social work training and promoting training within the broader social care workforce.

Summary of working relationships

2.31. In common with all Arms Length Bodies (ALBs), on issues of

governance and assurance, all the HSC bodies are directly accountable to the Department. Detailed accountability arrangements are set out in section 6 of this Framework Document.

2.32. Article 67 of the Health and Personal Social Services (Northern Ireland) Order 1972 as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009 provides that "In exercising their respective functions, health and social care bodies, district councils, Education and Library Boards and the Northern Ireland Housing Executive shall co-operate with one another in order to secure and advance the health and social welfare of Northern Ireland."

2.33. Under the Reform Act, the Department has an overall duty to promote an integrated system of health and social care designed to improve the health and social well-being of the people in Northern Ireland. All health and social care bodies must work closely and co-operatively with the Department, with each other and with organisations outside the Department, in the manner best calculated to further that overall duty. Whilst this general duty of co-operation is paramount, there are a number of specific areas where co-operative working needs to be highlighted and these are dealt with in the following paragraphs.

2.34. The Department sets the strategic context for the commissioning of health and social care services through a Commissioning Direction to the HSCB. It may also direct the HSCB as to the performance indicators it should employ in improving the performance of HSC Trusts.

The Health and Social Care Board and the Public Health Agency

2.35. Under Section 8 of the Reform Act, the HSCB is required to produce an annual commissioning plan in response to the Commissioning Direction, in full consultation and agreement with the PHA. The form and content of the commissioning plan is directed by the Department in accordance with Section 8 of the Reform Act. This requirement is at the core of the

key working relationship that translates the strategic objectives, priorities and standards set by the Department into a range of high quality, accessible health and social care services and general improvement in public health and wellbeing. In practice, the employees of the HSCB and PHA work in fully integrated teams to support the commissioning process at local and regional levels.

2.36. Developing, securing approval for and implementing the annual commissioning plan and associated Service and Budget Agreements with providers is the responsibility of the HSCB. The HSCB is, however, statutorily required to have regard to advice and information provided by the PHA and cannot publish the plan unless it has been approved by the PHA. In the unlikely event that the HSCB and the PHA cannot agree on the commissioning plan, the matter is referred to the Department for resolution. The HSCB and the PHA must also work together in a fully integrated way to support providers to improve performance and deliver desired outcomes.

2.37. Given the Department's retained responsibilities in areas such as human resources and estate management, strategic planning for health and social services must take place in a spirit of co-operation between the Department, the HSCB, the PHA and other HSC stakeholders, notwithstanding the formal accountability arrangements described elsewhere in this Framework Document.

Health and Social Care Board and HSC Trusts

2.38. Trusts must provide services in response to the commissioning plan, and must meet the standards and targets set by the Minister. Service and Budget Agreements (SBAs) are the administrative vehicle for demonstrating that these obligations will be met. SBAs are established between the HSCB and Trusts setting out the services to be provided and linking volumes and outcomes to cost.

2.39. Working with the PHA as appropriate, the HSCB is responsible for managing and monitoring the achievement by Trusts of agreed objectives and targets, including financial breakeven. At the same time, the HSCB and PHA also work together closely in supporting Trusts to improve performance and achieve the desired outcomes.

2.40. Section 10 of the Reform Act gives the HSCB power, subject to the approval of the Department, to give guidance or direction to a Trust on carrying out a Trust function. Before giving direction, the HSCB is required to consult with the Trust concerned except when the urgency of the matter may preclude consultation. The HSCB must not however give any direction or guidance to a Trust that is inconsistent with this Framework Document or inconsistent with any other direction or guidance already given to the Trust by the Department.

Health and Social Care Board and Family Practitioner Services

2.41. Primary care in general and family practitioner services (FPS) in particular are central to the health and social care system. Family practitioners and those who work with them in extended primary care teams act as the first point of contact and as a gateway to a wider variety of services across the HSC. The HSCB has a key role to play in managing contracts with family practitioners, not only in terms of pay and performance monitoring but also in terms of quality improvement, adherence to standards and delivery of departmental policy. The HSCB is accountable to the Department for the proper management of FPS budgets.

Business Services Organisation and the Wider HSC

2.42. The role of BSO is to provide support services on behalf of HSC bodies as directed by the Department. The relationships between the BSO and HSC bodies are governed by the development of SLAs between the BSO and the relevant organisation setting out the range, quantity, quality

and costs of the services to be provided. These SLAs will develop in accordance with the phased expansion of the range of services provided by the BSO.

Patient and Client Council and Wider HSC

2.43. In addition to the overall requirement on HSC bodies to co-operate with each other to secure and advance the health and social welfare of Northern Ireland, Section 18 of the Reform Act places a specific duty on certain HSC bodies, as defined in the Act, to co-operate with the PCC in the exercise of its functions. This means that HSC bodies must consult the PCC on matters relevant to the latter's functions and must furnish the PCC with the information necessary for the discharge of its functions. Furthermore, HSC bodies must have regard to advice provided by the PCC about best methods and practices for consulting and involving the public in health and social care matters.

2.44. The PCC's relationship with the other HSC bodies is therefore characterised by, on the one hand, its independence from these bodies in representing the interests and promoting the involvement of the public in health and social care and, on the other, the need to engage with the wider HSC in a positive and constructive manner to ensure that it is able to efficiently and effectively discharge its statutory functions on behalf of patients, clients and carers. It also has considerable influence over the manner in which consultations are conducted by the HSC.

2.45. The PCC's functions do not include a duty to consult on behalf of the HSC. Each HSC body is required to put in place its own arrangements for engagement and consultation.

Regulation and Quality Improvement Authority, the Department and Wider HSC

2.46. The RQIA's relationship with the Department and other HSC bodies is

driven by its independent role in keeping the Department informed about the availability and quality of services, drawing on its regulatory functions, and its wider statutory responsibility to encourage improvement in the quality of services. HSC bodies look to the RQIA for independent validation of their internal arrangements for clinical and social care governance. Examples of RQIA's work in this respect can be seen within its rolling programme of special and thematic reviews within the HSC. The RQIA must also work closely with HSC Trusts in the discharge of its functions relating to regulation of independent sector providers, particularly in terms of safeguarding the interests of vulnerable people.

Special Agencies and the Department

2.47. Special Agencies carry out a range of discrete functions as set out above. Their primary relationship is with the Department, on behalf of which they discharge their functions. The services they deliver are largely in support of the wider health and social care system and they must therefore develop appropriate working relationships with other health and social care bodies.

The Northern Ireland Practice and Education Council, the Department and the HSC

2.48. The NIPEC's primary relationship is with the Department on behalf of which it discharges its functions. NIPEC also works closely with key stakeholders in the HSC system to support registered nurses, midwives and specialist community public health nurses to provide a safe and effective nursing and midwifery service to the population of Northern Ireland.

The Northern Ireland Social Care Council (NISCC), the Department and the Wider HSC

2.49. The NISCC's primary relationship is with the Department, on behalf of which it discharges its functions. The NISCC provides a framework for commissioners and providers to promote consistency in standards of conduct and practice throughout the social care system. The NISCC also works closely with its registrants and other key stakeholders to achieve its aims of raising the quality of social care practice.

3. SETTING THE AGENDA

Establishing the Priorities

3.1. In terms of setting the strategic agenda for the Health and Social Care system, Section 2 of the Reform Act requires the Department to:

i develop policies to secure the improvement of the health and social wellbeing of, and to reduce health inequalities between, people in Northern Ireland;

ii determine priorities and objectives for the provision of health and social care;

iii allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way;

iv set standards for the provision of health and social care;

v formulate the general policy and principles by reference to which particular functions are to be exercised.

3.2. The Department sets the strategic vision and priorities for Health and Social Care. The strategic vision provides an overarching direction of travel for the HSC that reflects already well-established policies and strategies. The strategic vision underpins the Department's contribution to budget process and Programme for Government (PfG) and, flowing from this, provides the context for the development of an annual Commissioning Direction, Priorities for Action (PfA), Commissioning Plan and Trust Delivery Plans (TDPs).

3.3. The Programme for Government (PfG) and a framework of Public Service Agreements (PSAs) express the Executive's strategic aims and

policies in measurable objectives and targets.

3.4. The Department publishes annually Priorities for Action (PfA), which translates the PfG and other ministerial priorities into an achievable and challenging agenda for Health and Social Care.

3.5. The Department sets out the Minister's instructions to the commissioners in the annual Commissioning Direction under Section 8 (3) of the Reform Act. This reflects the priorities in the PfA as revised annually, and the relevant standards and obligations that apply every year. Hence this makes clear the framework within which the HSCB (including its LCGs) and the PHA commission health and social care.

3.6. Every year the HSCB is responsible for producing a commissioning plan in full consultation and with the approval of the PHA. The plan must outline how they plan to deliver on the key priorities standards or targets set in PfA. This plan provides the framework for each HSC Trust to develop its annual Trust Delivery Plan (TDP) detailing the Trust's response to the annual commissioning priorities and targets set out in the commissioning plan.

Allocating the resources

3.7. Section 2 of the Reform Act requires the Department to allocate financial resources available for health and social care, having regard to the need to use such resources in the most economic, efficient and effective way.

3.8. Resources available to the Northern Ireland Block are largely determined at the outcome of the HM Treasury Spending Review on the basis of the population based Barnett formula. This sets the overall Departmental Expenditure Limit (DEL) for Northern Ireland. The funding levels are normally set for three or more financial years and may be reviewed every two years or so. Within the constraints of the NI DEL, gross spending power available to the Executive can be increased, currently

through revenue generated from the Regional Rate and borrowing power within the Reinvestment and Reform Initiative. Within the overall Block limits set by Treasury (i.e the NI DEL), the NI Executive establishes, in the light of local priorities, the three or four year resource allocations for all NI Departments, which cover both current expenditure and capital investment. The PfG specifies the Executive's plans and priorities for the years covered by the relevant budget period, while a separate Investment Strategy establishes capital priorities over a 10-year period.

3.9. It is the Department's responsibility to secure, as part of the Budget process, resources that enable the health and social care system to satisfy the population's need for high quality, accessible services.

3.10. In allocating current expenditure to HSC bodies, the Department must strike a balance between facilitating full and timely deployment of resources to the frontline and the need to ensure that appropriate control of funds is retained centrally by the Department. The aim is to channel the maximum resources to the point of service delivery at the earliest possible stage, with appropriate controls in place to ensure that they are deployed in accordance with Government priorities.

3.11. A Capitation Formula informs the Department (and, in turn, the HSCB) as to the most fair and equitable allocation of revenue funding for LCG areas. It does this by taking into account the number of people living within an area, with suitable adjustments relating to the age, sex and additional needs (largely due to deprivation) of the populations in question. The HSCB is required annually to provide the Department with an assessment of equity gaps, including the potential for re-distribution of resources across LCG populations and to demonstrate that resources have in fact benefited the populations for which they were intended. Allocation of capital expenditure to HSC Trusts is managed by the Department, with input from commissioners on the associated current expenditure funding required. The capital allocation and reporting process in described in more detail later in this section.

Funding the Health and Social Care Board and the Public Health Agency

3.12. The HSCB is responsible and accountable for commissioning of services, resource allocation and performance management, whilst the primary objective of PHA is to protect and improve the health and social well-being of the Northern Ireland population.

3.13. Section 8 of the Reform Act requires the HSCB, in respect of each financial year, to prepare and publish a commissioning plan in full consultation with and approved by the PHA. Each organisation holds the administrative and programme resources appropriate to their respective roles and responsibilities. Where such resources are deployed outside the context of the commissioning plan, the HSCB and the PHA submit, for Departmental approval, separate business plans in respect of those resources.

3.14. The following principles apply in relation to the funding arrangements for the HSCB and the PHA:

i Each of the bodies receives the bulk of its funding directly from the Department and each organisation remains separately accountable for all of the funds allocated to it;

ii In accordance with the detailed commissioning arrangements set out in section four, the funds allocated to the HSCB are:

- Committed to secure the provision of health and social care services for local populations from the six HSC Trusts, Family Health Services and other providers, consistent with the approved Commissioning Plan; and
- used for staffing, goods and services associated with the discharge of its functions;

iii The PHA directly funds initiatives related to its core roles of health improvement, screening or health protection activity, partnership working with local government, staffing and goods and services. Plans for use of the PHA's funding are incorporated within the Commissioning Plan, developed by the HSCB in consultation with and the agreement of the PHA. Similarly, services commissioned by the PHA from HSC Trusts and independent practitioners are reflected the Commissioning Plan as appropriate. Whilst the payment of funds for these services is administered by the HSCB on behalf of the PHA through the Service and Budget Agreements with HSC Trusts, the PHA remains accountable to the Department for the deployment of the resources. In the case of services commissioned from Family Health Service contractors, such as GPs, the HSCB takes primary responsibility for contract management, taking input from the PHA as appropriate.

Funding the Patient and Client Council

3.15. The Department directly meets the operating costs of the Patient and Client Council (PCC) to ensure that it operates independently from the service. The PCC produces, for Departmental approval, an annual business plan demonstrating how these resources will be used.

Funding the Business Services Organisation

3.16. Funding for the Business Services Organisation's (BSO) operating costs will flow through Service and Budget Agreements (SBAs) with its customers, the other HSC bodies. The SBAs determine the range, quality and costs of services to be provided. Movement towards the position of the BSO as an organisation fully financed from its service agreements with customers is being staged over a transitional period from April 2009.

3.17. The Health and Social Care (Reform) Act requires BSO to ensure that the arrangements which it puts in place for securing support services for its customers are the most economic, efficient and effective way of providing such services. It is required to have these arrangements approved by the Department before they are put in place. The Department approves the BSO's annual corporate business plan.

Funding Health and Social Care Trusts

3.18. HSC Trusts access funds by means of Service and Budget Agreements (SBAs) with their commissioners. Trusts are required to submit annual delivery plans (TDPs) to the HSCB for approval. TDPs must address both the content of the agreed SBAs with commissioners and the wider range of other corporate responsibilities. The HSCB provides assurance to the Department about the service and financial viability of TDPs.

Funding the Regulation and Quality Improvement Authority

3.19. The RQIA is funded directly by the Department on the basis of the priorities and objectives set out in its annual business plan and 3- year corporate strategy, which are approved by the Department. RQIA generates the balance of income through statutory fee charges for regulation of establishments and agencies.

Funding the Northern Ireland Guardian ad Litem Agency

3.20. NIGALA is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department.

Funding the Northern Ireland Medical and Dental Training Agency

3.21. NIMDTA is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is

approved by the Department.

Funding the Northern Ireland Blood Transfusion Service

3.22. Resources are allocated initially to the HSCB and are then channelled to Trusts through their Service and Budget Agreements (SBAs). NIBTS accesses the funds through the SBAs it has with Trusts for its services.

Funding the Northern Ireland Practice and Education Council

3.23. The NIPEC is funded directly by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department.

Funding the Northern Ireland Social Care Council

3.24. The NISCC is funded substantially by the Department on the basis of priorities and objectives set out in its annual corporate business plan, which is approved by the Department. It also receives income from registration fees, Skills for Care and Development and in respect of student placements in the criminal justice sector (funded by the Department of Justice).

The Capital Allocation and Reporting Process

3.25. The strategic capital planning function, together with responsibility for overseeing procurement and performance management of capital programme delivery, rests with the Department. The Investment Strategy for Northern Ireland (ISNI), managed by the Strategic Investment Board (SIB) in conjunction with OFMDFM provides an indicative 10-year funding envelope for the Department. The Department contributes to the development of the ISNI, which is approved by the NI Executive.

3.26. Resources available to the Northern Ireland are largely determined at the outcome of the HM Treasury Spending Review on the basis of the population based Barnett formula. The NI Executive establishes, on the basis of its own priorities, the spending plans for all NI departments. In parallel, the Executive's infrastructure plans are set out in a separate 10-year Investment Strategy for Northern Ireland. The current Strategy covers the period 2008-2018.

3.27. To inform ministerial decisions on capital allocation, the Department conducts a biennial Capital Priorities Review, with input from a Policy Infrastructure Forum comprising representatives from the Department, the HSCB and the PHA. A 10-year rolling capital plan is produced as the output of these regular reviews.

3.28. The HSCB and the PHA are responsible for identifying and quantifying the services required to meet assessed needs and for commissioner endorsement of the associated current expenditure costs subject to considerations of affordability.

3.29. The Trusts and the HSCB (for ICT), are responsible for preparing and obtaining approval for business cases for the capital requirements needed to deliver the service. These business cases must have commissioner support before approval.

3.30. The Department has overall responsibility for the capital investment programme and also acts as a Centre of Specialist Expertise (COSE) and a Centre of Procurement Expertise (COPE) for capital infrastructure and undertakes a performance management role in relation to the estate.

3.31. The HSCB, taking account of professional advice from the PHA, is responsible for confirming the appropriate models of care to deliver health and social care across Northern Ireland and the associated indicative infrastructure requirements.

3.32. BSO is the responsible Centre of Procurement Expertise for the procurement of services, supplies and IT equipment.

4. COMMISSIONING

Introduction

4.1. The purpose of HSC commissioning is to improve and protect the health and social well-being of the people of Northern Ireland and reduce differences in access to good health and quality of life. Commissioning aims to achieve a progressive improvement in services through investment based on evidence of effectiveness, compliance with quality and efficiency standards and a focus on addressing the determinants of poor health and wellbeing. The involvement of patients, clients, carers and communities and engagement with other partners has a central role in the commissioning process.

4.2. The Department sets the policy and legislative context for health and social care in Northern Ireland. It also determines the standards and targets by which quality, access and outcomes should be measured and provides the strategic direction for the health and social care professions. The commissioning process, which includes resource and performance management and is led by the HSCB, translates the agenda set by the Department into a comprehensive, integrated commissioning plan for health and social care services. Commissioning must maintain a strong focus on identifying and prioritising the needs of patients, clients, carers and communities. In doing so, it is the driver for continuous service improvement and provides assurance that resources are delivering the maximum benefits for users and taxpayers alike. In management terms, the separation of commissioners and providers is designed to promote a patient and client-centred system.

The Commissioning Cycle

4.3. Commissioning includes the following activities:

i Assessing the health and social well-being needs of groups,

populations and communities of interest;

ii Prioritising needs within available resources;

iii Building the capacity of the population to improve their own health and social well-being by partnership working on the determinants of health and social well-being in local areas;

iv Engag ing with patients/clients/carers/families and other key stakeholders and service providers at local level in planning health and social care services to meet current and emerging needs;

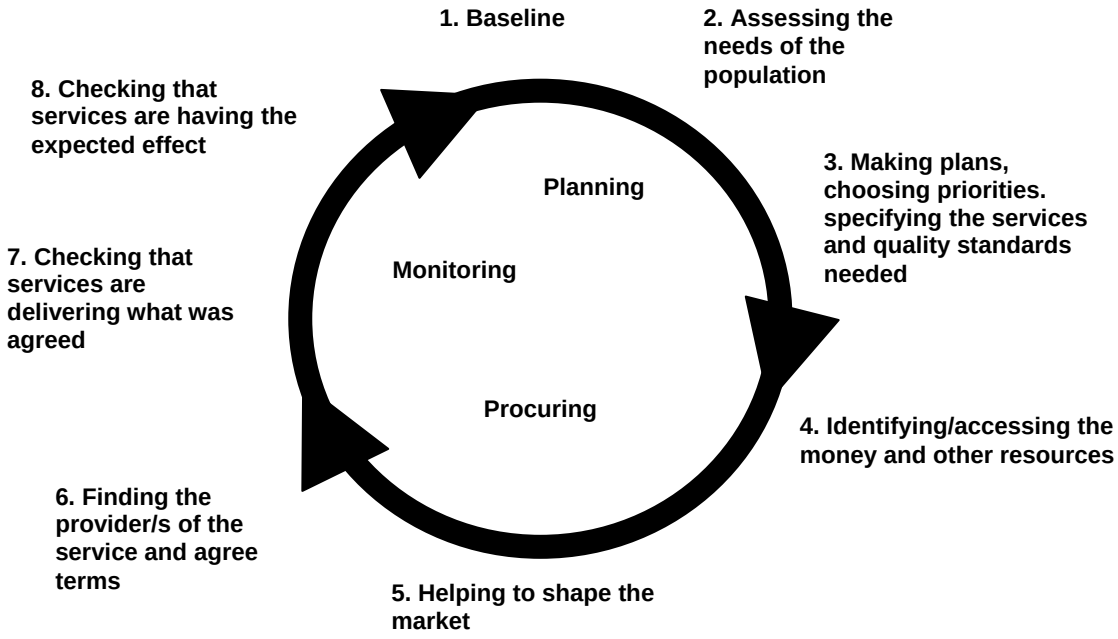
v Securing, through Service and Budget Agreements, the delivery of value for money services that meet standards and service frameworks for safe, effective, high quality care;

vi Safeguarding the vulnerable; and

vii Using investment, performance management and other initiatives to develop and reform services.

4.4. In the context of the integrated health and social care system in Northern Ireland, commissioning should be seen as an 'end to end' process. It organises activities around a commissioning cycle that moves through from assessing needs, strategic planning, priority setting, securing resources to address needs, agreeing with providers the delivery of appropriate services, monitoring that delivery, evaluating impact and feeding back that assessment into the new baseline position in terms of how needs have changed. Throughout the cycle, the HSCB and its LCGs engage with stakeholders, including service providers, at regional and local level.

4.5. Commissioners will facilitate a more integrated provider system by managing the interfaces between providers (statutory, independent and voluntary), developing provider networks and acting as 'guardians' of the care pathway.



The Commissioning Plan Direction

4.6. In exercising the powers conferred on it by Section 8 (3) of the Reform Act, the Department sets out the Minister's instructions to commissioners in an annual commissioning plan direction. The commissioning plan direction sets the framework within which the HSCB (including its LCGs) and the PHA commission health and social care.

The Commissioning Plan

4.7. Section 8 of the Reform Act requires the HSCB, in respect of each financial year, to prepare and publish a commissioning plan in full consultation with and approved by the PHA. The commissioning direction specifies the form and content of the commissioning plan in terms of the services to be commissioned and the resources to be deployed. The plan may not be published unless approved by the PHA. In the unlikely event of failure to agree the commissioning plan, the matter is referred to the Department for resolution.

Local Commissioning

4.8. The reformed system of commissioning introduced from 1 April 2009 established five geographically based Local Commissioning Groups (LCGs) that are co-terminus with the boundaries of the five Health and Social Care Trusts. The status of LCGs as committees of the HSCB is established in primary legislation.

4.9. LCGs have a lead role in the strategic commissioning process, in particular, having helped to shape strategic thinking, to apply it locally on behalf of their populations. They have responsibility for assessing health and social care needs in their areas, planning to meet current and emerging needs and securing the delivery of a comprehensive range of services to meet the needs of their populations. They have full delegated authority to discharge these responsibilities, including a significant ability to direct resources. The capitation formula identifies funds for the populations of each LCG area, and the HSCB is accountable for ensuring that they are used for that purpose. LCGs identify local priorities taking account of the views of patients, clients, carers, wider communities and service providers. They forge partnerships and involve a range of stakeholders in designing and reshaping services to better meet the needs of their local communities. The resources for each LCG population may be used to secure services for that population from any appropriate provider.

4.10. For the most part, the HSCB's Commissioning Plan reflects the decisions and recommendations of the LCGs in relation to the use of the capitation-based shares of the budget for their populations at local level. However, it is recognised that some services, by virtue of their specialist nature, restricted volume or statutory accountability, must be commissioned collaboratively on a regional basis, and hence the LCGs' decisions and recommendation will include contributions to the commissioning of regional services. The HSCB is responsible for establishing appropriate mechanisms for this process, which will ensure

that fair shares from the capitation-based budgets are committed to regionally commissioned services.

4.11. As committees of the HSCB, LCGs work within strategic priorities set by the Department, the HSCB, regional policy frameworks, available resources and performance targets. Section 9 (4) of the Reform Act requires LCGs to work in collaboration with the PHA and have due regard to any advice or information provided by it. To ensure a joint approach to commissioning, LCGs are supported by fully integrated, locally based, multi-disciplinary commissioning support teams made up of staff from the PHA and HSCB. Professional staff from both the HSCB and PHA are included in the membership of LCGs.

4.12. Each year the HSCB determines, in consultation with LCGs, the range of services to be commissioned locally and regionally and identifies the budgets from which such services are to be commissioned. LCGs prepare local commissioning plans, in keeping with the priorities and objectives of the HSCB. LCG commissioning plans are incorporated within the overall commissioning plan, which must be approved by the HSCB and the PHA.

Link between Commissioning and Performance Management

4.13. Monitoring performance of providers against the agreements they make in relation to service delivery is a key part of the commissioning cycle, and commissioners continue to ensure that this role remains core to how they work with providers. The HSCB and PHA must maintain appropriate monitoring arrangements in respect of provider performance in relation to agreed objectives, targets, quality and contract volumes.

4.14. The HSCB incorporating its LCGs must have appropriate monitoring arrangements to confirm that commissioned services are delivered, to benchmark comparative performance, and to ensure that quality outcomes, including positive user experience, are delivered.

4.15. Providers must have appropriate monitoring arrangements to ensure that they are meeting the requirements of commissioners and performing efficiently, effectively and economically.

4.16. The Department maintains appropriate monitoring arrangements in relation to the HSCB and the PHA to ensure that resources are used to best effect in the achievement of agreed strategic objectives and targets.

4.17. The HSCB and PHA also work together closely in supporting providers, through professional leadership and management collaboration, to improve performance and achieve desired outcomes. The HSCB is the lead organisation for supporting providers in relation to the delivery of a wide range of health and social care services and outcomes, with support provided by PHA professional staff. PHA is the lead organisation for supporting providers in the areas of health improvement, screening and health protection, with support provided by the performance, commissioning, finance, primary and social care staff of the HSCB.

Procurement by HSC Trusts

4.18. At the present time, it is not practical or desirable for the HSCB to contract directly with the full range of providers involved in the HSC system. The services involved are numerous, diverse, need to be provided flexibly and often need to be arranged at short notice, to meet the needs of individuals. Therefore a wide range of services commissioned by the HSCB are sub-contracted by Trusts to independent sector providers.

5 PERSONAL AND PUBLIC INVOLVEMENT

5.1 Patients, clients, carers and communities must be put at the centre of decision making in health and social care. This means that they must be properly involved in the planning, delivery and evaluation of their services. HSC bodies are accountable to people and communities for the quality, accessibility and responsiveness of the services they plan and provide.

5.2 Section 19 of the Reform Act places a statutory requirement on each organisation involved in the commissioning and delivery of health and social care to provide information about the services for which it is responsible; to gather information about care needs and the efficacy of care; and to support people in accessing that care and maintaining their own health and wellbeing.

5.3 This statutory requirement extends to the development of a consultation scheme, which must set out how the organisation involves and consults with patients, clients, carers and the Patient Client Council (PCC) about the health and social care for which it is responsible. Consultation schemes must be submitted to the Department for approval. The Department may approve a consultation scheme, with or without amendments, after consulting with the PCC.

5.4 Section 20 of the Reform Act specifies the form that consultation schemes should take, but this is supplemented by detailed policy guidelines for the HSC on personal and public involvement and the development and approval of consultation schemes.

Roles in Personal and Public Involvement (PPI)

5.5 In respect of Personal and Public Involvement (PPI), the Reform Act places a specific responsibility on the PCC to promote best practice in

involvement and in the provision of information about health and social care services. HSC bodies are required by the Reform Act to co-operate fully with the PCC in the discharge of these statutory responsibilities. The Department may consult the PCC in respect of specific consultation schemes before approving them.

5.6 The Department sets the policy and standards for Personal and Public Involvement (PPI). Working through the HSCB, the PHA has responsibility for ensuring that Trusts meet their PPI statutory and policy responsibilities and leading the implementation of policy on PPI across the HSC. A PPI Forum, chaired by the PHA and involving representatives from all HSC organisations, has been established for that purpose. This in no way detracts from the individual statutory responsibilities of organisations with regard to PPI.

5.7 The HSCB is responsible for ensuring that its LCGs establish arrangements for effective PPI which will allow the views of stakeholders to inform the development of commissioning plans. The HSCB should also ensure that Family Practitioner Services are meeting the requirements laid down in Departmental guidance on PPI.

5.8 HSC Trusts are responsible for establishing individual organisational governance arrangements, and for implementing their PPI consultation schemes, to meet their statutory duty of involvement, as well as any requirements laid down in Departmental guidance on PPI.

5.9 Special agencies also have responsibilities in respect of PPI. The NI Blood Transfusion Service (NIBTS), the NI Guardian Ad Litem Agency (NIGALA) and the NI Medical and Dental Training Agency (NIMDTA) should establish arrangements to ensure they meet their statutory duty of involvement and any requirements laid down in Departmental guidance. Each of these three special agencies will be accountable directly to the Department for the discharge of these functions.

5.10 The PCC will undertake research and conduct investigations into the most effective methods and practices for involving the public and provide advice on these to HSC organisations. The PCC also has an important challenge role for those HSC bodies prescribed in the Reform Act in respect of PPI, and will accordingly be expected to comment upon and scrutinise the actions and decisions of these bodies as they relate to PPI.

5.11 RQIA will continue to provide independent assurance to the Minister, via the Department, of the effectiveness of PPI structures in HSC organisations by continuing to monitor these as part of its programme of review of clinical and social care governance arrangements against the Quality Standards.

6 HOLDING THE SYSTEM TO ACCOUNT

Introduction

6.1. Ultimate accountability for the exercise of proper control of financial, corporate and clinical and social care governance in the HSC system rests with the Department and the Minister. Within a system of such magnitude and complexity, assurance about the rigour of control mechanisms can only be derived from the development and operation of robust systems and processes at all levels of decision making.

Performance and Assurance Dimensions

6.2. This section of the Framework Document describes the various lines of accountability and how they are exercised at different levels within the HSC system. The key performance and assurance roles and responsibilities are encompassed in the four dimensions of:

i Corporate Control – the arrangements by which the individual HSC bodies direct and control their functions and relate to stakeholders;

ii Safety and Quality – the arrangements for ensuring that health and social care services are safe and effective and meet patients' and clients' needs, including appropriate involvement;

iii Finance – the arrangements for ensuring the financial stability of the HSC system, for ensuring value for money and for ensuring that allocated resources are deployed fully in achievement of agreed outcomes in compliance with the requirements of the public expenditure control framework;

iv Operational Performance and Service Improvement – the arrangements for ensuring the delivery of Departmental targets and required service improvements.

Key Principles

6.3. The requirements in relation to performance and assurance roles may differ from body to body but some key principles underpin the overall approach to holding the HSC system to account:

i the Department has ultimate accountability for the effective functioning of the HSC across the four dimensions;

ii the Department will provide clear guidance across each of the four dimensions, specifying outputs and outcomes that are appropriate, affordable and achievable. This guidance will be developed with the involvement of the HSC bodies, consistent with their roles and responsibilities;

iii each HSC body is locally accountable for its organisational performance across the four dimensions and for ensuring that appropriate assurance arrangements are in place. This obligation rests wholly with the body's board of directors. It is the responsibility of boards to manage local performance and to manage emerging issues in the first instance;

iv the standard assurance arrangements and associated information streams within individual HSC organisations will, as far as possible, be used to meet the assurance requirements of the HSCB and PHA, and those of the Department, subject to such additional independent verification as may be deemed necessary;

v the Department, and in turn the HSCB and PHA (where they have a performance and assurance role in relation to one or more of the other bodies), will maintain a relationship with other HSC bodies based on openness and the sharing of information, adopting an informal, supportive approach to clarify and resolve issues as they

arise, and thereby minimising the need for formal intervention.

Corporate Control Dimension

6.4. Corporate control encompasses the policies, procedures, practices and internal structures which are designed to give assurance that the HSC body is fulfilling its essential obligations as a public body. Most of the requirements reflect those in place across the public sector, but a few have been instituted for reasons peculiar to the field of health and social care – notably the statutory duty of quality created by Article 34 of the HPSS (Quality, Improvement and Regulation) (NI) Order 2003. In addition to that obligation, the controls relate to: the existence of appropriate board roles, structures and capacity; corporate and business planning arrangements; risk management and internal controls; and monitoring and assurance of those processes.

6.5. All HSC bodies shall:

i adhere to the terms of the Accounting Officer appointment letter issued by the Department. This letter specifies the governance responsibilities and duties which the body owes to the Departmental Accounting Officer;

ii comply, in full, with the control framework requirements set out in the Management Statement/Financial Memorandum issued by the Department, in a form agreed by the Department of Finance and Personnel;

iii submit to the Department an annual Statement on Internal Control, signed by the Accounting Officer of the body, covering the range of issues in the standard form prescribed by the Department of Finance and Personnel, augmented by the additional health and social care-specific requirements set by the Department;

iv submit to the Department a mid-year assurance statement on control issues covering the same areas as the annual Statement on Internal Control;

v report as required on compliance with controls assurance and quality standards set by the Department including compliance with the Department's requirements for implementation of a risk management strategy and evidence that guidance on an assurance framework is being followed;

vi ensure that the appointment processes carried out by the body are demonstrably independent and free from external conflicts of interest;

vii adopt an Assurance Framework to strengthen board-level control and assurance in general, the Statement on Internal Control, and the mid-year assurance statement;

viii operate a board-approved scheme of delegated decision-making within the body based on systems of good practice updated by the Department;

ix ensure compliance with accepted or prescribed standards of public administration set by the Department – for example, in relation to equality of opportunity, equality legislation, complaints, etc;

x ensure compliance with the checklist of actions required of sponsor branches in the Department in obtaining assurance from their respective body's covering: roles and responsibilities; business planning and risk management; governance; and internal audit;

xi ensure compliance with procurement policy securing value for money, economically advantageous outcomes, equality of opportunity, sustainable development, etc., in accordance with the

policy framework set by the Executive and the Department of Finance and Personnel, key performance indicators set by the Department, the procurement strategy led by Regional Procurement Group (supported by BSO) and procurement under the Department's Infrastructure Strategy;

xii ensure that an Internal Audit function within each body operates to HM Treasury standards, including the requirement for external assessments, adhering to the professional qualifications, conduct and remit set out by the Department, and giving a comprehensive professional opinion from the chief internal auditor on the adequacy and effectiveness of the body's system of internal control;

xiii ensure implementation of agreed Northern Ireland Audit Office and Public Accounts Committee recommendations; and

xiv comply with the NI Executive's pay policy for the HSC e.g. arrangements for senior executive pay.

6.6. Compliance with the requirements at (i) – (x) are the subject of ongoing monitoring by the Department, and issues for resolution are resolved at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department.

6.7. In relation to the requirement at (xi) the Regional Procurement Group, supported by BSO, as a centre of procurement expertise, promotes and oversees implementation of the overall procurement strategy and monitors compliance with procurement policy, while the Department secures assurance on adherence to policy rules and achievement of key performance indicators. All capital infrastructure is procured in conjunction with the centre of procurement expertise within the Department.

6.8. Adherence to the requirement at with (xii) is subject to ad hoc scrutiny by

the Department's Head of Internal Audit, with issues resolved at bi-annual accountability reviews or through ad hoc action if deemed appropriate by the Department.

6.9. Compliance with (xiii) is the subject of ongoing monitoring by the Department (or HSCB or PHA as determined by the Department), with issues for resolution will be resolved at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department. Progress in relation to the recommendations is reported by the Department to the Northern Ireland Audit Office, Public Accounts Committee and the Department of Finance and Personnel.

6.10. Compliance at (xiv) is monitored by the Department, with issues for resolution addressed at bi-annual accountability reviews or through ad hoc action, if deemed appropriate by the Department.

Safety and Quality Dimension

6.11. Safety and quality covers a broad agenda, overlapping with many areas of operational performance and, to some extent, with financial performance and corporate control. It also applies to all programmes of care, including health improvement and health protection, and to infrastructure. This section describes assurance arrangements for specified elements of safety and quality, in particular, the arrangements for ensuring that HSC services are:

i safe - doing no harm to patients or clients and provided in an environment that is safe and clean;

ii effective - achieving agreed clinical and social care outcomes, which reflect high quality care and treatment and have a proven impact on health and wellbeing, especially prevention of poor health and wellbeing;

iii personalised - centred on the needs of individual patients clients and carers through their involvement in planning, delivery and evaluation.

6.12. Assurance to the Department and the Minister about the safety and quality of services is provided from a number of different sources. Each health and social body has clearly defined roles and responsibilities in this regard, which are summarised below.

6.13. The HSCB, working with the PHA on (i) to (viii) and (xii) below, is responsible for monitoring and reporting to the Department on:

i Compliance with Priorities for Action safety and quality requirements at least quarterly e.g. quality improvement plans;

ii Implementation of the RQIA and other independent safety and quality review recommendations in accordance with agreed plans;

iii Implementation of National Institute for Health and Clinical Excellence (NICE) technology appraisals endorsed by the Department;

iv Application by Trusts of lessons from adverse incidents and near misses (including those to be recorded on the PHA-managed RAIL system) and communicating, acting upon and reporting action taken in relation to safety information issued through the Northern Ireland Adverse Incident Centre Safety Alert Broadcast System (SABS);

v Evidence of provider-initiated action to improve safety and quality;

vi Family Practitioner Services' compliance with accepted standards e.g. clinical and social care governance arrangements, evidence of quality improvement, professional regulation and training and

development etc;

vii Trusts' compliance with accepted standards e.g. professional regulation and training and development (excluding those covered in para 6.14 (i) below);

viii Independent sector contracts related to waiting lists initiatives regarding for example conformity with clinical and social care governance arrangements and their performance on specified quality measures;

ix Independent sector contracts related to the provision of social care, regarding compliance with clinical and social care governance arrangements and specific quality standards;

x Implementation of statutory functions under agreed Schemes of Delegation;

xi Trust compliance with accepted standards for social care professionals e.g. professional regulation and training and development; and

xii Safety and quality aspects of HSCB contracts with independent sector providers.

6.14. The PHA is responsible for monitoring and reporting to the Department on:

i Trust compliance with accepted standards for medical, nursing and allied health professionals e.g. professional regulation and training and development; and

ii Compliance with statutory midwifery supervision requirements;

iii The identification and effective promulgation of learning from investigation of adverse incidents through the Regional Adverse Incident and Learning (RAIL) system and support for the development of quality improvement plans; and

iv Safety and quality aspects of PHA contracts with independent sector providers.

6.15. Joint Commissioning Teams led by the HSCB or PHA, as appropriate, are responsible for monitoring:

i Implementation of Service Frameworks;

ii Implementation of mandatory policy or guidance issued by the Department, which are not subject to formal performance arrangements, e.g. pandemic 'flu plans, quality of screening programmes, etc

iii Compliance with safety and quality and clinical and social care governance requirements specified by the commissioners of HSC services.

6.16. Trusts are responsible for monitoring independent sector contracts for health and social care to ensure compliance with relevant Departmental, HSCB or Trust guidance, including clinical and social care governance, relevant quality standards and arrangements to duly safeguard children and vulnerable adults.

6.17. The HSCB, working with the PHA, is responsible for monitoring Trust compliance with policies, standards and specific targets for the patient and client environment and support services including laundry and linen, catering, cleaning, portering and car parking.

6.18. The Department is responsible for monitoring:

i Compliance with policy, legislation and standards in respect of reusable medical devices;

ii Compliance with policy, legislation, standards and guidance in respect of the safe operation of life-critical healthcare-specific systems and processes.

6.19. In addition to assurance processes outlined above, the RQIA has an overall responsibility to encourage continuous improvement in the quality of health and social care across the public and independent health and social care sectors, against standards set by the Department, and to provide independent assurance on the quality of that care. When asked to do so by the Department it provides advice, reports or information on such matters relating to the provision of services or the exercise of its functions as may be specified in the Department's request. It may also, at any time, advise the Department on any changes which it thinks should be made in the minimum standards set by the Department. RQIA also undertakes a programme of planned thematic and governance reviews across a range of subject areas, examining services provided, and highlighting areas of good practice, and making recommendations for improvement and reporting lessons learned to the Department and the wider HSC. Such reviews may be conducted as part of RQIA's ongoing independent assessment of quality, safety and availability of HSC services or may be commissioned by the Department.

Finance Dimension

6.20. Appropriate financial accountability mechanisms are necessary to:

i Ensure that the optimum resources are secured from the Executive for health and social care;

ii Ensure the resources allocated by Minister/Department deliver the agreed outcomes and represent value for money;

iii Deliver and maintain financial stability, through effective operation of the financial accountability of Trusts via the HSCB to the Department;

iv Ensure that the commissioners can be assured that financing of services is managed on the agreed and approved basis set by the HSCB, its LCGs and the PHA;

v Facilitate the delivery of economic, effective and efficient services by rewarding planned activity that maximises effectiveness and quality and minimises cost; and

vi Facilitate the development of innovative and effective models of care.

6.21. All financial resources delegated by the Department to HSC bodies remain subject to the same standards of probity and accountability irrespective of where day-to-day management and control is vested.

6.22. All organisations are ultimately accountable to the Department for the achievement of overall financial balance. The Department monitors on a monthly basis the break-even performance of each organisation and, exceptionally, bids for unanticipated and inescapable in-year pressures. The HSCB monitors the performance and financial breakeven of Trusts, measuring against Service and Budget Agreements and delivery of service targets, reporting on its monitoring to the Department;

6.23. To guard against over-spending and minimise under-spending, the Department undertakes monthly monitoring of the overall HSC (and Departmental) financial position, reporting the evolving position to the Department of Finance and Personnel. The Department is also responsible for the strategic capital planning process and oversight of procurement and programme management, taking action where slippage or potential overspends become apparent. HSC Trusts are required to report on capital expenditure on a monthly basis and detailed liaison on projects is undertaken through quarterly Strategic Investment Group meetings.

6.24. The Department undertakes monitoring of the efficiency savings obligations contained in the Executive's Budget settlement. Each HSC body is required to provide such information in order to satisfy itself, and the Executive, that the conditions attached to the efficiencies are being met.

6.25. Trust Financial Returns and Strategic Resource Framework-related data, which provide essential information on expenditure on HSC services and contain cost comparisons across providers, continue to be produced under Departmental guidance. Responsibility for collation, analysis etc lies with HSCB.

6.26. The Department is responsible for keeping the counter-fraud strategy under review, and for the development and issuing of related guidance. It also approves publication of the annual fraud report and addresses performance issues relating to the counter-fraud assurance arrangements in each HSC body. It is for the BSO to maintain and provide to the Department all monitoring information that it, DFP or the NIAO may require. Each HSC body is required to comply with prescribed fraud prevention, fraud reporting, fraud investigation and other operational counter-fraud processes, availing itself of BSO support as appropriate.

6.27. The Department, informed by Department of Finance and Personnel, is the focal point for developing and cascading financial guidance, circulars and memoranda. This includes the specification of statutory and other reporting requirements.

Operational Performance and Service Improvement

6.28. Performance management and service improvement arrangements are those that are necessary to ensure the achievement of Government and ministerial objectives, standards and targets.

6.29. Section 8 of the Reform Act requires that the HSCB exercise its functions with the aim of improving the performance of HSC Trusts, by reference to such indicators as the Department may direct. In determining responsibilities for performance management and service improvement, the overriding principle is that, unless there is good reason to the contrary, as in the case of capital expenditure, estate management and Human Resources, all such functions should be undertaken by the HSCB because: this is a core function of the HSCB; it minimises the lines of accountability for providers; it maximises the 'breadth of sight' for the HSCB, allowing it to adopt a holistic view of performance taking account of all relevant factors.

6.30. Possible exceptions to this principle are areas for which the HSCB does not have lead responsibility, or where there is likely to be significant formal interaction with other Government departments, e.g. joint responsibility for the delivery of Public Service Agreement (PSA) targets (in which case the Department would take the lead on behalf of the HSC sector).

6.31. The HSCB is in the lead for monitoring and supporting providers in relation to the delivery of a wide range of HSC services and outcomes, with support from PHA professional staff. The PHA is in the lead for monitoring and supporting providers in the areas of health improvement, screening and health protection, with relevant support provided by the HSCB. The organisations are, therefore to establish and maintain a number of joint programme teams, consisting of relevant staff from each organisation.

6.32. In relation to the monitoring of provider performance, the resolution of any performance issues is a matter for the HSCB, in close co-operation with the PHA, escalating to the Department only if required.

6.33. With the approval of the Department, the HSCB and the PHA (where

appropriate) produce detailed practical definitions for the application of targets. They also put in place arrangements to: monitor progress against targets, assess risks to achievement; hold regular performance meetings with providers; and escalate risks as appropriate. The HSCB reports on this process to the Department to enable it to maintain an overview of performance in these areas. The HSCB also resolves performance issues, escalating to the Department only where such resolution cannot be achieved. Capital, estate management and human resource targets are performance managed by Department.

6.34. The HSCB is responsible for the collection of all routine information from HSC Trusts for performance monitoring or statistical publication purposes at agreed intervals and to agreed standards, and for providing this to the Department. This will minimise the potential for duplication and establish a clear, single channel for submission and validation of information

6.35. In pursuit of service improvements in their respective areas of responsibility, the HSCB and the PHA must:

i identify evidenced-based good practice and develop an annual programme of action;

ii take account of patient, client and carer experience, including lessons learnt from complaints;

iii lead regional reform programmes, issuing guidance and specifying required actions;

iv provide training and support;

v review Trust action plans;

vi provide support to individual providers to address specific issues

and manage provider-provider interfaces;

vii review implementation of reforms and make available any reports on progress;

viii make regular reports to the Department, as required, on their activities in this field.

6.36. Regarding Public Service Agreement targets, the Department is responsible for their development and agreement, and for reporting progress against them to the Office of the First Minister and Deputy First Minister and the Department of Finance and Personnel.

6.37. The Department sets HSC productivity and other HR-related targets and reports to Office of the First Minister and Deputy First Minister and the Department of Finance and Personnel on progress towards their achievement. The HSCB is responsible for the regular ongoing monitoring of progress by providers, addressing issues of under-performance where they arise, escalating to the Department only where necessary;

6.38. The European Working Time Directive has put in place compliance arrangements, for which the Department sets targets for the medical workforce. The HSCB monitors progress, addresses issues of under-performance and reports to Department on compliance and progress. It is for the HSCB to resolve any compliance etc issues, escalating matters to the Department's attention only where necessary.

6.39. The Department is responsible for setting targets and monitoring HSC Trust performance in relation to the level of compliance with policy, legislation, standards and guidance in respect of the management of the HSC estate. HSC Trusts are accountable for the practical application of such guidance etc, for the effective management of the associated operational risks, and for providing appropriate assurance as to the

discharge of these responsibilities. The Department has in place an appropriate review process to allow Trusts to report to the Department on a regular basis as to their overall management of the HSC estate.

Independent Challenge

6.40. In considering how the HSC system is held to account, special mention should be made of the Regulation and Quality Improvement Authority and the Patient and Client Council, both of which have a particular role to play. They each provide an independent perspective on the performance of the HSC system, one which validates and challenges the system's own performance management arrangements.

6.41. The RQIA focuses on the quality and safety of services, using statutory and other standards agreed by the Department to benchmark not only the services but also the governance frameworks within which they are provided. PCC focuses on the interests of patients, clients and carers in HSC services. This goes beyond a straightforward information or advocacy role; it includes working with HSC bodies to promote the active involvement of patients, clients, carers and communities in the design, delivery and evaluation of services. The RQIA and the PCC also have the power to look into specific aspects of health and social care and report their findings publicly to the Department.

6.42. Both of these organisations provide important independent assurance to the wider public about the quality, efficacy and accessibility of health and social care services and the extent to which they are focused on user needs.

7 Conclusio n

7.1 This Framework Document is a summary of the structures, functions and processes that underpin the planning, delivery and evaluation of health and social care services in Northern Ireland. It will be kept under continuous review in the light of emerging policy and legislation.

7.2 If you have any enquiries about the content of the Framework Document, please contact:

Office of Permanent Secretary
DHSSPS
Permanent.Secretary@dhsspsni.gov.uk

Appendix 10

DEPARTMENT OF HEALTH

MEMORANDUM
TEMPORARY AMENDMENT OF THE HEALTH AND SOCIAL CARE FRAMEWORK DOCUMENT FOR THE PERIOD JUNE 2020 TO May 2022

MEMORANDUM

Introduction

This memorandum describes temporary amendments made by the Department of Health to the Health and Social Care Framework Document (the Framework Document) which the Department has introduced for a period of up to 2 years with effect from June 2020. The amendments will be initially reviewed in January 2021 and thereafter kept under regular review by the Department. The two years period will be followed by a consultation on substantive and longer term changes to the Framework Document, reflecting both learning from this period, and the dissolution of the Health and Social Care Board (HSCB) which we anticipate to coincide with this timescale

The temporary amendments are made under the following Sections in the Health and Social Care (Reform) Act (Northern Ireland) 2009.

Department's general power

3.-(1) The Department may-

(a) provide, or secure the provision of, such health and social care as it considers appropriate for the purposes of discharging its duties under section 2; and,

(b) do anything else which is calculated to facilitate, or is conducive or Incidental, to the discharge of that duty.

Department's priorities and objectives

4.–(1) The Department shall determine, and may from time to time revise, its priorities and objectives for the provision of health and social care in Northern Ireland.

(2) Before determining or revising any priorities or objectives under this section, the Department must consult such bodies or persons as it thinks appropriate.

(3) Where the Department is of the opinion that because of the urgency of the matter it is necessary to act under subsection (1) without

consultation–

(a) subsection (2) does not apply; but

(b) the Department must as soon as reasonably practicable give notice to such bodies as it thinks appropriate of the grounds on which the Department formed that opinion.

The framework document

5. (3) The Department–

(a) shall keep the framework document under review; and

(b) may from time to time revise it.

Section 5. (5) In preparing the framework document, or any revision of it which appears to the Department to be significant, the Department must consult–

(a) each health and social care body as respects its functions (or persons considered by the Department to represent that body); and

(b) any other bodies or persons the Department considers appropriate.

(6) Each health and social care body shall have regard to the framework document in carrying out its functions.

In relation to Section 4(2) and Section 5(5) given the grave situation that Health and Social Care (HSC) is facing and the need therefore to move swiftly to begin the rebuilding of services, commencing from June 2020, the Department is engaging in an initial time limited sounding of the relevant bodies on the proposed temporary amendments and the establishment of the Management Board, to be followed by a 12 week consultation as soon as possible. While our normal practice would be to allow for a 12 weeks consultation period on such matters we are of the view that this two stage approach to engagement is reasonable and proportionate given the enormous rebuilding task that lies ahead and the need to implement this urgently.

Background

The Covid-19 pandemic has presented unprecedented challenges for the planning and delivery of HSC services in Northern Ireland, which prior to Covid-19 were already facing major strategic challenges in the form of an ageing population, increasing demand for services, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments. At the end of March 2020 there were some 307,000 patients on the outpatient waiting list, more than 93,000 waiting for inpatient and day case admissions and more than 131,000 patients waiting for diagnostic tests. The existing challenges confronting the social care sector, as described in the 'Power to People' report, have also been compounded by the pandemic.

Due to the need to redirect HSC resources to managing the Covid-19 pandemic, elective and diagnostic services have had to be curtailed with adverse impacts on the existing excessive waiting lists. The Department has collated a comprehensive assessment of the impact of Covid-19 covering the six weeks period from 9 March to 17 April 2020 across screening, primary care, community services, secondary care, and a wide range of programmes and projects. This detailed assessment indicates that the impact of the pandemic across HSC services, programmes and projects has been devastating, as resources have rightly been focused on the required emergency response. Further loss of service capacity is expected in the period from 18 April to 31 May 2020.

The impact of Covid-19 on HSC will be profound and long lasting. Covid-19 will be with us for some time and will continue to constrain service delivery across the HSC sector. Services will not be able to fully resume pre-Covid-19 delivery levels for some time due to the continued need to adhere to social distancing and for Personal Protective Equipment at volumes not required prior to the pandemic. In addition, the resilience of the HSC workforce is likely to have been eroded and will continue to be impacted with pressures particularly from the social care sector, which continues to be in the 'surge period'.

In the context of the situation described above, the HSC's overarching mission will be to incrementally increase HSC service capacity as quickly as possible across all programmes of care, within the prevailing Covid-19 conditions. The aim will be to maximise service activity within the context of managing the ongoing Covid-19 situation; embedding innovation and transformation; incorporating the Encompass programme; prioritising services; developing contingencies; and planning for the future all at the same time.

In order to achieve this mission the Department, through the temporary amendments to the Framework Document, and the establishment of a new Management Board, will give clear direction to the Health and Social Care Board (HSCB), Public Health Agency (PHA), Health and Social Care Trusts and the Business Services Organisation (BSO) of the Minister's priorities over the next two years to rebuild HSC services. To guide these bodies in this task the Department will publish a 'Strategic Framework for Rebuilding Health and Social Care Services' (the Strategic Framework). The Strategic Framework will address the adverse impact on the downturn of normal service delivery arising from the emergency plans that were introduced in March 2020 by HSC Trusts to respond to the surge in Covid-19 patients. The Strategic Framework will provide a basis on which to stabilise and restore service delivery as quickly as possible by requiring the above bodies to achieve the right balance between delivering Covid-19 and non-Covid-19 activity. The Department believes that it will take at least 2 years to achieve this, subject to the necessary investment being available and the effective management of Covid-19 during this period.

The temporary amendments to the Framework Document are therefore necessary to facilitate the optimum implementation of the Strategic Framework. In pursuance of this the Department re-commits to its statutory obligations for personal and public involvement and consultation while respecting the need for co-production with service users and the HSC workforce.

Amendments to the HSC Framework Document

The Department has produced the Framework Document to meet the statutory requirement placed upon it by the Health and Social Care (Reform) Act (NI) 2009. The Framework Document describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department. The Department has made the following temporary changes to the Framework Document.

Insertion of new paragraph 2.4 (all subsequent paragraphs are renumbered)

2.4 The Department has created a new temporary management board, the 'Management Board for Rebuilding HSC Services' which will come into being in June 2020 for a period of two years to be reviewed thereafter. The Management Board will report directly to the Minister and will be responsible for providing oversight and direction to the Health and Social Care Board (HSCB), the Public Health Agency (PHA), the Health and Social Care Trusts and the Business Services Organisation (BSO) on the implementation of the Department's 'Strategic Framework for Rebuilding HSC Services'. The Management Board will not exercise any other authority in relation to the statutory duties, roles and responsibilities, as specified in the Framework, Document which the Department has delegated to the HSCB, PHA and a number of other HSC bodies. The Management Board will be chaired by the Department's Permanent Secretary and its membership will be drawn from the Department's senior officials and other senior staff from across the HSC. The Minister's Special Adviser will attend meetings of the Management Board. The Minister and the Management Board will obtain advice from experts working in health and social care fields to inform its work in the rebuilding of HSC services as required.

Insertion of new paragraph 2.38 (all subsequent paragraphs are renumbered)

2.38 The Minister directs the HSCB, PHA, HSC Trusts and BSO that for the two year period commencing in June 2020 they are to prioritise their service planning, delivery and deployment of resources to stabilise and restore service delivery as quickly as possible by achieving the right balance between

delivering Covid-19 and non-Covid-19 activity. In pursuance of this priority the Commissioning Plan Direction (CPD), Commissioning Plan and associated Service and Budget Agreements (SBAs) for the 2019/20 financial year will be rolled forward into the years 2020/21 and 2021/22 and updated to reflect Departmental budget allocations in each of these years. Individual Trust Delivery Plans (TDP) for 2020/21 and 2021/22 should also prioritise activity designed to stabilise and restore service delivery as quickly as possible at the level of local commissioning and through regional collaboration with other Trusts guided by the Department's 'Strategic Framework for Rebuilding HSC Services'. The performance targets set out in the CPD, SBAs and TDPs for the financial year 2019/20 will be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the period of the Covid-19 emergency during the years 2020/21 and 2021/22.

Insertion of new paragraph 3.7 (all subsequent paragraphs are renumbered)

3.7 Paragraph 2.38 provides the overarching context for the implementation of the requirements in paragraphs 3.1 to 3.6 during the two year period commencing in June 2020.

Department of Health (NI)
June 2020

DIRECTION

2019 No. X

The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2019-2020

The Department of Health (DoH) [(a)], makes the following Direction in exercise of the powers conferred by sections 6, 8(3) and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009 [(b)]:

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2019 - 2020 and shall come into operation on 1 XXX 2019.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission, for the period 1 April 2019 to 31 March 2020, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include a summary of the financial allocations and set out how commissioning will serve to support the implementation of the Minister's strategic vision (as set out in Delivering Together) to transform the delivery of health and social care services. It should set out clear timescales and milestones for the delivery of commissioning intentions and the transformation of services.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board align with and support the implementation of the Minister's vision and delivery of priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998[(c)],

(a) Departments Act(Northern Ireland) 2016 c.5
(b) 2009 c.1 (N.I.) as amended by 2014 c.5
(c) 1998 c.47

the discharge of statutory duty of quality, delegated statutory functions and requirements under Personal and Public Involvement (PPI); and key Departmental standards, policies, strategies and guidelines.

3. The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will contribute to the four overarching strategic themes:

(a)*To improve the health of our citizens*.

(b)*To improve the quality and experience of health and social care.*

(c)*To ensure the sustainability of health and social care services provided*.

(d)*To support and empower staff delivering health and social care services*.

Performance indicators

4.In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the objectives and associated quality and performance indicators for the period April 2019 to March 2020.

5.The Regional Board shall record the information against the objectives and associated quality and performance indicators for the period April 2019 to March 2020.

Commissioning and the use of financial allocations

6.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from April 2019 to March 2020, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

Sealed with the Official Seal of the Department of Health on xxxxxx

Permanent Secretary
A senior officer of the Department of Health

Table of Contents

SCHEDULE

Objectives and Indicators for 2019 - 2020

Introduction

This Direction sets out the priorities, aims and improvement objectives for the HSC for the 2019/20 financial year. The achievement of the objectives set out in this Direction will; support the realisation of the vision for the future of health and social care as set out in "*Health and Wellbeing 2016: Delivering Together*"; contribute to the attainment of the aims of the *draft 2016 – 2021 Programme for Government* (in particular Outcome 4: "We enjoy long, healthy, active lives"), and underpin the Executive's population health framework "*Making Life Better*".

The Direction is structured around the four overarching and linked aims identified in *Delivering Together*, which acknowledge the challenges facing health and social care namely:

- to improve the health of the population;
- to improve the quality and experience of care;
- to ensure the sustainability of the services delivered; and
- to support and empower the staff delivering health and social care services.

Set out under each of the four *Delivering Together* aims are key objectives / goals that will progress the work to meet the future needs of the population and bring about a person centred model of care, including a shift from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

To allow progress towards each outcome to be tracked over time a number of associated quality and performance indicators have been identified against which the HSC should monitor progress and take improvement action as required. It is important to note that these indicators do not represent the totality of the information available to the HSC and the Department to ensure the smooth running of the system or inform the development, implementation and evaluation of policy.

The Commissioning Plan, developed in response to this Direction, must demonstrate how the services commissioned regionally and by LCGs in 2019/20 and beyond will contribute to the delivery of the four aims set out in *Delivering Together*, contribute to the identified outcomes in an integrated manner, sustain the pace of transformation and meet or exceed the specific objectives set out below.

Aim: To improve the health of the population

A key aim of the entire health and social care system in Northern Ireland is to improve the overall health and wellbeing of the population and to prevent ill-health. Whilst improvements have been noted, too many people still die prematurely or live with conditions that could have been prevented.

The strategic vision for future health and social care services seeks to support people to take greater control over their own lives and enable them to make healthy choices as well as helping to create an environment that makes such choices easier.

It is accepted that the health and social care service cannot do this in isolation and to achieve this aim we need to work with other partners across government and other sectors to tackle the root causes of ill-health and reduce health inequalities. Maximising the potential of the community planning process and other partnerships will be an important enabler. We will support the development of thriving and inclusive communities through working in partnership with communities and with other sectors.

The population health framework *"Making Life Better"* set the strategic context for the actions required from health organisations and other public bodies to improve health and reduce inequalities. Through implementation of this strategic framework, the Department of Health and other public bodies can create the conditions for individuals, families and communities to take greater control over their lives and be empowered and supported to lead healthy lives.

Key objectives/goals for the HSC for the period 2019/20 and beyond, to improve the health of the population, are set out at **Outcome 1 – Reduction of Health Inequalities.**

Outcome 1: Reduction of health inequalities

Achieving the aims of *Delivering Together* will result in the creation of an environment where people are supported to keep well in the first place. Through ensuring that people have the information, education and support to make informed choices around lifestyle, healthy eating, and the adoption of preventative actions such as maintaining good oral health we will empower people to take control of their own health and wellbeing and support them to stay healthy, well, safe and independent.

Work to support and enable healthy lives, and tackle the causes of health inequality spans the entire life course:

- helping pregnant women and their partners to make the choices that are best for them and their babies;
- ensuring that all children grow up in a stable and healthy environment;
- intervening early to provide support to families before issues become complex and difficult to reverse;
- supporting infant mental health;
- ensuring our young people are equipped for a healthy adulthood, and
- supporting people to continue to live active and healthy lives as they age.

Although we seek to address the needs of the entire population there are those who, at times, may require more focussed support such as people detained in prisons, the homeless, the travelling community and LGBT people.

Objectives/ goals for improvement:

Population Health

1.1 By March 2020, in line with the Department's ten year "*Tobacco Control Strategy*", to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.

1.2 By March 2020, to have commissioned an early years obesity prevention programme and rolled out a regionally consistent Physical Activity Referral Scheme. These programmes form part of the Departmental strategy, A Fitter Future for All, which aims by March 2022, to reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.

1.3 By March 2020, through implementation of the NI Breastfeeding Strategy increase the percentage of infants breastfed at discharge and 6 months as recorded in the Child Health System (CHS). This is an important element in the delivery of the "*Breastfeeding Strategy*" objectives for achievement by March 2025.

1.4 By March 2020, establish 3 "Healthy Places" demonstration programmes working with specialist services and partners across community, voluntary and statutory organisations to address local needs.

1.5 By March 2020, to ensure appropriate representation and input to the PHA/HSCB led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach.

1.6 By March 2020, to establish a baseline of the number of teeth extracted in children aged 3-5 years - as phase 1 of the work to improve the oral health of young children in Northern Ireland over the next 3 years and seek a reduction in extractions of 5%, against that baseline, by March 2021.

1.7 By March 2020, to commence the implementation of a regional prototype bariatric service, subject to the outcome of public consultation, business case approval and available funding in line with the implementation of recommendations set out in the Departmentally endorsed NICE guidance on weight management services.

Supporting Children and Young People

1.8 By March 2020, to have further developed, and implemented the "*Healthier Pregnancy*" approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation.

1.9 By March 2020, ensure the full delivery of the universal child health promotion programme for Northern Ireland, "*Healthy Child Healthy Future*". By that date:

- The antenatal contact will be delivered to all first time mothers.
- 95% of two year old reviews must be delivered.

These activities include the delivery of core contacts by Health Visitors and School Nurses which will enable and support children & young adults to become successful, healthy adults through the promotion of health and wellbeing.

1.10 By March 2020, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 "We give our children and young people the best start in life".

1.11 By March 2020 each HSC Trust will have established an Infant Mental Health Group and produced an Action Plan consistent with and informed by the "Infant Mental Health Framework for Northern Ireland" 2016."

1.12 By March 2020, the proportion of children in care for 12 months or longer with no placement change is at least 85%; and 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer them greater stability while in care.

Improving Mental Health

1.13 By March 2020, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a

Multi Agency Triage Team pilot (SEHSCT) and two Crisis De-escalation Service pilots (BHSCT & WHSCT) to test different models and approaches. Learning from these pilots should inform the development of crisis intervention services and support the reduction of the suicide rate by 10% by 2022 in line with the draft "*Protect Life 2 Strategy*".

1.14 By March 2020, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol and drug related harm and to reduce drug related deaths.

Supporting those with Long Term Conditions

1.15 By July 2020, to provide detailed implementation plans (to include recruitment status) for the regional implementation of the diabetes foot care pathway, plans should demonstrate an integrated approach making best use of all providers. Regional deployment of the care pathway will be an important milestone in the delivery of the "*Diabetes Strategic Framework*"

Associated quality and performance indicators

Population health (general)

A1 Healthy life expectancy.

A2 Average life expectancy for men and women.

A3 Life expectancy differential between the least deprived and most deprived areas in Northern Ireland, for men and women.

A4 Potential years of life lost from causes considered amenable to healthcare.

A5 Infant mortality.

A6 Age standardised death rate for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas.

A7 Maintenance of population vaccination coverage as reported in PHA Annual Report.

A8 Proportion of adults (aged 16+) consuming the recommended five portions of fruit and vegetables each day.

A9 Level of overweight and obesity across the life course (2 – 15) year olds and 16+.

Smoking

A10 Proportion of adults who smoke.

A11 Number of pregnant women, children and young people, and adults from deprived areas (lower quintile) who set a quit date through cessation services.

A12 Proportion of pregnant women who smoke.

Alcohol and substance misuse

A13 Proportion of adults who report having reached or exceeded the recommended weekly alcohol limit.

A14 Standardised rate of alcohol-related admissions to hospital within the acute programme of care.

A15 Standardised rate of drug-related admissions to hospital within the acute programme of care.

Child health and wellbeing

A16 Rate of births to mothers under 17 years of age (with breakdown against most deprived areas).

A17 Breastfeeding rate at discharge from hospital.

A18 Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.

A19 Proportion of looked after children who have experienced more than two placement changes. (Source is OC2)

A20 Length of time for best interest decision to be reached in the adoption process.

A21 Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type.

A22 Proportion of school-aged children who have been in care for 12 months or longer, who have a personal education plan.

A23 Percentage of care leavers aged 16 – 18 in education, training or employment by placement type.

A24 Percentage of care leavers at age 18, 19 and 20 years in education, training or employment.

Suicide and self-harm

A25 Achievement of the implementation of Protect Live 2 Strategy Action Plan (source Quarterly Project Board Highlight Reports)

A26 Number of ED repeat presentations due to deliberate self-harm.

A27 Self-reported mental health. (GHQ12 survey)

Long Term Conditions

A28 The number of unplanned admissions to hospital for adults with specified long-term conditions.

Aim: To improve the quality and experience of health and social care.

Delivering Together set out the roadmap for the transformation of health and social care services to deliver an integrated service capable of responding to future needs. Everyone in Northern Ireland will make use of those services at different points in their lives.

It is important that the HSC listens to and learns from their experiences, whether services are delivered well or things go wrong, and strives to ensure that everyone has a positive experience of the care or treatment they receive.

Quality 2020 provides the framework for the delivery of such services that are:

- centred on the needs of the patient/ client—everyone using HSC services should be treated with dignity and respect and should be fully involved in decisions about their treatment, care and support.
- safe—the care, treatment and support the HSC provides should never result in avoidable or preventable harm; and
- effective—everyone accessing HSC services should have the most appropriate treatment or care, in the most appropriate setting, with the best possible outcome.

Delivering Together confirmed the Minister's intention to build on Q2020 and other quality improvement work and to establish an Improvement Institute to better align existing resources in this important area.

Objectives / goals to address the quality and experience of health and social care are contained in the following Outcomes:

2 - People using health and social care services are safe from avoidable harm

3 - Improve the quality of the healthcare experience

4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

5 - People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

6 - Supporting those who care for others

Outcome 2: People using health and social care services are safe from avoidable harm

It is widely recognised that the design and delivery of health and social care must have quality and safety at its heart. The Expert Panel who produced the "*Systems not Structures*" report were clear that "any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this".

To meet this challenge the HSC needs to ensure alignment between quality improvement, partnership with those who use our services, and how we regulate those services. HSC working practices should proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs.

Objectives/ goals for improvement:

Safe in all Settings

2.1 By March 2020 all HSC Trusts should ensure safe and sustainable nurse staffing, including working towards the full implementation of phases 2, 3 and 4 of Delivering Care, maximising the use of any current or new funding, with an annual report submitted to HSC Trust Boards.

2.2 By 31 March 2020:

- Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 3%, as per the established recurring annual targets, taking 2018/19 as the baseline figure; and
- Using 2018/19 as the baseline, by March 2020 Trusts should secure the following in secondary care:
    - a reduction in total antibiotic prescribing (DDD per 1000 admissions) of 1-2%;
    - a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions;
    - a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions, and

    and EITHER

    - that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category,

    OR

    - an increase of 2% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use,

with the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 15% by 31 March 2024.

**For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.*

Safe in Hospital Settings

Reducing Gram-negative bloodstream infections

2.3 By 31 March 2020 secure an aggregate reduction of 17% of *Escherichia coli, Klebsiella spp.* and *Pseudomonas aeruginosa* bloodstream infections acquired after two days of hospital admission, compared to 2018/19.

2.4 In the year to March 2020 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of *Clostridium difficile* infection in patients aged 2 years and over, and in-patient episodes of Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection compared to 2018/19.

2.5 Throughout 2019/20 all clinical care teams should comprehensively scale and spread the implementation the NEWS KPI, and ensure effective and robust monitoring through clinical audit and ensure timely action is taken to respond to any signs of deterioration.

2.6 By March 2020, achieve full implementation of revised regionally standards, operational definitions and reporting schedules for falls and pressure ulcers across all adult inpatient areas.

2.7 By March 2020, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group.

Safe in Community Settings

2.8 During 2019/20 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.

Associated quality and performance indicators

Hospital Care

B1 Staffing levels as reported in regular reports from PHA Delivering Care Implementation Board.

B2 Number of records audited achieving 95% compliance of the accurately completed NEWS charts in all adult in-patient wards (excluding theatres and critical care departments).

B3 Number of incidents of hospital-acquired pressure ulcers (grade 3 and 4) occurring in all adult inpatient wards, and are classed as unavoidable from the current baseline data.

B4 Percentage compliance with the falls safe improvement bundle specified settings including adult acute inpatient and elderly care settings.

B5 Number of emergency admissions returning within seven days and within 8-30 days of discharge.

B6 Clinical causes of emergency readmissions (as a percentage of all admissions) for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF).

B7 Number of emergency readmissions with a diagnosis of venous thromboembolism.

B8 Number of emergency admissions and readmissions in which medicines were considered to have been the primary or contributing factor.

Community Care

B9 Number of revisits required to achieve compliance in (i) residential homes, (ii) nursing homes, in 2016/17 and 2017/18, as published by RQIA.

Outcome 3: Improve the quality of the healthcare experience.

The Health and Social Care system belongs to everyone and those providing services or availing of services can bring valuable insights into how it can best be organised and improved. Through working in partnership and utilising coproduction, patients, service users, families, staff, and politicians can all participate in the development of a person centred service which benefits us all.

In undertaking such work everyone who uses and delivers health and social care services should be treated with respect, listened to and supported to work as real partners.

Staff and patient voices from across the system should be aligned closely to the quality improvement, inspection and regulation systems to ensure issues are raised in as timely a manner as possible and addressed early: before they escalate to a complaint.

Objectives/ goals for improvement:

3.1 By March 2020, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment.

3.2 During 2019/20 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.

3.3 By September 2019, patients in all Trusts should have access to the Dementia portal.

3.4 By March 2020, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.

3.5 By March 2020 the HSC should ensure that the Regional Co-Production Guidance has been progressively implemented and embedded across all programme of care, this will include integrating PPI, Co-Production, and patient experience into a single organisational plan.

Associated quality and performance indicators

Palliative Care

C1 Implementation of a protocol to support the identification of patients with palliative and end of life care needs in Primary Care systems. [Source: PHA/ HSCB evaluation report of agreed protocol]

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

Timely access to the most appropriate services is considered a key indicator of quality and the patient experience. People rightly have an expectation that they should be seen and treated within a reasonable time in the most appropriate location. Prompt, early diagnosis and intervention can avoid the need for scarce acute sector services while supporting a high quality of life.

The way services are designed and delivered will continue to change, focussed on providing continuity of care in an organised and integrated way. Transformation will increasingly require working across traditional organisational boundaries within and outside the HSC, and the development of an environment characterised by trust, partnership and collaboration.

It will be important during the transition period that existing services are delivered to agreed standards, in a safe and timely fashion. The continued deployment of new performance/ accountability arrangements and associated Performance Improvement Trajectories will assist in securing steady improvement in existing services. Initially introduced in mid-2017/18 (covering elective, ED, Cancer services, mental health services and ambulance response times) the intention is to expand the arrangements to cover other CPD standards during 2018/19 and beyond.

Technology and new ways of working have a key role to play in transforming General Practice, including increasing access to GP services. Evidence from practices that have introduced telephone triage such as Ask My GP for example, suggests that this has helped increase the capacity to manage demand and consideration should be given to how such initiatives can be further developed and implemented.

Objectives/ goals for improvement:

<u>Primary Care and Community Setting</u>

4.1 By March 2020, to increase the number of available appointments in GP practices compared to 2018/19.

4.2 By March 2020, to have 95% of acute/ urgent calls to GP OOH triaged within 20 minutes.

4.3 By March 2020, reduce the number of unallocated family and children's social care cases by 20%.

<u>Ambulance Services</u>

The NI Ambulance Service faces growing demand for the services they provide. In response to this and other challenges the NIAS are transforming how they deliver their services. Although the introduction of new ways of working, such as Alternative

(or Appropriate) Care Pathways, has contributed to a reduction in the use of Acute Care facilities demand remains high for a prompt response to life threatening events.

4.4 Until the proposed adoption of a new clinical response model, when 72.5% of Category A (life threatening) calls should be responded to within 8 minutes, 67.5% in each LCG area, the HSCB should continue to work with the Trust to ensure performance is maintained at the previous target level.

Hospital Care Setting – Acute Care

When patients and service users need urgent treatment only provided in acute sector settings they often are frustrated by apparently lengthy treatment delays due the failure of the current service delivery model to provide a high quality service in a timely fashion.

The reform of community and hospital services so that they are organised to provide care where and when it is needed, in the most efficient manner, is a high priority. It is inevitable that the role of our hospitals will change as they focus on delivering the highest quality of specialist and acute care for patients across Northern Ireland. In responding to the objectives below it will be essential for the Commissioning Plan to demonstrate how such services are being transformed, with alternative models of care embedded across Northern Ireland: ensuring more people can be seen and treated effectively (including on a same/ next day basis), preventing unnecessary admissions to hospital, and supporting people to recover following periods of ill-health.

Proposals should include working towards the provision of the same level of care for inpatients seven days a week, the deployment of ambulatory care models, the utilisation of technology to provide timely access to specialist advice, cross trust collaboration, and the scaling up and rollout of proven new ways of care delivery.

4.5 By March 2020, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.

4.6 By March 2020, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

4.7 By March 2020, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

4.8 By March 2020, ensure that at least 16% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

4.9 By March 2020, all urgent diagnostic tests should be reported on within two days.

4.10 During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently

referred with a suspected cancer should begin their first definitive treatment within 62 days.

Hospital Care Setting – Elective Care

Often patients are referred to specialists for medical or surgical treatment of non-urgent or non-life threatening conditions that nevertheless require medical or surgical intervention. People rightly have an expectation that they should be seen and treated within a reasonable time. However, over the last number of years, meeting the rising demand has been challenging and it is clear that the current service model is no longer suitable.

The longer term goal set out in *Delivering Together* is to significantly reduce the current waiting times for assessment, diagnosis and treatment that have been described as unacceptable. The aim of the introduction of new ways of working, such as Elective Care Centres and Assessment and Treatment Centres, is to return to the maximum waiting times of nine and thirteen weeks that have previously been achieved.

In recognition that the introduction of a sustainable model, in a safe manner, must be undertaken methodically, the goals below represent realistic and achievable objectives that deliver stability.

4.11 By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.

4.12 By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

4.13 By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.

4.14 By March 2020, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Associated quality and performance indicators

Primary Care

D1 The number of contacts per 1,000 patients per week, for each GP practice contracting to provide the NILES Demand Management, through submission of a survey to HSCB.

D2 Percentage of routine GP "out of hours" calls triaged within one hour.

D3 Total out of hours GP attendances.

D4 Number of GP referrals to emergency departments.

NI Ambulance Service

D5 Number of ambulance responses where the outcome is that the patient does not attend hospital.

D6 (i) Patient handover times and (ii) ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes).

D7 Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital.

Acute Care

D8 Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to 12 hours and 12 hours or more, before being treated and discharged or admitted.

D9 Total time spent in emergency departments including the median, 95th percentile and single longest time spent by patients in the department, for admitted and non-admitted patients.

D10 (a)Number and percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes; (b) time from arrival to triage (initial assessment) for (i) ambulance arrivals and (ii) all arrivals; and (c) time from triage (initial assessment) to start of treatment in emergency departments.

D11 Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage scale at Type 1 or 2 Emergency Departments.

D12 Time waited in emergency departments between decision to admit and admission including the median, 95th percentile and single longest time.

D13 Percentage of people who leave the emergency department before their treatment is complete.

D14 Percentage of unplanned re-attendances at emergency departments within seven days of original attendance.

Stroke

D15 Average length of stay for stroke patients.

D16 90% admission to stroke unit within 4 hours of arrival.

D17 60% discharged to community stroke teams and 40% of these should be Early Supported Discharge.

D18 100% of eligible patients should be reviewed at 6 months.

[As reported in HSCB Stroke Dashboard]

Elective Care

D19 Number of GP and other referrals to consultant-led outpatient services.

D20 Percentage of routine diagnostic tests reported on (i) within two weeks and (ii) within four weeks of the test being undertaken.

Specialist drug therapies

D21 Number of patients waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.

D22 Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for Multiple Sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.

D23 Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye, and six weeks for the second eye.

Maternity

D24 Intervention rates, including percentage of babies born by caesarean sections.

D25 Number of babies born in midwife-led units.

Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

Successful implementation of a person centred model of care will rely on a comprehensive understanding of what is important to those delivering care and those receiving that care.

It will therefore be important that the principle of coproduction is at the heart of new initiatives for those with long term conditions, and that patients and service users are partners in the care they receive with a focus on increased self-management and choice.

Objectives/ goals for improvement

Increased Choice

5.1 By March 2020, secure a 10% increase in the number of direct payments to all service users.

5.2 By September 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.

Access to Services

5.3 By March 2020, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

5.4 By March 2020, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.

5.5 By March 2020, Direct Access Physiotherapy service will be rolled out across all Health and Social Care Trusts on a state of readiness basis.

5.6 By March 2020, to have published the Children and Young People's Emotional Health and Wellbeing Framework for school-aged children and young people in Northern Ireland.

Care in Acute Settings

5.7 During 2019/20, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

Associated quality and performance indicators

Supporting Independence

E1 Number of client referrals passed to reablement; number of clients starting a reablement scheme; and number of clients discharged from reablement with no on-going care package required'.

Patient Discharge

E2 Percentage of learning disability and mental health discharges that take place within seven days of the patient being assessed as medically fit for discharge.

E3 Number of learning disability and mental health discharges that take place after 28 days of the patient being assessed as medically fit for discharge.

Outcome 6: Supporting those who care for others

Carers are vital partners in providing care and it is important that they are supported while carrying out their caring responsibilities. The contribution of informal carers is crucial to the ability of people who require assistance to live independently in the community.

As the needs of carers continues to change, the type of support required must keep pace with that change. It will be important that they can strike a balance between the duties of the caring role and their right to live their own life and pursue their own goals and interests.

Objectives/ goals for improvement

6.1 By March 2020, secure a 10% increase (based on 2018/19 figures) in the number of carers' assessments offered to carers for all service users.

6.2 By March 2020, secure a 5% increase (based on 2018/19 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.

6.3 By March 2020, secure a 5% increase on the number of young carers attending day or overnight short break activities.

Associated quality and performance indicators

F1 Number of carers assessments offered, by Programme of Care.

F2 Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.

Aim: Ensure the sustainability of health and social care services provided

The objectives set out under the first two aims seek to improve the health of the Northern Ireland population and the quality of health and social care services provided to patients and service users. It is essential that these overarching aims are achieved within the resources available to the HSC.

The existing pressures and challenges arising from growing demand, patients living longer with complex needs, and an aging population have not diminished. Therefore services must operate as efficiently and effectively as possible, and provide the best possible outcome for patients.

However, operating existing services efficiently is not enough to meet the growing demand and it is clear that the HSC must change how health and social care services are delivered.

This will mean working with a system focus and in an integrated way that makes best use of the expertise and resources of all health and social care providers, and allows innovative ways of working to develop.

The Commissioning Plan should demonstrate that currently commissioned services represent the most efficient use of resources and outline how benchmarking of productivity and efficiency measures across providers has informed commissioning decisions. In addition, it should detail the steps being taken to bring about change that will provide the highest quality care in a cost effective manner—on the basis of single solutions for the region.

Key actions required of the HSC for the period 2019/20 and beyond, to provide sustainable health and social care services, are contained in the objectives set out in **Outcome 7 – Ensure the sustainability of health and social care services.**

Outcome 7: Ensure the sustainability of health and social care services

Established health and social care services are often accompanied by a plethora of checks, lists and forms developed over time to address particular issues.

Transforming such services and the bureaucracy around them, through investment in technology enabled business solutions such as encompass, will harmonise and standardise care and information processes. Such investment will ensure our staff have the required information at hand and are empowered to efficiently deliver a person centred model of care.

While awaiting the introduction of new business solutions it remains important to maximise the impact of the available resources to deliver the best patient outcomes, particularly in the facing of increasing financial pressures. HSC Trusts should therefore continue to develop multi-disciplinary, team-based approaches to delivering care aligned with GP Practices.

The HSCB, PHA and Trusts should demonstrate how they ensure services are operated in an optimal manner, and that all urgent patients referrals are prioritised and, thereafter, that all routine patients are seen in strict chronological order.

To reduce the impact of long waiting lists it will be important to maximise attendance rates, with outpatient appointment dates booked no more than six weeks in advance, and outpatient review appointments only taking place where there is a clear clinical need.

Objectives/ goals for improvement

Primary and Community setting

7.1 By March 2020, to ensure delivery of community pharmacy services in line with financial envelope.

7.2 By March 2020 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users and the baseline activity to measure this.

Hospital Setting

While demand for services continues to grow it is imperative that, in the short term, the HSC makes efficient use of the resources available.

7.3 By March 2020, to establish a baseline of the number of hospital cancelled, consultant led, outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment and by March 2020 seek a reduction of 5%.

7.4 By March 2020, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

7.5 By March 2020, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

7.6 By March 2020, to have obtained savings of at least £20m through the Medicines Optimisation Programme, separate from PPRS receipts.

Associated quality and performance indicators

Hospital efficiency

G1 Number, rate and ratio of new and review outpatient appointments cancelled by hospitals resulting in the patient waiting longer.

G2 Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient resulting in the patient waiting longer.

G3 Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust.

G4 Number of outpatient appointments with procedures (for selected specialties).

G5 Day surgery rate for each of a basket of 24 elective procedures to continue monitoring performance and enable continued benchmarking with rest of UK.

G6 Percentage of patients admitted electively who have their surgery on the same day as admission.

G7 Elective average pre-operative stay.

G8 Percentage of operations cancelled for non-clinical reasons.

G9 Elective average length of stay in acute programme of care.

G10 Excess bed days for the acute programme of care.

G11 Cost of a basket of 24 elective procedures (Day surgery as per G5) by Trust.

Prescribing efficiency

G12 Level of compliance of GP practices and HSC Trusts with the NI Medicines Formulary; and prescribing activity for generic prescribing and dispensing rates.

Aim: Support and empower staff delivering health and social care services

Those who work tirelessly, and with great skill and dedication, to provide our health and social care services are the HSC's most valuable resource. It is vital that the HSC invests in their future and ensures their health and wellbeing is valued and protected.

As the implementation of *Delivering Together* moves forward it is important to have an optimally sized and resourced workforce, with the right skills mix in place to deliver both the existing, commissioned services, promote health and wellbeing and support the transformation work.

In May 2018, the Department, as an outworking of Delivering Together, published the 'health and social care Workforce Strategy 2026', with the aim of meeting our workforce needs – and the needs of the workforce. The Commissioning Plan needs to take the aim, objectives, themes and actions of the strategy into account, and detail how resources will be allocated to support the implementation of the strategy.

While HSC staff include some of the most capable, committed and enthusiastic people in the public sector, the Expert Panel Report was clear that in order to bring about the required transformation they would be asked to change how they undertake their work and would need to develop new skills.

In order to embed the required culture of learning, quality improvement and partnership working throughout the HSC it will be necessary to develop Leadership and Change Management skills, critical to the successful delivery of the required transformation, across the range of health and social care staff and key independent practitioners. These skills will be delivered through the implementation of the HSC-wide Collective Leadership Strategy, and the values which underpin it. The Commissioning Plan should detail how resources will allocated to support the implementation of this work.

Key actions required of the HSC for the period 2019/20 and beyond, to support and develop the capabilities of HSC staff, are contained in the objectives set out in **Outcome 8 – Supporting and transforming the HSC workforce.**

Outcome 8: Supporting and transforming the HSC workforce

The HSC competes with other employers to secure the skills and talents of the best people. It must therefore become an employer and trainer of choice; leading by example; investing in the wellbeing of staff, and making a tangible and positive contribution to the health and wellbeing of not only health and social care staff but society as a whole.

The HSC can realise these goals through supporting the staff who deliver vital health and social care services and seeking to bring about positive change. Continued investment in training and development initiatives, along with the development of new multidisciplinary training programmes that maximise the effectiveness of the workforce will assist in achieving those outcomes.

The implementation of the Workforce Strategy will demonstrate to our health and social care workers that the transformation set out in *Delivering Together* is underway. The actions for 2019/20 described below will contribute to ensuring that an adequately-resourced and skilled workforce is available to take forward work to discharge departmental Programme for Government commitments.

Objectives/ goals for improvement

Implementing the Workforce Strategy

8.1 Contribute to delivery of Phase One of the single lead employer project by 31 July 2019 and Phase 2 by 31 January 2020; in line with the requirements set down by the Department.

Attracting, recruiting and retaining staff

8.2 By June 2019, to provide appropriate representation on the project board to establish a health and social care careers service.

Effective workforce planning

8.3 By March 2020, to have completed the first phase of the implementation of the domiciliary care workforce review.

8.4 By June 2019, to provide appropriate representation to the project to produce a health and social care workforce model.

Build on, consolidate and promote workforce health and wellbeing and staff engagement

8.5 By March 2020, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10 – 14 of the Workforce Strategy.

Supporting our staff

8.6 By January 2020, to ensure at least 50% of Trust frontline healthcare staff and at least 40% of Trust frontline social care staff have received the seasonal flu vaccine.

8.7 By March 2020, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2018/19 figure.

8.8 During 2019/2020 a workforce review of the social work workforce will be progressed to inform future supply needs and commissioning of professional training (subject to resource availability).

8.9 By March 2020, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG.

8.10 Improve take up in annual appraisal of performance during 2019/20 by 5% on previous year towards meeting existing targets (95% of medical staff and 80% of other staff).

Investing in our staff

8.11 By March 2020, 60% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2 by March 2020.

8.12 By March 2020, to have developed and commenced implementation of a regional training framework which will include suicide awareness and suicide intervention for all HSC staff with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services & mental health/addiction services) by 2022 in line with the draft Protect Life 2 strategy.

8.13 By March 2020, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts.

Associated quality and performance indicators

Sickness Absence

H1 Uptake of seasonal flu vaccine by frontline health and social care workers (as reported in PHA return to Dept).

H2 Percentage of HSC hours lost due to sick absence.

H3 Percentage of HSC staff trained in suicide awareness / prevention.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2019/20

1. The vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the vision and priorities during the year 1st April 2019 to 31st March 2020.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2019/20 financial year are resourced.

4. The objectives and indicators included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.

5. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

Health and Social Care Board

Public Health Agency

Draft Commissioning Plan 2019/20

August 2019

FINAL

Contents

FOREWORD

This Commissioning Plan (the Plan) describes the actions that will be taken across health and social care during the current financial year to ensure continued improvement in the health and wellbeing of the people of Northern Ireland, within the available resources. The Plan has been developed in partnership by the Health and Social Care Board (Board) and the Public Health Agency (Agency), and responds to the Department of Health (DoH) Commissioning Plan Direction.

Driving improvement in population health and in health and social care services underpins all the objectives contained within the Plan. The 2019/20 Plan sets out measures to promote good health and well-being, prevent illness, prevent harm to those receiving care and prevent complications of long term conditions. In essence the Plan sets out the priorities for health and social care to improve the experience of people at all stages of their life and their healthcare journey.

Specifically, the Plan identifies the key priority areas to be commissioned regionally and locally, with a particular emphasis on how providers will respond to demographic changes, service risks to the delivery of the modernisation and transformation agenda

It should be noted that the Plan does not seek to include all of the work being taken forward by Board and Agency in the current financial year. Rather, the Plan focusses on a number of key strategic and service priorities which are likely to yield the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level.

The Commissioning Plan has been produced within a challenging commissioning and financial context with continuing direct oversight by the Department. The Plan outlines a number of key investments to be made in 2019/20 consistent with prior discussion with the Department. Trusts have already been provided with indicative financial allocations for 2019/20 – from these allocations Trusts are

required to respond appropriately to the changing patient and client needs and to the specific service pressures identified within the Plan.

On behalf of the Board and Agency I would like to express my thanks to those across the health and social care sector who contributed to this Plan and who, on an ongoing basis, contribute to the successful delivery of our health and social care services and to improving the health of people in Northern Ireland.

VALERIE WATTS
Chief Executive,
HSCB & PHA

1.0 INTRODUCTION AND CONTEXT

1.1 The Purpose of the Plan

The Commissioning Plan sets out the priorities to be taken forward by Health and Social Care (HSC) and providers. The Plan has been developed in partnership by the Health and Social Care Board (Board) and the Public Health Agency (Agency), and responds to the Department of Health's 2019/20 draft Commissioning Plan Direction (CPD). In compiling the Commissioning Plan (the Plan), a collaborative approach was adopted by the Board and Agency with information, input and guidance drawn from a diverse and wide range of stakeholders. The priorities outlined within the Commissioning Plan also take account of the 2019/20 investments (Section 3).

The Plan also responds to the 2019/20 CPD which provides the context for commissioning through a number of themes, aims, outcomes and objectives. The Plan specifically responds to each of these areas within Section 4. In line with established commissioning arrangements, the Plan provides an overview of the system wide commissioning priorities for 2019/20 (Section 5) together with detail on the priorities at a local level (Section 6) as identified by Local Commissioning Groups (LCG). Outcomes from each detailing where the Plan responds to each of the CPD objectives can be found in Appendix 2. The Plan does not seek to highlight all of the work being taken forward by the Board, Agency and wider HSC system in 2019/20, instead focussing on the priority areas for development.

Throughout the Plan, explicit reference is made to the Board and Agency's specific priorities in relation to strategic service developments, patient pathways, transforming services and skill mix/workforce initiatives. Service providers will be expected to provide detailed delivery plans which respond to these priorities through TDPs or ICP work plans.

The financial allocation for 2019/20 includes a block sum to Trusts and as such the Plan assumes the 2018/19 commissioned values and volumes as a baseline. It is expected that relevant values and volumes will be amended following the

submission of the TDPs, which should reflect revised activity in light of investments.

1.2 Emerging issues within Health and Social Care

The context in which health and social care services are delivered continues to change year on year and at an increasing pace. Examples of these changes, many of which create significant challenges include:

- Improvements in healthcare, including developing technological advances including (Artificial Intelligence and Pharmaceutical developments).
- Increasing public expectations;
- Increasing demand for services and insufficient capacity to meet those demands across many areas of health and social care;
- Addressing health inequalities;
- Taking forward Departmental reviews and consultations;
- Aging population, particularly those over 85 including frail elderly;
- Increase in people with co-morbidities and long term conditions;
- Workforce challenges evident across the spectrum of children's services and in particular the retention and availability of social workers;
- Growth in the numbers of children and families requiring early intervention services;
- Increased demand for placements for children in the care of the state;

The role of the Board and Agency through the Commissioning Plan is to respond by commissioning services which meet the changing needs and expectations of the local population in partnership with other providers and sectors. Further information on the demographic and social changes highlighted above can be found in Section 2.

1.3 Delivering on Key Policies, Strategies and Initiatives

1.3.1 Transforming Services

Delivering Together provides the roadmap to take forward the work of transformation, reform and modernisation across the HSC system:

Delivering Together

Since the publication of *Delivering Together* in October 2016, progress has been made in implementing the following:

Building capacity in communities and in prevention, including:

- Support for vulnerable families and children;
- Early Prevention and supporting people to stay well – physically, mentally and emotionally;
- Improve the quality and safety of services provided by nursing and residential homes;
- Roll out of the *Community Resuscitation Programme.*

The 2019/20 Commissioning Plan includes specific objectives (Section 5) that build on current developments.

Providing more support in primary care, including:

- Primary Care Multi-Disciplinary teams have now been established in Down, Derry/Londonderry and West Belfast GP Federation areas;
- Further expanding the Multi-Disciplinary teams with regard to skill mix;
- Working at scale in terms of rolling out new initiatives to all 17 GP Federations.

The 2019/20 Commissioning Plan asks Integrated Care providers to detail relevant service developments.

Reforming our community and hospital services, including:

- Elective Care including the introduction of GP led services in vasectomy and enhanced minor surgery services, and the reduction of waiting lists;
- Unscheduled Care including Acute Care at Home;
- Reform of Adult and Social Care Support;
- Mental Health Services;
- Daisy Hill Pathfinder Project;
- Fermanagh and West Tyrone Pathfinder;
- Reconfiguration of Stroke, Diabetes, Pathology, Breast Assessment, Plastics and Burns, Cancer and Neurology Services;
- Continued implementation of the Paediatric Strategy;
- New Clinical Response Model for the Northern Ireland Ambulance Service.

There are a number of key service reforms being progressed as part of *Delivering Together.* The Plan sets out how many of these initiatives will continue to be taken forward in 2019/20 to ensure Northern Ireland continues to have quality services which are safe and sustainable in the medium to long term.

Power to People

In December 2016, an Expert Panel was established to provide an independent perspective on possible solutions to meet the challenges facing the adult care and support system in Northern Ireland and to ultimately develop proposals for reforming the system. The Panel's 16 proposals on how to reform the adult care and support system are contained in the report '*Power to People: proposals to reboot adult care and support in NI'*, which was published in December 2017.

The proposals contained in the Expert Advisory Panel in Adult Care and Support, remain under consideration by the Department of Health. However, work has begun to ensure a state of readiness against the underpinning principles behind the various proposals. This includes work in relation to the value of social care; keeping the citizen at the heart of what we do; supporting family carers; and building resilient communities.

Children's Services

Following the regional review of specialist regional facilities within children's social care services a number of transformative initiatives are being progressed. This includes strengthening core placement services such as the introduction of residential peripatetic support services, a regional approach to the recruitment and retention of foster carers, development of specialist targeted foster carers for separated and unaccompanied children. The recommendations of the Review of Residential Services has put in place a substantial transformative agenda, enjoining two departments, DoJ and DoH, who will lead on the transformation agenda and implementation of the recommendations. This work will be closely aligned to the wider transformation of children's services.

1.3.2 Achievement of Departmental Objectives

The CPD sets out the key aims, outcomes and objectives for the HSC system in 2019/20. While there are a number of performance targets within the CPD which, due to the current level of performance and wider financial challenges, will not be achievable in 2019/20, the Board and Agency will continue to work with Trusts to maximise performance, share good practice to improve services and facilitate regional approaches to address service delivery challenges. A Commissioning Plan Direction Outcomes Framework detailing where information can be found on specific objectives is at Appendix 2.

1.3.3 Commissioning for Outcomes

Access to health and social care services is essential for the population's health outcomes, but lifestyle, environment, education and income are even more important. A focus on the outcomes for the Northern Ireland population set out in the draft Programme for Government and the CPD requires a concerted effort on the part of individuals, local communities and institutions. An outcomes-based approach begins with broad agreed goals and asks what contribution each partner can make to achieving these. While the number of people who benefit and the quality of their experience of the delivery of services are important, the impact which the action makes on the wellbeing of the population is equally important.

The Board and Agency work with other partners, including through community planning partnerships, to commission and evaluate an increasing range of services on the basis of their contribution in improving population outcomes.

Outcomes Groups

Five outcomes groups (covering the five Trust areas) work to coordinate Early Intervention Family Support Services. This includes support to parents and direct support to children, young people and families. The outcomes groups are committed to developing effective links between universal services and early intervention family support.

Universal Services includes midwifery, health visiting and GP services and give children and young people the best start in Life. They help provide a range of Early Prevention and Intervention Programmes, for example, Getting Ready for Baby Programme for first time parents and Family Nurse Partnership for Young Parents. For families who require additional support, a range of services include allied health professional services and family support hubs.

Meeting the needs of the most vulnerable children in Northern Ireland is a key priority for the Outcomes Groups and partners are committed to liaising with the Outcomes Groups in the development of new early intervention initiatives and changes to existing arrangements.

Linked to this network the Board and Agency has allocated £100,000 to each outcomes group to commission early intervention family support services. The detail in regard to the specific Commissioning intentions can be found in Section 5 of the Plan.

1.4 Supporting the HSC Workforce

A key part of improving care quality is ensuring that those who deliver care are themselves well looked after and provided with the tools to discharge their duties effectively. *Delivering Together* re-affirmed that effective workforce engagement and planning are key enablers for transforming HSC services. As part of this vision the Board and Agency will continue to work with the DoH and

key stakeholders in the implementation of the *Health and Social Care Workforce Strategy 2026*[1] for Northern Ireland (CPD 8.5).

1.5 Improving Patient Pathways

Patient pathways are a way of setting out a process of best practice to be followed in the treatment of a patient or client with a particular condition or with particular needs. How these care pathways are developed, implemented and reviewed can have a significant impact on the care a patient will receive. It is important that care pathways are regularly reviewed and updated in line with available best practice guidance e.g. NICE, using innovative service improvement methodologies.

During 2019/20, plans will be put in place to continue to improve and transform pathways across elective care, unscheduled care, community services, social services and primary care settings. Further detail can be found within the Patient Pathways priorities highlighted in each of the service areas within Section 5.

1.6 Community Planning

The Commissioning Plan for 2019/20 takes account of community planning as a mechanism to provide change and to improve the health and wellbeing of the population.

In April 2015, the reform of Local Government resulted in the creation of 11 new councils. The new councils were given the responsibility of leading the community planning process for their area. Community plans identify long-term priorities for improving the social, economic and environmental well-being of the local area and the people who live there.

Community Planning Partnerships have been established comprising the council, statutory bodies, agencies and the wider community, including the community and voluntary sector. All 11 Community Plans, have now been agreed and

[1] https://www.health-ni.gov.uk/sites/default/files/publications/health/hsc-workforce-strategy-2016.pdf

launched. Local councils are all at different stages in action planning, using working groups and engagement and consultation to develop the plans. Each of the structures include a sub group with a focus on health and wellbeing and HSC colleagues are working locally and regionally to maintain a consistent approach ensuring that actions are reflective of strategic direction and are evidence based.

Work will continue to roll out approaches such as Ageing Well/ Age Friendly/Dementia Friendly; Take Five; initiatives which increase opportunities for participation in physical activity and promote healthy eating; the promotion and expansion of health literacy; the development of local environmental assets to increase physical activity and improve mental health and the promotion of volunteering, together with many more initiatives which will impact on the health and wellbeing of local communities over the coming years. The opportunities which Community Planning Partnerships present for enabling change and improvement of health and social care services will continue to be explored in collaboration with community planning partners and communities. There are 27 Locality Planning Groups as part of the Children and Young People's Strategic Partnership focus on developing and supporting multi-agency early intervention approaches. These groups work to support early intervention for populations. All of Northern Ireland is covered by this network.

Locality planning is about improving outcomes for children, young people and families at a local geographic level. It focuses on how service delivery organisations can engage more effectively with the community to better understand local issues and to work together to produce more effective responses to those issues.

Further detail on how the Board and Agency is involved in Community Planning including specific commissioning intentions for 2019/20 can be found within Section 6 of the Plan.

1.7 Co-Production, Personal & Public Involvement and Patient & Client Experience

Personal and Public Involvement (PPI) has been a statutory duty in the HSC since its inclusion in the HSC Reform Act in 2009. The advances achieved through the promotion and adoption of the PPI policy has been instrumental in helping to move towards achieving a culture change. The experience and expertise of the service user and carer is respected and regarded as equally valuable to those within HSC organisations and this will be further integrated as we move to embed co-production.

Delivering Together identifies partnership working as one of the five enablers in the delivery of HSC transformation. Leadership is vital to achieving success. The DoH published the HSC Collective Leadership strategy.[2] The implementation of this strategy in partnership should improve health and wellbeing for the people of Northern Ireland by harnessing the HSC system's strengths by working collaboratively and effectively across traditional boundaries.

The identified role of service users as informal leadership is identified as a key driver in service transformation in Northern Ireland to deliver interdependent, collaborative system leadership.

The DoH has produced a Co-production guide, *Connecting and Realising Value Through People*, which provides HSC organisations with a framework to further embed genuine partnership working in all planning and decision making processes. *Delivering Together* commits health and social care to:

- Adopt the co-production and co-design model for the development of new and reconfigured services;
- Maximise the lived experience (patient and carer) voice across the system;
- Engage staff, particularly those with relevant experience of using specific services.

[2] www.health-ni.gov.uk/sites/default/files/publications/health/hsc-collective-leadership-strategy.pdf (October 2017)

- Work with other providers of care, including those in the community and voluntary sector.

Set within PPI legislation, co-production creates the opportunity for people to work in genuine partnership and to take shared responsibility for improving health and social care outcomes. This requires a commitment to create opportunities for shared decision making to enable partnership working. This involves sharing information and developing collective evidenced based solutions.

The principle of shared decision making is deeply rooted in equality of opportunity for people who use services and those who provide them to influence decisions about health and wellbeing. As coproduction develops shared decision making should become the accepted approach in the design of services.

Whilst recognising that shared decision making does not mean everyone has the same authority, co-production seeks to empower partners to take shared ownership for the delivery of health and social care outcomes. This does not remove or dilute statutory accountability, however leaders act as catalysts in facilitating transformation by empowering people to work together to generate improvements in outcomes for the population. Objectives in regard to promoting co-production are demonstrated within the priorities set out in Section 5 of the plan.

2.0 CHANGING CONTEXT OF HEALTH AND SOCIAL CARE

As highlighted in Section 1, Health and Social Care in Northern Ireland continues to experience change within the context that services are delivered. This section provides a high level overview of some of these demographic and social changes. These drivers help to inform the regional and local commissioning priorities set out within Sections 5 and 6 of the Plan.

It is important that services are commissioned to respond to the assessed needs of the population, taking into account the limited resources available.

A key aspect in determining the needs of many health and social care services is the size and age distribution of the local population. The Board and Agency engage with their partners in the health and social care community to identify the needs of the communities we serve. This involves collating information about our changing population including age, ethnicity, life expectancy and a wide range of health measures. The aim is to ensure that the Board and Agency have the optimum health care intelligence available, to enable them to plan and secure the most appropriate treatments, services and support, to the local population.

2.1 Current Population

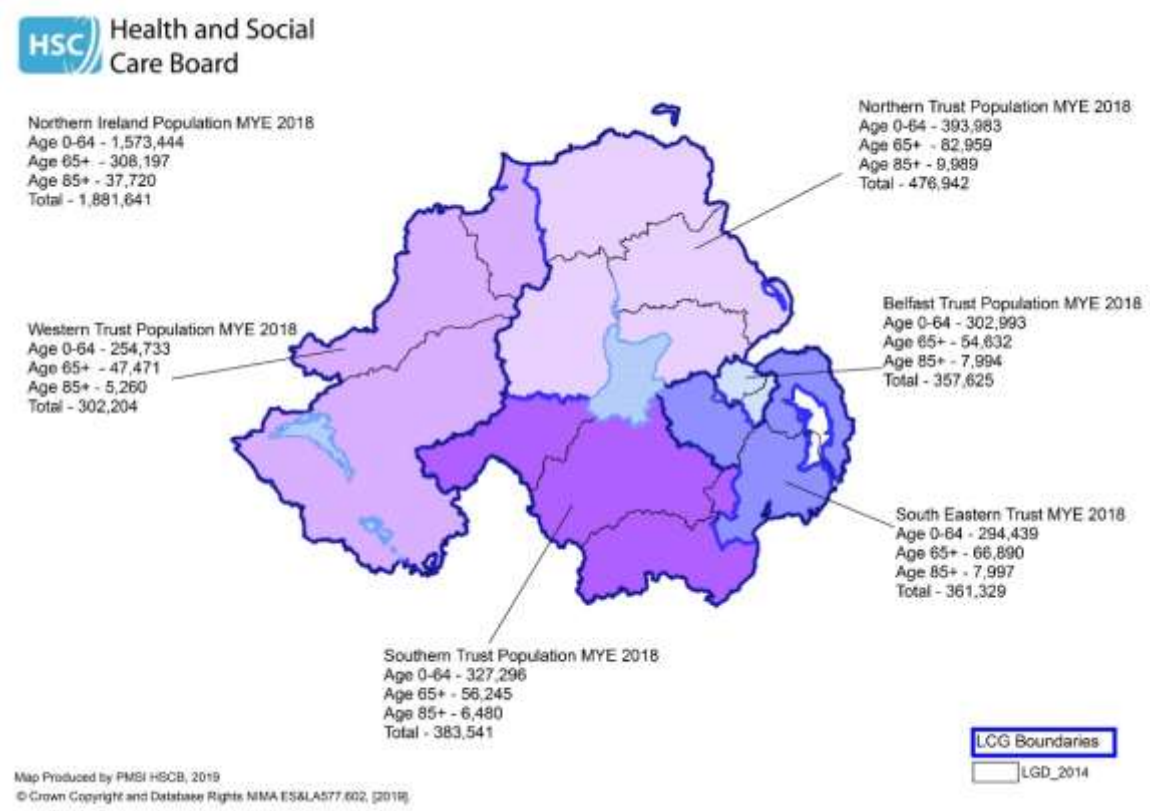
According to the recently published Mid-Year Estimates for 2017, Northern Ireland has the fastest growing population in the UK. Some of the key demographic changes are noted below:

- There are approximately 1.871m people living in Northern Ireland.
- There are estimated to be a total of 302,000 older people (65+ years) living in Northern Ireland – approximately 16% of the population.
- There are estimated to be a total of 391,000 children (0-15 years) living in Northern Ireland – 21% of the population.

The tables and charts below illustrate the demographic changes over the last 10 years in each of the LCG/Trust areas. A breakdown of the population split by each LCG/Trust area is mapped in Figure 1:

Figure 1

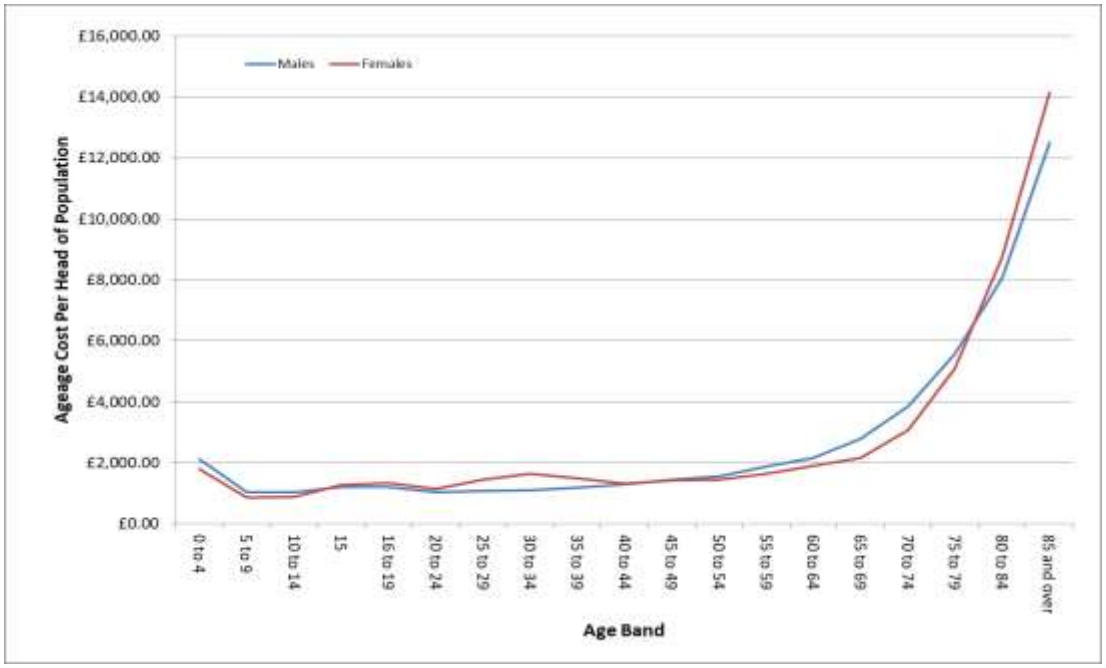
Northern Ireland resident population split by LCG / Trust area



Populations of a similar size may have different levels of need for health and social care services due to their differing age/gender distributions. The older population tends to require significantly more resources. Thus each local population is weighted according to those age and gender distributions. To illustrate these variations across local populations, the age/gender cost curve is shown below.

Age/Gender Cost Curve

Figure 2



All PoCs age/gender cost curve from 2017/18 Model

Table 1 shows how the population shares for each local area differ across age bands.

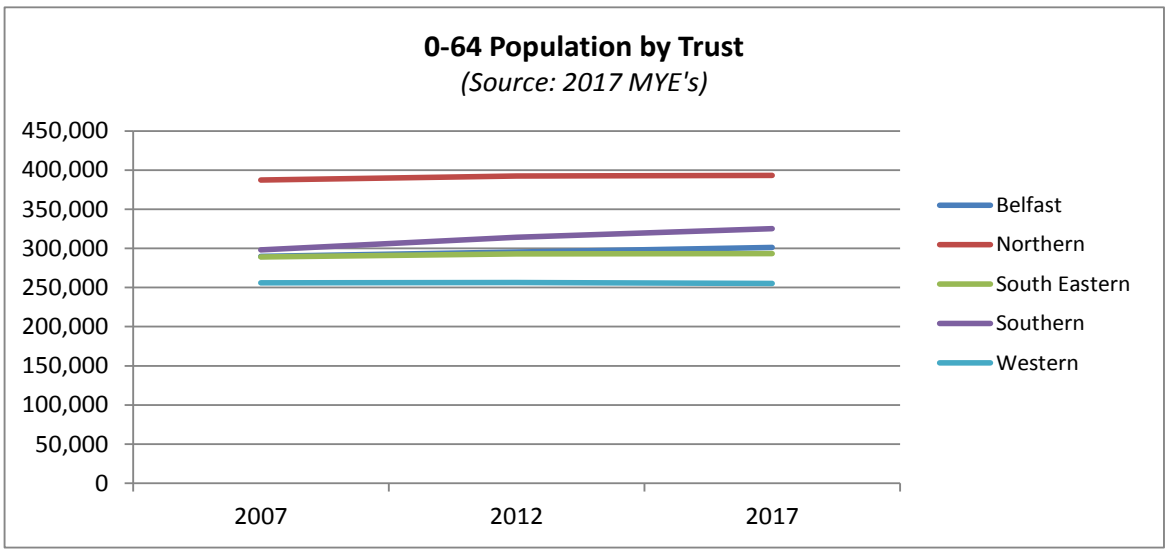
Total population percentage across age bands by area

Table 1

	Total Population	0-15	0-64	65+	85+
	% of NI	% of NI	% of NI	% of NI	% of NI
Belfast	19.0%	17.6%	19.2%	18.0%	21.5%
Northern	25.4%	24.8%	25.1%	26.9%	26.4%
South Eastern	19.2%	18.6%	18.7%	21.6%	21.1%
Southern	20.3%	22.3%	20.7%	18.2%	17.1%
Western	16.1%	16.7%	16.3%	15.3%	13.9%
NI	100%	100%	100%	100%	100%

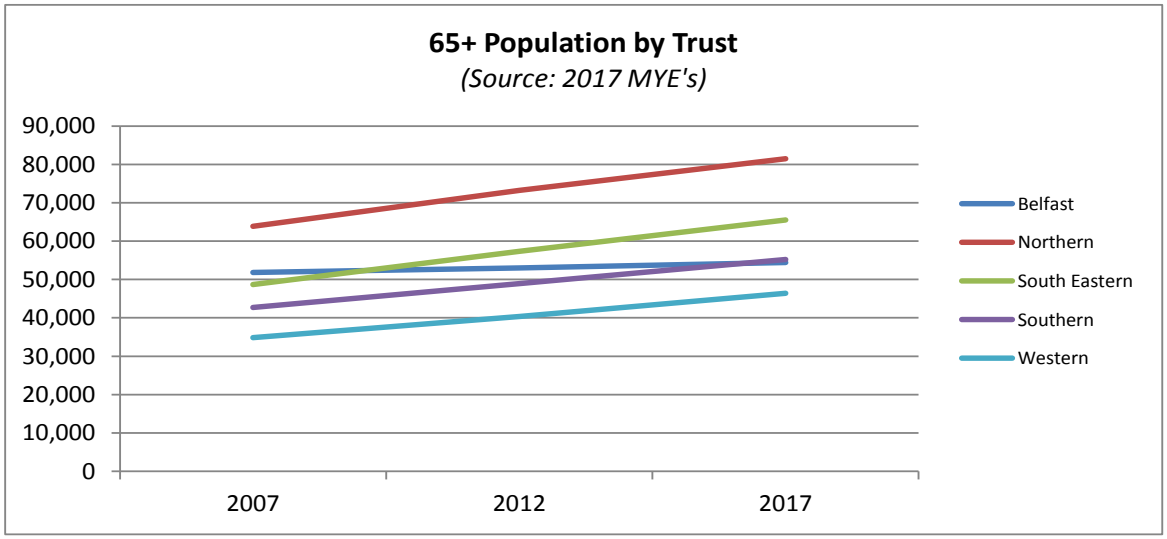
Figures 3 and 4 shows the estimated population numbers for each of the age bands and how these numbers have changed in the decade between 2007 and 2017.

Figure 3
Under 65 population



According to the 2017 Mid-Year Estimates 84% of the population are aged 0-64 years. Of the 0-64 population, the Northern Trust/LCG area has the highest proportion at 25.1% with the Western Trust/LCG area having the lowest proportion at 16.3%.

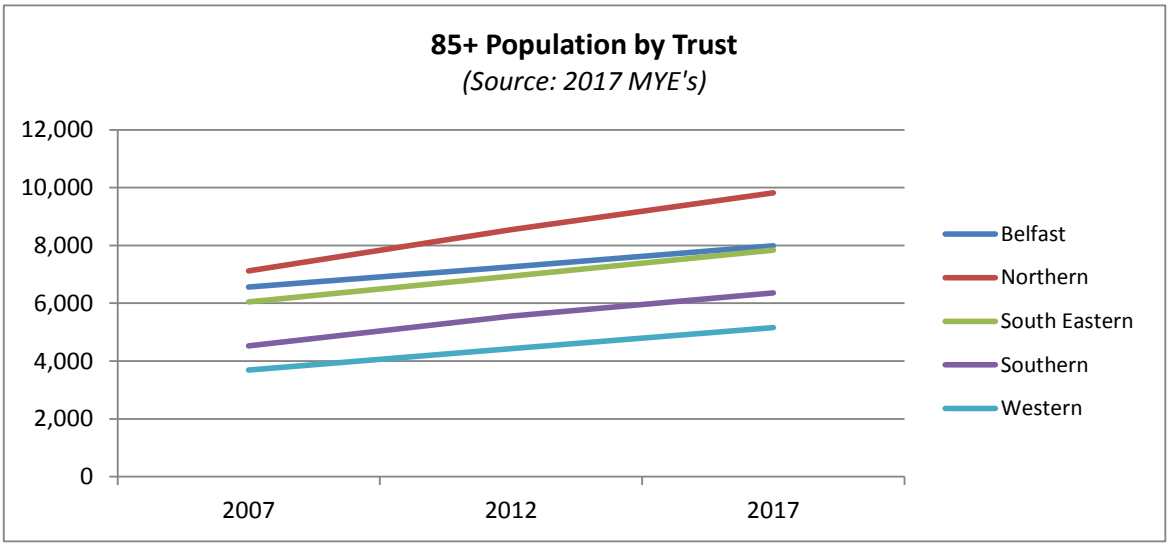
Figure 4
Over 65 population



According to the 2017 Mid-Year Estimates, 16% of the population are aged 65+ years. Of the 65+ population, the Northern Trust/LCG area has the highest

proportion at 26.9% with the Western Trust/LCG area having the lowest proportion at 15.3%.

Figure 5
Over 85 population



According to the 2017 Mid-Year Estimates, 2% of the population are aged 85+ years. Of the 85+ population, the Northern Trust/LCG area has the highest proportion at 26.4%, with the Western Trust/LCG area having the lowest proportion at 13.9%. However, of the 65+ population, Belfast Trust/LCG area has the highest % of those who are age 85+ at 14.7% compared to a Northern Ireland percentage of 12.3%.

Population Projections

Changes in age composition of the population will affect needs and demand for health and social care. Care needs are not evenly divided among age groups in the population and cost per capita tends to rise sharply with age. These changes inform the commissioning of services at regional and local level.

Regional Northern Ireland Population Projections

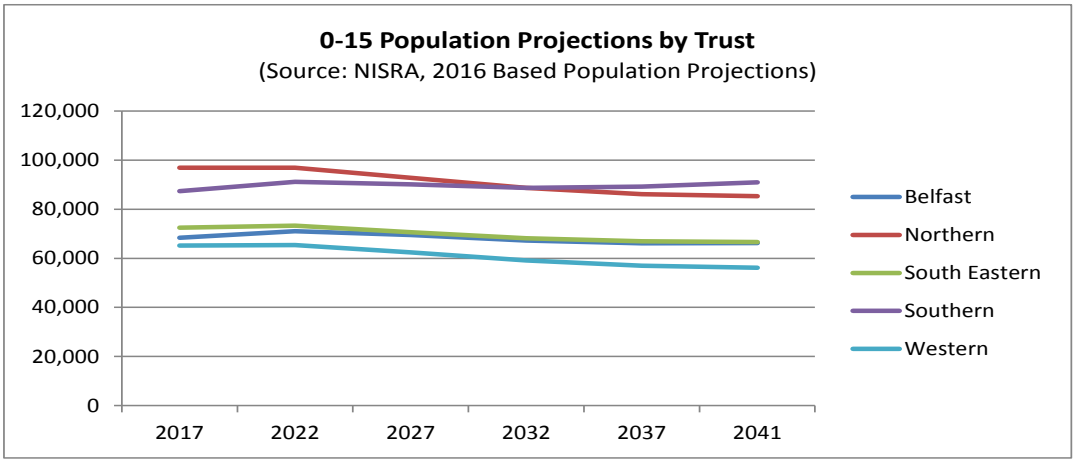
Over the 10 year period from 2017-2027, the population of Northern Ireland is projected to increase by 4 per cent to reach 1.946 million; rising again to 1.971 million by mid-2032 (an increase of 5.3 per cent).

The population is projected to increase to 2.007 million in the 25 year period from mid-2017 to mid-2042, an average annual rate of growth of 0.3 per cent. Natural growth is projected to be the main driver of this 136,000 population increase, with 127,300 more births projected than deaths. The Northern Ireland GP population is greater than the Northern Ireland population due to Cross Border patients on GP Registers at 197,162.

Local Population Projections

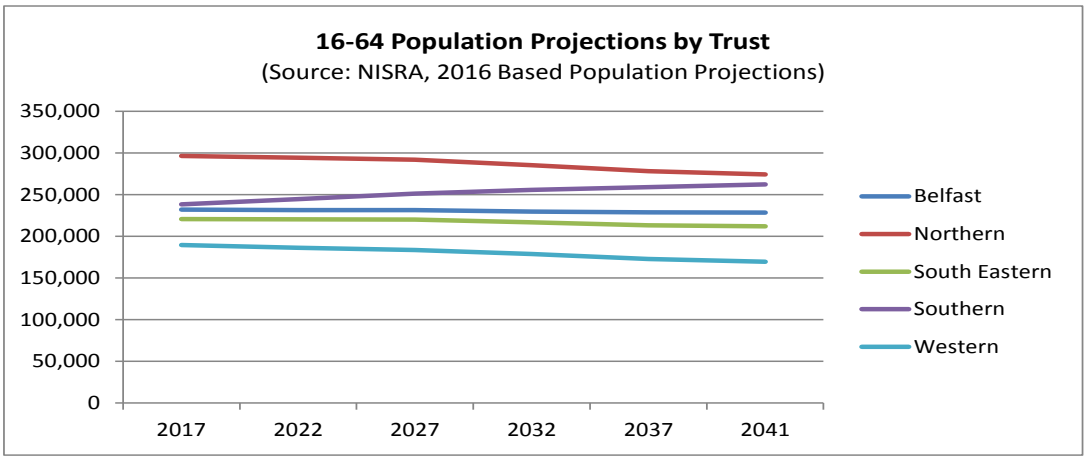
The tables and charts below illustrate the anticipated demographic changes over the next 24 years in each of the LCG/Trust areas (0-15, 16-64, 65+ and 85+ population).

Figure 6
Age 0-15 Population Projections by Trust



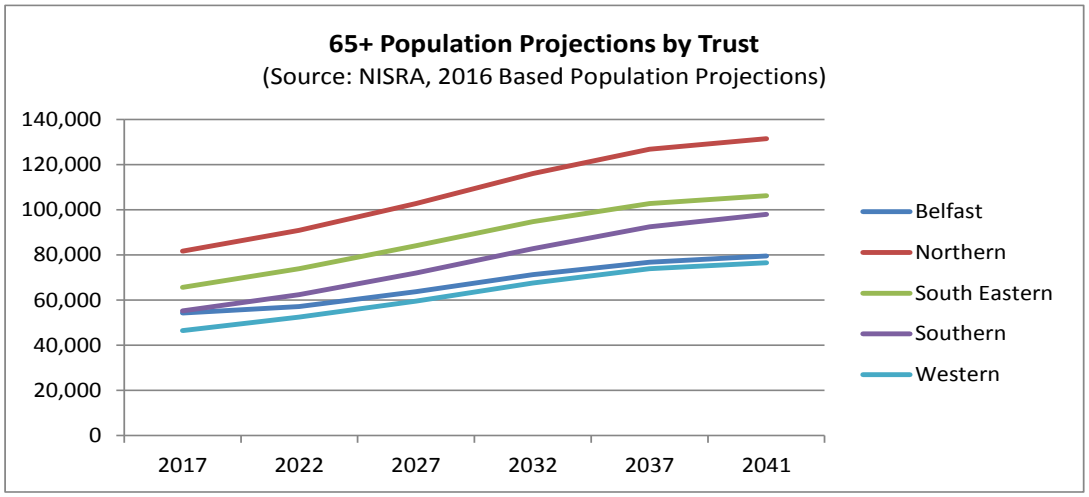
By 2041, it is projected that the 0-15 population in Northern Ireland will be approximately 365,000, an estimated decrease of 6% from 2017. The Southern Trust/LCG area is projected to have a 4% growth and the Western Trust/LCG area a projected decrease of 14%.

Figure 7
Age 16-64 Population Projections by Trust



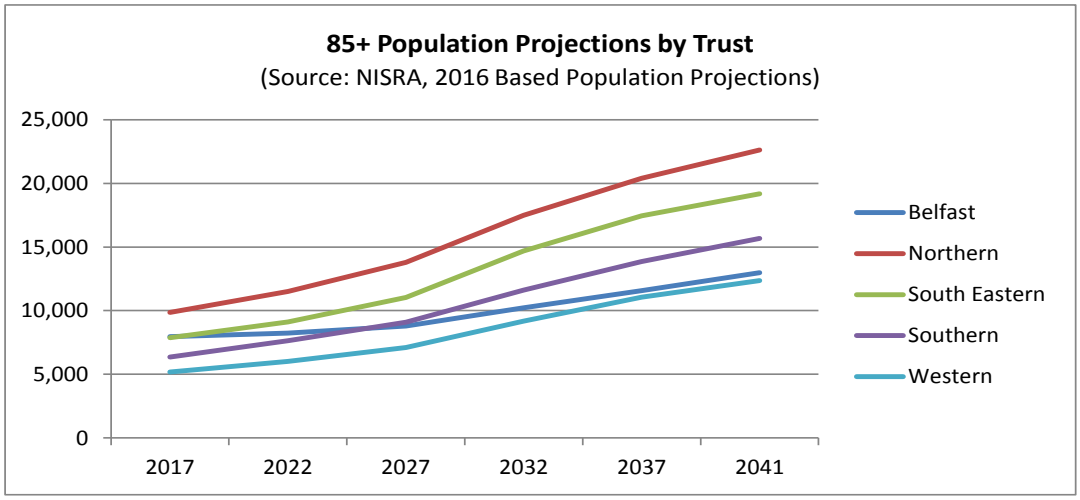
By 2041, it is projected that the 16-64 population in Northern Ireland will be approximately 1.15 million, an estimated decrease of 3% from 2017. The Southern Trust/LCG area is projected to have a 10% growth and the Western Trust/LCG area a projected decrease of 11%.

Figure 8
Age 65+ Population Projections by Trust



As widely expected, by 2041, it is projected that the 65+ population in Northern Ireland will be approximately 492,000, an estimated increase of 62% from 2017. By this date almost one in four people (24.5 per cent) will be in this age category. All Trust/LCG areas will experience significant increases in this population with the Southern Trust/LCG area projected to have the highest growth (77%) and the Belfast Trust/LCG area the lowest growth (46%).

Figure 9
Age 85+ Population Projections by Trust



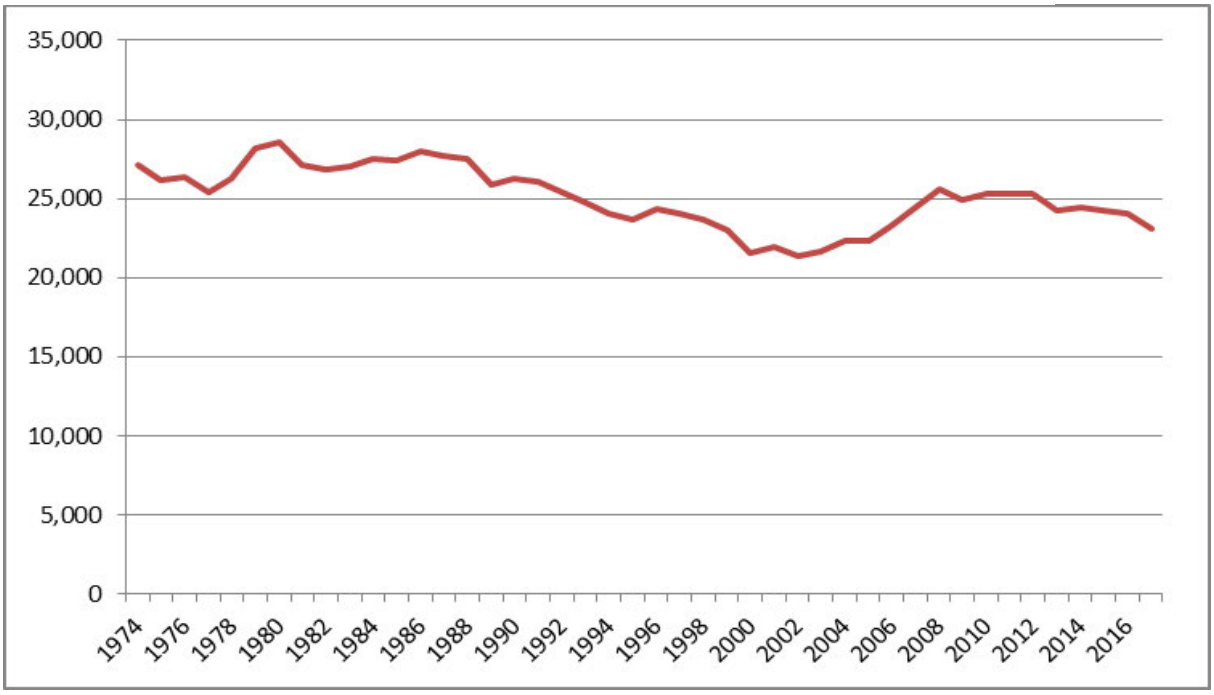
As widely expected, by 2041, it is projected that the 85+ population in Northern Ireland will be approximately 83,000, an estimated increase of 122% from 2017. By 2041, 4.1% of the population will be in this age bracket. All Trust/LCG areas will experience significant increases in this population with the Southern Trust/LCG area projected to have the highest growth (147%) and the Belfast Trust/LCG area the lowest growth (63%).

These projections show the real impact of the marked increase in the size of the population at older ages. The proportion of the population aged 65+ is projected to overtake that of children (those aged 0 to 15 years) by mid-2028 (20.1 per cent and 19.6 per cent respectively). While overall projected population growth over the 25 year period to mid-2041 is lower than in the rest of the UK (7.3 per cent compared with 11.2 per cent), the population is projected to age faster. For example, the number of people aged 85 and over is projected to grow by 130 per cent, compared with 107.1 per cent for the rest of the UK.

Births in Northern Ireland

Current projections suggest a levelling off of the birth rate, yet the historical pattern is one that shows fluctuation (see Figure 10). There are a variety of forces at work and it is hard to predict what future birth rates will look like.

Figure 10
Births in Northern Ireland (1974-2017)



Source: *https://www.nisra.gov.uk/publications/birth-statistics*

Life Expectancy in Northern Ireland

Life expectancy for females (82.4 years) was over 4 years higher than for males (78.1 years). This gap has continued to narrow over the last 30 years. Of the 16,036 deaths, the leading cause of death was cancer (29%), followed by circulatory disease (24%).

In 2017, 305 deaths by suicide were registered in Northern Ireland which decreased from the highest number of deaths registered in 2015.

2.2 Health Inequalities

As part of the Northern Ireland Health and Social Care Inequalities Monitoring System (HSCIMS), the DoH produces an annual Health Inequalities report[3] which provides analysis of health inequality gaps between the most and least deprived areas of Northern Ireland, across a range of indicators. Specific information on these indicators can be found in Appendix 3. Actions to be taken forward in 2019/20 can be found in Section 4.1 and Section 6 of the Plan.

[3] https://www.health-ni.gov.uk/news/health-inequalities-annual-report-2018

Life Expectancy and General Health

Between 2015 and 2017 the life expectancy gender gap between males and females in Northern Ireland was 3.8 years. For males, life expectancy at birth improved across all areas of Northern Ireland, with a faster rate of improvement observed in the most deprived areas, resulting in a narrowing of the inequality gap over the period although the most recent data appears to be reversing that trend.

For females, life expectancy between 2011 and 2013 and 2015 and 2017 remained constant in Northern Ireland in the most deprived areas, and increased slightly in the least deprived areas.

Healthy Life Expectancies and disability free life expectancies for men and women either declined or remained constant, and the inequality gaps in these have generally widened over the period since 2011and 2013.

Premature Mortality including avoidable deaths

Rates of premature mortality generally decreased over 2010-2016 in Northern Ireland and for the most and least deprived areas however the 2015-17 data appears to be showing a levelling out of this trend. The largest inequality gap was seen for respiratory mortality among under 75s, with rates in the most deprived areas being more than three and a half times that seen in the least deprived.

Amongst the indicators of premature mortality is an estimate of the numbers and rates of people who die prematurely from things which are considered to be avoidable by either being potentially preventable or treatable. This represents about 26% of deaths in Northern Ireland each year and just over four thousand people each year. Key contributors are lung cancer, heart disease and early stroke, alcohol and drug related deaths and suicides.

When analysed by deprivation quintile 35% of deaths in the most deprived areas were considered to be potentially avoidable while in the least deprived areas this dropped to 20%.

Inequalities monitoring data shows the rates per 100,000 population of these deaths had been declining however most recent data appears to show this decline having slowed or possible stopped.

Major disease

Inequality gaps for circulatory related hospital admissions, and prescriptions related to circulatory disease, remained constant between 2010-2017, with improvements seen in circulatory admission rates across Northern Ireland in the most and least deprived areas.

Despite an improvement in cancer outcomes in Northern Ireland the inequality gap has remained fairly constant over recent years. Inequality gaps for admissions due to respiratory disease widened between the most and least deprived areas and were the largest inequality gaps among the major disease indicators. The respiratory admission rate in the most deprived areas was double the rate in the least deprived for all ages, and more than double for those aged under 75 years.

Hospital Activity

Inequality gaps for emergency, elective inpatient, day case and all admissions remained fairly constant over the period 2013/14- 2016/17. While the gap for emergency admissions decreased, it continued to show the largest inequality of the four indicators analysed, with the rate among those living in the most deprived areas remaining almost two-thirds higher than that seen in the least deprived areas.

Mental Health

Large inequality gaps continue to exist for mental health indicators, with the latest position showing that rates of suicide and self-harm admissions in the most deprived areas were around three and a half times the rates seen in the least deprived areas. The inequality gap in self-harm admissions narrowed over the period with improvements observed for Northern Ireland and its most and least deprived areas. Prescription rates for mood and anxiety had increased

across all areas, with the rate in the most deprived areas two-thirds higher than in the least deprived in 2017.

Alcohol, Smoking and Drugs

Alcohol, smoking and drug related indicators continue to show some of the largest health inequalities monitored in Northern Ireland. Inequality gaps for drug related mortality and deaths due to drug misuse widened over the period analysed, with drug related mortality in the most deprived areas nearly five times the rate seen in the least deprived. The alcohol specific mortality gap remained very large with the rate in the most deprived areas about four and a half times the rate in the least deprived. Despite a rise and then slight fall in alcohol related admission rates across all areas, and a narrowing in the resultant inequality gap, the rate in the most deprived areas was nearly four and a half times that seen in the least deprived.

Pregnancy and Early Years

Changes in inequality gaps for health outcomes related to pregnancy and early years tended to vary over the period analysed. The smoking during pregnancy gap widened over the period, despite marginal improvements in rates across both the most and least deprived areas. In 2017, the under 20 teenage birth rate in the most deprived areas was four times the rate in the least deprived and the proportion of mothers reporting smoking in pregnancy in the most deprived areas was almost five times that in the least deprived.

Childhood Obesity

Inequality gaps relating to the proportion of primary 1 children classified as obese and those considered overweight or obese narrowed showed little change over the period analysed although individual year data varied. Conversely a widening of the inequality gaps relating to levels of Year 8 overweight or obesity was seen, mainly due to improvements in rates in the least deprived areas.

Figure 11
Summary of Regional Inequality Gaps

Most Notable Inequality Gaps		Most Notable Narrowing of Gaps	Most Notable Widening of Gaps
Female HLE	14.5 years	Male Life Expectancy at Birth	Male Healthy Life Expectancy
Male HLE	14.3 years	SDR – Avoidable: Children and Young People	Male Disability Free Life Expectancy
Smoking in Pregnancy	376%	SAR – Self-Harm	SDR – Drug Misuse
SDR – Alcohol	353%	Teenage Birth Rate U20	Smoking During Pregnancy
SDR - Drug Related	334%		

2.3 Deprivation

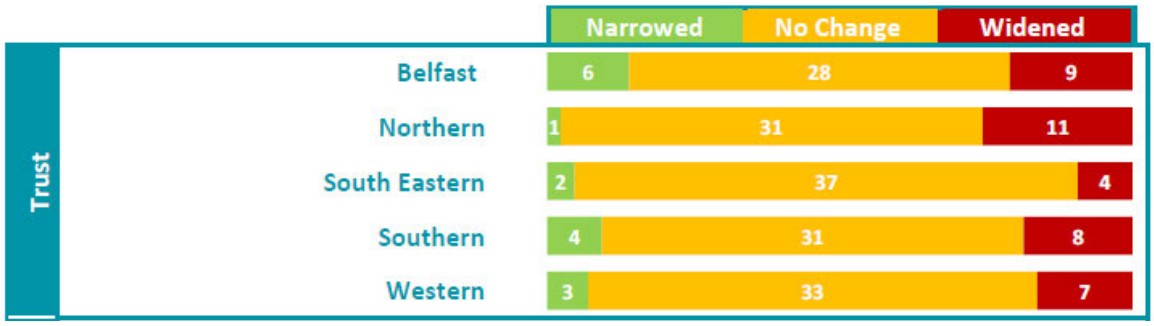
Factors outside the direct responsibility of the HSC system can also have significant implications for the health and well-being of our population. Health status can be influenced by socio economic factors such as deprivation which impact on disease prevalence and rates of mortality in local populations. For example, where levels of deprivation differ across local populations this can contribute to differences in health status.

Over the period analysed, within each Trust area there are more inequality gaps that have widened than narrowed. This was also true for the majority of Local Government Districts (LGDs) with the exception of Armagh City, Banbridge & Craigavon, Belfast and Newry, Mourne and Down. For each area analysed, the chart below shows the number of indicators that widened, narrowed, fluctuated or did not change across the period.

Largest Deprivation Inequality Gaps in each Trust/LCG Area

Recent information contained in the 2019 Health Inequalities Annual Report highlights the main health inequality gaps within the five Trust/LCG areas. The figure below indicates the five largest deprivation inequality gaps in each Trust/LCG Area.

Figure 12
Summary of Regional Deprivation



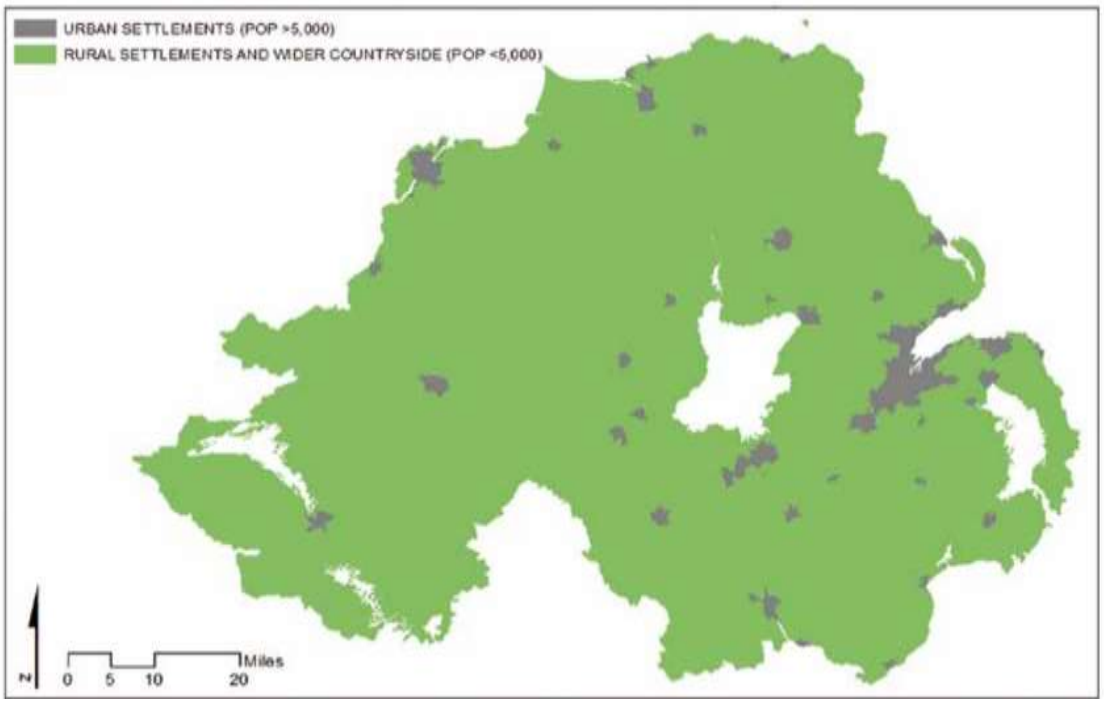
Source: Health Inequalities Annual Report 2019, Public Health Information & Research Branch, DoH

2.4 Rurality

The *Rural Needs Act* came into operation for Government Departments and District Councils on 1 June 2017 and for public authorities including the Board and Agency on 1 June 2018. The Act defines 'rural needs' as "the social and economic needs of persons in rural areas". A need can be considered to be something that is essential to achieve a standard of living comparable with that of the population in general. For example, it can relate to the ability to access key public services such as health and education, the ability to access suitable employment opportunities, and the ability to enjoy a healthy and active lifestyle.

Generally, the Act classifies settlements with fewer than 5,000 residents together with the open countryside as rural. Figure 13 below shows the geography of Northern Ireland, highlighting that a large proportion of the population live in rural settings.

Figure 13
Rural Settlements and wider countryside



A Guide to the Rural Needs Act (NI) 2016 for Public Authorities, DAERA, April 2018

Around 670,000 people in Northern Ireland live in a rural area representing approximately 37% of the population (2011 census). Most strategies and policies developed and implemented across government have a rural dimension and it is recognised that they can have a different impact in rural areas than urban areas due to issues relating to, for example, geographical isolation and lower population densities. It is recognised that as a result of rural circumstances people in rural areas may have different needs and therefore a policy or public service that works well in urban areas may not be as effective in rural areas.

The Act imposes an obligation on public authorities that is different to the commitment to 'rural proof' which the Northern Ireland Executive signed up to in 2002. The policy on 'rural proofing' required government departments to identify the potential impact that a policy or strategy would have on a rural area, to make a proper assessment of those impacts if they were deemed to be significant and, where appropriate, to make adjustments to the policy or strategy to take account of rural circumstances.

The strategic planning of HSC service provision to meet the needs of the population has traditionally taken cognisance of the relatively rural populations that exist, particularly in the Northern and Western LCG areas (Section 6.2 and 6.5). Ensuring local accessibility to services has been further strengthened by the *Rural Needs Act (NI) 2016*.

2.5 Homelessness

Homelessness is a term commonly used to describe a wide range of circumstances where people have no secure home. It is well documented that homeless patients have multiple issues which can prevent them from accessing GP services. The Board and Agency commissioned a Local Enhanced Service (Belfast Area) Enhanced Access and Healthcare for Homeless patients, which helps this vulnerable group access GP services, particularly in relation to management of long term conditions. Dedicated GP registration processes, educated staff, open access clinics and outreach have all been shown to help homeless patients engage with GP services.

People experiencing homelessness have considerably higher levels of morbidity (increased physical and mental health problems), reduced life expectancy (Standardised Mortality Ratio elevated x11 fold), and considerably worse lifestyle (in terms of diet, smoking, drug/alcohol misuse, etc.).

Therefore, work will continue to improve access to primary care and other health and social care services in Belfast and establish a regional process in 2019/20 to explore the development of an appropriate service for those who are homeless in all Trust areas.

Detail on specific actions for young people who are homeless and seeking to achieve a safe, stable return to a family can be found in Section 5.4.

3.0 COMMISSIONING AND THE USE OF FINANCIAL ALLOCATIONS

The CPD requires the Commissioning Plan to explain what services will be commissioned within the available budget. This includes providing details of how the total available resources, as specified by the DoH in its respective financial allocation letters to the HSCB and PHA for the financial year 2019/20, have been committed to Trusts and other organisations.

Given the financial context, extensive budget planning work to support the development of the 2019/20 financial plan has taken place between the DoH and the HSCB and Trusts. This chapter sets out:

- A summary of income sources for the HSCB and PHA in line with DoH 2019/20 Financial Allocation letters.
- A summary of HSCB and PHA expenditure areas for the planned additional investments in 2019/20.
- An analysis of HSCB and PHA allocations by Provider including Trusts.
- An analysis of HSCB and PHA allocations by Programme of Care.

In response to the Commissioning Plan, Trusts are required to provide Trust Delivery Plans (TDPs) which will incorporate individual financial plans for each Trust. These plans will provide further information on the details behind savings plans.

3.1 Summary of Income Sources - Budget Allocations HSCB and PHA

The DoH issued separate financial allocation letters for 2019/20 to the HSCB and PHA. These are summarised in **Table 2** below:

Income 2019/20

Table 2

Income 2019/20	HSCB £m	PHA £m	TOTAL £m
Opening Allocation	4,767.5	92.4	4,859.9
DOH Additional Funding	332.0	4.1	336.2
TOTAL	**5,099.5**	**96.6**	**5,196.0**

HSCB and PHA expenditure areas and funding sources

The DoH financial allocation letters set out how the additional resources available are to be applied in the financial year beginning April 2019. **Table 3** summarises the expenditure areas and funding sources.

A separate Transformation fund has been provided to cover the 2018/19 and 2019/20 as a £200m non recurrent investment over the two year period.

This information shown in the financial plan does not include the Transformation Fund element of the budget settlement in 2019/20.

2019/20 Summary of expenditure areas and funding sources

Table 3

2019/20			
		£m	£m
SOURCES	Allocation from DOH	336.2	
	Pharmacy Prescribing savings (£12m Primary Care, £8m Secondary Care)	20.0	
	Savings/Opportunities in Trusts (incl HSC Regional Savings Target)	42.9	*Table 4*
	Other savings	10.4	*Table 5*
	Total Sources		**409.4**
PRESSURES			
	Mental Health £10m	10.0	*Table 6*
	2018/19 Pay Award Recurrent	82.2	
	2018/19 Pay Award Non Recurrent	6.3	
	2018/19 Recurrent Pressures funded from Non Recurrent Sources	95.6	
	HSCB/PHA Inescapable pressures 2019/20		
	Inescapable Service Pressures	76.9	*Table 7*
	Family Health Services	33.1	
	Demography	20.7	*Table 8*
	Drugs and Therapies	14.7	
	National Living Wage, Apprenticeship Levy & Non Pay	59.7	
	Revenue Consequences of Capital Schemes	8.7	
	Other	1.5	
	Total Pressures		**409.4**

3.2 Sources

Allocations from DoH

The DoH issued separate financial allocation letters for 2019/20 to the HSCB and PHA. These allocation letters show the budgeted income for each respective organisation.

Pharmacy Savings

DoH has set a regional target of £20m. This challenging savings and efficiencies target has been established for medicines optimisation / prescribing across both primary care (£12m) and secondary care (£8m). The secondary care element in relation to medicines optimisation is shown in **Table 4** below.

Savings/Opportunities in Trusts

As part of the overall financial plan for 2019/20, Trusts have been tasked by DoH with developing draft savings plans to deliver their respective shares of a total of £42.9m of savings. Trusts are required, as part of this process, to inform the public about all savings options under consideration, and specifically indicate those that are considered to be major and/or controversial.

Table 4 provides the detail by Trust. The allocation of Trust shares takes account of relative cost efficiencies of local Trusts. It also takes account of each locality's planned share of available HSC resources. To address relatively lower levels of Health and Social Care expenditure on the Southern local population area generally and the gap from its target capitation expenditure, the Southern Trust (SHSCT) has not been allocated a savings target.

Savings/Opportunities in Trusts

Table 4

TRUST SAVINGS	Savings/Opportunities in Trusts £m	Pharmacy Prescribing Savings £m	TOTAL £m
BHSCT	17.7	3.9	21.5
NHSCT	7.7	1.2	8.9
SEHSCT	6.6	0.9	7.6
SHSCT	0.0	1.0	1.0
WHSCT	10.1	1.0	11.0
NIAS	0.8		0.8
Total	**42.9**	**8.0**	**50.9**

Other Savings

Table 5 sets out details on the other savings to be made.

Other Savings

Table 5

Other Savings	£m
Car parking charges	1.7
Agency/Locum	5.0
Dental	2.4
Admin budget reduction	1.3
TOTAL SAVINGS	**10.4**

3.3 Pressures

Mental Health Pressures

£10m pressures for Mental Health were funded non recurrently by the Confidence and Supply Mental Health ring fenced funding in 2018/19. This £10m has been made recurrent in 2019/20 and details are set out below in **Table 6.**

Mental Health Pressures

Table 6

Mental Health Pressures	£m
Physical Healthcare of people with serious mental illness	0.4
Addictions - Community staff Tier 3	0.1
Mental Health Regional Trauma Network Phase 2	0.5
Adults & children with Mental Health Problems whose family care arrangements break down	0.2
To support current level of psychological therapies	4.6
BHSCT Acute mental health facility	0.5
General demography growth and inflationary pressures	3.8
TOTAL PRESSURES	**10.0**

2018/19 Pay Award

The 2018/19 pay award was issued non-recurrently. This funding is the recurrent element of the pay award issued in 2018/19. A further £6.3m has been made non-recurrent. 2019/20 Pay award has not yet been agreed and is not included in these figures.

2018/19 Recurrent Pressures funded from Non Recurrent Sources

These are pressures from 2018/19 for which funding was not recurrently secured in 2018/19 and needs to be sourced from 2019/20 funding.

2019/20 Inescapable service pressures (£76.9m)

There are a range of inescapable and unavoidable service pressures for 2019/20. These are summarised in **Table 7**.

Inescapable service pressures

Table 7

Inescapable Pressures	£m
Full year effect of 2018/19 funding	29.4
Children	8.9
Specialist hospital services	2.1
Mental health	0.5
Learning Disability	1.5
Physical Disability	0.3
PHA	1.1
Diabetes	0.2
Acute Pressures	3.3
Independent Sector Fostering/Looked After Children	8.2
Energy Costs	5.3
Agency Nursing/Medical Locum	4.5
Unscheduled Care Capacity at Ulster hospital	1.0
Lab presssures/new contract	1.2
Infection Prevention and Control	2.0
Muckamore Abbey Hospital Review	1.5
Neurology Phase 2 Recall	0.5
3rd Cleans	0.5
Other	4.9
TOTAL PRESSURES	**76.9**

Investment is required to support the following:

- Specialist paediatrics
- Plastic surgery
- Renal services
- Adults with learning disability whose family arrangements breakdown
- Learning disability young people transitioning to adult services
- Community infrastructure for learning disability

- Adults and children with mental health problems whose family arrangements breakdown
- Regional mental health trauma
- Public health programmes including self-harm and FIT testing into the Northern Ireland bowel screening programmes

Family Health Services (£33.1m)

Family Health Services (FHS) pressures are primarily to cover anticipated increased costs in Prescribing, Dental, General Medical and Ophthalmic Services including demography, residual demand, and non-pay inflation.

Demography (£20.7m)

Table 8 provides an indicative split of demographic pressures across Programme of Care. These are informed by extrapolating per capita expenditure and population projections by Programme of Care and they reflect the projected reduction in births and increase in the older population.

Demography by Programme of Care
Table 8

	TOTAL
POC	**£m**
Acute Non Elective 1	7.680
Maternity 2	(0.268)
Family & Child Health 3	0.237
Elderly Care 4	11.000
Mental Health 5	0.995
Learning Disability 6	0.456
Physical and Sensory Disability 7	0.233
Health Promotion and Disease Prevention 8	0.295
Primary Health and Adult Community 9	0.072
TOTAL	**20.700**

Demography funding is specifically to allow Trusts to maintain the same level of service as in prior years whilst recognising this must be done within changes to the population numbers. Where population projections indicate that these numbers will increase within specific Programme of Care the associated funding

requirements are reflected in the pressures assessment. For most Programmes of Care population numbers are increasing, however the negative line in Table 8 for Maternity reflects the decrease in projected number of births although the increased complexity of maternity care may increase demands.

Drugs and therapies (£14.7m)

Drugs and therapies inescapable pressures relate to new NICE drugs and therapies, access to highly specialist drugs and therapies and growth on existing approved NICE therapies.

National Living Wage, Apprenticeship Levy and Non Pay (£59.7m)

The introduction of National Living Wage and Apprenticeship Levy creates further pressures in 2019/20. Non pay pressures take account of the impact of inflationary pressures on health and social care, which are estimated at a 2.6% increase.

Revenue consequences of capital expenditure (£8.7m)

This pressure covers the additional revenue requirement taking account of known new capital projects.

HSCB Allocations to Providers

Table 9 shows how the total of the HSCB and PHA allocations of £5,196m are indicatively allocated across providers at the time of the Commissioning Plan. The 'Other' category includes element of funding which will be attributed to providers at a later stage in the year when plans are fully formulated.

Indicative Allocations to Providers

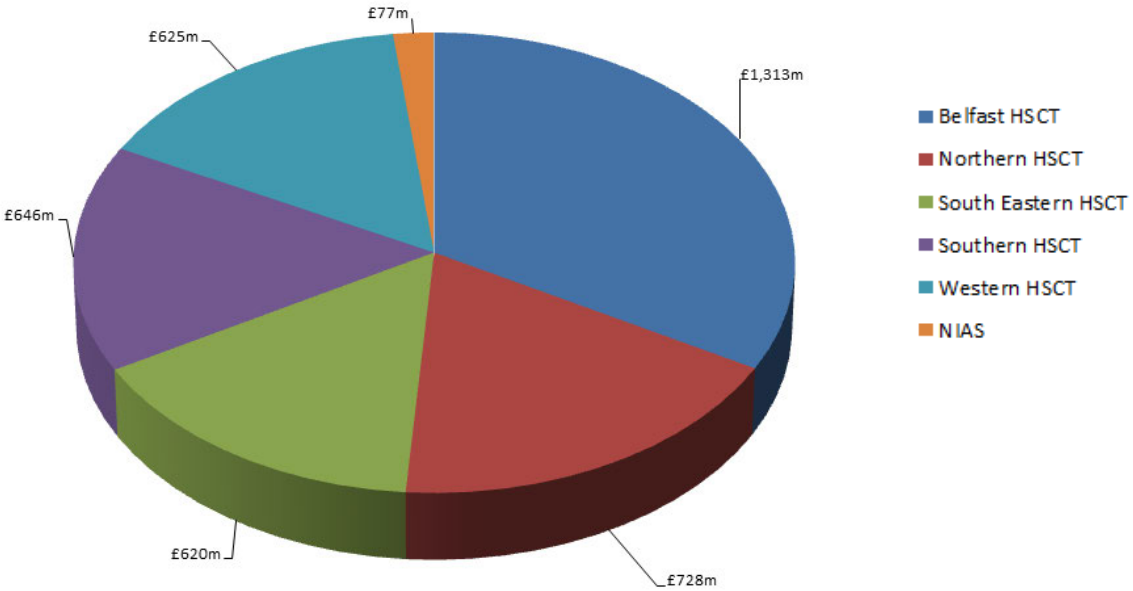
Table 9

Indicative allocations to Providers	£m
HSC Trusts	4,009
FHS	909
Other*	278
Total	**5,196**

*managed at HSCB/PHA including Elective and non-Trust contracts or held centrally at the time of the Commissioning Plan to be attributed to providers during the year

Figure 14 provides a sub analysis of the indicative allocations to Trusts.

Figure 14
Planned Allocations to Trusts



It is anticipated that the planned allocations to Trusts will not be sufficient to address all Trust pressures. Whilst the DoH will continue to work with the HSCB to manage the funding shortfall, Trusts should develop Trust Delivery Plans (TDPs) to manage these pressures from within their existing allocations in order to deliver a financial breakeven position.

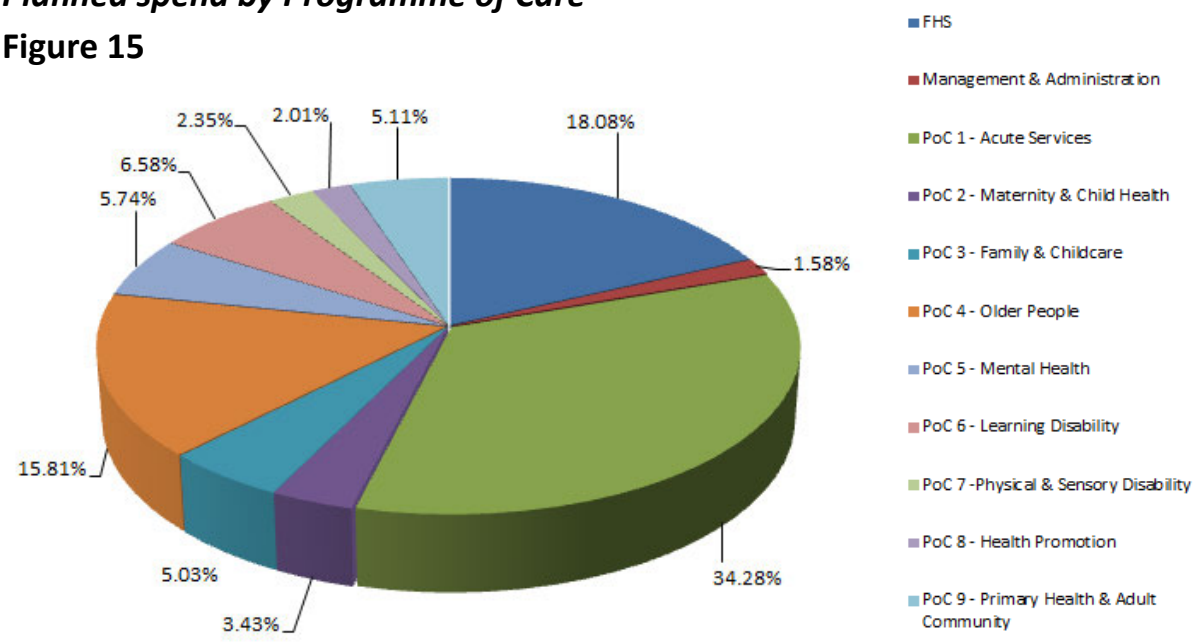
The HSCB will review these plans including any efficiency and savings proposals to ensure their deliverability and acceptability in the context of the need for financial breakeven, safety and quality considerations.

3.4 Planned spend by Programme of Care

Figure 15 provides an analysis of the HSCB and PHA planned allocations of the baseline across Programmes of Care. A more accurate picture of planned investment across the HSC by Programme of Care will be available when Trusts have completed their TDPs and this will then be incorporated into the SRF.

Planned spend by Programme of Care

Figure 15



TDPs are expected to be available in September. These will include an assessment of the Trusts' financial positions and savings measures.

4.0 OVERARCHING STRATEGIC THEMES

This section sets out how services will be commissioned in line with the four overarching strategic themes as set out within the Commissioning Plan Direction, namely:

- To improve the health of the population (Section 4.1)
- To improve the quality and experience of health and social care (Section 4.2)
- To ensure the sustainability of health and social care services provided (Section 4.3)
- To support and empower staff delivering health and social care services (Section 4.4)

4.1 Improving the health of the population

Improving the health of the population is a key responsibility of the Board and Agency. During the 20th century, life expectancy improved and, although inequalities in health have been ever-present, the population is healthier than ever before.

However, the UK is behind comparable nations on many key measures of health outcomes, and obesity rates are among the worst in western Europe. Improvements in life expectancy have also stalled and inequalities in health are widening.

An important shift is taking place with many conditions now managed as chronic long term conditions, and improvements in care have resulted in improved survival in many areas (See Section 5.7).

The Board and Agency seek to develop services under the following themes in the following areas to further improve the overall health of the population:

- Reduction of health inequalities
- Screening
- Health Protection

Specific commissioning intentions requiring input from Trusts can be found within the Population Health section of the Plan (Section 5.13).

4.1.1 Reduction of Health inequalities

Section 2.2 of the Plan highlights a range of health inequalities across various service areas. Improving health and reducing health inequalities requires coordinated action across health and social care, government departments and a range of delivery organisations in the statutory, community, voluntary and private sectors. Understanding the economic benefits and costs of preventive health interventions is only one of many inputs.

This is further reflected in "*Delivering Together* ", and underpinned in the Department of Health "*Making Life Better*" (MLB) Public Health framework. The current *Programme for Government* (PFG) outlines the need for a whole system approach to address the wider determinants of health and social wellbeing. This will be supported by HSC organisations working in tandem with non-statutory organisations with emerging opportunities through the local government Community Planning process, more information on Community Planning can be found in Section 1.6 and Section 6 of the Plan.

The Board and Agency are committed to supporting the DoH midterm review of MLB in 2019/20 and fully engage in the MLB regional network.

In support of this all Health and Social Wellbeing Improvement activity is underpinned by the six themes as set out in the MLB framework:

- Giving Every Child the Best Start
- Equipped Throughout Life
- Empowering Healthy Living
- Creating the Conditions
- Empowering Communities
- Developing Collaboration

During 2019/20 the Board and Agency will continue to build strong connections across society to improve health and wellbeing and reduce inequalities but with a greater emphasis on targeting resources on the key areas that impact on poor health as identified by the growing evidence base in this area.

Local Commissioning Groups (LCGs) have a key role in implementing MLB through engaging and working with community and voluntary organisations which play a vital role in enabling and empowering people to improve their health, representing and supporting the interests of vulnerable groups and the development of community capacity and social capital, and drawing on the strengths or assets within communities. LCGs work with communities to provide an environment that can help enable social inclusion and tackle health inequalities and the underlying contributory factors including poverty, housing, education and crime.

The development and implementation of delivery plans for the Programme for Government provides health and social care with an opportunity to improve health and wellbeing and influence the determinants of health inequalities out with our existing sphere of influence, for example, Healthy Places' co-ordinated approach across Government to improve health within local communities. Three pilot sites have been identified to test an intervention model based on the principles of co-production and co-design. The three areas are Lisnaskea, in County Fermanagh, the Glens area of County Antrim and the Ardoyne/Ballysillan area of North Belfast (CPD 1.4).

In response to the Commissioning Plan Direction, the Board and Agency will progress the following specific objectives:

Giving Every Child the Best Start

The Board and Agency will continue to progress the early years intervention agenda including:

- Continued delivery of the Family Nurse Partnership Programme, in all Trusts ensuring women who are eligible are assisted to have "a healthier pregnancy" and give our children and young people the best start in life,

providing developments in health visiting, early intervention services and family support hubs (CPD 1.10).

- Expansion of evidence based parenting support programmes which will support the implementation of the Infant Mental Health Action Plan and the work begun under the Early Intervention Transformation Programme.
- Implementation of the Northern Ireland Breastfeeding Strategy across all Trust areas with specific attention to the training of staff, peer support and maintaining the accreditation of facilities to meet the World Health Organisation UNICEF Baby Friendly standards, and expansion of the Breast Feeding Welcome Here scheme (helping to normalise breast feeding).
- Expansion of evidence based training and practice in implementing the Infant Mental Health Action Plan and addressing Adverse Childhood Experiences (CPD1.11).
- Ensuring the delivery of the universal child health promotion programme for Northern Ireland, "Healthy Child Healthy Future." (CPD 1.9)
- Exploring the development of an evidence-based childhood obesity prevention programme for Northern Ireland that can be delivered across sectors and in different settings to meet the needs of at risk families.
- Developing plans for those with complex needs such as addictions.

Equipped Throughout Life

The Agency is focusing attention on reducing the levels and consequences of frailty among older adults, enabling them to live healthier and more fulfilling lives. Key areas of focus will include:

- Falls prevention.
- Promotion of continence.
- Management of mild cognitive impairment.
- Preventing social isolation.
- A range of local health development programmes delivered through community networks.

- *Keep Warm* initiatives with vulnerable populations.

Empowering Healthy Living

The Agency will continue to implement a range of public health strategies to empower healthy living including:

- Reducing rates of obesity in children and adults through the rolling action plan of the multi-agency Regional Obesity Prevention Implementation Group.
- Developing and commissioning an early years obesity prevention programme for children 0-5 and their families
- Providing individuals with the knowledge, skills and opportunities to make healthier choices in relation to nutrition and physical activity.
- Expanding the 'Weigh to a Healthy Pregnancy' initiative to women with a BMI over 38 (previously available to those with a BMI of 40 or more).
- Commissioning enhanced workplace health initiatives with a focus on targeting vulnerable people in a range of employment settings to improve their physical and emotional health and wellbeing.
- Continuing to work with DoH in implementing a new strategy for the prevention of suicide and self-harm and the promotion of positive mental health.
- Contributing to the development of a Wellbeing Framework for Children and Young People led by the Department of Education.
- Roll out the Physical Activity Referral Scheme across the region.

Creating the Conditions

Specific commissioning intentions for 2019/20 include:

- Building capacity of local people to support vulnerable adults to live independently in caring and responsive communities, such as Creative Local Action Response and Engagement (C.L.A.R.E.).

- Leading and implementing programmes which tackle poverty (including fuel, food and financial poverty) and maximise access to benefits, grants and a range of social inclusion services for vulnerable groups.
- Developing and implementing a consistent approach to health and social wellbeing programmes, working with local government and other partners.

Empowering Communities

The Agency will continue work with a range of partners to use sports, arts, recreation and other leisure opportunities to improve the health and wellbeing of local populations. Specific commissioning intentions for 2019/20 include:

- Implementation of agreed action of the Regional Travellers Health Forum.
- Delivery of the Northern Ireland New Entrants service; and support to a range of community development and health programmes.

Developing Collaboration

Partnership working is important, e.g. the interface with the education sector to meet requirements of the *'Children's Co-operation Act NI (2015)* and *The Special Educational Needs and Disability Act NI (2016),* which includes completing an assessment, identifying and providing treatments or services to address children's Special Educational Needs (SEN).

As stated strengthening community development approaches as part of HSC Transformation highlights the importance of engaging meaningfully with communities. The Board and Agency will continue to support and extend strategic multi-agency partnerships in 2019/20, in particular making a full contribution to community planning processes with local government, to improve health and social wellbeing and reduce health inequalities.

In addition, members of the public, especially those likely to have a hospital admission that could be prevented through early action, will be encouraged to take actions to help them stay well during winter and assist them, their families and carers to make informed decisions on the appropriate services

to use. Actions include getting a flu vaccination, keeping homes warm and seeking timely advice from healthcare professionals when ill. It aims to help reduce hospital admissions and ease pressures on finite services.

Family Support Hubs

Across the early Intervention Infrastructure the impact of poverty on family life and the outcomes of the Child Welfare Inequalities Research is a significant part of the planning assumptions.

There are 29 Family Support Hubs providing early intervention support to families across Northern Ireland. All of Northern Ireland is covered by this network. A Family Support Hub is a multi-agency network of statutory, community and voluntary organisations that either provide early intervention services or work with families who need early intervention services. The network accepts referrals of families who need early intervention family support and uses their knowledge of local service providers and the Family Support Database (www.familysupportni.gov.uk) to signpost families with specific needs to appropriate services. Through the family support hub network across Northern Ireland there were 6,681 families supported in 2017/18.

4.1.2 Screening

Population screening is one of the most important public health functions. The Agency is responsible for commissioning and quality assuring the eight regional screening programmes across the HSC. Within these programmes, individuals are invited, who generally have no symptoms of the particular disease being screened, to determine if they have the disease, or are at risk of developing it. Population screening aims to identify these diseases and conditions at an early stage before they cause significant ill health and when they are amenable to treatment.

During 2019/20 specific commissioning intentions within population screening include:

1. ***Newborn Blood Spot Screening Programme*** – Introduce an expanded screening programme to increase the number of conditions tested for from five to nine, i.e. four additional Inherited metabolic disorders

2. ***Newborn Hearing Screening Programme*** – Prepare for the procurement and introduction of the 'Smart 4 Hearing' national IT service with the aim to introduce this in 2020. Benefits will include the reduction of manual processes within the programme, improved quality assurance and enhanced ability to report on national standards.

3. ***Diabetic Eye Screening Programme*** – A public consultation exercise was held to consider a future model for service delivery (April 2019). The Agency will commence work to implement the outcome of the consultation. The Board and Agency will work to ensure screening and hospital eye services meet the DESP standards endorsed by the Department.

4. ***Cervical Screening Programme*** –The Board and Agency will continue to take forward preparatory work for the introduction of primary HPV testing within the Cervical Screening Programme, subject to a future policy decision.

5. ***Bowel Screening Programme*** – Introduce a new screening test (quantitative Faecal Immunochemical Test (FIT)) during the final quarter of 2019/20 to improve programme effectiveness. The Board and Agency will work with Trusts to take forward the required procurement exercise and to commission related services to deliver this new test methodology and plan for the provision of sufficient colonoscopy sessions.

6. ***Abdominal Aortic Aneurysm (AAA) Screening Programme*** – The Board and Agency will continue to ensure AAA surgical services meet the AAA programme standards endorsed by the Department.

4.1.3 Health Protection

The Health Protection Service delivers on the statutory responsibilities of the Director of Public Health with respect to protecting the health of the Northern Ireland population from threats due to communicable diseases and environmental hazards. The Health Protection Service is a multidisciplinary service in the Public Health directorate in the Agency. It comprises consultants in health protection, nurses in health protection, epidemiology and surveillance staff, and emergency planning staff. It provides the acute response function to major issues, such as outbreaks of infection and major incidents. The Agency Health Protection Duty Room is the first point of call for all acute issues in relation to infectious disease incidents and for notifications of infectious diseases.

During 2019/20 the Board and Agency will continue supporting the introduction of a surveillance system for antimicrobial resistant organisms and a region wide programme on antimicrobial stewardship.

Communicable diseases disproportionately affect certain groups in the population including those at social disadvantage, living in poor housing conditions, migrants from countries that have higher prevalence of infectious diseases, and those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities.

Healthcare Associated Infections (HCAIs) are an important cause of morbidity and mortality. Levels of infections are increasing across Trusts. Tackling antimicrobial resistance is a key priority for the Chief Medical Officer and DoH.

Specific commissioning priorities for 2019/20 include:

- *Healthcare Associated Infections (HCAIs)including Surgical Site Infections (SSIs)*

- *Flu immunisation:*
  - Implementation of standardised data collection guidance on flu vaccine uptake in health care workers, from whatever source, for Trusts.
  - Ensure that at least 40% of the Trust staff (healthcare and social care staff) have received the seasonal flu vaccine (CPD 8.6).

- *Childhood immunisations:*
  - Work with the School Health Service to introduce the new HPV vaccine for boys.

- *Antimicrobial Resistance and Stewardship:*
  - Monitor antimicrobial resistance and develop improvement programmes for antimicrobial stewardship.

- *Clostridium Difficile:*
  - Reduce the number of in-patient episodes of Clostridium Difficile infection in patients aged 2 years and over and inpatient episodes of MRSA infection compared to 2018/19.

4.2 Improving the quality and experience of Health and Social Care

4.2.1 Ensuring that people using Health and Social Care services are safe from avoidable harm

Patient Safety is the avoidance of unintended or unexpected harm to people during the provision of health and social care. Patients should be treated in a safe environment and protected from avoidable harm. The Board and Agency place patient safety above all other issues, and are continually working to monitor and review services. While health and social care is both complex and pressurised, the Board and Agency are focused on ensuring that in regard to improving patient safety, the experiences of patients, clients and carers are shared, understood and acted upon and that those experiences; appropriately influence commissioning decisions.

In line with the goals of *Quality 2020 Strategy*, the recommendations from both '*Systems Not Structures'* and '*Delivering Together*', the need to take a strong position on Quality Improvement, with the patient and service user represented as part of this, is fundamental to our aspiration to transforming and delivering a quality service.

During 2019/20 and beyond, the Board and Agency working closely with Trusts and other organisations through existing regional structures will continue to lead and support the implementation of key quality improvement priority areas.

Implementing Quality and Safety Standards

The Board and Agency has a system in place via the Safety and Quality Alerts Team (SQAT) to provide the appropriate assurance mechanism that all Board and Agency actions contained within RQIA reports are implemented. This system of assurance takes the form of a 6-monthly report to the Governance Committee (March and September each year) which details the progress on implementation of a range of quality and safety recommendations from a range of organisations including NICE, RQIA etc.

Participation in Audit

Measuring the quality of health care is important because it tells us how the health system is performing, and lead to improvement in services provided. Participation in local, regional and national audits is key to improving the quality of care to patients. The national Sentinel Stroke National Audit Programme (SSNAP) audit for stroke care is driving improved quality in stroke care across Northern Ireland. Participation in the national stroke audit has highlighted numerous areas for all stroke services (hospital and the community) where improvement is possible on the stroke care pathway so that Northern Ireland performance matches other parts of the NHS.

The recent regional inpatient audit of diabetes care highlighted that 18.4% of in-patients when in hospital had diabetes and identified suboptimal care in:

- Medication management including medication and prescription errors
- Only 29% of inpatients were seen by a member of the diabetes team compared to 35% in England and Wales.
- Foot care
- 46% of patients had diabetes management problems that warranted referral to the diabetes team, of which 62.4% were actually seen by a member of the diabetes team.

Trusts are to develop action plans/quality improvement approaches to address the issues identified in the audit and resources have been allocated to facilitate improvements in this area.

National Confidential Enquiry into Patient Outcome and Death Reports (NCEPOD)

NCEPOD reports aim to improve standards and quality of medical and surgical care provided to adults and children by reviewing the management of patients through confidential surveys and reviewing care provision and resources. NCEPOD reports include recommendations on how health care could be improved.

Recent NCEPOD reports covered the topic areas of chronic neuro-disability, non-invasive ventilation, heart failure, perioperative diabetes, mental health in general hospitals, acute pancreatitis and sepsis. The Board and Agency through the Safety Quality and Alerts Team will work with providers either through existing groups/networks or set up task and finish groups to address recommendations in these reports and aim to improve standards of care.

NICE Guidance

NICE guidelines make evidence-based recommendations on a wide range of topics, from preventing and managing specific conditions, to providing social care to adults and children, and planning broader services and interventions to improve the health of communities. These aim to promote integrated care where appropriate, for example, by covering transitions between children's and adult services or between health and social care.

The DoH has a formal link with the Institute under which NICE Technology Appraisals, Clinical Guidelines and other types of guidance are reviewed locally for their applicability to Northern Ireland and, where found to be applicable, are endorsed by the DoH for implementation within Health and Social Care in Northern Ireland.

In commissioning services, applying the NICE quality standards and guidance that ensures clinical and cost-effectiveness provides explicit assurance to the population in the expectations on the quality of care to be provided.

RQIA

RQIA reports provide a rigorous assessment of the quality of care provided by services, advise on strategy implementation and make recommendations in areas where further development work is required. These reports are taken into account in the commissioning of services from statutory and non-statutory providers.

4.2.2 Improving the quality of the Healthcare experience

Listening to and acting upon patient and client experience is recognised as a key element in the delivery of high quality services. Working through the Regional HSC PPI Forum, the HSCB and PHA continue to ensure that service user involvement and co-production underpins the commissioning, delivery and monitoring of services.

Work in 2019/20 will also include:

- Considering options to reimburse service users and carers actively involved in supporting HSC work, including the peer service user/carer consultants.
- Reviewing monitoring arrangements for involvement and co-production in Trusts.
- Developing *Engage* as a one stop shop for Involvement, enhancing the information, resources and materials available on it.
- Developing integrated organisational plans for PPI, co-Production and Patient and Client Experience (CPD 3.5).

Patient Client Experience and 10,000 MORE Voices

The Board and Agency is responsible for monitoring and reporting to the DoH on the Patient Client Experience (PCE) Standards. Through the regional Patient and Client Experience Steering Group, HSC organisations continue to implement a comprehensive programme of work; including the continued roll out of 10,000 MORE Voices to measure experience, drive quality improvement, inform commissioning and ultimately enhance overall experience.

Work in 2019/20 will include:

- Working with Trusts to measure and report compliance to ensure that effective arrangements are in place to support the provision of safe and effective care and treatment in mixed gender accommodation.
- Adapting and implementing a range of Always Events in relation to:
  - Family Presence

- Mealtime Matters
- Acute Pain Management
- Respect and attitudes in NIAS
- 'What Matters to You'

This will include the implementation of online user feedback which supports service users to share their experience.

The work-plan for 2019/20 reflects the priorities detailed within section 5 and includes the lived experience of the carer, the lived experience of homelessness and the lived experience of mental health services.

Quality 2020

The PHA will continue to work with Trusts and other HSC organisations to lead the implementation of the Q2020 strategy. This includes working with key stakeholders to take forward the identified tasks for 2019/20 including:

- Reducing the re-occurrences of the 3 main categories of never events
- Developing professional leadership
- Supporting staff involved in SAI's and other incidents
- Implementation of Always Events throughout the HSC
- Improving patient safety through multidisciplinary human factors and simulation based education

Patient and Client Council (PCC)

The PCC is an independent and influential 'voice' that makes a positive difference to the experience of health and social care for the Northern Ireland population. The vision of the PCC is to support and promote health and social care services that are shaped by the experiences of patients, clients, carers and the wider community.

In support of this, the PCC publishes a range of reports on the experience of service users which help to inform planning and delivery of health and social care services both regionally and locally. Current reports can be accessed at www.patientclientcouncil.hscni.net. The Board and Agency will take cognisance of these reports which help to inform the priorities detailed within Section 5 (HSC System Priorities) and Section 6 (Local Commissioning Priorities) of the Plan.

Northern Area Prototype

A new integrated approach is being taken forward in the Northern LCG area. This approach is being led by the Northern Trust and the proposal is to establish a Northern Area Network that will have membership from across the HSC to plan and deliver services for the Northern area. A Trust/Primary Care Provider Partnership will facilitate closer working between Primary Care and the Trust. The network will include a range of statutory and non-statutory organisations, including services users and local Council representatives, who will have a stake in the local area and an accountability to deliver on shared plans.

It is proposed that four Locality Integrated Care Partnerships will be established, covering Causeway and the Glens, Mid Ulster, Antrim/Ballymena and East Antrim. These Partnerships will be further supported by Neighbourhood teams to ensure understanding of local need to inform decision-making. Emerging priorities include diabetes, musculoskeletal pathways and frailty. The Northern Area Prototype may be applied in all localities.

The Commissioning Plan describes some of the objectives for 2019/20 but it is recognised that in this current year much of the emphasis will be in planning rather than delivery.

Medicines Optimisation

Commissioning Plan Direction 2.7 identifies improvements in compliance with the Medicines Optimisation Quality Framework. Whilst the Framework applies across a range of services, it has particular relevance in unscheduled care, paediatrics (including specialist paediatrics), maternity services and care of the

elderly in supporting patient flow and timely discharge. Effective arrangements should be put in place to ensure that Trusts achieve 70% compliance with the Medicines Optimisation Quality Framework (MOQF) consistent with CPD 2.7 requirements. Trusts should demonstrate how this improvement in compliance will be achieved, with particular emphasis in this section on the Pharmacy/patient pathway interface including medicines reconciliation and discharge and all corresponding metrics to monitor progress. The Board will work with Trusts to agree the necessary infrastructure to deliver the requirements of the Framework. During 2019/20, the Board and Agency will seek to establish baseline compliance for community Pharmacy and general practice. Further detail can be found in Section 5.4.4.

Healthcare within the Criminal Justice System

The health and social care system continues to develop a more comprehensive understanding of the complex needs of those individuals who come into contact with the criminal justice system. Those within our criminal justice system are often the most vulnerable in our society with long standing health and social care needs, both physical and psychological. Historically, there has been a focus on those individuals detained in our four prisons, however new emerging partnership models under transformation highlight greater collaboration with the PSNI and other agencies, both statutory and voluntary, which provide services to those detained or leaving detention.

The Board and Agency's approach will be to ensure that those in contact with the criminal justice have access to the equivalent level of service as those in the community and to ensure that on release from prison for example, pathways are in place to ensure continuity of care. The Department of Health and the Department of Justice have finalised a joint healthcare strategy for the criminal justice system with an associated action plan to ensure that children, young people and adults in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour. This strategy and action plan will provide a new emphasis on this complex aspect of health and social care provision.

4.2.3 Health and Social Care services are centred on helping to maintain or improve the quality of life of people that use them

High quality health care is safe, effective, person centred (child and family centred for children), timely, efficient and equitable. Quality in health care is a broad concept and includes providing people with a positive experience of care, reducing premature mortality and ill health, improving recovery from acute and long term illness, ensuring timely care and treatment and treating patients in a safe environment.

Quality 2020 is a 10 year strategic framework for improving quality in health and social care in Northern Ireland through transforming the culture of services by continuous quality improvement, strengthening the workforce, measuring improvement, raising the standards of care and integrating care between hospital and community services.

During 2019/20 the CPD requires the HSC to ensure that 60% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and that 5% have achieved training at level 2 by March 2020 (CPD 8.11).

Quality improvement draws on a wide variety of methodologies, approaches and tools. Quality Improvement focusses on:

- understanding the problem and the processes including patient pathways
- analysing the demand, capacity and flow of the service
- choosing the tools to bring about change, including leadership and clinical engagement, skills development, and staff and patient participation
- evaluating and measuring the impact of a change.

This section highlights a number of developments which help to improve the quality of service in specific programmes of care and more generally across all service areas. Where applicable these approaches are reflected in the specific objectives for services identified in Section 5.

Evidence-based Care

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

Implementation of quality standards and guidance supports the delivery of care in line with the best available evidence of clinical and cost-effectiveness. It also helps people be more aware and better informed in regard to their care which helps improve population health and prevent disease.

NICE guidelines make evidence-based recommendations on a wide range of topics, from preventing and managing specific conditions, to providing social care High quality health care is safe, effective, person centred (child and family centred for children), timely, efficient and equitable.

Quality Improvement Plans (QIPs)

The Board and Agency is required through the *HSC Framework (DHSSPS, 2011)* to provide professional expertise to the commissioning of health and social care services that meet established safety and quality standards and support innovation.

The Board and Agency provide support to Trusts and gain assurances on progress with regional safety and quality priorities through Quality Improvement Plans (QIPs). During 2019/20 the PHA and HSCB will link closely with Trusts to improve the following areas:

Falls

Falls are a significant cause of harm to patients in receipt of HSC services. Effective arrangements should be in place to implement and measure 'falls safe' interventions to reduce harm. By March 2020, Trusts should work towards achieving full implementation of revised regionally standards, operational

definitions and reporting schedules for falls across all adult inpatient areas (CPD 2.6).

During 2019/20, Trusts should continue to monitor and report the total number of falls and measure the incidents of falls resulting in moderate to major/Catastrophic; improve compliance with agreed elements of Part A and Part B of the falls safe bundle and demonstrate a percentage reduction in those which cause moderate to major/Catastrophic and link with regulated services to develop and test a regional sign posting guide in respect of falls management.

Pressure Ulcers

Pressure ulcers are a largely preventable adverse event and an important measure of the quality of care within organisations. Specific actions to be taken forward in 2019/20 include:

- adherence to the SKIN bundle requirements in order to reduce harm from pressure ulcers.
- monitoring and reporting the number of pressure ulcers grade 2 and above; and measure the incidents of pressure ulcers grade 3 and 4 and the number of those which were avoidable from current baseline data.
- supporting the development of regional guidance in relation to adult safeguarding and pressure ulcer care.
- achieving full implementation of revised regionally standards, operational definitions and reporting schedules for pressure ulcers across all adult inpatient areas. (CPD 2.6)

Venous Thrombosis Embolism (VTE)

VTE is a recurring cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service. NICE guidance has been endorsed by DoH and implemented in Northern Ireland. Specific priorities for 2019/20 include:

- assessing the risks of VTE and bleeding which is a key priority for implementation of the guidelines.

- measuring and improving compliance with VTE risk assessment across all adult inpatient hospital wards.
- reducing the number of emergency readmissions with a diagnosis of venous thromboembolism.

National Early Warning Scores (NEWS)

Identifying early deterioration in patients' conditions is an important factor in improving outcomes. Specific priorities for 2019/20 include:

- implementation the NEWS KPI, ensuring effective and robust monitoring through clinical audit and ensuring timely action is taken to respond to any signs of deterioration.
- developing arrangements to implement the scale and spread of NEWS 2.

Sepsis6

Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Sepsis 6 is a set six of interventions which can be delivered by any healthcare professional and must be implemented within the first hour. The Safety Forum will work with Trusts to scale and spread implementation of Sepsis 6 in pilot wards in each Trust, in the following settings:

- Emergency Departments
- Medical Units
- Surgical Units
- HDU/ICU

The PHA will work with community nursing in each Trust to identify priorities for sepsis identification in community settings.

The Regional Trauma Network

The Regional Trauma Network involves the design, co-production, and implementation of an integrated service model i.e.; statutory, voluntary, and community sector services to respond to the needs of children, young people and adults with trauma-related psychological and psychosocial difficulties.

The Health and Social Care element of the Regional Trauma Network will improve access to the highest quality trauma services for the population of Northern Ireland by creating a specialised local trauma team in each Health and Social Care Trust. This service is an enhancement to existing mental health and psychological therapy services. The Regional Trauma Network is for children, young people and adults who are experiencing clinically significant levels of psychological trauma, irrespective of the origin of the trauma.

The specialist mental health professionals within each local trauma team will deliver evidence-based trauma treatments. They will also develop research, training and education strategies that will inform future national and international practice in relation to psychological trauma.

The four strategic outcomes that the Regional Trauma Network aims to deliver are:

- People have improved access to quality trauma care.
- There is improved partnership working with the people of Northern Ireland to deliver highest quality trauma care.
- People receive world leading, effective and evidence-based trauma care.
- An international centre of excellence for training, research, and trauma care is developed.

The Regional Trauma Network will be delivered on an incremental basis involving:

- Systematic stakeholder engagement and consultation;
- The development of referral and service-user pathways;
- Continuous learning and analysis of evidence;
- Better understanding of needs; and
- The formulation of recommendations for ongoing service improvement.

In designing and implementing the Regional Trauma Network, we are committed to delivering **accessible**, **acceptable**, and **effective** trauma services. Service users are at the heart of this commitment.

A 'Shared Lives' Approach

The Board and Agency are working with the five Trusts and Shared Lives Plus, to expand and strengthen adult placements and short breaks for older people through a Shared Lives approach, as an alternative to home care and care homes for people in need of support (CPD 6.2). Service users requiring support are matched with compatible Shared Lives carers and families, who support and include the person into their family and community life.

A Shared Lives approach to adult placement focuses on allowing meaningful relationships to develop between service users and their Shared Lives carers, something that is sometimes missing in the delivery of traditional care and support services. It provides the service user with the support they need to live as independently as possible and remain part of their communities, offers a greater choice in terms of who is providing support and the setting in which this support is delivered.

A Regional Steering group to oversee the implementation of the objectives has been established and is led by the Board and Agency with representatives from Shared Lives Plus and Trust staff from both Learning Disability and Older People. The Steering Group has been meeting regularly and a project structure is in place to support the implementation of a regional action plan.

Learning Disability

The Board and Agency will continue to support Trusts to deliver person centred care in line with the Bamford vision for people with a learning disability to be living integrated into their own communities and supported to enjoy opportunities for work, social relationships and activities according to their individual interests and priorities. To this end, the Board and Agency will continue to represent the needs of people with a learning disability across government Departments to develop day opportunities, independent travel, and housing support. Supporting family carers, improving access to physical health care, and rolling out self-directed support will also be priorities.

Recovery in Mental Health

The Board and Agency will continue to work with the Trusts to enable people using mental health services to participate as equal partners in their treatment for serious mental illness, and support them to take responsibility for ensuring their own health and wellbeing. This includes:

- Rolling out Wellness Action Recovery Planning (WRAP) for co-produced/co-delivered care and treatment planning.
- Delivery of co-produced/co-delivered education and support through Recovery Colleges.
- Support the development of self-sustaining, peer led relapse prevention and carer support services.

Enhanced role of eHealth and new technology

Investment in eHealth solutions and services is critical to supporting safe, efficient and resilient services, and maximising opportunities for innovation. Working with the DoH Chief Digital Information Officer the Board and Agency is responsible for the development and maintenance of implementation plans across the HSC to deliver the objectives in the HSC eHealth and Care Strategy, published in March 2016.

During 2019/20, the Board and Agency will work with Trusts to take forward the following developments:

- Procurement of an integrated Health and Care platform, via the Encompass programme, to further embed the successes of the Northern Ireland Electronic Care Record (NIECR) and other programmes, to establish an integrated digital platform to provide world-class support for digital service management for sustainable health and wellbeing services.
- Procurement of a Laboratory Information Management System (LIMS) as part of the wider Pathology Modernisation programme, replacing existing systems.
- Procurement of a new NIPACS solution with the existing contract due to end in September 2022 enabling the recommendations of the Regional Imaging Review to be taken forward.

- Further development and roll out of community information systems and deployment of mobile devices to support care delivery in both the community and acute settings.
- Further development and enhancement of the technology infrastructure which underpins and facilitates the delivery of services.
- Further exploitation of the ‘patient portal’ ‘pathfinder’ project to support those who have Dementia, and their families and carers, and to further develop a one-stop patient portal for other conditions, such as diabetes. (CPD 3.3)
- Further development, and roll out of eReferral, eDocument transfer, and eTriage to support safer, faster care.
- A process of guided self-assessment of organisational digital maturity in order to support the delivery of the eHealth and Care strategy.

4.2.4 People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

Everyone receiving health and social care should have the level of care appropriate to their needs. This is particularly important for those who may be in their later years or where there are co-morbidities such that decisions regarding the type of care and where that care is provided should take account of the individuals' clinical needs but also their personal choices and their priorities.

Reform of Domiciliary Care

As part of the wider reform of adult social care, the Social Care and Children's Directorate is leading on work to develop a new model of domiciliary care. A number of pilot 'proof of concept' projects are already in place regionally to underpin this work.

Domiciliary care is a lynchpin service and has a number of key strategic interfaces which in themselves underpin the wider HSC system (i.e. hospital, community, care homes sector, re-ablement and carer support).

In terms of scale alone, domiciliary care is a service of critical importance – in 2018 approximately 270,000 contact hours were provided; during a DOH survey week in September 2018, over 23,000 people were noted to be in receipt of this service.

Challenges relate to the reform of domiciliary care whilst ensuring the future sustainability of a service that plays such an important role in the lives of many of the most vulnerable people in Northern Ireland. The new service model will adopt an 'outcomes-based approach', focusing upon the achievement of agreed outcomes that are important to service users themselves.

Domiciliary care is provided by both statutory and independent sector providers so the stability of the provider base remains an important issue going forward, as too is the recruitment, retention and training of the domiciliary care

workforce - a workforce whose important role often goes unrecognised and whose own career aspirations and training needs can be overlooked.

Frailty Network

Frailty is not an illness, but a syndrome that combines the effects of natural ageing with the outcomes of multiple long-term conditions, a loss of fitness and reserves *(Lyndon 2014).* Frailty has been described as "one of the most challenging consequences of population ageing" (Clegg et al, 2013) and its prevalence increases with age. It is estimated that between a quarter and a half of our population aged 85+ are frail – this age group is also one of our largest population growth areas, with an estimated increase of 42% over the period 2019 to 2029 (NISRA mid-year estimates, 2016 based).

To support the objective of enabling older adults to live healthier and more fulfilling lives, the Frailty Network was launched in March 2019. Within the frailty programme, a structure has been established with wide reaching stakeholder input to develop services which support those identified as living with frailty as well has having a focus on prevention and early intervention to secure the best outcomes for our older population. During 2018/19, a number of key pieces of work were developed to support the establishment of this structure, including a detailed review of evidence on frailty, extensive service user engagement through Age NI and a frailty symposium, which prioritised the establishment of a network. During 2019/20 an expert panel will oversee a series of task and finish groups, which will explore and make recommendations on:

- Key public health messages around Frailty;
- Identification of Frailty;
- Assessment Tools for Frailty;
- Education;
- Service model / NI Roadmap for Frailty;
- Service user outcomes and experience.

In addition, a project ECHO (Extension for Community Healthcare Outcomes) has been established and commenced in June 2019. This draws together all groups involved in the care of those who are living with frailty and supports learning and sharing of knowledge. During 2019/20, Trusts will participate in the NHS Benchmarking Audit for Managing Frailty in Acute Settings and the NHS Benchmarking Audit for Intermediate care has been tailored to collect specific information on how frailty is assessed in community settings.

Self-Directed Support

Self-directed support is a unique partnership between families, individuals, HSC services, third and independent sector organisations and Government bodies.

Self-directed support and personalisation continues to enable people to plan and choose health and social care support that is more flexible and can better suit their individual needs. As part of personalisation, individuals are supported to make informed choices about meeting their assessed needs and where they wish to, are supported to manage the support they receive.

Self-Directed Support empowers people to direct their own care and support and to make informed choices about how their support is provided. Regardless of the care setting, services can be tailored to become more suited to individuals' choices and preferences.

As of March 2019, approximately 26,000 Service Users and 4,800 Carers have received a SDS package. Three levels of Self-Directed Support training was provided to approximately 10,000 HSC Staff and External organisations across the region.

Regional Implementation of Adult Social Care Outcome Tool (ASCOT)

ASCOT is suite of measures designed to capture information about an individual's social care related quality of life. ASCOT is a validated tool developed by PSSRU (Kent University) widely used across England Wales and Scandinavian countries as the tool of choice to measure Social Care related outcomes.

HSC Trusts in Northern Ireland use the ASCOT Tool in support of the Self-Directed Support Initiative to measure individual outcomes, and the impact of support service provision via the Social Care Related Quality of Life score (SCRQoL).

Locality Planning Groups

There are 27 Locality Planning Groups as part of the CYPSP focus on developing and supporting multi-agency early intervention approaches. These groups work to support early intervention for populations. All of Northern Ireland is covered by this network.

Locality planning is about improving outcomes for children, young people and families at a local geographic level. It focuses on how service delivery organisations can engage more effectively with the community to better understand local issues and to work together to produce more effective responses to those issues.

Locality planning is about understanding community assets and strengths and ensuring that service delivery organisations seek to support those assets/strengths. It does this by:

- Developing shared information, knowledge and expertise about the local area;
- Identifying opportunities to improve outcomes for children and young people by working better together;
- Building a commitment to early intervention;
- Building an effective partnership.

Palliative Care

Palliative Care is about improving the quality of life for those with needs and improving the experience of those important to them. The Regional Palliative Care Programme – *Palliative Care in Partnership*, brings together people with palliative care needs, those who care from them, clinicians and other professionals, service providers, planners and DOH to ensure we deliver a whole system, holistic approach to support and care. Ensuring that 'what matters to

me' is addressed for each person with needs, whether the need be physical, psychological, social or spiritual.

For some people, where they are cared for, matters to them. Given the choice most people would prefer to be cared for in their own home (which includes residential and nursing home) at the end of life. In 2017, 47% of all deaths occurred in hospital, 20% in nursing homes, 4% in hospices and 29% in other places (home). The Board and Agency aim to support a greater number of people who wish to be supported in their own home where this is appropriate.

To help people achieve their preferred place of care and ensure they have an optimal quality of life *Palliative Care in Partnership* is working to raise awareness of Palliative Care, implement processes to ensure earlier identification of palliative care needs, allocating those individuals with a keyworker to help co-ordinate care across the system. The service also aims to provide opportunities for people to have advance care planning conversations and record them if they wish to do so. These actions should continue to improve access to generalist and specialist palliative care services.

The Board and Agency also recognise the need for a greater societal discussion about planning for death, dying and bereavement and will be aiming to promote this conversation in the coming years.

4.2.5 Supporting those who care for others

Families and friends take on significant levels of caring for their loved ones making enormous contributions both to the HSC and society as a whole. For many carers, this commitment is life-long. As the needs of carers change, so too the type and nature of the support provided through HSC needs to change.

It is vital that carers have access to reliable, accurate information at a time that best suits them. In 2019/20 work will continue to ensure that information to support carers is available through the website, NI Direct.

Assessment of the needs of individual carers should be straightforward, requiring the least amount of bureaucracy as possible. In 2019/20 an electronic version of the NISAT Carers' Assessment will be rolled out, so increasing both the speed of assessment and reducing unnecessary duplication. Alongside this there is a requirement that the Trusts will provide staff training to promote carers' assessments ensuring that they are routinely offered and that carers are encouraged to participate in support planning (CPD 6.1).

The Board and Agency will ensure that the Standards and Key Performance Indicators in relation to support for carers contained in relevant Service Frameworks are adhered to and reported on regularly so that improvements can be identified.

The needs of young carers will continue to receive a particular focus, building on links with the voluntary sector which can offer support to meet the specific emotional and practical needs of young people who find themselves in the caring role. During 2019/20, the Board and Agency will seek to increase the number of *Understanding the Needs of Children in Northern Ireland (UNOCINI)* assessments provided to young carers.

Finally, work will continue within the Carers Strategy Implementation Group to ensure that the needs and views of carers are central to the development of

new and innovative ways to support carers, including the use of personalised budgets and self-directed support as appropriate.

4.3 Ensuring the sustainability of Health and Social Care services

A sustainable health and care system works within the available environmental, financial and social resources in order to meet the needs of the population today and into the future. This requires the HSC system to adapt how it delivers services, promotes health, improves prevention, understands its corporate social responsibility and develops more sustainable service models.

A sustainable health and care system is achieved by delivering high quality care and improved public health without exhausting these resources. This section of the Commissioning Plan sets out examples of service model redesign and workforce requirements to better utilise resources to meet the needs of the Northern Ireland population.

A sustainable health and care system should provide services which are evidence-based, available 24 hours a day / 7 days a week, providing good patient outcomes at all times. Due to the size of the population and changing demographics in Northern Ireland (see Section 2), some regional and local services find it difficult to sustain such service provision.

Specific issues affecting a range of services include the recruitment and retention of staff, the size and skill mix of the workforce and the ability to provide the minimum activity required for clinicians to maintain their skill level.

Links to other specialist providers

In some cases where the numbers of patients are particularly low for some specialist services, the Board, Agency and local Trusts will seek to establish links with other providers within GB and ROI.

Maintaining safe and effective acute specialist services is best supported through establishing a range of formal and informal clinical alliances with tertiary and quaternary providers in GB/ROI. These arrangements provide resilience to services locally as well as supporting clinical staff in areas such as peer review and participation in wider MDTs for more complex cases. Good

progress has been made on this with over 40 in-reach arrangements now in place to support adult and paediatric specialist services.

Regional Assessment and Surgical Centres

The Elective Care Plan (published in February 2017) sets out the approach to redressing the waiting list crisis through major reform and transformation to sustainably improve elective care services and build capacity in the HSC. The aim is to ensure the provision of day case services is more sustainable by locating such services in a small number of dedicated centres.

Two prototype Regional Assessment and Surgical Centres (RASC) for varicose veins and cataract procedures have been operational since December 2018 and form part of the long-term plan to reduce waiting lists. It is expected that the development of prototype RASC will increase productivity by between 15-30% which will help to reduce waiting times for patients.

In March 2018, the Department announced that the same approach is to be rolled out across a wide range of specialties, meaning the provision of thousands of day case routine operations will be transferred to dedicated sites. The aim is to move all clinically appropriate day case surgery to RASC by December 2020. The specialties involved are general surgery and endoscopy, urology, gynaecology, orthopaedics, ENT, paediatrics and neurology. Newly established groups will take plans forward in each specialty, including identifying preferred sites for the centres. This work will help inform a regional model for day case surgery across Northern Ireland.

Daisy Hill Pathfinder

Building on the success of the Daisy Hill Pathfinder project in 2018/19, the Southern LCG will continue to work with the Southern Trust and other stakeholders to take forward other recommendations of the Pathfinder Group including a model of care which will meet the unscheduled care needs of the people of Newry and Mourne.

Fermanagh and West Tyrone Pathfinder

In 2019/20, the Board and Agency will work with the Western Trust which is currently progressing the concept of 'Connected Communities', with the aim of connecting particularly isolated areas in Fermanagh and South Tyrone to health services and community services. The Pathfinder will identify which services are required to meet the needs of the population and determine how these services can be sustained over the long term.

Breast Assessment

There are challenges sustaining breast assessment services in every Trust. Breast Assessment services in Northern Ireland have, over the past number of years, at different times and in different locations, encountered difficulties in delivering timely access to breast assessment for cancer. These challenges have arisen largely as a consequence of issues with the recruitment and retention of key clinical staff, in particular consultant radiologists.

The changes proposed are currently the subject of a public consultation after which the Board and Agency will work with Trusts to take forward implementation measures as determined by DoH.

4.4 Supporting and Empowering Staff delivering Health and Social Care Services

The workforce is the most valuable asset in Health and Social Care Services and can, at its best, be at the forefront of a high quality, safe and effective service. Attracting, recruiting and retaining staff continues to be an issue across a range of service areas. Recognising and valuing the contribution of the workforce, improving workforce intelligence and workforce planning will be a key theme in the *Health and Social Care Workforce Strategy 2026* for Northern Ireland.

The Commissioning Plan Direction sets out a number of specific actions to support the workforce in 2019/20. The HSCB and PHA will work in partnership with relevant other relevant organisations to take forward the following actions:

- Contribute to delivery of Phase One of the single lead employer project (CPD 8.1)
- Provide appropriate representation on the project board to establish a health and social care careers service (CPD 8.2).
- Produce a health and social care workforce model (CPD 8.4).
- Reduce Trust staff sick absence levels by a regional average of 5% compared to 2017/18 figure (CPD 8.7).
- Improve uptake up in annual appraisal of performance during 2019/20 (CPD 8.10)
- Commence implementation of a regional training framework which includes suicide awareness and suicide intervention for all HSC staff (CPD 8.12).

It will also be important that this is supported by systems that promote multidisciplinary training, multidisciplinary blended skill mix and attracting, recruiting and retaining enough of the right people, with the right skills into Health and Social Care.

A number of other specific areas of development are outlined below and within the programmes of care detailed in Section 5.

Multi-Disciplinary Teams (MDTs)

Health and Wellbeing 2026: Delivering Together sets out a vision for an enhanced primary care service, within a set of reformed HSC services. It highlights the need to move towards a system that seeks to deliver mental, physical and social wellbeing. The Primary Care Multi-Disciplinary Team will be responsible for this strategic programme in order to deliver reform and service improvement with significant impact across care settings. Multi-Disciplinary Teams (MDTs) involve the inclusion t of practice-based physiotherapists, mental health workers and social workers in GP practices; these professionals will work alongside GPs and practice staff with the aim of better meeting the needs of the local population. Significant investment in additional nursing specialist roles such as health visiting and district nursing has been made as part of the MDT model.

Delivering Care

Currently there are eight phases underway within the Delivering Care Framework. During 2019/20, the Board and Agency will continue to work with Trusts to further develop each phase in line with the Delivering Care Nursing Framework. There will be a greater emphasis on enhancing the role of nurse prescribers in primary and secondary care, and additional non-medical prescribing places will be commissioned, which will also support the transformational agenda.

District Nursing Framework

The District Nursing Framework (2018-2026) provides the strategic direction for the provision of district nursing services in Northern Ireland. The Public Health Agency is leading on the implementation of the Framework using a collective leadership approach. The Regional District Nursing Framework Implementation Group includes a wide range of stakeholders and continues to provide oversight and direction. A number of works streams will continue to deliver key outcomes and include:

- Neighbourhood District Nursing;
- Quality Indicators;
- Education, Workforce and Succession Planning;

- Information and IT; and
- Safe caseloads.

The Agency will also provide support to the development of a career pathway for district nursing

Enhanced role of AHPs

Allied Health Professions (AHPs) are critical to the ongoing assessment, treatment and rehabilitation of patients throughout the illness episodes whether transient or long lasting. AHPs enable children and adults to make the most of their skills and abilities and to develop and maintain healthy lifestyles. They play a crucial role in 'transitioning' patients between different care settings and across service boundaries within health services, e.g. from secondary care to primary care. Advanced practice AHPs are contributing to the transformation of primary care as part of the wider primary care multi-disciplinary care teams and in the transformation of secondary care, improving patient flow, and expediting diagnosis and prevent hospital admissions.

The DoH has mandated that Paramedics are now designated as AHP professions. As part of HCPC registration, Paramedics are now moving towards being an all graduate profession. Interim arrangements for registration involve Paramedics completing a foundation degree at University of Ulster. Trusts, through AHP Leads, are now tasked with facilitating non-ambulance clinical placements for Paramedics. These placements currently involve 150 hours across a number of departments - including emergency departments, coronary care units, theatres, obstetrics, gynaecology and paediatric wards. Therefore AHP Leads must liaise closely with Trust Executive Directors of Medicine, Trust Executive Directors of Nursing, University of Ulster Lead Educators and NIAS Lead Educators to ensure appropriate governance frameworks are in place around these placements.

In Northern Ireland, on average 31,000 referrals per month are made to 'elective AHP services' equating to around 374,000 elective referrals per year. As the population ages and with the anticipated increase in the burden of Long Term Conditions this is expected to increase. In addition to elective services,

patients also require timely access to AHP services in acute hospital services, specialist tertiary services and in hospital outpatient settings. Specific areas for development in 2019/20 are as follows:

- ensuring that by March 2020, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional (CPD 5.3);
- implementing non-medical independent prescribing for physiotherapists and podiatrists in primary and secondary care;
- completing Statutory Assessment advice reports to the Education Authority (EA) within the designated timeframe for children with possible Special Educational Needs (SEN);
- embedding the regional podiatry led diabetic foot-care pathway;
- implementing the recommendations of the DOH AHP workforce reviews and the AHP element of the Interdisciplinary Specialist Palliative care workforce review;
- extending the rollout of Direct Access Physio across all Trusts based on a state of readiness (CPD 5.5);
- piloting first contact physiotherapy in primary care;
- developing dysphagia services (CPD 5.4):
    - develop regional dysphagia training (CPD 8.13);
    - evaluate the impact of food/fluids terminology (IDDSI);
    - work towards improved access to specialist assessment including an evaluation of innovations in dysphagia practice;
    - provide minimum recommendation for the provision Northern Ireland dysphagia friendly food;
    - improve the awareness and reporting of dysphagia Serious Adverse Incidents and Adverse Incidents;
    - develop a dysphagia personal and public involvement forum;
    - standardise SLT dysphagia reporting.

Enhanced role of Pharmacists

The use of medicines is the most common healthcare intervention with over 40 million prescriptions for medicines issued in primary care alone each year. The cost and complexity of medicines use has increased over the past 20 years in line with demographic changes. Those demographic changes have seen the rise in long term conditions and it is now common for people to be ten medicines in order to manage a range of conditions. Such polypharmacy may be necessary in certain cases. However with polypharmacy, there is a need for patients, carers and healthcare professionals to know about the medicines that are prescribed, understand the treatment goals and monitor their effects so that positive outcomes are achieved. The need for greater management of medicines has been well recognised given the inherent risks associated with medicines. To that end, there has been a shift in emphasis for the pharmacy workforce. Pharmacists are respected for their broad knowledge around medicines. The use of their skills in more patient facing roles has developed over the years and this has seen pharmacists being moved into clinical pharmacy roles including roles in which they can prescribe.

In Northern Ireland, each Trust has a designated Medicines Optimisation in Older People (MOOP) Team headed up by a consultant pharmacist. In primary care, there has been a significant development of the role of Pharmacists based in GP practices. These staff undertake clinical medication review, medicines reconciliation and support more effective management of repeat prescribing. In order for pharmacists to take on these more clinical roles, there has been the development of the role of Pharmacy technicians to support the dispensing function.

The introduction of dispensing robots has also supported the development of the workforce with automation replacing some of the routine dispensing tasks. During 2019/20, there will be a continued focus on clinical pharmacy services in primary and secondary care and developing the workforce appropriately to ensure the delivery of both new clinical roles and the maintenance of safe and effective dispensing practice.

Enhanced role of nurse prescribers

A UK study (2011) [4] highlighted the growing evidence of the competency of nurse prescribers, and the need to focus more on the impact that the role may have on enhancing the quality and safety of patient care. A Review into the Impact and Status of Nurse Prescribing in Northern Ireland 2014[5] included patients'/service users' experience and impact on patients of nurse prescribers.

Patients were asked through an adapted questionnaire to evaluate both the benefit and the impact of the nurse prescribing role. A total of 150 responses were received from patients who were in contact with nurse prescribers from cardiology; primary care; mental health; respiratory; dermatology; acute pain clinic and through Macmillan services; smoking cessation; catheterisation laboratory; vascular and diabetes. The positive messages received were found to be similar to findings in other studies, and clearly indicated the impact on patients. The benefits include improved access to appropriate advice and medication, greater understanding and ability to self-manage.

During 2019/20 there will be a greater emphasis on enhancing the role of nurse prescribers in primary and secondary care, and additional non-medical prescribing places will be commissioned, which will also support the transformational agenda.

[4] Jones K. , Edwards M. & While A. (2011) *Nurse prescribing roles in acute care: an evaluative case study*. Journal of Advanced Nursing 67(1), 117–126. doi: 10.1111/j.1365-2648.2010.05490.x

[5] http://www.nipec.hscni.net/download/projects/previous_work/provide_adviceguidanceinformation/impact_nurseprescribing/publications/NursePrescribing-Final.pdf

5.0 HSC SYSTEM WIDE COMMISSIONING

5.1 Cancer Services

Service Context

Cancer is primarily a disease of older people. As our population both ages and grows, so too does the incidence of cancer. Around 24 people are diagnosed with cancer each day in Northern Ireland, around 8,500 per year. By 2026, this is expected to rise by around 40% to approximately 12,200 cases per year[6]. Current estimates suggest that around 87,000 people have lived with cancer over the last 10 years. With more new diagnoses and improvements in care and survival, the number of people living with and beyond care is increasing every year. As the incidence and prevalence of cancer continues to grow and as new and innovative treatments continue to emerge, ensuring that people with cancer have the right care and support across their care pathway will present a growing challenge.

Service Challenges in 2019/20

The Oncology Services Transformation Project commenced in April 2018, reviewing the current service across Northern Ireland. The project is bringing together cancer professionals, people with lived experience of cancer, cancer charities and GPs. Having identified a range of themes in the current service, the transformation project is using a Quality Improvement approach to bring forward new and improved patient pathways for both Systemic Anti-Cancer Therapy (SACT) and Radiotherapy. These pathways have been co designed with people living with cancer and involve new ways of working supported by practitioners with advanced skills in nursing, pharmacy, therapeutic radiography and medical physics working in a medically led and supported service.

Achievement of Departmental Targets

The Board and Agency will continue to work with Trusts through the specialty-specific regional groups that have been established to develop innovative long term solutions to the ongoing workforce and capacity issues in these services. Pending the implementation of longer term solutions, the Board will continue to

[6] http://www.qub.ac.uk/research-centres/nicr/CancerInformation/official-statistics

hold monthly performance meetings with all Trusts via the Cancer Service Improvement Forum. This will facilitate the sharing of best practice across the region and identify opportunities for delivering improved performance, specifically in relation to cancer referrals and treatment times (CPD 5.1).

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency, working through the existing regional structures, will continue to seek to improve the availability, accessibility and patient experience in relation to cancer services. In addition to the ongoing pressures in relation to cancer 62 day waits, one of the key areas of focus will continue to be the growing pressures in the provision of non-surgical oncology.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to deliver cancer access targets. (CPD 4.10)	Trust responses should demonstrate plans to improve compliance against cancer access standards across all relevant services.
2.	Effective arrangements should be in place to work as part of a network to ensure timely access to breast assessment across Northern Ireland.	Trust responses should demonstrate a willingness to take forward recommendations from the Review of Breast Assessment Services.
3.	Effective arrangements should be in place to support peer review of the SACT service and review of the sarcoma and thyroid MDTs.	Trust responses should demonstrate plans to participate in peer review and to take forward any actions that may arise.
4.	Effective arrangements should be in place to ensure implementation of the Regional Information System for Oncology and Haematology (RISOH) within haematology services.	Trust responses should demonstrate a clear commitment to the implementation of the electronic patient record and electronic prescribing modules of RISOH within haematology services in line with the agreed regional project plan.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to further develop radiotherapy services across Northern Ireland.	Northern Ireland Cancer Centre (NICC) and North West Cancer Centre (NWCC) to roll out delivery of Deep Inspiration Breath Hold (DIBH) across Northern Ireland to Breast patients who would benefit from this Radiotherapy technique. Belfast Trust response should confirm the establishment of a regional service to deliver Stereotactic Ablative Radiotherapy (SABR) for Oligometastatic disease and Lung patients at NICC during 2019/20.
6.	Effective arrangements should be in place to support the delivery of a sentinel lymph node biopsy (SLNB) service for malignant melanoma.	Trust responses should demonstrate a willingness to work with the Board and Agency to agree and implement a regional pathway and service specification for SLNB for malignant melanoma.
7.	Effective arrangements should be in place to improve the patient experience of people using cancer services.	Trust responses should demonstrate a commitment to taking forward actions arising from the findings of the 2018 Cancer Patient Experience Survey.

Transformation

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to ensure the provision of appropriate non-surgical oncology services.	Trust responses should demonstrate plans to transform non-surgical oncology services including the development of project prototypes and appropriate skill mix.
9.	Effective arrangements should be in place to ensure the provision of SACT.	Trust responses should demonstrate a clear commitment to taking forward plans for the expansion of non-medical prescribing of SACT and take forward any recommendations from the peer review of the service.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
10.	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce in Northern Ireland in line with national benchmarks and the agreed regional CNS development plan.	Trust responses should demonstrate the particular actions to be taken in 2019/20 to expand the CNS workforce and to demonstrate impact through the collation of regionally agreed KPIs.

5.2 Care of the Elderly

Service Context

The most significant demographic change impacting on health and social care services is the increase in the number of people aged over 65, particularly those over 85. Although many have healthy and active lives, older people place significant demands on acute and community services. This demographic have made significant contributions to the system over their lifetime in terms of tax and National Insurance paid, so at this stage of their lives, older people should expect access to a range of high quality services that will meet their needs in a timely and appropriate manner.

Whilst there is a need to continue to promote healthier lifestyles, encourage independence and support carers, the challenges associated with managing the interface between acute and community services and sustaining a viable network of community based support services are priorities which need to be addressed. Within this context, a Shared Lives approach is planning to develop and strengthen the provision of its services for older people. Shared Lives approaches recruit and match dedicated individuals to provide service users who require long or short term placements within host care homes.

'Power to People: proposals to reboot adult care and support in Northern Ireland' - The Expert Advisory Panel emphasised at the outset the fundamental importance of a human rights approach in which people with care and support needs enjoy the same entitlements to quality of life and wellbeing as all other citizens.

Service Challenges in 2019/20

- Supporting the development of services and care pathways for older people that offer improved choice and better enable people to live full and independent lives in the community.
- Ensuring the achievements of the Dementia Strategy are resourced and further embedded into Trust services as a best practice model.

- Improving patient flow within the acute sector - addressing avoidable discharge delay issues.
- Working with the independent care home and domiciliary care sector to ensure the market has the flexibility and capacity to respond to increasing demands for service.
- Ensuring the required workforce expertise and skill mix are available to support the new models of care and support developed as part of the reform of adult social care agenda.
- Cascade peer education/self- protection programmes such as "Keeping Yourself Safe" or equivalent training for Adults at Risk of Harm across services and settings.
- Offer a model of social care using a Shared Lives approach which enables older people to remain living in their communities, build long term sustainable relationships and reduce social isolation.

Areas of development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to services for older people. Specific issues and opportunities in 2019/20 are as follows:

- Continue to develop and implement Self-Directed Support service arrangements that create real choice and control for services users and Carers to manage or commission social care support (CPD 5.1 & CPD 5.2).
- Continue to implement a regional Outcomes support planning approach that delivers personalised services to support Service Users and those who Care for them.
- Continue to support the integration of ASCOT into HSC Trust Community Information Systems.
- Fully Integrate outcome focused approaches across all programmes of care and social care practice.

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure the implementation of requirements contained in Adult Safeguarding and Protection in Partnership (2015).	Trust responses should demonstrate plans to promote the development of the Adult Protection Gateway model.
2.	Effective-arrangements should be in place to support people living with frailty. The Frailty Network was launched in March 2019 and a structure has been established with wide reaching stakeholder input to develop services which support those identified as living with frailty as well has having a focus on prevention and early intervention to secure the best outcomes for older people.	Trusts will continue to participate in frailty network initiatives. Trusts will continue frailty prototypes operational since 2018, in line with direction from the Frailty Expert Panel. This includes the provision of scheduled monitoring and evaluation information to contribute to discussions around future models of care. Trusts participate in the NHS Benchmarking Audit for Managing Frailty in Acute Settings. Trusts should ensure that data requirements are met in line with agreed timescales.
3.	Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with dementia.	Trust responses should outline plans to work with ICPs to scope and cost a phased approach to the new stepped care model for older people and for people with dementia.
4.	Effective arrangements (local and regional) should be in place to ensure continuity of care in the event of any business failure / closure within the Care Home Sector.	Trusts should work with Board/Agency and other relevant organisations to ensure regional contingency plans are in place to respond to Care Home Closures, specifically where a service failure incident occurs that is beyond the capacity of an individual Trust to respond effectively.
5.	Effective arrangements should be in place to implement the recommendations of the National Audit of Intermediate Care (NAIC) in 2018, particularly in relation to bed based Intermediate Care.	Trust responses should demonstrate plans to develop multi-disciplinary home based services.

6.	Effective arrangements should be in place to provide shared lives approaches of care to older people who may require short breaks or long term placements (CPD 6.2).	Trust responses should demonstrate outline plans to implement shared lives approaches into their services for older people.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to optimise capacity to meet the needs of people with dementia.	Trust responses should demonstrate plans to work within the regional strategic implementation arrangements to develop early intervention models and timely access to memory services.
8.	Effective arrangements should be in place to address the issue of delayed discharges from the acute sector and other institutional settings due to the non-availability of independent sector community based services especially domiciliary care.	Trust responses should demonstrate plans to ensure capacity within the community /domiciliary sector to accommodate timely hospital discharge.
9.	Effective arrangements should be in place to provide services for carers that can be developed to maintain individuals to live as independently as possible in their own home (CPD 6.1 & 6.2).	Trust responses should demonstrate plans to expand and promote the assessment of needs and the availability and uptake of short breaks.
10.	Effective arrangements should be in place to review existing day opportunities for older people to ensure that they meet current needs and expectations.	Trust responses should demonstrate plans to review existing day care provision to make best use of resources.
11.	Effective arrangements should be in place to support the full implementation of the regional model of reablement.	Trust responses should demonstrate a review of local progress with reablement, in line with the regional model and targets.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
12.	Effective arrangements should be in place to optimise recent demography funding to meet domiciliary care demand and wider demographic demand.	Trust responses should demonstrate plans to deliver the recent investment in demography to meet the needs of the aging population. Trusts should also demonstrate how their plans better position their services to deliver the new regional model of domiciliary care.
13.	Effective arrangements should be in place to optimise capacity to support the numbers of people aged over 65 and over 85.	Trust responses should demonstrate plans to actively promote a range of healthy ageing initiatives in areas such as promoting good nutrition, social inclusion and falls prevention.
14.	Effective arrangements should be in place to support an appropriate balance of services between the statutory and independent sectors in relation to domiciliary and residential care. (CPD 2.8)	Trust responses should demonstrate plans to support reform of statutory residential care, domiciliary care and the Reform of Adult Social Care.
15.	Effective arrangements should be in place to support the development of intermediate/step down care to relieve pressures on acute care and promote rehabilitation.	Trust responses should demonstrate options to remodel existing provision or develop new services.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
16.	Effective arrangements should be in place to promote self-directed support to increase individual choice and facilitate responsive remodelling of service models. (CPD 5.2)	Trust responses should demonstrate plans to optimise opportunities for services tailored to user needs and include the training and development of staff.
17.	Effective arrangements should be in place to ensure there is appropriate skill mix within the domiciliary care workforce to facilitate the implementation of the new domiciliary care model (CPD 8.3).	Trust responses should evidence planning around the recruitment, remuneration, recognition and retention of the domiciliary care workforce.

5.3 Elective Care

Service Context

Elective care is care that can be scheduled in advance because it does not involve and emergency.

Demand for Elective Care services continues to exceed current Trust capacity, resulting in increasing waiting times to access elective services across Northern Ireland. Until mid-2014, a programme of planned recurrent and non-recurrent investments had the effect of reducing outpatient, diagnostic, inpatient and day case waits, however the challenging financial position and underperformance since then has resulted in a deterioration of waiting times.

The Department of health published the Elective Care Plan in 2017 which sets out plans to transform primary, community and secondary care services to meet future demand for elective care. The Board and Agency will continue to work with Trusts, Integrated Care Partnerships and GP Federations and other primary care providers including optometrists and dentists to further develop and implement plans to reform and modernise elective care services consistent with the commitments set out in the Elective Care Plan.

Service Challenges in 2019/20

A growing elderly population, increasing patient expectations and advances in medicine and technology, coupled with the current recruitment and retention challenges will have a direct impact on service delivery in 2019/20.

During 2019/20 work to ensure effective arrangements are in place to provide appropriate vaginal mesh services. Trusts should contribute to and work with the Northern Ireland review of complex uro-gynaecology services necessitated by the vaginal mesh pause and publication of revised NICE guidance.

Achievement of Departmental Targets

Investment is required in both core service and waiting list initiatives in 2019/20 to reduce waiting times and deliver sustainably shorter waiting times by

ensuring capacity is sufficient to meet demand (CPD 4.9, 4.11, 4.12 and 4.13). Additional inpatient beds, theatres and scanning equipment, supported by consultants, nursing, imaging, AHP and other clinical staff will be required to meet current capacity gaps. The Board and Agency will continue to work with Trusts to maximise the delivery of funded capacity and ensure the application of good waiting list management.

The Board and Agency will also continue to work with Trusts to ensure patients in adult inpatient areas are cared for in the same gender accommodation where appropriate. (CPD 3.1)

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to services for elective care.

The HSCB and PHA work with Trusts to establish a baseline of the number of hospital-cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment (CPD 7.3) and reduce the percentage of funded activity associated with undelivered elective care services (CPD 5.3).

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to establish and implement a regional programme of pathology transformation.	Trust responses should confirm the Trust will continue to engage with and support the establishment of the Regional Pathology Agency including: • The regional workforce and training plan; • The quality and regulatory framework; • The clinical effectiveness strategy; • The LIMS Programme Plan.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place in primary and community care settings to minimise the need for patients to be referred by GPs and wider primary care to hospital consultants for specialist assessment.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to support the development of new enhanced services in primary and community care settings in a range of specialities including: • Minor Surgery • Gastroenterology • ENT • Gynaecology • Dermatology • Dermatology Photo Triage • Rheumatology • MSK/Pain Management • Trauma and Orthopaedics • Cardiology • Neurology • Urology • Ophthalmology • Vascular surgery • Vasectomy
3.	Effective arrangements should be in place to establish Regional Assessment and Surgical Centre's across Northern Ireland.	Trust responses should demonstrate how they are supporting the planning and implementation of Regional Assessment and Surgical Centres (RASC) in a number of areas as follows: • 2 prototype RASCs for varicose veins and cataracts • General Surgery • Endoscopy • Urology • Orthopaedics • Gynaecology • ENT • Paediatrics • Neurology

4.	Effective arrangements should be in place at the interface between primary and secondary care, organised around the needs of patients with effective communication between GPs and wider primary care and hospital consultants.	Trust responses should confirm that they will continue to engage with and support the regional scheduled care reform process, working with appropriate partners, to include further roll out of e-referral and e-triage arrangements. Trust responses should demonstrate actions to improve the efficiency and effectiveness of outpatients, diagnostics and treatment services in line with the Transformation, Reform and Modernisation agenda, which includes partnership working with ICPs.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to improve further the efficiency and effectiveness of elective care services (outpatients, diagnostics and inpatients/day case treatment) delivered by Trusts.	Trust responses should demonstrate the specific actions being taken in 2019/20, working with appropriate partners, to improve elective care efficiency and effectiveness including: • Development of one stop 'see and treat' services linked to unscheduled care services as appropriate. • The rollout and uptake of e triage to help streamline the patient pathway. • Application of Transforming Cancer Follow Up principles to transform review pathways. • Maximisation of skill mix opportunities in the delivery of assessment, diagnostic and treatment services. • Direct access diagnostic pathways to improve patient access to appropriate tests.
6.	Effective arrangements should be in place to support the monitoring of clinical outcomes to further improve the quality and effectiveness of interventions.	Trusts should demonstrate the specific actions they are undertaking to expand Patient Reported Outcomes Measures (PROMS) and other similar indicators.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to ensure the appropriate volume and case mix of staff are in place to deliver the agreed strategic priorities.	Trust responses should demonstrate that all reasonable steps have been taken to fill all vacant posts and, where clinically appropriate, increase skill mix.

5.4 Family and Childcare Services

Service Context

The Family and Child Care Programme is a legislated service with adherence demonstrated through the Delegation of Statutory Functions. Children are presenting with increasingly complex needs which continues to place demand on resources. An increased focus on societal awareness and responsibility for the wellbeing of children is required to ensure that all children have a positive experience of childhood. Where additional support for families is required, it should be made available at the earliest opportunity to help prevent future trauma as well as inputting positively to a child's emotional and mental well-being. This will be supported by the delivery of the Children and Young People's Developmental and Emotional Wellbeing Framework.

Regional and Trust based care placement services are integral to meeting need and the provision of care and accommodation to children and young people who become subject to care arrangements under the *Children (Northern Ireland) Order 1995*.

At March 2019 there were 3,286 children in the care of Trusts (5.5 % in residential children's homes and 78.1% in kinship and non-kinship foster care). On occasions, and based on assessed needs and risk, a small number of children are placed in regional specialist facilities or in placements outside of the jurisdiction.

Service Challenges in 2019/20

The number of children in care is steadily increasing year on year. Placement capacity to respond effectively to increasing demand is evident across all Trusts. A key challenge going forward is to meet the increasing need for appropriate placements that will effectively meet the increasingly complex needs of children who require a care placement.

Other challenges include workforce availability, meeting the needs of children with a disability and complex health care needs, capacity of the CAMHS service to meet assessed need as base line funding has not been increased since 2012, prevention and early intervention services.

The Board, and in particular the Social Care and Children Directorate, will continue to work with Trusts to discharge a number of Statutory Functions including Safeguarding. The reporting arrangements for Delegated Statutory Functions will be reviewed in 2019/20 (CPD 7.2).

Achievement of Departmental Targets

The increasing demand for Child and Adolescent Mental Health Services (CAMHS) remains a challenge and the Board will continue to work with Trusts to complete and implement the regionally agreed CAMHS Integrated Care Pathway and to reconfigure existing investment to establish a Managed Care Network for Children and Young People with Acute and High Intensity Care Needs to ensure a more standardised approach and streamlined access to services.

In working to ensure, as far as possible, that children grow up in a stable environment, the Board will build on the work carried out with Trusts in actively reviewing and redesigning the regional facilities and promoting residential care structures. Trusts will also complete the *Understanding the Needs of Children in Northern Ireland (UNOCINI) Review* which the DoH will lead on as part of the roll out of the implementation of Signs of Safety Framework.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient/client experience in relation to family and childcare services. The *Signs of Safety Framework* will be part of this improvement process into 2019/20. Sitting alongside this will be the implementation of

Adverse Childhood Experiences (ACEs) and Trauma informed practices across Trusts, which will form the foundation of the reform and modernisation of children's services into the future.

Implementation of key priorities identified through the regional workshops during 2018/19 which focussed on edge of care, children in care/placement services, post adoption support and children with a disability will be a primary focus of the work during 2019/20. This work will be undertaken in parallel to the recommendations of the review of regional services for children and young people.

The Board will continue to support the Children and Young People's Strategic Partnership (CYPSP) to develop effective early intervention support services. The CYPSP supports vulnerable families through a Northern Ireland wide early intervention infrastructure. The CYPSP partners are committed to supporting this model.

The development of the model will be set within the strategic context of the Executive Children and Young People's Strategy for Northern Ireland (2017-2027), the draft Family and Parenting Support Strategy for Northern Ireland and the Looked After Children Strategy. The model consists of the Outcomes Groups, Family Support Hubs, the Locality Planning Groups and the network of early intervention services.

Specific issues and opportunities in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to implement the Managed Care Network for Children and Young People with Acute and High Intensity Care Needs as recommended by the independent review into CAMHS Inpatient Services (CPD 4.14)	Trust responses should demonstrate plans to contribute to the development and establishment of a Managed Care Network for Acute CAMHS which includes Secure Care, youth Justice and Forensic CAMHS to deliver a more consistent service across the region and equitable access to acute services.

2.	Effective arrangements should be in place to prevent the increasing threat of Child Sexual Exploitation (CSE) as identified by the Marshall Inquiry.	Trust responses should detail their reporting arrangements to the Board in relation to the regional action plan and ensure that the CSE leads continue to coordinate CSE Trust assessments.
3.	Effective arrangements should be in place to safeguard children and promote their welfare in line with Co-operating to Safeguard Children (2017).	Trust responses should demonstrate plans to • provide effective safeguarding services • ensure robust HSC child protection processes are in place • ensure safeguarding policy and procedures are in place relating to referrals, assessment, service planning, case management and record keeping • monitor and audit effectiveness of policy, practice and service provision in achieving specified outcomes for children and young people. • ensure access to an effective range of therapeutic supports based on assessed needs.
4.	Effective arrangements should be in place to meet the requirements of the Children's Co-operation Act (2015) and the Special Educational Needs and Disability Act (2016).	Trusts responses should demonstrate plans which • evidence partnership working with the EA • evidence improvements in the provision of timely advice for children undergoing Statutory Assessment • deliver necessary support/interventions to meet children's identified needs.
5.	Effective arrangements should be in place to improve data collection in CAMHS services to capture need, demand activity, outcomes and service user experience.	Trust responses should demonstrate how they will use information to assess the effectiveness of CAMHS and evaluate outcomes, fully implement CAPA and ensure effective case management in line with NICE guidance. Trusts responses should demonstrate plans to strengthen NICE approved Psychological Therapies to include a skills analysis and workforce plan to identify gaps in the delivery of evidenced based therapies and skill mix

		requirements to deliver a range of therapeutic interventions.
6.	Effective arrangements should be in place to support the CYPSP multiagency children's services planning process	Trust responses should set out how the work of the Outcomes Group and the network of family support hubs and locality planning groups are to be supported.

Patient / Client Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to appropriately manage the increasing number of children with complex health care needs and challenging behaviour.	Trust responses should demonstrate how service provision will meet the needs of children with complex health care needs and challenging behaviour and that Trusts demonstrate how funding has addressed the core issues.
8.	Effective arrangements should be in place to appropriately manage the increasing number of Looked After Children (LAC) entering the system. (CPD 1.12)	Trust responses should demonstrate how: • criteria will be set to ensure children become looked after where there is a clear indication that their long term outcomes will be improved or removal is required in order to safeguard the child/young person; • Trusts should also evidence a systematic approach in reducing the need for children to become looked after through prevention and family support services • initiatives will be put in place to increase the number of placements and specify how these will be provided including the development of regional retention and recruitment strategy for foster care, for the recruitment of specialist foster carers, parent child placements, post adoption support and stability of placements/prevention of placement disruptions and breakdowns in placements; • support will be provided to young (16/17 year olds), homeless individuals who are seeking to achieve a safe, stable return to a family;

		• appropriate safeguarding measures will be put in place for extra-ordinary placements; • intensive edge of care interventions and family support will be provided to enable children to remain within their families where this is in the child's best interest. • required volumes of service activity for 2019/20 will be delivered.
9.	Effective arrangements should be in place to ensure the stability of mainstream care placement arrangements for children in care	Trust responses should demonstrate a reduction in unplanned care placement moves for children in care and use of effective interventions to deescalate crisis and prevent moves for children in care, particularly into high end regional facilities
10.	Effective arrangements should be in place to appropriately manage the increasing number of unplanned/emergency placements where children are known to a Trust.	Trusts should demonstrate effective use of Network meetings, FGC, Pre Proceedings Resource panel to ensure contingency arrangements identified which best meet the assessed needs of children and young people where there is the potential for an admission to care.
11.	Effective arrangements should be in place to ensure a seamless care pathway for LAC which promotes stability and permanency for children. (CPD 3.2)	Trust responses should demonstrate arrangements to ensure stable care pathways for LAC and deliver permanency within the quickest possible timeframe. Effective arrangements and monitoring should be in place to ensure LAC achieve permanence in line with the agreed policy. Trust responses should demonstrate plans to ensure equitable access to GEM (Going the Extra Mile) services for all young people in foster care in line with regional policy and procedures on permanence and the outworking of the Trust permanency panels.
12.	Effective arrangements should be in place to ensure that children's care plans	Trust responses should demonstrate how robust assessments (in keeping with policy and

	explicitly state what is to be achieved by the admission to care, the child and young person's views about their care plan, what is expected from parents in order for the child to return home and the anticipated duration of the placement. (CPD 3.2)	procedures) will be undertaken for all children who are to return home, enabling the Trust to determine the feasibility of such a move and to identify any support required to maintain the placement and discharge any existing Care Order. This assessment should outline how the child/young person's views have been taken into account in agreeing the care plan.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
13.	Effective arrangements should be in place to meet the increasing demand for Autism Services to include the creation of an integrated care system for Children, Young People with Developmental, Emotional and Mental Health services.	Trust responses should demonstrate plans to address autism waiting lists in line with the Autism Access Standard and support the development of an integrated service model to include assessment, early intervention, diagnostic and transitional services supported by using the additional recurrent funding identified by the Board.
14.	Effective arrangements should be in place to manage the increasing demand in CAMHS and the continued implementation of the stepped care model focusing on: improvement of the interfaces between acute and CAMHS community care including secure care and Youth Justice; integration of CAMHS and children's neurodevelopmental (autism and ADHD) provision.	Trust should demonstrate plans to: • Demonstrate the management of service demand. • Improve interface arrangements between CAMHS acute and community care, secure care and with Youth Justice. • Integrate CAMHS, Autism and ADHD services to ensure effective access based on assessed needs to children, young people and their families. • Ensure implementation of the CAMHS Integrated Care Pathway.
15.	Effective arrangements should be in place to strengthen and improve placement services for children	Trusts should evidence developments to improve placement services including residential care, foster care and post adoption support.
16.	Effective arrangements are in place to ensure transitions/exit from care, are timely and well planned and co-	Trusts should evidence arrangements are in place to ensure young people in transition placements or being discharged from care have

	ordinated.	robust plans which demonstrate a current assessment of their needs, how these will be met and arrangements for ongoing monitoring and support.

5.5 Family Practitioner Services

Family Practitioner Services provide the first point of contact in the health care system, acting as the 'front door' to health and social care in Northern Ireland. Family practitioner services include general medical contractors, general dental contractors, general ophthalmic contractors and pharmacy contractors.

5.5.1 Dental Services

Service Context

There are 1,050 General Dental Practitioners (GDPs) in Northern Ireland working across 380 practices. Approximately 1.1m people are registered with a GDP for health service care and each year under the General Dental Services (GDS) over 1.7m courses of treatment are provided. In the past, the Northern Ireland population had poor oral health, however, in recent years significant improvements have been observed in both children's and adult's dental health.

Service Challenges in 2019/20

As a result of demographic changes within Northern Ireland the proportion of the population classified as elderly has grown by 35% over the last 10 years. Also in recent decades the levels of tooth loss among adults has fallen dramatically. Taken together, these trends have resulted in rapid growth in the number of frail elderly patients with significant oral health needs.

Achievement of Departmental Targets

The Board and Agency will contribute to the DoH Children's Oral Health improvement Group to improve the oral health of children and young people in Northern Ireland. (CPD 1.6)

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing structures will continue to seek to improve the availability, accessibility and patient experience in relation to dental services.

Integrated Care will seek to take forward the following:

- developing a pilot PDS scheme to enhance primary care service provision for elderly people who are dependant.
- inviting expressions of interest for a standardised new primary care oral surgery contract in Quarter 4.
- continuing the existing pilot PDS in Oral Surgery to increase the amount of treatment provided by High Street Oral Surgery Specialists and therefore reduce Trust referrals.
- further developing the electronic prior approval process with the aim of reducing the mean turnaround time for new prior approval submissions to less than 14 days.
- rolling out the email and CCG elements of the eDentistry Strategy to 75% and 25% of all GDS practices respectively by the end of March 2020.

Specific issues and opportunities for Trusts in 2019/20 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to reduce the number of patients referred to Trust Oral Surgery/OMFS services.	Trusts should demonstrate plans to: • examine alternative ways of managing the high numbers of patients referred to Trust Oral Surgery/OMFS services from non-dental sources. • ensure that appropriate Oral Surgery referral criteria are in place.

5.5.2 General Medical Practitioner Services

Service Context

In Northern Ireland around 1.9 million patients are registered with 325 GP practices. General Practice is often the first point of contact with the health and care system, GPs often manage patients' care needs but are also the gateway for appropriate referral to secondary care. As the population ages and as people live longer with complex health needs, the demand on GP services increases.

Primary Care Elective Care reform continues apace with GP led services for MSK, Dermatology, Vasectomy, Gynaecology and enhanced Surgery established and being rolled out across Federation providers.

The 2019/20 NILES Key Information Summary specification was issued in March 2019 to all EMIS GP practices, and also to several Vision and Merlok GP practices that did not avail of the service in 2017/2018.

Service Challenges in 2019/20

During 2019/20 and beyond, the HSCB working closely with General Practitioners will continue to seek to ensure the provision of safe and effective general medical services, whilst delivering major transformation initiatives across primary care.

Achievement of Departmental Targets

Work will continue to increase the number of available appointments in GP practices across Northern Ireland (CPD 4.1) and timely triage of acute/urgent calls to GP OOH (CPD 4.2). However, the increasing demand combined with workforce issues require further collaborative work through:

- GP practices supported by other professions including nurses, pharmacists, physiotherapists, mental health workers/ teams and social workers working as multi-disciplinary teams, embedded in GP practices.
- GP practices working together as Federations.

- GPs managing practice demand differently via practice based pharmacists and elective care pathways.

Areas of development in 2019/20

During 2019/20 and beyond, the HSCB and PHA working through the existing structures will continue to seek to improve the availability, accessibility and patient experience in relation to general medical services.

Integrated Care will work with providers across primary care and Trusts to take forward the following:

- develop an innovative enhanced service to manage demand for Urgent Care in General Practice with the initial focus on managing demand for urgent care in the late afternoon/early evening.
- introduce an enhanced service to develop the Key Information Summary in GP practices. This information will provide continuity of care for the patient.
- expand the GP Retainer scheme to a further 11 places, creating a total of 36 places. These places should be targeted at GPs thinking of reducing their sessional commitment, leaving practice or retiring and which will help build long term sustainability in the workforce.
- lead and support the local implementation of 'Making Every Contact Count' (MECC) which aligns with and enhances implementation of *Delivering Together* and *Making Life Better.* MECC has also been identified as a supporting action for the *Programme for Government Delivery Plan (CPD 1.15).*
- establish Multi-Disciplinary Teams (MDTs) in the initial prototype Federations across Derry, Down, West Belfast, Causeway, Newry Mourne and district.
- commission wave 5 of the practice based pharmacists recruitment initiative across all areas of N Ireland.

Specific issues and opportunities for Trusts and Federations in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure multi-disciplinary teams are embedded within Primary Care.	Participating Trusts and Federations should demonstrate plans for the continued implementation of the primary care MDT model, which will include; • practice based social workers • increased nursing and health visitor capacity • practice based first contact physiotherapists and • practice based mental health support
2.	Effective arrangements should be in place to ensure the implementation of Phase 7 Delivering Care (Practice Nursing Workforce).	Federations should demonstrate plans to recruit additional nursing staff as part of the recommendation of the review of the general practice nursing workforce and training profiles.

5.5.3 General Ophthalmic Services

Service Context

General Ophthalmic Services (GOS) are commissioned through contracting arrangements with 271 high street optometry and optical practices where approximately 600 optometrists carried out in excess of 470,000 HSC-funded sight tests in 2018/19. As GOS practices are generally the first port of call for primary eye care, these members of the extended primary care team are an important resource in both helping people to see well and live independent lives. Importantly, in line with *Delivering Together*, these optometrists also play a key role in expanding capacity and capability in primary care, managing more people closer to home and away from acute hospital settings where possible.

Service Challenges in 2019/20

Delivering Together and the *Elective Care Plan* set out the blueprint for how services should be delivered, integrating systems and services to offer improved outcomes centred on the needs of individuals. Through the eye care partnerships strategy this challenge has been taken up and embedded in ophthalmic services, where a pathway approach seeks to ensure that the user is seen by the right person, in the right place, at the right time. As ophthalmology is a high demand specialty, accounting for ten percent of all outpatient activity, much of it for long-term conditions, major challenges remain in meeting this need and offering timely access to appropriate ophthalmic care.

Areas for development in 2019/20

During 2019/20 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve availability, accessibility and patient experience in relation to general ophthalmic services in line with the objectives of *Delivering Together*.

Integrated Care will seek to take forward the following:

- establishment of the Northern Ireland Eyecare Network to provide a framework to support the planning and delivery of current and future ophthalmic services.
- ensuring optimal uptake of eReferral within primary care ophthalmic contractor practices and work to implement referral for advice and eTriage.
- ensuring access to NIECR is optimised and that primary care ophthalmic contractors have access to a Combined Ophthalmic Encounter tab, Diabetic Eye Screening Report, Eye Casualty Symphony system, and Macular Electronic Patient Record reports.
- ensuring contracts, infrastructure, governance, audit and accountability structures are in place to facilitate transfer of a proportion of cataract post-operative reviews to the community optometry setting.
- embedding Project ECHO as the platform to support the delivery of the enhanced service for OHT monitoring and review in primary care. ECHO will enable 'within-sector' and 'cross-sector' collaboration.
- developing a business case to build on the initial pilot in 2017 for optometrists to access their Non-Medical Prescribing (NMP) clinical training in secondary care.
- providing training opportunities for primary care ophthalmic professionals, and create opportunities for collaboration and integration with secondary care professionals to support demand management and transformation initiatives.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Prototype modelling around day case Elective Care Centres for cataracts offer the potential to better manage demand, increasing capacity in primary care optometry to facilitate community review	Trust responses should demonstrate plans to: • ensure that patients suitable for community post-operative review are identified and discharged to that setting.

	of post-operative cataract procedures. Integrated Care will ensure that arrangements are in place to facilitate transfer of a proportion of cataract post-operative reviews to community optometry.	• facilitate pathways to ensure that patients requiring repatriation back to secondary care management are functional and equitable.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to facilitate the planning and delivery of optometry-led enhanced services aligned to identified eyecare pathways (glaucoma, acute eye). These services will assist in managing demand within the primary care setting. Integrated Care will develop plans to • roll out a primary care service for the monitoring and review of patients with Ocular Hypertension (OHT) • performance manage the regional enhanced service for the management of acute non-sight threatening eye conditions (NI PEARS) across all LCG areas.	Trust responses should ensure that: • patients suitable for community OHT review are identified and discharged to that setting, with appropriate pathways for advice and repatriation of those patients whose clinical status changes. • any remodeling of acute eye clinics (“Eye Casualty”) takes cognisance of and recognizes the regional NIPEARS enhanced service, and plans service configurations accordingly.

5.5.4 Pharmaceutical Services and Medicines Management

Service Context

Medicines are the most frequently used intervention in healthcare with over 40 million prescriptions issued each year in primary care and several million more prescriptions in secondary care. With the publication of *'Northern Ireland Medicines Optimisation Quality Framework'* by DoH in 2016, standards and requirements for the processes to support safe and effective provision of medicines within the region are identified. The progress made in the past number of years needs to be built upon to realise the medicines optimisation ambition.

In primary care, the two key service areas relevant to medicines optimisation are General Medical Services (GMS) and Pharmaceutical Services. Demand and capacity issues have been a feature of GMS while at the same time, the strategic drivers have been to move activity into primary care. The same can be said for pharmaceutical services.

Service Challenges in 2019/20

Building on previous years, during 2019/20 and beyond, the HSCB working closely with Community Pharmacy Contractors, General Practitioners, Trusts, other service providers and patients will continue to seek to ensure the provision of safe and effective medicines supported by effective pharmaceutical service provision. Given the competing demands, financial and workforce issues, collaborative working will be important. This will include the implementation of new contractual arrangements for community pharmacy services.

The most significant challenge facing the service currently is workforce. Whilst plans are in progress to increase undergraduate pharmacy places, it will take a number of years before these reach fruition. Supporting the service in the interim, and indeed beyond, given the growth in demand and usage scale of medicines, must involve optimising the capacity of the qualified pharmacy

resource. Investment in pharmacy technicians and in training pharmacy technicians will support this approach.

Aside from the investment into GP practice based pharmacists, the scale of the contribution of drug savings to the wider savings programme has not, in most instances, been specifically linked to a corresponding need in pharmacy infrastructure. Further progress with efficiency improvements is dependent on an increase in pharmacy capacity and as such the HSCB will seek to secure recognition of this need in saving plan discussions.

Achievement of Departmental Targets

In 2018/19, the efficiency programme in primary and secondary care which focuses on drug costs delivered against the target set. In 2019/20, a target of £12m prescribing efficiencies has been identified for primary care with a further £8m for secondary care.

Opportunities to make off-patent savings within the high cost specialist drugs budget will continue. Yields from these savings will vary from year to year and it is prudent for the service to profile the staged release of recurrent savings consistent with the annual saving targets. This will improve the stability of the savings programme in low yield years and may support non recurrent investment opportunities in those years where the yields are higher. Opportunities to reduce total antibiotic prescribing in primary and secondary care will also be maximised.

In 2018/19, an interim financial envelope was established for pharmaceutical services and there is now an opportunity to move community pharmacy services forward in line with the agreed contract framework (CPD 7.1).

Areas for development in 2019/20

During 2019/20 and beyond, the HSCB and PHA working through the existing regional structures will continue to seek to improve availability, accessibility and

patient experience in relation to pharmaceutical services in line with the objectives of *Delivering Together*.

Integrated Care will seek to take forward the following:

- rolling out secure access to the HSC net; access to NIECR; and access to HSC mail to community pharmacists
- delivering £20m efficiencies with £8m from secondary care and £12m from primary care (CPD 7.6).
- provide an emergency supply of medicines via community pharmacy.
- develop a community pharmacy Living Well Service including delivery of 5 campaigns through community pharmacy in 2019/20.
- develop an implementation plan for adherence services for patients in need of adherence support within community pharmacy.
- provide prescribing and medicines supply models across primary and secondary care.
- develop enhanced clinical governance arrangements within community pharmacy.
- develop additional community pharmacy security measures.
- take forward the recommendations of the Pharmacy Workforce review.

Specific areas for development for Trusts in 2019/20 are as follows:

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure the skill mix of the Pharmacy workforce is appropriate.	Trusts should engage with the Board to develop plans to increase and consolidate pharmacy technician posts to make best use of existing skill mix such that pharmacists can be deployed on clinical, patient facing duties.
2.	Effective arrangements should be in place to ensure that Trusts achieve 70% compliance with the Medicines	Trusts responses should demonstrate how this improvement in compliance will be achieved with particular emphasis on the

	Optimisation Quality Framework (MOQF) consistent with CPD 2.7 requirements.	pharmacy/patient pathway interface including medicines reconciliation, discharge and all corresponding outcome metrics to monitor progress.
3.	Effective plans should be in place to deliver £20m efficiencies with £8m from secondary care and £12m from primary care (CPD 7.6).	Trusts should demonstrate plans to work to achieve the maximum efficiencies possible within 2019/20.

5.5.5 Primary Care Infrastructure Development

Service Context

The Primary Care Infrastructure Development (PCID) Strategic Implementation Plan was developed based on a hub and spoke model and sets out the regional plan for investment in primary care infrastructure. It includes an outline of the prioritised hub projects within the programme and proposed funding plan.

Each hub will be a 'one stop shop' for a wide range of services including GP and Trust led primary care services and supports multi-disciplinary working. This model will improve access to, and responsiveness of, primary and community care services, particularly making available more specialised services nearer to where people live and work. This includes provision of an enhanced diagnostic and treatment capability where appropriate. Spoke facilities include smaller health centres and GP surgeries which accommodate GP practices supported by other professions working as multi-disciplinary teams.

Service Challenges in 2019/20

The pressures experienced by the GP workforce are exacerbated by issues with premises. Investment in GP premises will be a key part of securing the model of primary care into the future. These premises are GP owned, Trust owned and leased from third parties. All parties have a responsibility to provide premises that are fit for purpose and will support the continued delivery of General Medical Services into the future.

In addition, the design of the next tranche of hub developments must meet the needs of the population now and into the future through supporting new ways of working and flexibility in design.

Areas of development in 2019/10

During 2019/20, Integrated Care will seek to take forward the following:

- developing business cases for increased capacity within Trust premises and support applications for improvement grants for GP owned/leased premises.
- delivery of the Hub and Spoke model by completing business cases for the next tranche of Hub developments.

Specific areas for development for Trusts in 2019/20 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Ensure appropriate infrastructure is in place to support the delivery of Multi-disciplinary working arrangements and an increase in capacity with GMS.	Trusts should support the development of business cases for improvements to Trust owned premises and explore opportunities for increasing capacity for the delivery of General Medical Services.

5.6 Healthcare within the Criminal Justice System

Service Context

In 2017/18 there were 3,878 prison committals and the average daily population was 1,448 across the three prison estates. Prisoner Health Services are delivered within the three prison establishments of Maghaberry, Magilligan and Hydebank Wood College which includes the Women's Prison and the Young Offenders Prison and are managed by the South Eastern Trust.

The healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities are a particular priority. Rates of mental ill health for those in prison are significantly higher than the general population, with the prison population having a much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses. Work continues on developing better integration with community and secondary care services on committal and discharge. There is also an imperative to ensure that, following the identification of prisoners' healthcare needs at committal, these are followed up with appropriate action.

Improving Health within Criminal Justice is a strategy and action plan that aims ensure that children, young people and adults in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour.

Service Challenges in 2019/20

The profile of prisoners within the three sites continues to change with an overall older age profile. This year, challenges remain in respect of issues associated with the misuse of prescribed medicines and the supply of illicit drugs, ensuring a robust staffing model and implementation of the out working of the Review of Vulnerable Prisoners. The DoH/DoJ strategy *'Improving Health Within Criminal Justice Strategy*', contains key recommendations for prison healthcare and the wider provision of health within the criminal justice system which have implications for all Health and Social Care Trusts.

Areas for development in 2019/20

The Prison Health Planning Team has in place a 10 point plan for the commissioning of prison health services and will be taking this forward in conjunction with the Trust along with the opportunities presented from confirmation of a number of exciting transformational proposals and *'Improving Health Within Criminal Justice'* strategy and action Plan. In addition the prison health planning team will be overseeing the potential regional roll-out of the new model of nurse-led care for people detained in custody suites within police stations.

In addition, it is envisaged support from DoH/DoJ will be secured to roll out custody healthcare via a 24 hour nurse led service to eight further PSNI custody suites. Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to implement *Improving Health within Criminal Justice*.	All Trusts should demonstrate plans to take forward the key cross-cutting actions identified within the *Health in Criminal Justice* action plan in partnership with the relevant lead organisations.
2.	Effective arrangements should be in place to ensure equivalency in regard to health screening.	SET should take steps to ensure equivalency of access to health screening undertaken in Northern Ireland for those in prison custody settings.
3.	Effective arrangements should be in place to ensure appropriate in-reach services.	SET, as the lead organisation, should make a determination on the potential for an in-reach counselling/mentoring service and review referral pathways from custody settings to self-harm services.
4.	Effective arrangements should be in place to understand social care needs among prisoners.	SET should collate and analyse information/data about the prison population to identify current support and/or social care needs of prisoners and any unmet social care needs.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to enhance and promote the screening of prisoners in respect of TB, Latent BBV and HPV.	SET should demonstrate plans to review its health protection and screening processes across sites and evaluate testing, uptake and bring forward recommendations for future provision.
6.	Effective arrangements should be in place to ensure appropriate use of prescribing information to assist medicines management/optimisation	SET should demonstrate plans to ensure safe use of prescription medications in all custodial settings including: • procedures for supervised swallow • medicine management operational systems • promotion of existing guidance.
7.	Effective arrangements should be in place to address the mental health needs of prisoners in custodial settings.	SET should demonstrate plans to put in place the range of skill mix needed within prison and community workforce to support the recovery of prisoners with mental health needs through: • psychological therapies- ensuring consistency with services provided in the community. • consistent practice approach for personality disorder and forensic mental health in line with existing 'You in Mind' care pathways.
8.	Effective discharge arrangements should be in place for those individuals to be released from prison.	All Trusts should put in place effective discharge planning arrangements with the SET to ensure people leaving criminal justice settings receive appropriate follow on health and social care (including ensuring GP registration) and to include appropriate interventions.
9.	Effective arrangements should be in place to develop Telehealth and technology options in prison.	SET should provide detail of the mix of Telehealth options to support in-reach and outreach services into custodial settings.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
10.	Effective arrangements should be in place in regard to workforce and revised skill mix models.	SET should demonstrate steps to strengthen its complement of staff by looking at opportunities to implement new skill mix arrangements to provide a more sustainable staff profile. All Trusts should develop a training needs analysis which will inform recommendations to the strategy for all health, social care and criminal justice professionals working within the Criminal Justice System to promote cross-discipline awareness.
11.	Effective arrangements should be put in place to maximise AHPs within the skill mix of the prison healthcare staff to support specific opportunities for service transformation.	SET should demonstrate plans to utilise enhanced AHP support to take forward public health initiatives across prison sites.

5.7 Learning Disability

Service Context

The number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in Northern Ireland. A life course service response is required to support people to live as healthy, fulfilling and independent lives as possible. Crucial to this is support for families and other carers who continue to provide the bulk of care and support which people need.

Service Challenges in 2019/20

During 2019/20 and beyond, the Board and Agency with Trusts, Service Users, Family Carers and other key stakeholders will complete a review of services for adults with a learning disability to agree a regionally consistent Learning Disability Service Model (LDSM) based on the Bamford principles of integration and empowerment and take forward the "ordinary lives" agenda outlined in Bamford.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to services for learning disability.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to address deficits in assessment and treatment in LD inpatient units as highlighted by the Independent Review of Muckamore Abbey Hospital (and other incidents affecting NI patients in private Learning Disability (LD) hospitals) (CPD 2.8)	Trusts should demonstrate plans to develop community based assessment and treatment services for people with a learning disability with a view to preventing unnecessary admissions to LD hospital and to facilitate timely discharge.

2.	Effective arrangements should be in place to complete the resettlement and address the discharge of people with complex needs from learning disability hospitals to appropriate places in the community (CPD 5.7)	Trusts should demonstrate plans to work in partnership with service providers and other statutory partners to develop suitable placements for people with complex needs.
3.	Effective arrangements should be in place to support families providing care and deliver on the "ordinary lives" objectives. (CPD 6.2 & 6.3).	Trusts should demonstrate plans to review and reform day services; further develop supports for family carers, and short break opportunities to support families caring for someone with a learning disability at home.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to develop a regionally consistent service model for people with a learning disability.	Trust Project Leads should work as part of the regional LDSM Team to coordinate engagement and service reform required within their own organisations.
5.	Effective arrangements should be in place to develop "Shared Lives" models of care to increase the availability of alternative family based living opportunities for people with a learning disability.	Trusts should demonstrate plans to appoint a senior lead officer to deliver the agreed regionally consistent Shared Lives project within their Trust area.
6.	Effective arrangements should be in place to appropriately manage people with LD developing dementia and other conditions associated with old age including short breaks/respite which are varied and flexible in nature (CPD 6.1 & 6.2)	Trust responses should demonstrate how short breaks/respite will be extended outside of the traditional model in order to meet the needs of families/carers including Dementia Memory Services and other appropriate services.
7.	Effective arrangements should be in place to increase the number of individuals availing of community based day opportunities.	Trust responses should demonstrate what specific actions will be taken in 2019/20 to further develop partnership working with community / voluntary / independent sector organisations to meet the needs of individuals already in services or coming through transition.

8.	Effective arrangements should be in place to improve health care for people with a learning disability.	Trust responses should demonstrate plans to • ensure key information gathered through the annual health check initiative is collated, analysed and shared in order to inform health and wellbeing plans. • participate in the evaluation of the "health passport" for people with a learning disability. • support people with a learning disability to access health screening programmes.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to develop Multi-Disciplinary services in community settings to address the actions required within the Independent Review of Muckamore Abbey Hospital.	Trusts should demonstrate plans to recruit multidisciplinary teams to build the community infrastructure to support people with a learning disability outside of hospital settings. Trusts should demonstrate plans to work with their independent sector partners to build the skills and capacity of their workforces to enable them to support and sustain people with complex needs in their community placements.

5.8 Managing Long Term Conditions

Maintaining good health requires people to be empowered to make healthy lifestyle choices and to be aware of risk factors for preventable diseases e.g. heart disease, stroke and Type 2 diabetes. When patients are diagnosed with a long term condition (LTC), they should be supported in managing their condition effectively through the provision of information and patient education programmes, and developing the knowledge and skills they need to maintain or enhance their health and well-being as well as their clinical, emotional and social outcomes.

There are a number of regional and local forums that provide an opportunity for professional staff, service users and carers to meet regularly to discuss areas of concern and need for development. Examples of regional groups include the stroke network, the chronic pain forum and the respiratory forum. Locally in each of the five Trust areas there are Integrated Care Partnerships (and GP Federations in the future) involving Trust, primary care staff and users in the design and delivery of local services.

Using data to improve outcomes of care for people with LTCs is now a reality, through projects such as the Data Quality in Practice (DQIP) initiative, which uses pseudo anonymised data extracted from general practice, which is risk-stratified for diabetes, respiratory, stroke and frail elderly. This will facilitate the targeting of services to those in greatest need and those most likely to benefit from interventions.

With an ageing population, the need to design services to deal with co-morbidity (patients with more than one LTC) will increase as LTCs are more common in older age groups.

5.8.1 Coronary Heart Disease

Service Context

Coronary heart disease (CHD) occurs when coronary arteries become narrowed by a build-up of atheroma, a fatty material within their walls. The pain or discomfort felt from such narrowing is called angina and if a blockage occurs it can cause a myocardial infarction (heart attack).

CHD is one of the leading causes of death in Northern Ireland. It is also the leading cause of death worldwide and is responsible for nearly 1,700 deaths in Northern Ireland each year, an average of around five deaths each day. Since the 1960's, CHD death rates have fallen in Northern Ireland by 75%. Around 74,000 people are living with CHD in Northern Ireland and over 17,400 have been diagnosed with heart failure.

Service Challenges in 2019/20

The number of investigations for trans-catheter aortic valve implantation (TAVI) cases continues to grow in Northern Ireland and its expansion is being monitored to ensure adherence to standards for patient selection and time to procedure.

Rapid Access Chest Pain Clinics (RACPCs) are designed to assess and diagnose people presenting with intermittent stable chest pain indicating suspected stable angina. The majority of referrals to RACPCs in Northern Ireland are from General Practitioners (GPs) or from Emergency Department (ED) clinicians. Further engagement with clinicians is planned in 2019/20 to ensure that referrals comply with NICE CG95 - Chest pain of recent onset: assessment and diagnosis. Trust should continue to take this guidance into account when developing CT scanner specifications.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency will continue to seek to improve the availability and accessibility of and patient experience of cardiology services. Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that referrals to Rapid Access Chest Pain Clinics (RACPC) comply with NICE CG95 - Chest pain of recent onset: assessment and diagnosis.	Trust responses should demonstrate plans that are in place to engage with referrers (mostly GPs and emergency departments) on NICE CG 95 to include unstable chest pain (when emergency department attendance or admission is most appropriate) and stable chest pain.
2.	Effective arrangements should be in place to ensure that there is an appropriate clinical physiology workforce in place to deliver cardiac investigations.	Trusts should work with the Board/Agency to develop a regional clinical physiology workforce plan by March 2020.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Effective arrangements should be put in place to ensure that patients receive timely access to TAVI implantation	All Trusts should demonstrate plans to streamline investigations for patients awaiting TAVI within 28 working days. The Belfast Trust response should demonstrate that plans are in place to routinely monitor adherence to standards for patient selection and time to procedure within 7 working days of being deemed fit for the procedure.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be put in place to develop models for cardiac rehabilitation services.	The Board will work with all Trusts to finalise a needs assessment of cardiac rehabilitation by December 2019 to inform future service planning.

5.8.2 Diabetes Care

Service Context

There were 96,000 adults (aged 17+) in Northern Ireland living with Type 1 and Type 2 diabetes at the end of March 2018. Type 2 diabetes accounts for 90% of all cases of diabetes in adults and the increase in cases can be explained by rising levels of obesity and an ageing population. There are 1,200 children and young people with Type 1 diabetes attending paediatric clinics and sporadic cases of Type 2 diabetes are now being seen in paediatric clinics.

Over 9% of all pregnancies in Northern Ireland are complicated by diabetes, and gestational diabetes accounts for 92% of cases. This increase in diabetic pregnancies can be explained by rising levels of obesity, changes to diagnostic thresholds for diagnoses of gestational diabetes (GDM) and older women having babies. This rapid increase in numbers of women with diabetes in pregnancy, particularly GDM, requires changes to services to meet the needs of pregnant women with diabetes.

Service Challenges in 2019/20

Long term capacity building is required to ensure improved access to structured diabetes education programmes across Northern Ireland for adults and children leading to significant reductions in waiting times.

Achievement of Departmental Targets

The Diabetes Network has been established and is supported by a network team located in the Board. In November 2019 the Diabetes Strategic Framework will celebrate its third year. The Network will review progress over the life of the implementation plan and develop a refreshed clinical strategy.

Areas for development in 2019/20

In 2019/20 the following areas for development will be addressed as part of planned investment:

- Improved access to all areas of the feet care spectrum from screening to multi-disciplinary care, including implementation of the Northern Ireland Diabetic foot pathway in all Trusts.
- Further roll out of community diabetes management building on best practice service, testing new "models of diabetes" care that allow more care to be provided in community settings.
- Further increasing of capacity for diabetes in pregnancy clinical services
- Adoption of region wide protocols for best practice inpatient management.
- Piloting in patient diabetes teams in five Trusts to address the findings of the 2016 in-patient audit.
- Continued expansion in access to insulin pumps and NICE approved new technologies.

Specific issues and opportunities for 2019/20 are:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be put in place to develop services for women with diabetes in pregnancy in Northern Ireland.	Trusts responses should demonstrate plans to build capacity in clinical delivery through additional commitment of consultants, midwifery, dietetics, nursing etc. (or combination of all). This could also include developing new models of care depending on the risk profile of women.
2.	Effective arrangements should be put in place to implement the funding for piloting of in-patient diabetes teams and new models of care in the community.	Trusts responses should demonstrate action plans to improve patient experience in hospital including impact on length of stay.
3.	Effective arrangements should be in place to expand the number of structured Diabetes Education programmes in the 5 Trusts for people with Type 1 and Type 2 diabetes.	Trusts should describe the additional number of programmes provided, participants seen and participants completed.

4.	Effective arrangements should be in put in place to implement the NI Diabetic Foot Care Pathway.	Trust responses should detail plans to support the implementation of the NI diabetic foot pathway, including the vascular surgery interface.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be put in place to provide education and support for people recently diagnosed with diabetes.	Trust responses should demonstrate plans to expand current provision of Structured Diabetes Education (SDE) and the associated catch up programme for those requiring it.
6.	Effective arrangements should be put in place to develop patient pathways for insulin pumps and Continuous Glucose Monitoring (CGM).	Trust responses should demonstrate plans to implement a regional solution for the supply of replacement and new insulin pumps. Trusts should implement NICE guidance on the availability of CGM for the relevant cohort of patients.
7.	Effective arrangements should be put in place to ensure appropriate usage of Freestyle Libre.	Trust responses should demonstrate plans to complete the ABCD audit of Freestyle Libre including a specific timescale for completion.
8.	Effective arrangements should be put in place to improve transition arrangements for transfer of care from paediatric to adult diabetes services.	Trust responses should demonstrate plans to use 'Ready Steady Go Hello' materials in transition planning and also work with the Change Lab project being facilitated by Diabetes UK.
9.	Effective arrangements should be put in place to provide education and support for children with diabetes.	Trust responses should demonstrate plans to ensure all children have updated "annual health plans" and promote the use of the regional communication booklets with schools and early years settings by parents for insulin injections and insulin pumps.
10.	Effective arrangements should be put in place to ensure children with diabetes are treated in age appropriate settings.	Trust responses should demonstrate plans to accommodate children with diabetes up to their 16th birthday for inpatients and outpatient services.

11.	Effective arrangements should be put in place to optimise new and existing care pathways for mothers and babies with complex needs.	Trusts responses should demonstrate plans to ensure clear pathways are in place for the diagnosis and management of women with Type 1, Type 2 and Gestational Diabetes during pregnancy and delivery.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
12.	Effective arrangements should be put in place to develop new models of care for people with diabetes.	Trusts responses should demonstrate plans to develop community diabetes capacity and address the needs of vulnerable groups.

Skill Mix/Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
13.	Effective arrangements should be put in place to provide appropriate workforce and education programmes for staff working in specialist and generalist areas across primary, secondary and tertiary care in the care and treatment of people living with diabetes.	Trust responses should demonstrate plans to develop workforce and education programmes in collaboration with the Diabetes Network.

5.8.3 Pain Management

Service Context

More than 400,000 people in Northern Ireland living with pain persisting beyond the expected period of recovery. It is often the most distressing and disabling symptom of many long term conditions like diabetes, cardiovascular diseases and arthritis, as well as being a long term condition in its own right. Persistent pain can be prevented and treated successfully in community, primary and secondary care.

Service Challenges in 2019/20

A five year elective plan for Musculoskeletal (MSK) services has been developed and provides a strategic programme of investment and improvement across the region, with the primary objective of addressing gaps and inequity of access for MSK/pain patients.

Prescription drug misuse has been highlighted as an issue due to the increasing numbers of deaths related to the misuse/abuse of drugs of commonly prescribed drugs, including treatments to manage pain. Development of non-drug treatments are important for chronic non-malignant pain management as it is now recognised that long term use of high strength opiates are not always beneficial.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency working through existing regional structures and processes including the Northern Ireland Pain Forum will continue to seek to improve pain management service availability, accessibility and patient experience.

Specific issues and opportunities for 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to enhance the skills and capacity of secondary care pain management teams and their scope for integrated working in line with *Core Standards for Pain Management Services in the UK* published by the Faculty of Pain Medicine at the Royal College of Anaesthetists in 2015. This should include capacity for a leadership role in educating and training practitioner colleagues in other secondary, primary and community care services.	Trust responses should demonstrate plans to: • support staff education and training for improved and integrated bio psychosocial management of patients with persistent pain. • ensure patients with complex needs can be seen earlier to prevent or halt more difficult to reverse deterioration.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to ensure patients have timely access to supported self-management options as part of a stepped care model, including those provided with the help of expert patients, peer and lay trainers in community settings.	Trust responses should demonstrate plans for a range of supported self-management options in line with a stepped care model. Depending on local service configuration and priorities, this may include: • expanding existing self-management programmes and local support groups • reconfiguration of community services • increasing capacity of pain management programmes (PMP) provided by specialist pain management teams.
3.	Effective arrangements should be in place to ensure patients are managed along regionally agreed integrated pathways to improve outcomes and patient experience.	Trust responses should demonstrate plans to support ICPs, GP Federations and MDTs in primary care in developing integrated patient pathways including initial assessment for painful long-term conditions including but not restricted to arthritis and fibromyalgia.

4.	Effective arrangements should be in place to ensure patients with persistent pain have equitable access to evidence based services.	Trust responses should demonstrate plans to optimise patient flows by improving referral pathways for patients with persistent pain, including: • cross speciality triage criteria between primary care, core physiotherapy, ICATS, rheumatology, orthopaedics and pain management • improved access to evidence base interventional pain management treatments.

Skill Mix / Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be put in place to deliver a sustainable regional multidisciplinary persistent pain management service for children and young people with complex needs.	The Belfast Trust response should demonstrate plans to support delivery of this service on a sustainable basis in line with multidisciplinary models of good practice.
6.	Effective arrangements should be in place for multidisciplinary and interagency working across the wide ranging spectrum of patient need to meet the challenges of prescription drug misuse.	Trust responses should include work with other HSC organisations to implement good practice and innovative interventions for patients with persistent pain, including plans to reduce prescription drug misuse.

5.8.4 Respiratory

Service Context

Respiratory disease is the most commonly reported physical long term illness in children and young people and the third most commonly reported in adults, after musculoskeletal and circulatory disorders.

Care for people with respiratory diseases is a major contributor to overall expenditure on health and social services. A report by the British Lung Foundation concluded that the cost of respiratory disease to the UK economy was approximately £11 billion in 2014.

Service Challenges in 2019/20

Exacerbations of respiratory illnesses are the most common factor for unplanned admissions, which places rising demands on health and social care providers.

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency, working with service providers and users through existing and evolving processes, will seek to improve the availability and accessibility of and patient experience of respiratory services.

Specific issues and opportunities for 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to continue to implement the recommendations of relevant review and evidence based guidance including: • 2015 RQIA review of respiratory teams • NCEPOD reports • NICE Guidance	Trust responses should demonstrate plans to: • Maintain meet standards in line with best available evidence. • Develop services in line with recommendations arising from service reviews, audits and existing or new publications.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to ensure appropriate integrated pathways for adults and children across community, primary, secondary and tertiary care.	Trust responses should demonstrate plans to: • Implement the safe discharge paediatric asthma care pathway. • Develop effective monitoring and evaluation methodologies to record relevant service and patient level data • Manage the 'local network' for respiratory care through Integrated Care Partnerships. • Develop and implement the agreed NI service model for patients with Interstitial Lung Diseases. • Develop CCG guidance and referral pathways for pulmonary rehabilitation, home oxygen and sleep disorder services.
3.	Effective arrangements should be in place to promote self-management, self-directed care and other suitable training programmes for patients.	Trust responses should demonstrate plans to deliver referral pathways to appropriate self-management programmes including pulmonary rehabilitation and further lifestyle improvement and maintenance programmes. Plans should reflect the concepts of co-design and co-production in improving and developing services in line with the *Delivering Together* agenda.

Transforming Services /Skill Mix and Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to support the development of networked services across Northern Ireland for the following: • Long term ventilation (LTV)) • Ambulatory Care Pathways in the Unscheduled Care Reform Programme including Home IV antibiotics services. • Implementation of COPD,	Trust responses should demonstrate plans to: • Review the procurement of long term ventilation services and implement the relevant recommendations. • Facilitate respiratory teams to develop ambulatory care pathways for patients requiring same day respiratory care, where appropriate. • Participate in a regional task and finish group to standardise the Home

	bronchiectasis, paediatric and adult asthma audit recommendations.	Intravenous Anti biotic and Anti-Viral service for respiratory patients (OPAT) as required.

5.8.5 Stroke Services

Service Context

In Northern Ireland there are 36,000 stroke survivors, 2,800 people[7] admitted to hospital every year with a diagnosis of stroke and approximately 1,000 stroke related deaths. The evidence base to support high quality stroke care continues to expand and have implications for the delivery of stroke care.

Approximately a quarter of all nursing home residents have had a stroke, and around 300 stroke patients are admitted to residential care each year in Northern Ireland. Current community stroke services treat around 2,000 new stroke patients every year. There are many opportunities to reduce the burden of stroke through the provision of better preventative, acute and community care. The national stroke audit SSNAP and the 2014 RQIA report into stroke services made several recommendations for improving stroke care in Northern Ireland. The DoH is currently undertaking a public consultation on stroke services which will report in late 2019.

Service Challenges in 2019/20

In Northern Ireland stroke patients continue to experience significant delays in admission to stroke units related to unscheduled care bed pressures. The performance of hospital and community stroke services in Northern Ireland as recorded in the national audit is improving but further improvement is possible. Transformation funding has facilitated the expansion of early supported discharge and community stroke teams in 2018/19 which should improve the discharge experience of patients. The Board and Agency continue to work with the Belfast Trust to expand access to thrombectomy (clot retrieval) services taking account of the service pressures they face.

Areas of development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to stroke services.

[7] HSCB statistics - PMSI (2018)

A number of areas for development have been identified for focused improvement and investment in 2019/20 including:

- Developing Early Supported discharge teams and community Stroke teams.
- Improving the number of stroke patients admitted to a Stroke Unit bed within 4 hours of attendance.
- Building capacity within clot retrieval service in the BHSCT with a step wise approach to expand the service hours.

Specific issues and opportunities for 2019/20 are as follows:

Strategic Priorities

	ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to provide appropriate stroke services for younger people as 20% of all stroke occurs in people aged under 65.	Trust responses should demonstrate plans to improve stroke services for younger stroke patients in line with the recommendations of the RQIA inspection report (2014) to include vocational rehabilitation.
2.	Effective arrangements should be in place to ensure that all stroke patients are admitted in line with NICE guidance.	Trust responses should outline plans to review their operational protocols for admission and develop processes that ensure more than 90% of acute stroke patients are admitted to a stroke unit as the ward of first admission within 4 hours
3.	Effective arrangements should be in place to provide appropriate specialist spasticity services for stroke survivors.	Trust responses should develop a regional pathway for the management of spasticity after stroke.
4.	Effective arrangements should be in place to provide thrombolysis as a treatment for acute ischaemic stroke (CPD 4.8).	Trust responses should demonstrate initiatives to ensure at least 16% of acute ischemic stroke patients, attending each of its hospitals, receive thrombolysis and that those patients who receive thrombolysis do so within 60 minutes of arrival.

5.	Effective arrangements should be in place to provide mechanical thrombectomy for large vessel stroke as an effective intervention for selected stroke patients (CPD 4.8).	The Belfast Trust response should demonstrate plans for the continued development of regional stroke mechanical thrombectomy services as per the NICE guidance.
6.	Effective arrangements should be in place to provide assessment within 24 hours of all suspected TIAs on a 7 day basis.	Trust responses should demonstrate plans to provide ambulatory services for suspected high risk TIA patients seven days a week, in line with NICE (NG128)
7.	Effective arrangements should be in place to facilitate, where appropriate, early supported discharge (ESD) of acute stroke patients from hospital.	Trust responses should detail how ESD services for stroke patients will be made available seven days a week, able to respond within 24 hours of discharge and provide the required levels of therapy.

5.9 Maternity and Child Health

This section includes maternity services, neonatal services and paediatrics services, including specialist paediatric services. Given the close linkages across these specialities, there is a need to maximise interface opportunities across and to work together to stabilise the workforce, target investment and deliver on giving every infant the best start in life. A more joined up approach to planning will be taken forward under the auspices of the recently established Maternity and Child Health Planning Team, which will endeavour to forge stronger relationships across the sectors, both in Board and Agency and across Trusts.

5.9.1 Maternity and Neonatal Services

The Maternity Strategy 2012-2018 sets the context for the delivery of maternity services across Northern Ireland, promoting improvements in care and outcomes for women and babies from pre-conception through to the postnatal period. The Board and Agency will continue to take forward the recommendations of the RQIA review into the implementation of the Maternity Strategy.

There were 22,851 births in Northern Ireland during 2018/19 (NISRA). Each year around 1,800 babies require admission to a neonatal unit. This is a relatively small cohort of infants but as they are the most vulnerable action is required to ensure that their outcomes are optimised to give them the best start in life. A recent review of neonatal services identified that more capacity was required in the region of 3-4 intensive care cots in RJMS. The Board and Agency will work with Trusts to realign capacity across the region to provide a resilient regional service for the most acutely ill infants who cannot be managed elsewhere in the region.

In 2018/19, new interim arrangements for paediatric post-mortems and placental histology were put in place with Alder Hey Hospital in Liverpool. The service is working well and the Board and Agency have been liaising closely with the BHSCT and other stakeholders to ensure a seamless transfer to the new

arrangements, including ongoing support for parents. The Board will also continue to work with Belfast Trust and other stakeholders to consider options to provide a safe and resilient service locally including exploring the potential for minimally invasive post mortems.

Service Challenges in 2019/20

In maternity services, while the number of births has largely remained static, there is a continuing rise in the number of women with long term conditions such as diabetes, obesity, multiple pregnancies and older mothers.

There are ongoing challenges with medical and nurse staffing in neonatal units and there is a need to maximise the capacity that we have, and work to reduce out of region transfers for babies in utero and neonates. This will require work to be taken forward with paediatrics, to address current deficits in nurse staffing levels, and wider workforce issues around junior doctor cover.

Areas for development in 2019/20

During 2019/20 the Board and Agency, working through the existing regional structures, will continue to seek to improve the patient experience in relation to maternity, neonatal and child health services.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that appropriate pre-conceptual advice and care is available so that women are supported to be as healthy as possible at the time of conception to improve outcomes for mother and baby (CPD1.8).	Trusts should continue to work with the Board, Agency and other partners through the maternity strategy implementation group to develop population based approaches and pre-conceptual pathways for women who may become pregnant.
2.	Effective arrangements should be in place to ensure that required data is captured to monitor service activity, compliance with standards and to underpin quality	Trust responses should demonstrate commitment to collecting data to evidence best practice and identify opportunities for further service improvement. Plans should

	improvement work.	include evidence of full utilisation of NIMATS and Badgernet. Trusts should confirm the collection of data to facilitate the regional outcome focused dashboards developed for maternity and neonatal care under the Maternity Collaborative and Neonatal network.
3.	Effective arrangements are in place to support multidisciplinary learning and service improvement through regular multi-disciplinary morbidity and mortality review.	Trust responses should evidence how the multi-disciplinary aspect of the Departmental direction with regard to the child death process is being developed.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to ensure that the agreed regional antenatal care pathway is delivered. This pathway, developed by the Maternity Strategy Implementation Group, is designed to promote a healthy pregnancy and improve outcomes for mothers and babies – including a reduction in low birth weight – through a range of actions including reducing smoking and high quality antenatal care.	Trust responses should demonstrate how they will implement the agreed regional care pathway for antenatal care for women with low risk pregnancies to include antenatal group-based care and education (Getting Ready for Baby); and UNICEF Baby Friendly Initiative Standards.
5.	Effective arrangements should be in place to ensure that women with complex pregnancies are offered the best possible care in line with national evidence based guidelines.	Trusts should demonstrate how they will deliver services to meet the needs of more complex pregnancies. Responses should evidence: • Plans to implement the 'Weigh to a Healthy Pregnancy' programme to provide access to women with a BMI over 38. • Progress in implementing the NICE guidelines on multiple pregnancies, including the delivery of dedicated 'twin

		clinics'. • Plans to implement the regional care pathway for women with epilepsy.
6.	Effective arrangements should be in place to offer early pregnancy assessment pathways for women.	Trusts should continue to work with the Board/Agency to support the development and implementation of early pregnancy assessment pathways based on NICE guidelines.
7.	Effective arrangements should be in place to ensure that there is appropriate monitoring of transfers to the RoI that take place because of capacity constraints.	Trust should put in place effective arrangements to monitor the number and care pathway for in-utero and ex-utero transfers between NI and the RoI.
8.	Effective arrangements should be in place to ensure that opportunities to offer early intervention and prevention of long term disability by enhanced therapy services in neonatal units are realised.	Trust responses should demonstrate how recent investment in AHP services for neonatal units is being deployed and how they will ensure that the input will focus on neurodevelopment and nutritional support.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to care for women who have recurrent miscarriages.	Trusts should continue to work with the Agency and Board to implement the agreed clinical pathway for women who have recurrent miscarriage. Trusts should input as appropriate to the regional MDT for those complex cases.
10.	Effective arrangements should be in place to ensure that mothers and babies are not separated unless there is a clinical reason to do so.	Trusts should demonstrate how antenatal, postnatal and neonatal services aim to prevent avoidable admissions to neonatal units and paediatric services. Trusts should continue to work with the Agency and Board to scope the requirements for transitional care and outreach services.

Skill Mix/Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
11.	There would be an opportunity to enhance skill mix further with the appointment of additional maternity support workers to work alongside midwives to support mothers.	Trusts should demonstrate plans to work with the Agency and Board to scope out the requirement for additional maternity support workers and how they could be best utilised to support services.

5.9.2 Paediatrics

Service Context

The Department launched two new strategies: *A Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community 2016-2026* and *A Strategy for Children's Palliative and End of Life Care 2016-26.*

The Paediatric Strategy focuses on acute hospital services (both generalist and specialist); the management of transition of such services into adult services and the interface between hospital and community services. It is recognised that the majority of children and young people are, and will continue to be, treated in the community, usually by GPs and other primary care professionals such as children's nurses, midwives, health visitors, social workers, allied health professionals, community pharmacists and general dental practitioners. There is a clear association between the start a child gets in life and their future health and wellbeing. As such, the links between the *Paediatric Strategy* and the *Strategy for Maternity Care 2012-18* are recognised and promoted.

Specialist Paediatric Services

Specialist acute paediatric hospital services include tertiary or quaternary level services, normally provided as a single service for the population of Northern Ireland, commissioned through a single provider in Northern Ireland or through designated centre/s in Great Britain or ROI. Many of the specialist acute paediatric hospital services have interfaces with other service areas. In commissioning these services, the Board and Agency ensure a collaborative approach across relevant commissioning teams which take cognisance of those

interfaces and aims to provide consistent and equitable services for the population.

Service Challenges in 2019/20

The *Paediatric Palliative Care Strategy* sets the strategic direction for the palliative and end of life care with the aim of improving the existing care and support for children and young people with life-limiting or life-threatening conditions, as well as their families. It focuses on the enhancement of the child's quality of life and support for the family and also includes symptom management, provision of short breaks and care through death and bereavement (CPD 6.1 & 6.2). Children's palliative care is different to adult palliative care as children often need to be cared for over extended periods of time. Approximately 150 children, with life limiting or life threatening conditions, in Northern Ireland die each year.

The Board and Agency have made some progress with the implementation of the recommendations contained within these strategies and will continue to drive forward change, subject to the availability of staff and resources. The Child Health Partnership has been established and a work programme is being developed for the first year.

During 2019/20 and beyond, the Board and Agency, working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to specialist paediatric services. Some specialist services will need to be commissioned from providers in GB, particularly if the service required is very specialist and the anticipated activity for the population of Northern Ireland means it is not possible to provide the service locally in line with best practice (see section 4.3).

Areas for development in 2019/20

During 2019/20 the Board and Agency, working through the existing regional structures, will continue to seek to improve the patient experience in relation to paediatric services.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that care is provided as close to home as possible with children only being transferred to the regional children's hospital for a service which is not provided locally.	Trust responses should describe arrangements for primary care to access senior decision makers and how same day and next day assessment is facilitated. Trusts should continue to work with the Board/Agency to develop and test models of care which reduce the reliance on in-patient and secondary care paediatric services. Trusts to implement the regional pathway for the management of patients on high flow oxygen, in partnership with the Critical Care Network by March 2020.
2.	Effective arrangements are in place to support multi-disciplinary learning and service improvement through regular multi-disciplinary morbidity and mortality review.	Trust responses should evidence how the multi-disciplinary aspect of the developing child death process is being progressed.
3.	Effective arrangements should be in place for the provision of Paediatric Cardiac Services in line with the Ministerial decision on the establishment of an All-Island Network. An increasing number and range of elective cardiac procedures, as well as emergency and urgent cases are now being accommodated in the ROI. The paediatrician with a specialist interest role in cardiology is being established in both Southern and Western Trusts.	Belfast, Southern and Western Trusts should demonstrate how they will work with the Board/Agency through the specialist paediatrics group and all-island structures to take forward the implementation of the service model for congenital cardiac services set out in the full business case for the All-Island CHD Network. This should include local developments as well as developments planned on an all-island basis.

4.	Effective arrangements should be in place to improve the resilience, sustainability and access to specialist paediatric services	Belfast Trust should advise of any emerging vulnerabilities in specialist services including proposed contingency arrangements to address these vulnerabilities. Belfast Trust should demonstrate arrangements which improve resilience, sustainability and access to specialist paediatric services including: • A workplan for the paediatric lead for rare disease by 30 September 2019. • Further expansion of the paediatric centralised waiting list by 30 March 2020, for paediatric surgery, gastroenterology, electroencephalograms (EEG) and neurology. • Network arrangements will be put in place by December 2019 for Paediatric Plastic and Burns Services, and Metabolic and Neurodisability Services, with a provider outside NI. • A Paediatric Ophthalmology Network will be developed in Northern Ireland by March 2020. • Belfast Trust will ensure work that Paediatric Haematology/ Oncology Service meets Peer Review Standards by the end of October 2019. • The development of a paediatric neuromuscular physiotherapy service will be developed in year. The Belfast Trust should outline how this service will meet the needs of the paediatric neuromuscular service. • Paediatric pharmacy services should be expanded to meet the needs of the RBHSC. • Paediatric AHP service should be expanded to meet the needs of the RBHSC. • An extracorporeal photopheresis (ECP) service has been established. Belfast Trust should demonstrate the service capacity within the service and

		demonstrate that there are sufficiently trained staffing in NI to sustain the service in the longer term. • Ensure timely and appropriate access to paediatric trauma and orthopaedic services.
5.	Effective arrangements should be in place to implement the Paediatric Red Blood Screening Strategy by January 2020 and ensure that patients admitted have dietetic support when required.	A dietetic team will be in place to ensure that patients with Inherited Metabolic Disorders (IMD) have sufficient dietetic support in hospital. Additional investments in paediatric metabolic services are designed to ensure that the vulnerable paediatric metabolic service is further strengthened and enabled to implement the red blood screening strategy. Belfast Trust should demonstrate how this additional capacity will meet the needs of the Strategy.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
6.	Effective arrangements should be in place to offer short stay assessment and ambulatory models of care in all paediatric units. These should be available during times of peak demand.	Trusts should demonstrate arrangements for same day and next day assessment of children where this is deemed appropriate.
7.	Effective arrangements should be in place to deliver a sustainable scoliosis service.	Belfast Trust should demonstrate how it will: • deliver a timely and effective scoliosis service and waiting lists are accurate, consistent and compliant with extant DoH guidance; • ensure commissioned capacity is fully utilised (RVH, MPH and RBHSC) and is accessible; • deliver scoliosis surgery within ministerial

		targets; • submit a formal escalation plan for any projected breach.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to ensure children and young people receive age appropriate care up to their 16th birthday.	Trust responses should demonstrate that their paediatric services can accommodate children up to their 16th birthday. Trust responses should also demonstrate plans to ensure that children's care is provided locally and only transferring to RBHSC to access tertiary services. Trusts should also describe how they will ensure that children aged up to their 16th birthday, who are admitted to hospital, are cared for in an age appropriate environment by staff with paediatric expertise.

5.10 Mental Health Services

Service Context

The development and delivery of mental health services is governed through the implementation of the Regional Mental Health Care Pathway and the Mental Health Service Framework. The development and delivery of mental health care has been organised around a Stepped Care framework. The framework supports the integration of systems and practices across primary, secondary and specialist mental health care services. This model aims to promote a culture of earlier intervention, facilitates co-production and enables the development of outcome, recovery orientated approaches across all mental health care services.

The DoH plan to enact the Deprivation of Liberty requirements of the Mental Capacity Act (Northern Ireland, 2016) will provide a robust legal framework and safeguards for substitute decision making on behalf of people 16 years + with impaired cognitive functioning who require Health & Social Care interventions. Whilst the impact will fall across all programmes of care, implementation is being led by the Adult Mental Health Programme.

Service Challenges in 2019/20

The ageing workforce places increasing demands on the recruitment and retention of professionals, in particular nurses and approved social workers. This is being compounded by the draw of experienced staff away from core services by the establishment of new services including Multi-disciplinary teams in primary care, the Regional Trauma Network and Enhanced Mental Health Liaison services. Sustaining the workforce required to deliver high quality core mental health services is likely to be the most significant challenge in the coming year.

Achievement of Departmental Targets

The Board and Agency will work with Trusts to further enhance out of hours capacity in order to de-escalate individuals presenting in social and emotional crisis through implementation of a Multi-Agency Triage Team pilot (SEHSCT)

and two Crisis De-escalation Service pilots (BHSCT and WHSCT) to test different models and approaches (CPD 1.13).

The Board and Agency will also work with providers to reduce waiting times for people requiring access to child and adolescent mental health services (CPD 4.14) and ensure that people who are assessed as medically fit for discharge are discharged within 28 days (CPD 5.7).

Areas of development in 2019/20

Investment has been made available to develop enhanced hospital liaison services in acute general hospitals, mental health workers in Primary Care multidisciplinary teams, and the Regional Trauma Network.

The review of mental health inpatient care identified the need for a regional mental health collaborative to improve the quality efficiency and effectiveness of the mental health inpatient estate and regionally consistent community based acute services. The Board and Agency will support the HSC Trusts to develop a Regional Mental Health Collaborative.

The then Minister of Health gave a commitment to improve treatment services for women experiencing perinatal mental health problems and in support of this the Board and Agency have developed options for the establishment of dedicated perinatal mental health community and in-patient treatment service.

The Board and Agency are also committed to the further development of the Regional Trauma Network in line with the North/South agreement. Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangement should be in place to deliver Phase 1 of the Regional Trauma Network which will provide treatment for people with complex Post Traumatic Stress	Trust responses should demonstrate plans to recruit multi-disciplinary teams to work with the Victims and Survivors Service to deliver evidence based therapies to people with

	Disorder (PTSD) (as identified in the Stormont House Agreement).	complex Post Traumatic Stress Disorder (complex PTSD) symptoms as a result of the trauma of the NI Troubles / conflict. Trusts should also develop services build for people with similar clinical presentation from marginalised / hard to reach groups.
2.	Effective arrangements should be in place to develop enhanced mental health liaison services in acute general hospitals.	The NHSCT response should provide plans to consolidate their enhanced mental health liaison service and extend to the Causeway hospital including people under 18 years and people with a learning disability in acute general hospital settings. BHSCT, SEHSCT, SHSCT and WHSCT responses should detail plans to extend the availability of their mental health liaison services and develop costed delivery plans for a full fidelity model.
3.	New legal requirements for HSC Trusts to provide systems and processes to implement and administer the Deprivation of Liberty requirements from the Mental Capacity Act (Northern Ireland 2016) will be enacted from 1 October 2019.	Trusts should develop arrangements and the infrastructure required to enable them to discharge new statutory duties for assessing capacity and authorising deprivations of liberty as required by the Mental Capacity Act (Northern Ireland) 2016. This should include: • Arrangements for assessments of mental capacity, best interests, medical examinations and the completion of associated reports. • Operating HSC Trust multi-disciplinary panels for the approval of applications for a deprivation of liberty. • Arrangements for short-term detentions • Administrative and governance infrastructure to support the operation of short-term detentions, Trust DoL Panels; monitor forms and processes; and report on activity as required. • Cover expenses for the provision of Medical Reports by authorised medical

		practitioners that are not directly employed by the HSC Trusts (generally the patients GP) • Release key staff to complete the training required to authorise them to perform legal duties and functions (including; complete formal assessments of capacity; make Best Interests determinations; provide prescribed medical reports; make application to the Trust DoL panel; sit as a member of a Trust Panel).

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to implement the recommendations from the review of acute mental health services	Trust responses should detail plans to engage in the development of a regional mental health collaborative to implement the reforms recommended by the Review Team, particularly in relation to mental health inpatient treatment and care.
5.	Effective arrangements should be in place to implement the recommendations from the review of acute mental health services. The review also identified deficits in the regionally consistent quality and performance information to support robust strategic planning.	Trust responses should demonstrate plans to join the NHS Benchmarking Scheme for adult mental health services to improve the quality of performance information to support robust strategic planning.
6.	Effective arrangements should be in place to implement the recommendations from the review of the Addictions Care Pathway including substitute prescribing (CPD 1.14).	Trust responses should demonstrate plans to revise and reform their Addictions Services in line with the recommendations of the review when it is completed.
7.	Develop a stepped care pathway for the enhancement and further development of dedicated perinatal mental health services.	Provide timely access to high quality mental health care and treatment to women in pregnancy and early postpartum. Ensure the needs of the women are met and

		the potential risk to both mother and child are minimised. Provide services and support to prevent avoidable relapses and reoccurrence in vulnerable women.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to ensure the continued recruitment and retention of Approved Social workers (CPD 8.10).	Trust responses demonstrate plans to review their current ASW model to ensure current and future demand for services is met.
9.	Effective arrangements should be in place to ensure an appropriate skill mix in community mental health teams with reference to best practice evidence and recommendation with Delivering care Phase 5b (Nursing).	Trust responses should demonstrate plans to fill vacancies and improve capacity, including peer support workers to enhance community teams recovery focused practice.

5.11 Northern Ireland Ambulance Service (NIAS)

Service Context

The NIAS plays an essential role in supporting effective unscheduled pathways, maximising patient flow through hospitals and assisting patients to access elective care. Due to the continued increase in demand for ambulance services, the Board has supported training of additional paramedics and recognises that additional staff are required in coming years to ensure safe, effective emergency ambulance response in line with a new clinical response model (CRM). The model is already operational in other parts of the UK, and has proved successful.

The recent public consultation by NIAS proposing a move to a new clinical response model (CRM) confirmed that this is a desirable approach for Northern Ireland. The CRM ensures that patients who are life-threatened will be prioritised for an 8-minute response and others will be triaged to ensure the appropriate ambulance is sent first time in a clinically appropriate time.
In this 2019/20, the Board will monitor the introduction of the CRM and its component targets and standards and seek improved performance in line with projections.

Reform of Emergency Ambulance Control in 2018/19 has included additional capacity to respond to emergency calls and expansion of the paramedic-led Clinical Support Desk. These measures have contributed to an increase in clinically-appropriate non-conveyance of patients to hospital, either treating at home or referring to a community service which would meet the need identified by the attending paramedic.

Following RQIA inspections in 2017 and 2018, NIAS has been engaged in a programme to improve cleanliness in ambulance vehicles and stations and in rolling out staff training and assurance processes on infection control. The programme has proven to require major service reform and the Board is committed to support NIAS in its efforts to ensure quality and safety for patients.

Service Challenges in 2019/20

Performance against 8-minute Category A emergency response target has deteriorated further in 2018/19. Investment in emergency ambulance staff is necessary in the next 5 years to keep pace with demand and also to ensure performance meets the requirements of the CRM, for life-threatened patients and other patients requiring an emergency or urgent response.

RQIA inspections of emergency ambulances and ambulance stations during 2017/18 identified significant considerable issues relating to infection control. NIAS is engaged in an extensive improvement programme to address these issues, including improved cleaning regimes; additional infection control staff training; and introduction of rigorous monitoring and audit systems. The Board is committed to support NIAS in this important quality and safety work.

Non-emergency patient transport continues to experience pressure in the face of patient demand outstripping NIAS capacity. The Board remains committed to consulting on eligibility criteria which would prioritise patients with mobility difficulties. Moreover, the Board recognises significant opportunities to further develop volunteering to support patients travelling from isolated areas. Emerging issues in booking of transport by GPs will also need to be addressed.

Achievement of Departmental Targets

NIAS is unlikely to achieve the 8-minute Category A emergency ambulance response target in 2019/20 and the introduction of the CRM will be the basis of performance monitoring this year (CPD 4.4).

Areas for development in 2019/20

During 2019/20 and beyond, the Board and Agency, working through the existing regional structures, will continue to seek to improve the availability, accessibility and patient experience in relation to the NIAS.

Specific issues and opportunities in 2019/20 are as follows:

Strategic Priorities

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that available capacity within NIAS is maximised in the context of increasing demand for services.	The NIAS response should: • demonstrate plans to improve emergency response times across NI in line with the clinical response model • outline how the capacity-demand review will ensure alignment of NIAS resources with predicted demand.
2.	Effective arrangements should be in place to introduce a new clinical response model (CRM) which prioritises the sickest and deploys the most appropriate resources based on improved triage. The Board accepts there is a shortfall in ambulance capacity to fully realise this model in coming years.	The NIAS response should outline plans to introduce the Clinical Response Model, following recent public consultation broadly supporting the model.
3.	Effective arrangements should be in place to address the recommendations raised by RQIA following infection control inspections.	The NIAS should provide a detailed, costed improvement plan to respond to the recommendations within the RQIA inspection report.
4.	Effective arrangements should be in place to manage the increasing demand for non-emergency transport.	The NIAS response should outline how it will work with the Board to introduce eligibility criteria for non-emergency transport which prioritises patients with mobility difficulties.
5.	Effective arrangements should be in place to better coordinate Hospital-related non-emergency transport and to maximise benefits of procuring independent providers on a regional basis.	The NIAS response should outline progress in relation to the pilot with Belfast Trust which is coordinating hospital-related non-emergency transport and efforts to realise this to cover the whole region long-term.
6.	Effective arrangements should be in place to appropriately manage the increasing demand on emergency ambulance services in the winter period.	The NIAS response should bring forward a winter plan which outlines how it will manage increased demand in winter 2019/20.

Patient Pathways

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to improve ambulance turnaround times in hospitals.	The NIAS response should describe how it will significantly improve the handover time for patients.
8.	Effective, integrated arrangements, organised around the needs of individual patients, should be in place in community settings to provide care for people at home, avoiding the need for hospital attendance and admission.	The NIAS response should demonstrate how it is embedding the range of alternative care pathways across all localities in NI during 2019/20, including the paramedic-led clinical decision desk.
9.	Effective arrangements should be in place to fully utilise the Helicopter Emergency Medical Service (HEMS) to support the existing road-based emergency service.	The NIAS response should demonstrate how it will monitor the performance of HEMS during 2019/20 in line with the Commissioning Specification and agreed key performance indicators.
10.	Effective arrangements should be in place to facilitate and promote collaboration, coordination, communication, learning, sharing of information between different agencies providing resuscitation training.	The NIAS response should demonstrate how it will work with existing providers of community resuscitation and ensure a smooth transition to the new model of community resuscitation that reflects the recommendations of the 2014 Northern Ireland Community Resuscitation Strategy.
11.	Effective arrangements should be in place to deliver appropriate CPR and BLS training programmes.	The NIAS should provide plans to increase access to CPR training across NI and Basic Life Support (BLS) training in community and educational settings via: • Engagement with CPR training providers • Engagement with Voluntary and Community organisations • Further development of Community and first responder schemes
12.	Effective arrangements include the development of public information / guidance about Automatic External Defibrillators (AEDs) covering purchasing, maintenance, location, access and signage.	The NIAS should provide plans to develop website literature and guidance information materials on AEDs.

Skill Mix/Workforce

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
13.	Effective arrangements should be in place to provide training programmes for paramedics which address accreditation difficulties with existing programmes.	The NIAS should outline how it will work with the Board and DoH to develop proposals to support the training of new paramedics which may include a university degree route, building on the foundation level training which commenced in 2018/19.
14.	Effective arrangements should be in place to realise the workforce requirements outlined in the NIAS Capacity-Demand Exercise (July 2017), specifically reform in Field Ops, building on reform already underway in Control.	The NIAS should outline how it will take forward workforce reform, including recruitment and training requirements.

5.12 Palliative and End of Life Care

Service Context

Palliative care, as it relates to adults, focuses on the provision of care and support to those in the population who have an advanced progressive illness. Palliative Care was historically associated with cancer care; however a palliative care approach is appropriate for all those with a progressive condition such as dementia, other neurological conditions and the increasing numbers of very frail elderly within our population. *End of life care*, is described as the period of time during which an individual's condition deteriorates to the point where death is either probable or would not be an unexpected event, within the coming 12 months.

One percent of the Northern Ireland population is estimated to benefit from a palliative care approach (approximately 19,000 people). Of the actual deaths in Northern Ireland each year (15,923 in 2018) it is estimated that 80% (almost 12,738 of people who died) could have benefited from a palliative care approach.

The extant Northern Ireland strategy on Palliative Care - *Living Matters: Dying Matters* and other key strategic drivers form the framework for a regional Palliative Care Programme, *Palliative Care in Partnership* which has joined all partners in a comprehensive rolling work-plan, which aims to improve the quality of care under four key priority areas:

1. Early identification of palliative care need;
2. Allocation of a keyworker to coordinate care;
3. Providing the opportunity for have advance care planning conversation and;
4. Appropriate specialist and generalist palliative care services.

Service Challenges in 2019/20

In respect of out of hours care for patients with palliative care needs, there remains, across the region, variability in access to specialist palliative care advice. The Board and Agency will continue to seek ways of increasing the voices of service user and carers within the programme structures to ensure that they have a clear input into the design and development of services, both regionally and at locality level.

Work has been ongoing to improve the access and the utility of medicines within the end of life setting. Given the range of medicines used, there are important governance and safety issues to manage alongside the requirement to meet the needs of patients and service users. There are also specific challenges within the hospice setting in regard to optimising medicines.

Achievement of Departmental Targets

The Palliative Care in Partnership Board recognises the emerging opportunities to engage with broader society to support the concept of a public health approach to palliative and end of life care which will include an emphasis on advance care planning. In 2019/20, arrangements will be taken forward with key stakeholders in this regard including work to identify individuals with palliative and end of life care needs in acute and primary settings (CPD 3.4).

Areas for development in 2019/20

The Palliative Care Programme will seek to update and enhance the programme needs assessment analysis. The opportunity to work with the NHS Benchmarking Network on the National Audit of the Care at the End of Life will be an important opportunity, over the next three years, to benchmark care at the end of life in Northern Ireland against GB counterparts and implement changes in the acute sector where appropriate.

As referred to above, the Board will wish to engage with the Hospice providers and Trusts to examine medicines management issues in order enhance this aspect of service.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to embed Advance Care Planning within operational systems.	Trust responses should demonstrate plans to ensure that those with progressive conditions should be offered the opportunity to access and to record their individual wishes.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to improve the identification of palliative care patients in primary care – identification prototype. (CPD 3.4)	Trust responses should demonstrate plans to ensure that practices taking part in the identification prototype are supported to hold regular MDT meetings [details of practices taking part in the prototype will be shared with Trusts].
3.	Effective arrangements should be in place to increase the capacity of the out of hours rapid response nursing service across the region to provide full regional coverage of the Marie Curie led service.	Trust responses should demonstrate plans to ensure that current gaps in the service are addressed and that specific proposals are brought forward by the Belfast and South Eastern Trusts/Localities to describe how the service integrates with the generic out of hours district nursing services.
4.	Effective arrangements should be in place to implement a specialist palliative care out of hours advisory rota across the region.	Trust responses should demonstrate plans to ensure commitment to working collectively and with voluntary partners to develop a sustainable model to provide access to specialist palliative care advice out of hours.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to improve the education and training of the professional workforce in palliative care.	Trust responses should demonstrate plans to support staff to attend relevant courses to strengthen palliative care capacity.

5.13 Physical Disability

Service Context

Physical and Sensory Disability (PSD) services caters for people of all ages ranging from people with congenital disabilities through to those who acquire disability as a result of trauma or chronic degenerative and possibly life limiting conditions. There are many people living with PSD with co-complexities which require services to work together such as people with progressive/ degenerative neurological conditions, e.g. Motor Neurone Disease, Muscular Dystrophy, Huntington's Disease etc. It is important that HSC organisations support and empower people living with PSD to live their lives as independently as possible.

People living with PSD will access a range of services in acute and non-acute settings from a range of statutory and non-statutory providers.

Service Challenges in 2019/20

The following challenges are ongoing for people with PSD:

- Corporate ownership of Access to Health and Social Care for people with PSD in its widest sense; this ranges from people with sensory loss not receiving information in an accessible format through to people in 'hard to reach' categories who are also for example BME; LGBT; people with sensory loss with dementia, etc.
- Training for HSC staff to understand the disparate needs of people with physical and /or sensory disabilities; complaints are common regarding services not being aware of needs of people with Sensory Loss.
- The development of Sensory Loss Pathways to consolidate significant work undertaken by the Regional Strategy Implementation Group as mandated by the PDSI Strategy.
- To support the transition of people living with PSD from childhood to adulthood to older people's services.

- Transition for children living with disabilities to adult services should be seamless and not detrimental to children/young people and their families.
- Trusts continue to highlight the need of age appropriate accommodation /care facilities.
- Independent living for people who require a mobility aid, such as a wheelchair, requires swift access to AHP services.
- Accessible accommodation.
- Access and control of support services.
- Adaptive and/or assistive technologies.

Areas of development in 2019/20

The DoH 2012-2015/18 Physical and Sensory Disability Strategy and its Action Plan was the first regional strategy for this Programme of Care. The initial Action Plan was concluded in 2018/19 and the DoH announced in December 2018 that it will work with the Board and Agency to establish a new Regional Disability Forum to drive forward continuous improvements to access and services for individuals with physical, sensory, and communication disabilities. The membership and terms of reference for this new Forum will be established in 2019/20.

Associated with this activity, the Board has committed to delivering on any outstanding/emerging actions linked to the previous strategy. This will include renewal of working groups convened around the themes of sensory impairment and physical disability, incorporating representatives from the HSC Trusts, service users, the community/voluntary sector, Disabled and User-Led People's Organisations (known as DUPLOs), etc.

During 2019/20 and beyond, the Board and Agency working through these regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to PSD impairment services. Specific issues and opportunities in 2019/20 are as follows:

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure the seamless transition of people with Physical and/ or Sensory Disability from children's services to adult services and from adult services to Older People's services.	Trust responses should demonstrate plans that ensure seamless transition for people with Physical and Sensory Disability who are approaching age thresholds for Adult services and Older People's services.
2.	Sensory Loss pathways to ensure people with sight loss and/or hearing loss are implemented to deliver better outcomes for service users	Trust responses should demonstrate effective proposals to implement sensory loss pathways bridging community and acute sectors.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Effective arrangements should be in place to develop a Physical and Sensory Disability structure/ network which facilitates regional, multi-agency strategic planning for the needs of people with Physical and/ or Sensory Disability.	Trust responses should demonstrate equitable access to Health and Social Care for people with Physical and Sensory Disability including: **Access** • Trusts to ensure people with Sensory loss/ Disability are empowered to access HSC services (i.e. statutory HSC services and services provided by Community and Voluntary / Independent sectors). • Trusts should ensure communication with people with sensory loss is in an accessible format to include appointments, access to interpreting, signage and access to healthcare information. **Buildings** • Trusts should ensure all HSC facilities have visual display units and hearing loops which are working and ensure HSC staff are fully trained in use. • Signage in HSC facilities should meet HSC accessibility standards.

		Equipment • Trusts should ensure equitable access to equipment (including adaptive/ assistive technologies) and accessible, age appropriate accommodation/ care facilities for people with Physical and/or Sensory Disability.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Trusts and their independent sector suppliers should have effective arrangements in place to ensure staff are trained to understand the disparate needs of people with Physical and/or Sensory Disability.	Trust responses should demonstrate plans to ensure all HSC staff including HSC provider staff in Community and Voluntary / Independent sectors receive mandatory disability training.

5.14 Population Health

Service Context

Population health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

Supporting and equipping people to live a long, healthy life is central to achieving population health outcomes. In working to achieve this, we will continue to support the Department of Health (DoH) in the delivery of the draft PFG delivery plans.

Improving health and reducing health inequalities requires coordinated action across health and social care, government departments and a range of delivery organisations in the statutory, community, voluntary and private sectors.

The Department of Health strategy "*Making Life Better"* provides a framework for reducing inequalities. The current *Programme for Government* (PFG) outlines the need for a whole system approach to address the wider determinants of health and social wellbeing.

Section 4.1 of the Plan provides further detail on improving the health of the population which is one of the overarching themes of this Plan.

Service Challenges in 2019/20

During 2019/20 and beyond, the HSCB and PHA will continue to seek to improve the targeting and accessibility of services for people who face the greatest heath inequalities across Northern Ireland. The gap in health inequalities continues to grow between our most and least deprived areas and we seek to invest on a proportionate basis.

We need to invest early to maximise gains in health improvement throughout the life course. For example, 22% of children are already overweight or obese when they arrive in P1. We know that of every 20 children who were obese at

age 5, only 2 were a healthy weight when aged 11. Conversely of every 20 children who had a healthy weight at age 5, 15 of them were still a healthy weight at age 11.

We know that drug and alcohol misuse, suicide and cardio vascular disease continues to account for a significant proportion of the gap in life expectancy between those in our most and least deprived areas.

Areas for development in 2019/20

During 2019/20 and beyond, the HSCB and PHA, working through the existing regional structures, will continue to seek to improve the availability, accessibility and patient experience in relation to services to improve population health.

Specific issues and opportunities in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to reduce the levels of obesity within the NI population, particularly in those aged 0-5 years. (CPD 1.2)	Trusts responses should demonstrate plans to provide individuals with knowledge, skills and opportunities to make healthier choices in relation to nutrition and physical activity. Trust responses should also set out plans to implement a regionally consistent, family focussed weight management programme engaging health visiting teams.
2.	Trust responses should demonstrate plans to implement the "Tobacco Control Strategy", including smoking cessation services. (CPD 1.1)	Effective arrangements should be in place to reduce the number of pregnant women, manual workers and young people who smoke.
3.	Effective arrangements should be in place to reduce Healthcare Associated Infections (HCAIs) including Surgical Site Infections (SSIs). (CPD 2.3)	Trusts, supported by PHA, should develop and deliver improvement plans to reduce infection rates for all HCAIs including Esherichia coli, Klebisella spp. and pseudomonas aeruginosa in line with the Departmental objectives. This will be monitored via PHA surveillance programmes for HCAIs and SSIs.

4.	Effective arrangements should be in place to support women during pregnancy. (CPD 1.10)	Trust responses should demonstrate plans to ensure delivery of the Family Nurse Partnership Programme, ensuring women who are eligible are assisted to have "a healthier pregnancy" and give our children and young people the best start in life, providing developments in health visiting, early intervention services and family support hubs.
5.	Effective arrangements should be in place to promote and maintain Baby Friendly Initiative standards. (CPD 1.3)	Trust responses should demonstrate plans to increase local breastfeeding initiation and sustainability rates including provision of breastfeeding training for midwives, health visitors, Sure Start staff, neonatal nurses and AHPs. Trusts should also demonstrate plans to ensure availability of peer support, increase access to information and support from maternity support workers in the early post-natal and neonatal period and implement electronic tracking of donor milk. Any other local Breastfeeding Programmes should be included.
6.	Effective arrangements should be in place to support the Frailty Agenda including falls, physical activity, mild cognitive impairment (MCI)/dementia, nutrition Isolation and loneliness.	Trust responses should demonstrate plans to ensure delivery of the implementation of Frailty pathway including falls prevention, promotion of physical activity and nutrition, approach to MCI/dementia, approaches to isolation and loneliness.
7.	Effective arrangements should be in place to provide services to people who are homeless as these individuals often experience very challenging health inequalities, including a much lower life expectancy.	Trust responses should demonstrate plans to ensure a multifaceted issue/ approach/ solutions to different types of homelessness, including plans for those with complex needs such as addictions. Trusts should include the range of services for Homeless people including information on access and referral to services and specific

		care pathways for a range of acute and long term health conditions and access to support for mental health and substance misuse issues.

Patient / Client Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to increase the number of childhood immunisations.	Trusts should demonstrate plans to increase childhood immunisations, especially where uptake is below target levels or the rates of uptake have decreased.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to ensure de-escalation of patients presenting to trusts and emergency services with emotional and social crisis. (CPD 1.13)	Trusts should demonstrate plans to enhance OOH capacity and effectively reduce presentations to ED and unscheduled care for individuals who are in social and emotional crises.
10.	Effective arrangement should be in place for HSC facilities to lead by example in preventing obesity by adopting minimum nutritional standards developed in partnership by PHA, Food Standards Agency and Safe Food.	Trusts should demonstrate plans to effectively implement regionally agreed minimum Nutritional Standards in HSC settings.

Skill Mix / Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
11.	Effective arrangements should be in place to ensure consistency in provision of and availability of workplace health to employees in all HSC settings. (CPD 8.9)	Trust responses should demonstrate plans to adopt consistent approaches in line with the agreed WHO model for workplace health.
12.	Effective arrangements should be in place to Implement Infant and Perinatal Mental Health workforce and service	Trust responses should demonstrate plans to provide Infant and Perinatal Mental Health training for all relevant staff.

	development. (CPD 1.11)	

5.15 Sexual Health Services

Service Context

Sexual health is a broad concept including healthy sexuality along the life course, reproduction, family planning, contraception, prevention, detection and management of sexually transmitted disease (STD) including HIV and illnesses caused by other blood borne viruses like hepatitis in its various forms. It can also include culturally determined behaviours related to sexual practices and identities. It encompasses both the promotion of good sexual health and the provision of sexual health and social services to prevent, manage and improve sexual health impairment. The development and delivery of sexual health services in Northern Ireland are informed by the 2008 Strategy for Sexual Health Improvement and the 2013 RQIA Review of Clinical Specialist Sexual Health Services.

Service Challenges in 2019/20

During 2019/20, work will be required to continue delivering services to meet a growing demand while experiencing staffing pressures. It is recognised that demand for sexual health services outstrips capacity to deliver. A recent Trust telephony audit undertaken as part of a LEAN project showed that the GUM service in that Trust received 1,500 calls per week, which is more than any other specialty in the Trust.

The Board and Agency are aware that HIV rates are increasing in Northern Ireland, while rates continue to fall across all other areas of the UK. The drug PrEP is taken by HIV negative people before sex to reduce the chance of getting HIV and is viewed as a step-change in HIV prevention.

Further expansion of access to testing is required as there is less testing in Northern Ireland. The continuing escalation in gonorrhea and syphilis diagnoses must also be addressed as an urgent health priority.

Areas for development in 2019/20

- Primary care partnership working with GP federations for better sexual and reproductive health (SRH)
- Implementation of a Consultant led Genito-Urinary Medicine (GUM) service in both the NHSCT and SHSCT.

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure provision of clinical sexual health services in higher education settings, including services such as condom distribution, pregnancy testing, contraception advice and STI testing.	The Belfast Trust response should demonstrate actions to refine and develop the Further Education model for delivering sexual health and wellbeing services/initiatives to individuals under 25 years of age. Other Trusts should demonstrate the numbers of schools and staff that have received training from the Sexual Health Teams as a percentage of the total number of schools that need to have access to training.
2.	Effective arrangements should be in place for safe and clinically governable SRH and GUM services to respond to patient need within 48 hours.	Trust responses should demonstrate plans to improve patient access times and clinical governance arrangements by appointing the required clinical support staff. Trust responses should demonstrate actions to strengthen sexual health service provision for routine patients closer to home in collaboration with Primary Care Providers through partnership and collaborative working.
3.	Effective arrangements should be in place for patients to access telephone and online advice for clinical sexual health matters including family planning and sexually transmitted infections.	Trust responses should demonstrate how the agreed mobilisation process to implement an on-line STI service will be promoted and how the Trust will support the NHSCT based pilot in 2019/20.
4.	Effective arrangements should be in place for evidence-based promotion of sexual	Trust responses should demonstrate plans to provide targeted sexual health promotion

	health and wellbeing for young people and adults, including HIV awareness, STI prevention, with a particular focus on those most at risk.	messages, focusing on those most at risk and explore the potential of social media and other technologies in collaboration with the Public Health Agency.
5.	Effective arrangements should be in place for Trust Health promotion staff to support the whole schools model of Relationships and Sex Education (RSE) provided by the BHSCT Sexual Health team.	Trust responses should demonstrate plans to continue to provide support through their staff to those schools who receive whole school which RSE training in their area as required.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
6.	Effective arrangements should be in place to provide integrated sexual health services to vulnerable parts of the population	Trust responses should demonstrate plans to develop the co-location of GUM and Sexual Reproductive Health service delivery in geographical areas of need, and to vulnerable populations e.g. in prisons and children's homes.
7.	Effective arrangements should be in place to ensure that HIV prevention clinics are established for high risk groups.	Belfast and Western Trust response should confirm the timescales for implementing the HIV/PrEP clinics. Each Trust response should also confirm that the patient pathway and eligibility criteria for accessing these clinics have been shared The Board/Agency will work with each Trust to put in place formal arrangements to monitor and evaluate these clinics given that they have been funded though the transformation process.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place between local and regional GUM services to support a prototype HIV high risk reduction clinic within the defined agreed eligibility criteria for the administration of PrEP as part of a regional and clinically agreed risk reduction package for the assessed patient.	Trust responses should demonstrate how they would support and monitor the effectiveness of the additional weekly clinics in the Belfast and Western Trust for those identified as high risk and meeting the agreed eligibility criteria.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements need to be put in place to ensure sustainability of clinical sexual health services	Trust responses should demonstrate actions to identify staff training and succession planning needs and communicate these to appropriate regional workforce planning colleagues in the Agency.
10.	Effective arrangements should be in place to ensure all relevant staff are trained in sexual health issues, including core skills such as awareness, attitudes, information, communication skills, sexuality and relationships.	Trust responses should demonstrate actions to ensure the identification of staff who require training in sexual health promotion and deliver of training as required, including learning disability sexual health training.

5.16 Specialist Services

Service Context

Specialist acute hospital services include tertiary or quaternary level services, normally provided as a single service for the population of Northern Ireland, commissioned through a single provider in Northern Ireland or through designated centre/s in Great Britain/ROI. There are around 70 specialities and sub specialties covered by the current commissioning arrangements. High cost specialist drugs are also commissioned as a specialist service.

Many of the specialist acute hospital services have interfaces with other service areas. In commissioning specialist services the Board and Agency ensure a collaborative approach across relevant commissioning teams which take cognisance of those interfaces and aims to provide consistent and equitable services for the population. In this regard, specialist Acute Hospital services will continue to develop strong clinical alliances with specialist providers in GB and ROI, making best use of available information and communication technologies to facilitate a partnership approach delivery of care, where it is required (see section 4.3).

Service Challenges in 2019/20

Some specialist services will need to be commissioned from providers in GB, particularly if the service required is very specialist and the anticipated activity for the population of Northern Ireland means it is not possible to provide the service locally in line with best practice.

Building resilience in specialist services provision for the future

The biggest challenge for this area of commissioning is recruitment of specialist clinical staff to sustain safe and effective services in Northern Ireland. Good progress has been made in building resilience in local services through clinical alliances with the wider NHS and ROI.

Achievement of Departmental Targets

The Board and Agency are committed to working with DoH and Trust to take forward the establishment of a prototype regional obesity management service (ROMS) for Northern Ireland, including the establishment of a surgical clinic to be located in the South West Acute Hospital (CPD 1.7).

Areas for Development in 2019/20

During 2019/20 and beyond, the Board and Agency working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to specialist services. Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure: • New patients continue to access previously approved specialist drug therapies. • Access to new NICE TAs, HSTs and other NICE recommended therapies during 2019/20.	Trust responses should demonstrate how they will engage with the Board to inform the projected requirements associated with the increase in the number of patients on existing treatment regimes across a range of conditions. Responses should also demonstrate how Trusts will deliver on the requirements of new NICE TAs in line with planned investments.
2.	Effective arrangements should be in place to continue to progress the implementation of the Northern Ireland Rare Disease Plan working in partnership with the NI Rare Disease Partnership Board/Agency membership of the national Rare Disease Advisory Group ensures that Northern Ireland is fully engaged in the planning and evaluation of highly specialist services	Belfast Trust should develop by the end of September 2019, a stakeholder engagement plan to work with local Trusts and national colleagues, the HSC and NI RDP in identifying opportunities to further implement the NI Rare Disease Implementation Plan in respect of adult and paediatric services. Workplan for the adult lead for rare disease by 30 September 2019 (see also Specialist Paediatrics).
3.	Effective arrangements should be in place to deliver a future model for consultant	Belfast Trust should work with Board/Agency and DoH to finalise by September 2019 the

	staffing to ensure delivery of a robust and sustainable Infectious Diseases service for the future.	future model for consultant staffing across infectious disease, virology and microbiology that can deliver a robust and sustainable Regional Adult Infections Disease Service for the future.
4.	Effective arrangements should be in place to progress the work of the Plastics and Burns Project Board which will provide strategic direction for the service and respond to the RQIA recommendations (2017) In particular, the Project Board will agree a service specification and develop options for the future configuration of plastics and burns services, including consideration of a single service/site model.	Belfast and South Eastern Trusts should continue to take forward actions in the RQIA review, reporting progress to the Plastics and Burns Project Board. The Trusts should input to project products, including: • Needs assessment • Service profile • Service specification • Gap analysis
5.	Effective arrangements should be in place to improve the resilience, sustainability and access to Cochlear Implant Service.	The Belfast Trust response should detail proposals for a sustainable service model by December 2019 to include additional consultant capacity.
6.	Effective arrangements should be in place to improve the resilience, sustainability and access to nephrology and transplant surgery services.	Belfast Trust should demonstrate plans to put in place arrangements for a model for consultant staffing that can deliver a robust and sustainable renal transplant surgery service in the future. Southern Trust should demonstrate plans to put in place arrangements for a model for consultant staffing that can deliver a robust and sustainable nephrology service in Daisy Hill and Craigavon Hospitals.
7.	Effective arrangements should be in place to meet the demand for supporting services given the increase in bone marrow transplants.	Belfast Trust has a 5 year plan for increasing staffing and this should continue to be implemented in a timely manner.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
8.	Effective arrangements should be in place to deliver a sustainable scoliosis service.	Belfast Trust should demonstrate plans to: • deliver a timely, accurate and effective monitoring of programme of activity and waiting lists consistent and compliant with extant DoH guidance • ensure commissioned capacity is fully utilised (RVH, MPH and RBHSC) and is accessible, for appropriate cases, within the clinically recommended timescale. • deliver scoliosis surgery within ministerial targets detailing any short to medium term subvention required to fully deliver these. • submit a formal escalation plan for any projected breach out with the specified clinically determined window for treatment detailing the process by which this will be addressed to secure treatment within the planned timescale. • detail proposed service models, level of investment to meet any gap in service, both in RVH and RBHSC, expected volumes to be delivered in 2019/20 from new investment by September 2019.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to ensure the opening of the Phase 2B Critical Care Unit to accommodate the transfer of ICU/HDU capacity with the service to be fully operational in 2019/20. Work will continue to progress during 2019/20 on the current role, scope of responsibility and accountability arrangements offered by the Northern Ireland Critical Care Network and how it might best develop consistent with the	Belfast Trust should demonstrate by September 2019, via a project plan, how it will secure the balance of the Phase 2B staffing to deliver a full bed complement of 8 HDU and 17 ICU beds as well as the 2 ICU beds associated with trauma which will also transfer into Phase 2B. All Trusts should demonstrate full commitment to collaborate in the provision of safe, effective, clinically equitable access to ICU. The Northern Ireland Critical Care

	vision set out in *Delivering Together*.	Network will support this with improvements in timely monitoring of bed availability, clear escalation protocols, timely discharge and staffing levels.
10.	Effective arrangements should be in place to deliver a sustainable neuromuscular service for Northern Ireland.	The Belfast Trust should outline how the adult neuromuscular physiotherapist service will meet the needs of adults with neuromuscular conditions and support the transition of children and young people to adult services.

5.17 Unscheduled Care Services

Service Context

Unscheduled care is when someone accesses health and social care services unexpectedly. This can occur at any time, and crosses the traditional boundaries between primary, community and hospital services. It means that there must be 24/7 access to urgent and emergency care services.

In the last five years, the overall number of Emergency Department (ED) attendances has increased by 24%, and improving performance as well as the patient experience remains a priority for the Board and Agency.

Service Challenges in 2019/20

The delivery of safe and effective unscheduled care remains a challenge for commissioners and providers. Hospitals across Northern Ireland are facing ongoing pressures resulting in growing numbers of patients waiting longer to be seen, treated and either discharged or admitted to hospital. This is a result of the growing number of elderly people in our population, along with an increase in the proportion of discharges from hospital that are complex. Other factors include workforce pressures within nursing and domiciliary care which impact on the sustainability of the current pattern of emergency and urgent care services, as well as meeting patient expectations.

Achievement of Departmental Targets

The achievement of Departmental standards in respect of the 4 and 12 hour standards (CPD 4.5) and complex discharge from an acute hospital (CPD 7.5) from hospital continue to challenge health and social care organisations. Ensuring patients commence treatment following triage with 2 hours (CPD 5.3) and ensuring inpatient treatment for patients with hip fractures within 48 hours also remain challenging (CPD 4.7).

In 2019/20 the Board and Agency will continue to work with Trusts through the established local and regional groups in place to embed and further develop

services that avoid ED attendances, provide alternatives to admission to hospital, provide care in the community that will support timely discharge from hospital.

Areas for development in 2019/2020

The Board and Agency will continue to work within existing regional structures to seek to improve the availability, accessibility and patient experience in relation to services for unscheduled care. There will be a particular focus on frail elderly patients, and the Board and Agency will continue to work with Trusts on a number of transformation initiatives including Intermediate Care and Acute Care (AC@H) to assist in addressing some of these pressures.

Work will continue on embedding ambulatory care pathways for unscheduled care that will support both ED attendance avoidance and as appropriate reduce the need to be admitted to hospital support with pathways across primary and secondary care.

Specific areas for development in 2019/20 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to enhance a therapeutic frontline home based intermediate care team, responding rapidly and with a focus on recovery, independence and patient experience.	Trust responses should demonstrate plans to deliver rapid response with professional review at home by a member of the team within 4 hours, bed days saved, re-admission avoidance and admission avoidance.
2.	Effective arrangements should be in place to ensure availability of a regional Outpatient Parenteral Antibiotic Therapy service.	Trust responses should demonstrate how the service will enhance the governance and stewardship of intravenous antibiotic prescribing as well as reduce the number of patients waiting in hospital to be discharged on IV antibiotics.
3.	Effective arrangements should be in place to build on the 7 day working for Physiotherapists, Occupational Therapists,	Trust responses should demonstrate a reduction in time from referral to / request for AHP support to first contact; a reduction in

	Pharmacists and Social Workers in base wards building on the 2014 paper "Improving Patient Flow in HSC Services".	patients declared as a complex delay over 48 hours; increased AHP contacts at weekends and over holiday periods.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to ensure Trusts have in place local arrangements for site co-ordination/ control room to manage patient flow.	Trust responses should demonstrate a sustainable robust rota over 7 days, 365 days of the year that provides a single point of contact for system control.
5.	Effective arrangements should be in place to provide Acute / Enhanced Care at Home that provides active treatment by health care professionals in the persons own home for a condition that would otherwise require acute hospital in-patient care.	Trust responses should demonstrate how, working with appropriate partners Acute / Enhanced Care at Home services will be made available 24/7 and linkages to core primary / community care teams and NIAS.
6.	Effective arrangements should be in place to provide care to seriously injured patients at a regional Major Trauma Centre with the aim of increasing survival following major trauma and reducing the incidence of long-term disability from injuries.	Trust responses should demonstrate how arrangements will be put into place to provide a consultant-led service for the care and coordination of patients including rapid access to specialist services related to trauma.
7.	Effective arrangements should be in place to ensure patients receive access to rehabilitation services to maximise their recovery following major trauma.	Trust responses should demonstrate how patient care will be enhanced by arrangements for AHP resources to support timely access to rehabilitation services in acute and general care settings.
8.	Effective arrangements should be in place to support the prompt diagnosis and effective management of patients who have symptoms suggestive of flu.	Belfast Trust should provide extended working day for flu testing in the regional virology laboratory to include use of rapid testing from 9.00am to 11.00pm Monday to Sunday from 1 October to 31 March 2020. District General Hospital microbiology laboratories in the Northern, South Eastern, Southern and Western Trusts should provide

		rapid local flu testing 9-5pm Monday to Friday for all hospital samples from 1 October to 31 March 2020.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to increase the number of unscheduled care patients managed on ambulatory pathways avoiding the need to be admitted to hospital.	Trust responses should demonstrate the ambulatory care pathways prioritised for implementation / enhancement in 2019/20 plans for same day / next day referrals to services as well as direct GP access for patient management advice.

6.0 LOCAL COMMISSIONING

Local Commissioning Groups (LCGs) have responsibility for assessing the needs of their populations using a wide range of data as well as local intelligence gathered from engagement with service users and carers, local communities, community planning partners and service providers. This enables LCGs to be sensitive to local needs and priorities and influence regional commissioning plans. The combination of a regional and local approach to commissioning means that service improvements can reflect local population need while being rolled out across the region at pace and scale for the benefit of all.

LCGs also have a lead role at local level for planning and commissioning services, including securing local implementation of regional plans. They ensure that plans are developed with their local populations and service providers. *Delivering Together* set out a plan that aims to empower local providers and communities to work in partnership. This includes health and social care trusts, independent practitioners, such as GPs, and voluntary providers embracing new models of care. Such an approach has the potential to harness the strengths of different parts of the system, across traditional organisational boundaries, across sectors and beyond what is traditionally considered to be the health and social care sector. LCGs put this into practice through plans for integrated and continuous local care for the populations they serve.

Local service providers, including Trusts, GPs, Community Pharmacists, community and voluntary organisations and service users and carers are all represented on Integrated Care Partnerships (ICPs). LCGs are working with ICPs to establish formal Locality Networks across LCG-Trust geographies in which they can co-design service changes that reflect the needs of the LCG population and are adapted to the health and wellbeing circumstances in local communities. The Northern Area Prototype (section 4.2.2) may be applied in other localities.

LCGs commission ICPs to co-design person-centred care pathways which ensure that people are able to navigate to the right care and receive that care from the right person in a setting which suits their needs. By commissioning social prescribing, LCGs can ensure that GPs and other care professionals can make greater use of the assets which already exist in local communities to prevent ill-health and help people live as well as possible with their condition.

LCGs represent the HSC Board on the 11 Community Planning Partnerships where they are able to work with a wide range of partners to develop population plans which focus on outcomes and secure the contribution of education, housing, transport and other providers with a significant influence on health and wellbeing. An outcomes-based approach enables an evaluation of the impact of improvements in people's lives as a whole.

- The Belfast LCG will lead the development of a Community Winter Plan aimed at avoiding preventable excess winter deaths. This evidence-led outcomes-based approach will involve the use of data from a range of agencies to target particular areas of need. It will also enable frontline staff across community partners, community and voluntary sectors and local volunteers to identify people who are vulnerable and help provide them with a full assessment of their needs, a single point of contact and specific practical support over the coldest days in winter. It will also address the wider determinants of health and wellbeing issues such as fuel poverty, benefits support and housing conditions.

- The South Eastern LCG is working with Lisburn and Castlereagh City and Ards and North Down Councils on the important theme of Ageing Well. Pooled resources from strategic partner organisations has contributed to the appointment of an Ageing Well coordinator who has worked with both statutory and community and voluntary organisations to ensure a cross-sectoral emphasis on health ageing and a joining up of key services across both council areas.

Both Ards and North Down and Lisburn City Councils have sought to establish a community of life savers to promote a community response to out of hospital cardice arrest. Working with NIAS and partners in the community and voluntary sector, arrangements are in place for community training, appropriate assess to Automated External Defibrillators (AEDs) and the registering and maintenance of AEDs.

- The Community Crisis Intervention Service (CCIS) is a community-led initiative responding to individuals in distress, potentially vulnerable or at significant risk of self-harm and/or suicidal behaviour. A key initiative within the Derry City and Strabane District Community Plan, the pilot service funded by the Board, Agency and WHSCT is managed by the Council and supported by a multi-agency group of statutory and voluntary bodies and delivered by Extern. In its first 6 months, more than 50 people received support, some avoiding ED attendance and most agreeing a safety plan. Ulster University will evaluate the pilot in the autumn and its ongoing delivery will then be considered.

The Local Commissioning Plans which follow provide further detail on the particular needs, issues and opportunities for that specific population in 2019/20. However there are a number of local priorities for 2019/20 which are common across all LCG areas including:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
L1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	Trusts should state the volumes by service which they will deliver in reflecting the Full Year Effect of previous investments and additional funding provided within this Commissioning Plan.
L2	Effective arrangements should be in place to ensure patients who can be discharged to their own home are supported to do so as soon as appropriate.	Trust responses should demonstrate plans to implement the recommendations of the Northern Ireland Intermediate Care Audit and provide more home-based community rehabilitation.

L3	Effective arrangements should be in place to ensure people at risk of Type 2 Diabetes should be offered self - management support	Trusts should demonstrate plans to work with their ICP partners to support implementation of the Diabetes Prevention Programme
L4	Effective arrangements and infrastructure should be in place to support an integrated model of care across the LCG/Trust area.	Trusts should demonstrate plans to re-configure community services and estate to support multi-disciplinary working embedded with general practice, including co-location.
L5	Effective arrangements should be in place to ensure patients referred by GPs for Talking Therapies are able to access the service to meet their needs as soon as possible.	Trusts should work with its ICP partners to ensure that patients who are referred can access the service in a timely way.
L6	Effective arrangements should be in place to ensure that diagnostics /imaging services are appropriate.	Trusts should demonstrate plans to: • Optimise utilisation of available diagnostic facilities • Ensure capital priority is given to timely replacement of existing equipment and that plans are in place for additional equipment where indicated. • Optimise productivity of diagnostic facilities. • Optimise and develop skill mix within imaging teams • Ensure value for money and productivity from outsourced work where necessary. Trust responses should include detailed plans, implementation timelines, slippage assumptions and any potential savings impact. Plans should detail the level of investment, stating the source and the expected volumes to be delivered in 2019/20.
L7	Effective arrangements should be in place to appropriately manage the increasing number of older people over 75 years.	Trust responses should outline progress in the establishment of 24-hour community nursing, building on investment to date in district nursing, Rapid Response nursing and treatment rooms, additional palliative care

		nursing support Trusts should also provide an overview of its plans to better coordinate the range of community nursing services in place.
L8	Effective arrangements should be in place to ensure that services provided are safe, effective and delivered in accordance with national guidance.	Trusts should demonstrate plans to implement guidance and actions in relation to: • NICE guidance • NCEPOD reports • RQIA reports

6.1 Belfast Local Commissioning Plan

Local needs assessment

The total population of the LCG is expected to increase by 4000 people (1.2%) by 2022. The fastest growing cohort is aged 60-84. The number aged over 85 is also increasing but other age groups are expected to change little or decline over the next few years.

Areas of deprivation cover 29% of the LCG area. GP registers show that these areas have the highest prevalence of respiratory and cardiovascular disease and some cancers, which are the main causes of premature death. Deaths from suicide and alcohol and drugs also explain the difference in life expectancy between the less deprived and more deprived areas of Belfast. The higher prevalence of long term health conditions also leads to the significant difference in Healthy Life Expectancy, a measure of the quality of life, in more deprived areas. Poor health and wellbeing in more deprived areas is associated with low performance across a wide range of other outcomes (see Appendix 3). GPs, local communities and the Belfast Strategic Partnership have highlighted the fundamental importance of emotional health and wellbeing to physical health, the prevalence of common mental health conditions such as depression and anxiety

The poor health and wellbeing outcomes in more deprived areas is reflected in the pattern of demand for urgent and emergency care which shows higher rates of attendance and admission from those areas. Demand for primary mental health care also reflects patterns of deprivation as does the rates of prescribing of prescription drugs for depression, anxiety and pain relief. Most of the more deprived areas are within North and West Belfast. South Belfast has fewer of such areas but has a larger number of people suffering from severe mental illness who require inpatient and community support. East Belfast has the oldest population profile which creates additional demand for services supporting those with dementia and frailty, as well as other age-related conditions.

Partnership working

The complex influences on health and wellbeing outcomes and their inequalities in Belfast requires a strong partnership approach with local communities, service users and carers, Community Planning partners and ICPs. The LCG is a member of the Belfast Strategic Partnership and the Belfast Community Planning Partnership.

The LCG area covers all of the Belfast LGD and part of the Lisburn and Castlereagh City LGD. Priorities in the Belfast Agenda community plan include the aim by 2035 to reduce the gap in Life Expectancy between the most and least deprived areas by 33% and to provide integrated support for early years and families. The Community Action Plan for Lisburn and Castlereagh City Council includes improvements in mental health, physical activity, ageing well and a community of life-savers.

Key local issues and opportunities

In Belfast, under the auspices of the Community Planning Partnership, the LCG will lead the development of a winter resilience plan to avoid preventable deaths which will coordinate actions by all stakeholders across the city that can make a contribution to supporting those at risk over the winter period to remain safely at home. In its leadership of the Healthy Ageing Strategic Partnership it is supporting the implementation of the Age Friendly Belfast Plan 2018-21. In 2019/20 it will produce a three-year plan to reduce isolation and loneliness, support the extension of community-led Dementia-Friendly Neighbourhoods to all four ICP areas, and produce an Age Friendly Charter for Community Pharmacies. In Lisburn and Castlereagh the LCG is working closely with the Council to develop a health hub at the Dundonald Ice Bowl which will include GP and Pharmacy services alongside Council and community services. The LCG is also supporting the Task Force undertaking an Appreciative Inquiry into social assets in North Belfast and is supporting the community organisations in the Whiterock to develop a local community wellbeing plan centred on Whiterock Health Centre and Leisure Centre campus. The LCG will also continue to work with the Belfast Trust to re-configure the location of community services to match local need. In 2020 this will see the development of new premises for

two GP practices at the Everton Complex with the potential for associated community services in future.

The LCG has established, with the Trust and ICPs, a Locality Network to develop population-wide approaches to outcomes. Priorities for Belfast ICPs in 2019/20 are: expanding the number of patients receiving acute care at home and the number receiving a falls assessment to prevent a further fall; further roll-out of GP direct access to Clinical Assessment Units to avoid Emergency Department attendances where possible; a protocol for identification of patients attending Emergency Departments who could benefit from end of life care; support for people with Diabetes and those at risk of developing Diabetes; the continued development of a respiratory network and the development of a test site for the regional Dementia pathway which links primary care and Trust services with the local Dementia-friendly neighbourhood.

In 2019/20 the LCG will also support the development and testing of a pilot for a new model of homecare in North Belfast. This involves an assessment of the extent to which community-led person-centred alternatives can reduce the need for traditional homecare for clients and carers who have low to moderate needs.

In 2019/20 the LCG will work with Belfast ICPs to ensure that as many people as possible take up and complete the commissioned alternatives to prescription drugs, including pain management programmes and talking therapies.

Specific local issues / opportunities in 2019/20 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
B1	Effective arrangements should be in place to ensure unscheduled care services in the Belfast LCG/Trust area are safe, sustainable and accessible.	Belfast Trust should work with its ICP partners to expand clinical assessment services and secure direct access for GPs.
B2	Effective arrangements should be in place to ensure that maternity services are	Belfast Trust should work with the LCG towards an agreed workforce plan for the

	arranged to meet the needs of all pregnant women.	Belfast Maternity Hospital
B3	Effective arrangements should be in place to plan appropriate care for people at risk of hospital admission in the Belfast LCG/Trust area.	Belfast Trust should work with its ICP partners to extend access to the Falls service which provides support for patients to remain at home.
B4	Effective arrangements should be in place to ensure people who require palliative care are identified and effective arrangements should be in place to ensure people requiring end of life care are supported to remain at home where that is their wish.	Belfast Trust should work with its ICP partners to ensure that people who require urgent or emergency care and are terminally-ill are identified and have a care plan developed and should work with voluntary sector partners to implement the out of hours rapid response service for end of life patients ensuring the capability of cross Trust working in response to patient need.
B5	Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with dementia.	Belfast Trust should work within ICPs to (i) identify a prototype test site, (ii) map out current provision within that locality for the whole dementia journey and (iii) specify gaps against the regional pathway and take forward implementation where possible.

6.2 Northern Local Commissioning Plan

Local Needs assessment

According to the Mid-Year Estimates for 2017, there are 474,773 people resident in the Northern LCG (NLCG) area. The total population of the LCG is expected to rise to 482,230 (an increase of 7,457 i.e. 1.57%) by 2022.
The NLCG has one of the fastest growing older populations with those in the 85 and over category anticipated to grow by 16.58% from 9,862 in 2017 to 11,498 in 2022. The number of people in the working population (16 - 64 year olds) is expected to continue to decline in the same time frame and this poses challenges around workforce and skills replacement.

The recent Northern Ireland Measures of Multiple Deprivation (NIMMD 2017) indicate that the Northern LCG fares relatively well in terms of overall levels of deprivation. There are however pockets of deprivation in each of our localities across each of the seven domains. Most notably for the Northern area, the biggest inequality is in terms of Access to services.

The Northern area covers 1,733 square miles and is very different in terms of its population distribution. There are large urban centres in East Antrim with good transport links to Belfast and beyond. Contrast this with the network of towns and villages and large rural hinterland of Mid Ulster, Antrim/Ballymena and the Causeway area, which are often at a distance from services and have dispersed populations and poor infrastructure and transport connectivity.

Ambulance response times for category “A” calls are below the target response times for all of the NLCG and there are particular issues for response times in more rural areas. Work continues with Dalriada Urgent Care to maximise the efforts of a network of First Responder Schemes and this has been given added impetus by community planning in a number of areas, particularly Mid Ulster.

Partnership working

Partnership working affords the Northern LCG an opportunity to work with other partners to address the wider determinants of health. The Northern LCG continues to work with Mid and East Antrim, Causeway Coast and Glens, Mid Ulster and Antrim and Newtownabbey Borough Councils to implement the actions in the Community Plans. The Northern LCG represents the Board across the four Council areas both at Strategic Partnership Board level and on the various health and wellbeing working groups.

The NLCG is working with the NHSCT and other partners to develop the Northern Area Prototype which aims to integrate all local stakeholders in the planning and delivery of services. At its core, will be four Locality Integrated Care Partnerships with shared plans and accountability for local service delivery.

The NLCG continues to collaborate with regional and other colleagues to develop a network of health and care centres to improve access to integrated services. Mindful that one size does not fit all, the LCG is looking at opportunities to improve the service offering in different localities according to local need. Further information can be found in Section 4.2.2.

Along with Community Planning partners, the LCG will continue to progress a range of actions which target the needs of the local populations. These range from increasing opportunities for participation in physical activity, improving the uptake of obesity prevention programmes and the promotion of healthy eating. One area of focus has been collaboration to support older people to live independent and active lives and to help them to stay connected. The Northern LCG has worked with community planning partners in the Mid and East Antrim area to develop an 'Ageing Well Model'. Based on a similar approach in Mid Ulster, the model was designed by the partners following consultation with older people and has been commissioning on behalf of the Community Planning Partnership.

In Antrim and Newtownabbey, the recently appointed Age Friendly Co-ordinator will be working with the Community Planning Partners to progress the aim of becoming a World Health Organisation Age Friendly Community. In order to address the concerns around mental health, partners will continue to work together to promote Take 5 steps to wellbeing in schools, local businesses and the community.

In light of the growing prevalence of dementia, the NLCG has been working with other statutory and voluntary partners to progress dementia friendly training and to promote dementia friendly initiatives in local communities such as ecumenical dementia friendly church services. Further work is planned with the arts and cultural departments of the local Councils and with the Councils and Sport NI in the roll out of physical activity programmes specifically designed for people with dementia.

Engaging with local communities is ongoing key objective for Community Planning partners. The Community Engagement Platform which has been established in Causeway Coast and Glens will provide an opportunity to build relationships and help highlight the collective interests of the local community and voluntary sector while acting as a borough wide platform for consultation and engagement.

The NLCG continues to lead the Dalriada Pathfinder Partnership in the Ballycastle area to address the health and wellbeing needs of the population. In addition to the successful Living Well Moyle approach which reconnects people with their local community, the Pathfinder Partnership has recently participated in the consultation on the introduction of the Health Places initiative to the wider Glens District Electoral Area. Healthy Places is a cross-cutting demonstration programme which aims to improve health, address inequalities, and improve wellbeing and wider social outcomes.

Three priorities have been earmarked for initial focus:

- Transport connectivity;

- Men's sheds
- I-solutions to isolation

Key Local Issues and Opportunities

With a growing number of older people and increasing demand for unscheduled care services, the LCG will continue to work as part of the Local Area Network to help plan unscheduled care services for the local health economy. An Acute Care at Home scheme is planned which aims to deliver acute services for older people in their own home, where appropriate. Ambulatory services will be enhanced to try to manage more people on an outpatient basis and closer to their homes where this is possible. Work continues through the Local Network to establish a GP Proactive Ward round in nursing homes to help minimise avoidable ED attendances from nursing homes.

Specific local issues/opportunities in 2019/20 include:

LOCAL PRIORITY		PROVIDER REQUIREMENT
N1	Effective arrangements should be in place to deal with the fragility fractures which are associated with increased morbidity and mortality.	Northern Trust's response should demonstrate plans to: • support the development of the Fracture Liaison Osteoporosis Service in the NHSCT area. • investigate people to detect osteoporosis and initiate appropriate treatment. • provide a comprehensive nurse led assessment at a one stop clinic at the Health and Care Centre in Ballymena to take place either one session per week or one full day per fortnight. The service should provide Dexa scanning using the current resource which is in place, blood testing and risk factor analysis, consultant-led management decisions and a consultant-led clinic once a month.
N2	Effective arrangements should be in place for patients to access telephone and on-line advice for clinical sexual	Northern Trust's response should demonstrate how the agreed mobilisation process to implement an on-line STI service will be

	health matters including family planning and sexually transmitted infections.	promoted and supported in 2019/20.
N3	Effective arrangements should be in place to support the implementation of a GUM Consultant led service in 2019/20.	Northern Trust's response should illustrate how the recently appointed GUM Consultant will take forward and implement an enhanced sexual health service, including HIV, for Northern residents. It is important that this local service reflects the regional direction of travel and supports a network approach.

6.3 South Eastern Local Commissioning Plan

Local Needs assessment

The South Eastern LCG area has a population of almost 360,000 covering the areas of Ards and North Down, Lisburn and South Down. The area is predominantly rural with a number of sizable conurbations. As the south east is close to greater Belfast, a significant proportion of the working population commute, on a daily basis in and out of Belfast.

The total population of the south east is expected to increase by almost 9000 people (2.5%) before 2022, the second highest increase in Northern Ireland. Most of this increase in population will be in the over 65 and over 85 year olds groups which will rise by 12.8% and 16.3% respectively. The population under 65 years of age will only marginally increase by 0.2%.

The south east population is generally above the Northern Ireland average in most aspects of health and wellbeing. Residents can expect to enjoy the highest life expectancy in Northern Ireland. Males on average currently have a life span of 79.5 years, while the female average is 83.1 years. This positive picture masks the issue of inequalities between communities in the south east which means that life expectancy differs for those who are residents in the locality's 20% most deprived areas. Males in the most deprived areas can expect to live 3.6 years less than the south east average, while females will live 2.5 years less. While the longevity of our population is to be celebrated, it does also signpost major challenges in respect of planning to care for an older population that may be living with more complex conditions such as dementia and advanced frailty. This is particularly relevant to the south east given that it has the oldest age profile in Northern Ireland.

In respect of some of the causes of premature mortality from conditions such as circulatory, respiratory and cancer the south east has some of the lowest death rates.

The percentage of adults classed as overweight or obese is 65% which is 2% above the Northern Ireland average. This reflects a more sedentary lifestyle prevalent in first world countries and which is a major factor in the development of a range of complex conditions in later years, most significantly diabetes.

When looking at mental health in regard to self-harm, suicide and prescribing of mood related medication, the south east sits below the Northern Ireland average vis-a-vis these rates. The south east is also generally below the Northern Ireland average in most of the key indicators associated with alcohol/drug misuse and smoking, however the prevalence of adults drinking in the south east in the highest in Northern Ireland.

Analysis of health inequalities in 2018 demonstrate that in respect of the Northern Ireland average, across the 45 indicator areas of inequality, there were in the south east no indicators worse than the Northern Ireland average, with 15 indicators remaining unchanged and 30 areas now better than the Northern Ireland average. However, despite the overall positive position of the health and wellbeing of the south east population, the LCG recognises the disparity across communities associated with these indicators and the levels of inequality which are often linked to levels of income and social deprivation.

Partnership working

Addressing the future needs of the south eastern population requires an integrated and partnership approach. The LCG continues to support the strong partnership culture established in the localities and the work of the Integrated Care Partnerships in the design and co-production of new services to transform health and social care. The LCG is also participating in the emerging service networks in areas such as elective, unscheduled care, diabetes and palliative care which support the local implementation of regionally driven initiatives.
Of specific interest to the LCG is our participation in the evolving community planning process across the south east. The LCG is working with Ards and North Down, Lisburn City and Castlereagh and Newry, Mourne and Down Councils at a strategic level to drive, in particular, the health and wellbeing agenda, the true impact of which is reliant on agencies outside of health and social care

environment like education, housing and council services and harnessing the capacity of the community sector.

The contribution from the voluntary and community sector continues to grow and the SE LCG is supportive of plans to expand community development approaches across Northern Ireland in the future.

Key local issues and opportunities

To address the key issues in the south east the LCG will develop new working arrangements. The LCG welcomes the development of emerging Locality Network arrangements to tackle areas of continuing concern in regard to unscheduled care, elective performance and palliative and end of life care provision. Pathway approaches, for example in relation to unscheduled care, will require enhancing community services; ensuring admission avoidance [where appropriate for the patient], maintaining good patient flows within hospital and focusing on timely discharge from hospital to an appropriate community setting, primarily the individual's home.

Improving access to mental health and therapy services in the south east, both in regard to community and acute provision will remain a key issue in the coming planning period. The LCG will work with colleagues in the South Eastern Trust and the DoH to pursue an urgent solution to the acute mental health needs of the population while ensuring a continued focus on community based solutions

The LCG understands the importance of strong primary and community care services to underpin the health and social care system. It welcomes the commitment to building the Primary and Community Care Centre in Lisburn on the Lagan Valley Hospital site. The LCG will work with the SE Trust to complete its Primary Care infrastructure model with a future focus on the needs of the Ards and North Down communities.

Following the opening of the medical ward block at the Ulster Hospital, building work has continued on the new Acute Services Block that will enable the

remaining medical beds in the Ulster Hospital to transfer to single room accommodation by 2021. The LCG and our partners will seek to support new transformation models of acute care that maximise the new hospital facilities

The LCG will continue to work with a range of partners on the transformation agenda for HSC. Taking a whole systems approach to health care, this opportunity should see significant changes in the way services are provided and improve the quality of care. New initiatives in community services such as the new district nursing model, the establishment of a multi-disciplinary Team model with the Down GP federation and the review of domiciliary care to develop a new model of care and support at home and transformation projects with nursing homes, and introducing shared lives approaches of care, all point to opportunities to significantly shift care and improve quality.

Success in implementing change in the coming planning period will be reliant on the availability of staff across many professional areas. Steps to enhance the workforce through skill mix and retention opportunities will be important to ensure the delivery of the transformation agenda.

Specific local issues/opportunities in 2019/20 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SE1	Effective arrangements should be in place to plan appropriate care for people at risk of hospital admission in the SE LCG area.	SE Trust should demonstrate plans to enhance the Enhanced Care at Home service to transform the service to respond to the acuity for patients who need ED attendance or hospital admission.
SE2	Effective arrangements should be in place to ensure the provision of Enhanced Pain Management Services	SE Trust should demonstrate plans to work with partners to ensure access to pain management services in the community and additional psychological support for those with chronic long term conditions.
SE3	Effective arrangements should be in place to ensure the further development of	SE Trust should demonstrate plans to work with the ICP and other partners, to deliver a

	Family and Reproductive Health Services	family planning service with plans for an integrated Family and Reproductive Health Service in 2019/20.
SE4	Effective arrangements should be in place to ensure people requiring end of life care are supported to remain at home where that is their wish.	SE Trust should demonstrate plans to work with voluntary sector partners to implement new rapid response opportunities with a particular focus on nursing homes and hospital/ED in-reach.
SE5	Effective arrangements should be in place to improve dental care for older people in residential care.	The Trust should demonstrate plans to improve the oral health of older people in residential homes.

6.4 Southern Local Commissioning Plan

Local Needs assessment

According to the Mid-Year Estimates for 2017, there are 358,708 people resident in the Southern LCG area, accounting for over 20% of the total Northern Ireland population. Almost a quarter of those living in the Southern area are children aged 0-15 years and just under 15% are people aged 65 and over. Population projections suggest that within the next five years, the total number of people living in the Southern area will increase by over 4% (17,882 persons) to 398,194. Within this period, the highest growth rate will be seen in the older age groups. By 2022, the 65+ population will have increased by 13.1%, including 20.3% growth in the population aged 85 and over. This equates to an additional 7,229 people aged 65 and over. The number of children aged 0-15 will continue to grow, with a projected increase of 4.4% (3,841 children) in this age group over the next five years. Furthermore, if current trends continue, projections indicate that by 2032, the Southern area will have the highest child population.

In terms of the 2017 Multiple Deprivation measures for Northern Ireland, 15 of the 100 super output areas (SOAs) ranked as most deprived in the multiple deprivation domain are in the Southern area. 11 of the 100 most deprived SOAs in the health and disability domain are in the Southern area.

Over 52,000 people in the Southern area are on a GP register of people suffering from hypertension, whilst 22,574 people are registered as having asthma. Over 17,000 people (aged 17+) are on GP registers as having diabetes and over 14,000 are registered as having heart disease[8]. Many will be registered as having more than one condition, the likelihood of which increases with an ageing population. In terms of mental health, 3,186 people were on registers in Southern area GP practices as having a mental health condition.

[8] *Qualities and Outcomes Framework Data Southern Area 2017*

Partnership working

The Southern LCG participates in three community planning partnerships across the Southern area – Armagh, Banbridge and Craigavon; Newry Mourne and Down and Mid-Ulster. Using key indicators of need such as lifestyle data, life expectancy rates and numbers of preventable deaths, partnerships, through extensive engagement have identified a number of priorities which have been translated into action plans.

The LCG works closely with local Integrated Care Partnerships to address priority areas such as management of demand for scheduled care and the development of a range of innovative primary and community care services to provide care closer to home.

Key local issues and opportunities

A Local Network Group for Unscheduled Care was established in 2017/18 comprising a range of representatives including Southern Trust, NIAS, service users, general practice, Board/Agency. The LCG will support the Locality Network in developing a 2019/20 Winter Resilience Plan which will include actions to both manage demand for services within community and primary care settings and address pressures in the unscheduled and urgent care systems.

The LCG will continue to work with the Trust, Primary Care, ICPs and a range of other stakeholders to further develop the range of ambulatory care services available in the Southern area, avoiding the need for emergency admission where appropriate.

The LCG will continue to work with the Southern Trust and other stakeholders to support the recommendations of the Daisy Hill Hospital Pathfinder Group in delivering a model of care which will meet the unscheduled care needs of the people of Newry and Mourne.

Specific local issues/opportunities in 2019/20 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
S1	Effective arrangements should be in place to ensure unscheduled care services in the Southern LCG/Trust area are safe, sustainable and accessible.	Southern Trust should demonstrate plans to develop the range of ambulatory care services that are available across the Southern area including services which offer direct access to advice and support for GPs.
S2	Effective arrangements should be in place to enhance the Trauma and Orthopaedic Team, recognising the significant growth in fracture demand.	Southern Trust should demonstrate plans to ensure there is sufficient access to theatre capacity for the enhanced team together with a realistic timeline for implementation of the enhanced service.
S3	Effective arrangements should be in place to meet the acute care needs of older people.	Southern Trust should demonstrate plans to maximise capacity in the acute care at home team, ensuring full geographical coverage and work towards implementation of a single point of access for the range of services for older people. The Trust should work with its ICP partners to review current arrangements for Direct Admission, community support to maintain patients at home including use of Step-up beds and review of additional plans to address the current conversion rate.

6.5 Western Local Commissioning Plan

Local Needs Assessment

According to the Mid-Year Estimates for 2017, there are 301,448 people resident in the Western LCG area. The total population of the LCG is expected to increase by approximately 3000 people (0.9%) by 2022. The fastest growing population in the LCG area are those in the 85 and over category which is anticipated to grow by 16.8% in 2022. Similarly, the growth in the over 65 population is also significant with increases of 6,000 people (12.9%) expected in the same timeframe.

One in four people (25.3%) residing within the Western area in 2013 were living within the most deprived of the Northern Ireland deprivation quintiles. Across Northern Ireland, 18.8% of the population live in the most deprived quintile.

The Western population shows higher prevalence of long-term conditions than NI as a whole for a range of conditions recorded within the GP Quality and Outcomes Framework. In 2018/19, there was higher prevalence of atrial fibrillation, asthma, hypertension, cancer, COPD, cardiovascular disease, dementia, depression, mental health, osteoporosis, and palliative care.

Mental health is considerably worse, particularly due to anxiety and depression. Smoking remains higher than average. More people are likely to suffer pain and discomfort than for Northern Ireland as a whole. There is higher rate of children in need.

Partnership working

The LCG was closely involved in bids from Western GP Federations and Western Trust to pilot primary care multi-disciplinary teams. One of these bids was successful, led by Derry GP Federation and work continues to put in place key staff required, with particular progress notable in physiotherapy, social work and mental health. The LCG anticipates considerable benefits will be realised for patients and general practice and hopes that this will also lead to reduced pressure in other parts of the HSC system in the North-West.

The LCG is represented on both Derry City and Strabane District and Fermanagh and Omagh Community Planning Partnerships. Work to take forward community plans is underway in both partnerships and opportunities exist to take forward HSC priorities with partners as well as inputting to work which will benefit HSC. Key developments with statutory partners include a pilot of the Derry Crisis Intervention Service, funded by the LCG and Agency, and collaborative working on the council masterplan for the Strabane Canal Basin.

The LCG continues to work in partnership with the five local community networks covering the Western area. In recent years this partnership has enabled a focus on service user experience of HSC services, including unscheduled care initiatives undertaken in 2017 which reached over 1,000 people. The networks have recently completed presentations providing an overview of how the HSC service is planned and works to more than 500 people through a series of community-based meetings based on information provided by the LCG. It is hoped that this approach will increase understanding of the issues and challenges facing Health and Social Care.

The LCG is closely involved in projects being rolled out by CAWT with funding from EU Interreg V programme. The projects offer opportunities to develop significant new approaches to delivering services in an acute hospital, for children in need, older people and people with mental health problems and significant developments are planned in the Western area.

Key local issues and opportunities

The LCG will continue to work closely with the Western Integrated Care Partnerships on their continued work on outpatient reform. Key developments include:

- An integrated and person centred model of care for frailty;
- Initiatives to enhance safe, effective, compassionate care to residents living in care homes;
- Effective care and support to those with diabetes;
- Implementation of the palliative care priorities;

- Improved health and wellbeing for older people and people with Long Term Conditions through a person centred and co-produced approach;
- Local implementation of stroke prevention priorities;
- Improved respiratory services;
- Implementation of the Regional Dementia Care Pathway;
- Carers Strategy Regional Action Plan; and
- Opiate substitute prescribing.

Specific local issues / opportunities in 2019/20 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
W1	Effective arrangements should be in place to provide safe and sustainable services within the Fermanagh and West Tyrone area.	Western Trust's response should demonstrate plans to implement the outworking of the Fermanagh and West Tyrone Pathfinder including proposals to test Connected Communities in 3 areas and update on progress in other aspects of the Pathfinder programme.
W2	Effective arrangements should be in place to ensure unscheduled care services in the Western area are safe, sustainable and accessible.	Western Trust should provide an overview of plans to develop unscheduled care, including ambulatory care and acute care at home. The Trust should contribute to the production and implementation of a Winter Resilience Plan.
W3	Effective arrangements should be in place to develop modern, appropriate accommodation for the emergency department, theatres and related services on the Altnagelvin site.	Western Trust's response should outline progress in relation to the business case for Altnagelvin Phase 5.2 which the LCG anticipates will be completed during 2019. In parallel, work is underway to produce a business case for the planned Cityside Health and Care Hub and the Trust should also provide an update on progress with this.
W4	Effective arrangements should be in place to provide safe and sustainable	Western Trust's response should demonstrate plans to introduce a specialist dietician to

	gastroenterology services. The LCG has also invested in specialist dietetics to undertake review of patients with Coeliac Disease, thereby allowing consultant gastroenterologists to focus on more chronic gastroenterology conditions.	undertake reviews of patients with Coeliac Disease, including extension of the service to the Southern Sector in due course.
W5	Effective arrangements should be in place to provide safe and sustainable urology services for patients living within the Fermanagh area. The LCG has recognised that a disparity of access for Western patients emerged in Urology and has agreed to transfer Fermanagh patients currently referred to SHSCT to WHSCT which will lead to improved access and equity. Additional investment is being finalised with Western Trust.	Western Trust's response should outline plans to commence a urology service for Fermanagh patients during 2019/20 and assure the Board that current good performance within Urology will be maintained following service expansion.
W6	Effective arrangements should be in place to provide safe and sustainable neurology services within the Western Trust	Western Trust's response should outline plans to extend medical cover in neurology services and consider opportunities for skill mix and alternative care pathways, such as GP direct access to MRI for head pain.
W7	Effective arrangements should be in place to expand the consultant-led Endometriosis service.	Western Trust's response should outline plans to provide direct access for patients requiring Endometriosis services so that the quality of care can be enhanced. Responses should include an update on progress towards introducing the nurse specialist service for women which the Board has funded.
W8	Effective arrangements should be in place to continue work on outpatient reform.	Western Trust's response should demonstrate plans to support ICP outpatient reform including: • fatty liver pathway, • Haemochromatosis Venesection, DMARD monitoring,

		• NI roll out of primary care Joint injections service Western Trust's response should also demonstrate support for ICPs plans to pilot remote control Atrial Fibrillation and focused work on development of portfolio opportunities for GPs in the West.

Appendix 1: Delivering on Key Policies and Strategies

While the majority of these strategies are specifically referenced within the Plan, the Board and Agency remain committed to the delivery of all existing policies, frameworks, guidance and strategies highlighted below. It should be noted that it is not an exhaustive list.

- Draft Programme for Government (2016-2021)
- Delivering Together
- Quality 2020
- Rural Needs Act
- Institute of Healthcare Improvement Liaison
- Service Frameworks
- Workforce Planning and Development
- Sexual Health Strategy
- Domestic Violence and Sexual Violence Strategy
- A Strategy For The Development Of Psychological Therapy Services
- Adult Safeguarding: Prevention and Protection in Partnership
- Making Life Better
- Maternity Strategy
- Physical and Sensory Disability Strategy
- Delivering Care: Nurse Staffing in Northern Ireland
- Primary and Community Care Infrastructure
- eHealth and Care strategy
- Living Matters Dying Matters
- RQIA Reports
- Northern Ireland Rare Disease Implementation Plan
- NICE guidance

Appendix 2: Commissioning Plan Direction Outcomes Framework

COMMISSIONING PLAN DIRECTION OUTCOME		SECTION
Aim: To improve the health of the population		
Outcome 1: Reduction of health inequalities		
Population Health		
1.1	By March 2020, in line with the Department's ten year *"Tobacco Control Strategy"*, to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.	5.14
1.2	By March 2020, to have commissioned an early years obesity prevention programme and rolled out a regionally consistent Physical Activity Referral Scheme. These programmes form part of the Departmental strategy, A Fitter Future for All, which aims by March 2022, to reduce a level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.	5.14
1.3	By March 2020, through implementation of the NI Breastfeeding Strategy increase the percentage of infants breastfed at discharge and 6 months as recorded in the Child Health System (CHS). This is an important element in the delivery of the *"Breastfeeding Strategy"* objectives for achievement by March 2025.	5.14
1.4	By March 2020, establish 3 "Healthy Places" demonstration programmes working with specialist services and partners across community, voluntary and statutory organisations to address local needs.	4.1.1
1.5	By March 2020, to ensure appropriate representation and input to the Agency/ Board led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach.	5.5.2
1.6	By March 2020, to collate survey data to establish a baseline position regarding the mean number of teeth affected by dental decay, among 5 year old children, and seek a reduction of 5% against that baseline by March 2021.	5.5.1
1.7	By March 2020, to commence the implementation of a regional prototype bariatric service, subject to the outcome of public consultation, business case approval and available funding in line with the implementation of recommendations set out in the Departmentally endorsed NICE guidance on weight management services.	5.16

Supporting Children and Young People		
1.8	By March 2020, to have further developed, and implemented the *"Healthier Pregnancy"* approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation.	5.9
1.9	By March 2020, ensure the full delivery of the universal child health promotion programme for Northern Ireland, *"Healthy Child Healthy Future"*. By that date: • The antenatal contact will be delivered to all first time mothers. • 95% of two year old review must be delivered. These activities include the delivery of core contacts by Health Visitors and School Nurses which will enable and support children and young adults to become successful, healthy adults through the promotion of health and wellbeing.	4.1.1
1.10	By March 2020, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 "We give our children and young people the best start in life".	4.1.1 & 5.14
1.11	By March 2020 each HSC Trust will have established an Infant Mental Health Group and produced an Action Plan consistent with and informed by the "Infant Mental Health Framework for Northern Ireland" 2016.	4.1.1 & 5.14
1.12	By March 2020, the proportion of children in care for 12 months or longer with no placement change is at least 85%; and 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer then greater stability while in care.	5.4
Improving Mental Health		
1.13	By March 2020, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a Multi-Agency Triage Team pilot (SEHSCT) and two Crisis De-escalation Service pilots (BHSCT and WHSCT) to test different models and approaches. Learning from these pilots should inform the development of crisis intervention services and support the reduction of the suicide rate by 10% by 2022 in line with the draft "*Protect Life 2 Strategy*".	5.10 & 5.14
1.14	By March 2020, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol and drug relation harm and to reduce drug related deaths.	5.10

Supporting those with Long Term Conditions		
1.15	By July 2020, to provide detailed implementation plans (to include recruitment status) for the regional implementation of the diabetes foot care pathway, plans should demonstrate an integrated approach making best use of all providers. Regional deployment of the care pathway will be an important milestone in the delivery of the "*Diabetes Strategic Framework*".	5.8.2
Aim: To improve the quality and experience of health and social care		
Outcome 2: People using health and social care services are safe from avoidable harm		
Safe in all Settings		
2.1	By March 2020 all HSC Trusts should ensure safe and sustainable nurse staffing, including working towards the full implementation of phases 2, 3 and 4 of Delivering Care, maximising the use of any current or new funding, with an annual report submitted to HSC Trust Boards.	4.4
2.2	By 31 March 2020: • Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 3%, as per the established recurring annual targets, taking 2018/19 as the baseline figure; and • Using 2018/19 as the baseline, by March 2020 Trusts should secure the following in secondary care: ○ a reduction in total antibiotic prescribing(DDD per 1000 admissions) of 1-2%; ○ a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions; ○ a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions, and ○ and EITHER ▪ that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category, OR ▪ an increase in 2% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use with the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 15% by 31 March 2021. **For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.*	5.5.4 & 5.17
Safe in Hospital Settings		
Reducing Gram-negative bloodstream infections 2.3	By 31 March 2020 secure an aggregate reduction of 17% of *Escherichia coli, Klebsiella spp. And Pseudomonas aeruginosa* bloodstream infections acquired	5.14

	after two days of hospital admission, compared to 2018/19.	
2.4	In the year to March 2020 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of *Clostridium difficile* infection in patients aged 2 years and over, and in-patient episodes of Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection compared to 2018/19.	4.1.3
2.5	Throughout 2019/20 all clinical care teams should comprehensively scale and spread the implementation the NEWS KPI, and ensure effective and robust monitoring through clinical audit and ensure timely action is taken to respond to any signs of deterioration.	4.2.3
2.6	By March 2020, achieve full implementation of revised regional standards, operational definitions and reporting schedules for falls and pressure ulcers across all adult inpatient areas.	4.2.3
2.7	By March 2020, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group.	3.2, 4.2.2, 5.2, 5.5.4 & 5.6
Safe in Community Settings		
2.8	During 2019/20 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.	4.2.1, 4.2.2, 5.2 & 5.7
Outcome 3: Improve the quality of the healthcare experience		
3.1	By March 2020, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment.	5.3
3.2	During 2019/20 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.	5.4
3.3	By September 2019, patients in all Trusts should have access to the Dementia portal.	4.2.3
3.4	By March 2020, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.	5.12

3.5	By March 2020, the HSC should ensure that the Regional Co-Production Guidance has been progressively implemented and embedded across all programmes of care, including integrating PPI, Co-Production, and patient experience into a single organisational plan.	1.7 & 4.2.2
Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them		
Primary Care and Community Setting		
4.1	By March 2020, to increase the number of available appointments in GP practices compared to 2018/19.	5.5.2
4.2	By March 2020, to have 95% of acute/urgent calls to GP OOH triaged within 20 minutes.	5.5.2
4.3	By March 2020, reduce the number of unallocated family and children's social care cases by 20%.	5.4
Ambulance Services		
4.4	Until the proposed adoption of a new clinical response model, when 72.5% of Category A (life threatening) calls should be responded to within 8 minutes, 67.5% in performance is maintained at the previous target level.	5.11
Hospital Care Setting – Acute Care		
4.5	By March 2020, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.	5.17
4.6	By March 2020, at least 80% of patients to have commenced treatment, following triage, within 2 hours.	5.17
4.7	By March 2020, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	5.17
4.8	By March 2020, ensure that at least 16% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.	5.8.5
4.9	By March 2020, all urgent diagnostic tests should be reported on within two days.	5.3
4.10	During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.	5.1

Hospital Care Setting – Elective Care		
4.11	By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.	5.3
4.12	By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.	5.3
4.13	By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/day case treatment and no patient waits longer than 52 weeks.	5.3
4.14	By March 2020, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).	5.10 & 6.0
Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them		
Increased Choice		
5.1	By March 2020, secure a 10% increase in the number of direct payments to all services users.	5.2
5.2	By September 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget. Trust arranged services, or a mix of those options, to meet any eligible needs identified.	4.2.4 & 5.2
Access to Services		
5.3	By March 2020, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.	4.4
5.4	By March 2020, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.	4.4
5.5	By March 2020, Direct Access Physiotherapy Service will be rolled out across all Health and Social Care Trusts on a state of readiness basis.	4.4
5.6	By March 2020, to have published the Children and Young People's Emotional Health and Wellbeing Framework for school-aged children and young people in Northern Ireland.	5.4
Care in Acute Settings		
5.7	During 2019/20, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.	5.7 & 5.10

Outcome 6: Supporting those who care for others		
6.1	By March 2020, secure a 10% increase (based on 2018/19 figures) in the number of carer's assessments offered to carers for all service users.	4.2.5 & 5.2
6.2	By March 2020, secure a 5% increase (based on 2018/19 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	4.2.3, 5.2, 5.7, 5.9.2 & 6.2
6.3	By March 2020, secure a 5% increase in the number of young carers attending day or overnight short break activities.	4.2.3, 5.7 & 5.9.2
Aim: Ensure the sustainability of health and social care services provided		
Outcome 7: Ensure the sustainability of health and social care services		
Primary and Community setting		
7.1	By March 2020, to ensure delivery of community pharmacy services in line with financial envelope.	5.5.4
7.2	By March 2020 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users and the baseline activity to measure this.	5.4
Hospital Setting		
7.3	By March 2020, to establish a baseline of the number of hospital-cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment, and by March 2020 seek a reduction of 5%.	5.3
7.4	By March 2020, to reduce the percentage of funded activity associate with elective care service that remains undelivered.	5.3
7.5	By March 2020, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital, take place within six hours.	5.17
7.6	By March 2020, to have obtained savings of at least £20m through the Medicines Optimisation Programme, separate from PPRS receipts.	3.2 & 5.5.4
Aim: Support and empower staff delivering health and social care services		
Outcome 8: Supporting and transforming the HSC workforce		

Implementing the Workforce Strategy		
8.1	Contribute to delivery of Phase One of the single lead employer project by 31 July 2019 and Phase 2 by 31 January 2020; in line with the requirements set down by the Department.	4.4
Attracting, recruiting and retaining staff		
8.2	By June 2019, to provide appropriate representation on the project Board to establish a health and social care careers service.	4.4
Effective workforce planning		
8.3	By March 2020, to have completed the first phase of the implementation of the domiciliary care workforce review.	5.2
8.4	By June 2019, to provide appropriate representation to the project to produce a health and social care workforce model.	4.4
Build on, consolidate and promote workforce health and wellbeing and staff engagement		
8.5	By March 2020, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10-14 of the Workforce Strategy.	1.4
Supporting our staff		
8.6	By December 2019, to ensure at least [40%] of the Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.	4.1.3
8.7	By March 2020, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2017/18 figure.	4.4
8.8	During 2019/20, a workforce review of the social work workforce will be progressed to inform future supply needs and commissioning of professional training (subject to resource availability).	5.10
8.9	By March 2020, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG.	5.14
8.10	Improve take up in annual appraisal of performance during 2019/20 by 5% on previous year towards meeting existing targets (95% of medical staff and 80% of other staff).	4.4
Investing in our staff		

8.11	By March 2020, 60% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2 by March 2020.	4.2.3
8.12	By March 2020, to have developed and commenced implementation of a regional training framework which will include suicide awareness and suicide intervention for all HSC staff, with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services and mental health/addiction services) by 2022 in line with the draft Protect Life 2 strategy.	4.4
8.13	By March 2020, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts.	4.4

Appendix 3: Regional and Local Key Population Health Facts

Below are listed the main population health indicators based on the most recent data available. The Regional Northern Ireland and comparative Trust/LCG areas positions are displayed for ease of reference and clearly highlight differentials between Trust/LCG areas across key health indicators.

Indicator Category – Life Expectancy and General Health

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	SE	South	West
Male Life Expectancy at Birth	2014-16	Years	78.5	76.4	79.2	79.5	79.1	78.3
Female Life Expectancy at Birth	2014-16	Years	82.3	81.3	82.9	83.1	82.5	82.2
Male Life Expectancy at 65	2014-16	Years	18.3	17.3	18.4	18.8	18.6	18.4
Female Life Expectancy at 65	2014-16	Years	20.7	20.0	21.0	21.0	20.7	20.3
Male Healthy Life Expectancy	2014-16	Years	59.1					
Female Healthy Life Expectancy	2014-16	Years	60.9					
Male Disability Free Life Expectancy	2014-16	Years	55.3					
Female Disability Free Life Expectancy	2014-16	Years	56.4					
General Health (adults)	2016/17	% Very good/Good	73%	67%	73%	78%	74%	72%
Longstanding Illness (adults)	2016/17	%	42%	51%	44%	43%	37%	36%
Limiting Longstanding Illness (adults)	2016/17	%	30%	39%	30%	28%	27%	28%
General Health (young people: school years 8-12)	2016	% Very good / Good	84%	83%	80%	82%	86%	86%
Longstanding Illness (young people: school years 8-12)	2016	%	24%	25%	26%	28%	21%	23%
Limiting Longstanding Illness (young people: school years 8-12)	2016	%	14%	12%	15%	16%	12%	12%

Indicator Category – Premature Mortality

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	SE	South	West
Potential Years of Life Lost	2014-16	Years lost per 100 persons	8.6	10.6	7.7	7.7	8.4	8.9
Standardised Death Rate Amenable	2012-16	Deaths per 100,000 population	127	164	117	110	120	132
Standardised Death Rate Preventable	2012-16	Deaths per 100,000 population	205	263	188	179	195	216
Standardised Death Rate Avoidable	2012-16	Deaths per 100,000 population	242	313	222	211	228	252
Standardised Death Rate Avoidable: Children and Young People	2012-16	Deaths per 100,000 population	22					
Standardised Death Rate Circulatory U75	2012-16	Deaths per 100,000 population	75	96	68	66	73	76
Standardised Death Rate Respiratory U75	2012-16	Deaths per 100,000 population	34	47	32	26	29	39
Standardised Death Rate Cancer U75	2012-16	Deaths per 100,000 population	151	182	139	137	150	154
Standardised Death Rate All Cause U75	2012-16	Deaths per 100,000 population	369	462	337	329	359	385

Indicator Category – Major Diseases and Conditions

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Standardised Admission Rate Circulatory	14/15 - 16/17	Admissions per 100,000 population	2,170	2,019	2,339	2,080	2,201	2,157
Standardised Admission Rate Circulatory U75	14/15 - 16/17	Admissions per 100,000 population	1,525	1,503	1,566	1,445	1,553	1,557
Standardised Prescription Rate Antihypertensive	2016	Rate per 1,000 population	226	238	223	223	226	221
Standardised Prescription Rate Statin	2016	Rate per 1,000 population	171	173	167	160	177	182
Standardised Admission Rate Respiratory	14/15 - 16/17	Admissions per 100,000 population	2,055	2,249	1,999	1,961	1,959	2,142
Standardised Admission Rate Respiratory U75	14/15 - 16/17	Admissions per 100,000 population	1,506	1,688	1,391	1,397	1,462	1,675
Standardised Incidence Rate Cancer	2009-15	Incidence per 100,000 population	555	599	544	527	558	554

Indicator Category – Mental Health

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Standardised Admission Rate Self-Harm	12/13 - 16/17	Admissions per 100,000 population	173	219	142	169	170	176
Crude Suicide Rate	2014-16	Deaths per 100,000 population	15.9	22.1	12.6	14.8	15.4	15.8
Standardised Prescription Rate Mood and Anxiety	2016	Rate per 1,000 population	213	239	207	204	204	218
12-item General Health Questionnaire (GHQ12)	2016/17	% scoring highly (score of 4 or more)	17%	22%	16%	18%	13%	17%

Indicator Category – Alcohol, Smoking and Drugs

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Standardised Admission Rate Alcohol	14/15 - 16/17	Admissions per 100,000 population	721	1,095	511	636	599	884
Standardised Death Rate Alcohol	2012-16	Deaths per 100,000 population	16.4	24.8	12.8	14.2	12.8	19.5
Standardised Death Rate Smoking	2012-16	Deaths per 100,000 population	157	198	149	136	148	166
Standardised Incidence Rate Lung Cancer	2009-15	Incidence per 100,000 population	80	105	74	67	75	81
Standardised Death Rate Lung Cancer	2012-16	Deaths per 100,000 population	67	89	62	55	63	69
Standardised Admission Rate Drugs	14/15 - 16/17	Admissions per 100,000 population	220	297	186	210	191	226
Standardised Death Rate Drugs	2012-16	Deaths per 100,000 population	6.6	11.9	5.2	5.2	5.7	5.2
Standardised Death Rate Drug Misuse	2012-16	Deaths per 100,000 population	3.7	6.9	2.9	3.1	3.1	2.5
Prevalence of cigarette smoking (adults)	2016/17	% current cigarette smokers	20%	24%	19%	16%	21%	17%
Prevalence of cigarette smoking (young people: school years 8-12)	2016	% current cigarette smokers	4%	7%	4%	5%	4%	4%
E-cigarette use (adults)	2016/17	% current eCigarette users	6%	10%	4%	6%	6%	4%
E-cigarette use (young people: school years 8-12)	2016	% current eCigarette users	5%	8%	4%	6%	5%	2%
Persons accessing smoking cessation services	2016/17	Number of people setting a quit date	18637	4137	3683	2913	4094	3810
Prevalence of drinking alcohol (adults)	2016/17	% adults (18+) who are drinkers	80%	82%	76%	83%	82%	78%
Ever taken an alcoholic drink (young people: school years 8-12)	2016	% young people who have ever taken an alcoholic drink	32%	35%	36%	38%	28%	25%
Prevalence of drinking alcohol (young people: school years 8-12)	2016	% young people who drink at present (from rarely to daily)	23%	21%	29%	27%	21%	15%

Young people getting drunk (school years 8-12)	2016	% young people who report having been drunk	14%	16%	17%	18%	12%	9%
Young people getting drunk (school years 8-12)	2016	% young people that drink that report having been drunk	45%					
Lifetime prevalence of taking drugs (young people: school years 8-12)	2016	% young people who have taken named drugs in their lifetime	4%	5%	3%	6%	3%	2%
Last year prevalence of taking drugs (young people: school years 8-12)	2016	% young people who have taken named drugs in the last year	3%	5%	2%	5%	3%	2%
Last month prevalence of taking drugs (young people: school years 8-12)	2016	% young people who have taken named drugs in the last month	2%	4%	1%	3%	2%	2%
Treatment for alcohol and/or drug misuse (18 and over)	2017	Census - Snapshot - Number in treatment as at 1st March 2017	5256	1176	946	719	1022	1057
Treatment for alcohol and/or drug misuse (Under 18s)	2017	Census - Snapshot - Number in treatment as at 1st March 2017	713	322	77	122	36	151

Indicator Category – Pregnancy and Early Years

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Infant Mortality	2012-16	Deaths per 1,000 live births	4.5	5.0	4.0	4.8	4.4	4.8
Smoking in pregnancy	2016	Proportion of mothers smoking (%)	13.4 %	17.8 %	13.7 %	12.7 %	10.5 %	12.6 %
Teenage Birth Rate U20	2016	Births per 1,000 population	10.0	15.7	8.8	9.1	8.7	8.1
Teenage Birth Rate U17	2016	Births per 1,000 population	1.7	3.4	1.4	1.6	1.5	1.0
Healthy Birth Weight	2016	Proportion of live births (%)	90%	87%	91%	89%	91%	90%
Low Birth Weight	2016	Proportion of live births < 2,500g (%)	6.3%	7.2%	5.9%	6.5%	5.7%	6.2%
Breastfeeding on Discharge	2016	Proportion breastfeeding (%)	46.1 %	45.8 %	45.1 %	48.9 %	48.6 %	41.1 %
Smoking in the home	2016/17	% not allowed in the home	83%	77%	84%	85%	85%	85%
Smoking in family cars	2016/17	% never allowed in any car	86%	88%	86%	87%	84%	86%
Young people having sexual intercourse (school years 8-12)	2016/17	% young people who have ever had sexual intercourse	4%	6%	5%	5%	4%	3%

Indicator Category – Diet and Dental Health

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belfast	North	South East	South	West
P1 Body Mass Index: Obese (Male)	2015/16	Obese (%)	4.5%	4.6%	4.3%	4.5%	5.1%	4.0%
P1 Body Mass Index: Obese (Female)	2015/16	Obese (%)	6.4%	6.0%	6.9%	5.5%	6.7%	7.0%
P1 Body Mass Index: Overweight or obese (Male)	2015/16	Overweight or Obese (%)	18.2%	18.7%	19.6%	17.5%	17.0%	18.1%
P1 Body Mass Index: Overweight or obese (Female)	2015/16	Overweight or Obese (%)	25.9%	24.5%	28.3%	22.9%	24.7%	28.9%
Y8 Body Mass Index: Obese (Male)	2015/16	Obese (%)	6.6%	5.6%	7.8%	4.6%	7.2%	7.6%
Y8 Body Mass Index: Obese (Female)	2015/16	Obese (%)	6.5%	5.4%	7.1%	5.7%	6.1%	8.0%
Y8 Body Mass Index: Overweight or obese (Male)	2015/16	Overweight or Obese (%)	26.7%	25.5%	29.0%	19.5%	29.2%	29.7%
Y8 Body Mass Index: Overweight or obese (Female)	2015/16	Overweight or Obese (%)	27.9%	25.8%	29.4%	22.6%	29.6%	31.9%
Standardised Dental Registrations	2016	Indirectly standardised registration Rate	100	97	102	102	102	95
BMI classifications (adults): Obese	2016/17	Obese (%)	27%	25%	28%	28%	27%	24%
BMI classifications (adults): Overweight or obese	2016/17	Overweight or Obese (%)	62%	61%	62%	64%	61%	63%
BMI classifications (children 2-15): Obese	2016/17	Obese (%) based on IOTF guidelines	8%					
BMI classifications (children 2-15): Overweight or obese	2016/17	Overweight or Obese (%) based on IOTF guidelines	25%					
Meeting 5 a day recommendation (adults)	2016/17	% consuming 5 or more portions of fruit or vegetables each day	43%	39%	42%	40%	50%	45%
Meeting 5 a day recommendation (young people: school years 8-12)	2016	% consuming 5 or more portions of fruit or vegetables each day	17%	18%	17%	19%	18%	16%
Meeting recommended levels of physical activity (adults)	2016/17	% adults aged 19+ meeting CMO's Physical Activity guidelines	55%	53%	55%	60%	56%	49%
Meeting recommended levels (young people: school years 8-12)	2016/17	% meeting CMO's Physical Activity guidelines	13%	15%	12%	12%	13%	12%
Sedentary behaviour weekdays (adults)	2016/17	% adults aged 19+ over 4 hours sedentary time weekday	44%	49%	43%	38%	46%	42%
Sedentary behaviour weekends (adults)	2016/17	% adults aged 19+ over 4 hours sedentary time weekend	54%	55%	56%	49%	59%	47%

Appendix 4: Northern Ireland Population Statistics

Population Growth 2007- 2017 (0-64, 65+ and 85+ population)

0-64 Population by Trust

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belfast	289,660	291,930	293,544	295,068	295,470	295,266	296,289	297,826	299,918	300,655	301,187
Northern	387,235	389,906	391,496	392,001	392,538	392,278	391,778	392,206	392,718	392,998	393,331
South Eastern	288,926	290,273	291,791	292,334	292,396	292,797	291,710	291,324	292,120	292,518	293,216
Southern	298,108	302,968	306,645	309,344	311,881	314,223	315,445	317,835	320,100	323,093	325,095
Western	255,826	256,575	256,490	256,451	256,271	256,251	255,369	255,391	254,941	255,118	255,030
Northern Ireland	**1,519,755**	**1,531,652**	**1,539,966**	**1,545,198**	**1,548,556**	**1,550,815**	**1,550,591**	**1,554,582**	**1,559,797**	**1,564,382**	**1,567,859**

Source: 2017 MYEs

65+ Population by Trust

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belfast	51,816	52,133	52,295	52,547	52,870	52,987	53,329	53,728	53,860	54,051	54,406
Northern	63,866	65,570	67,414	69,298	71,005	73,251	74,946	76,845	78,470	80,078	81,442
South Eastern	48,723	50,201	51,850	53,665	55,316	57,300	59,078	60,977	62,531	64,175	65,492
Southern	42,681	43,818	44,991	46,255	47,540	48,922	50,267	51,556	52,876	54,138	55,217
Western	34,842	35,778	36,817	37,870	39,031	40,359	41,514	42,810	44,087	45,313	46,418
Northern Ireland	**241,928**	**247,500**	**253,367**	**259,635**	**265,762**	**272,819**	**279,134**	**285,916**	**291,824**	**297,755**	**302,975**

Source: 2017 MYEs

85+ Population by Trust

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belfast	6,561	6,721	6,850	7,037	7,234	7,255	7,318	7,579	7,754	7,901	7,986
Northern	7,118	7,388	7,622	7,937	8,152	8,541	8,725	9,031	9,313	9,631	9,820
South Eastern	6,050	6,187	6,311	6,544	6,731	6,939	7,053	7,300	7,466	7,672	7,838
Southern	4,527	4,793	4,989	5,218	5,386	5,552	5,639	5,811	6,032	6,215	6,357
Western	3,690	3,841	3,960	4,094	4,262	4,426	4,549	4,723	4,895	5,042	5,153
Northern Ireland	**27,946**	**28,930**	**29,732**	**30,830**	**31,765**	**32,713**	**33,284**	**34,444**	**35,460**	**36,461**	**37,154**

Source: 2017 MYEs

Population Projections Trends by Trust (0-15, 16-64, 65+ and 85+ population)

0-15 Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	68,346	71,086	69,543	67,241	66,127	66,215
Northern	96,910	96,929	92,780	88,649	86,082	85,301
South Eastern	72,444	73,255	70,652	68,158	66,894	66,670
Southern	87,359	91,103	90,094	88,683	89,195	90,988
Western	65,180	65,384	62,439	59,099	56,994	56,201
Northern Ireland	**390,239**	**397,757**	**385,508**	**371,830**	**365,292**	**365,375**

Source: NISRA, 2016 Based Population Projections

16-64 Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	232,171	231,526	231,311	229,764	228,667	228,341
Northern	296,306	294,350	291,958	285,395	278,083	274,222
South Eastern	220,658	220,447	220,110	216,812	213,292	212,089
Southern	238,444	244,645	251,331	255,769	258,942	262,272
Western	189,639	186,315	183,533	178,617	172,893	169,373
Northern Ireland	**1,177,218**	**1,177,283**	**1,178,243**	**1,166,357**	**1,151,877**	**1,146,297**

Source: NISRA, 2016 Based Population Projections

65+ Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	54,310	57,135	63,667	71,247	76,734	79,519
Northern	81,651	90,951	102,709	116,055	126,815	131,431
South Eastern	65,622	73,897	84,103	94,693	102,715	106,237
Southern	55,266	62,446	71,944	82,784	92,412	97,972
Western	46,431	52,426	59,570	67,562	73,926	76,566
Northern Ireland	**303,280**	**336,855**	**381,993**	**432,341**	**472,602**	**491,725**

Source: NISRA, 2016 Based Population Projections

85+ Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	7,968	8,226	8,792	10,233	11,578	12,986
Northern	9,862	11,498	13,803	17,502	20,411	22,623
South Eastern	7,862	9,119	11,042	14,683	17,448	19,190
Southern	6,359	7,647	9,099	11,617	13,858	15,683
Western	5,187	6,020	7,110	9,177	11,052	12,362
Northern Ireland	**37,238**	**42,510**	**49,846**	**63,212**	**74,347**	**82,844**

Source: NISRA, 2016 Based Population Projections

Percentage increase in Population by Trust (0-15, 16-64, 65+,85+ and total population)

0-15 POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	68,618	17.6%	71,086	3.6%
Northern	96,991	24.8%	96,929	-0.1%
South Eastern	72,589	18.6%	73,255	0.9%
Southern	87,262	22.3%	91,103	4.4%
Western	65,224	16.7%	65,384	0.2%
NI	390,684	100.0%	397,757	1.8%

0-64 POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	301,187	19.2%	302,612	0.5%
Northern	393,331	25.1%	391,279	-0.5%
South Eastern	293,216	18.7%	293,702	0.2%
Southern	325,095	20.7%	335,748	3.3%
Western	255,030	16.3%	251,699	-1.3%
NI	1,567,859	100.0%	1,575,040	0.5%

65+ POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	54,406	18.0%	57,135	5.0%
Northern	81,442	26.9%	90,951	11.7%
South Eastern	65,492	21.6%	73,897	12.8%
Southern	55,217	18.2%	62,446	13.1%
Western	46,418	15.3%	52,426	12.9%
NI	302,975	100.0%	336,855	11.2%

85+ POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	7,986	21.5%	8,226	3.0%
Northern	9,820	26.4%	11,498	17.1%
South Eastern	7,838	21.1%	9,119	16.3%
Southern	6,357	17.1%	7,647	20.3%
Western	5,153	13.9%	6,020	16.8%
NI	37,154	100.0%	42,510	14.4%

TOTAL POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	355,593	19.0%	359,747	1.2%
Northern	474,773	25.4%	482,230	1.6%
South Eastern	358,708	19.2%	367,599	2.5%
Southern	380,312	20.3%	398,194	4.7%
Western	301,448	16.1%	304,125	0.9%
NI	1,870,834	100.0%	1,911,895	2.2%

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the DHSSPS in Northern Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / long term conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the Board and Agency), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction (CPD) – a document published by the Department of Health (DoH) on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not funded with public money. These organisations are also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

Delivering Care - *Delivering Care* sets out principles for commissioners and providers of Health and Social Care services for planning nursing workforce requirements. It was published in March 2014.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (Board) – The Board role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the Northern Ireland Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, pharmacists, community health and social care

providers, hospital specialists and representatives from the independent, community and voluntary sector as well as service users and carers.

Lesbian, Gay, Bisexual and Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the Board arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Palliative Care – the active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the Board/Agency which provides a strong independent voice for the people of Northern Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (Agency) – the role of the Agency is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Trust Delivery Plans (TDPs) – in response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Departmental targets, key themes and objectives outlined for the year ahead.

HEALTH AND SOCIAL CARE BOARD
PUBLIC HEALTH AGENCY

COMMISSIONING PLAN 2011/2012

15 November 2011

Health and Social Care Board

Public Health Agency

Contents

Foreword

Legislation enacted on 1 April 2009 created a new commissioning system in Northern Ireland with the establishment of a region-wide Health and Social Care Board (including five Local Commissioning Groups (LCGs) and a Public Health Agency).

The Health and Social Care Board is required by statute to prepare and publish each year a Commissioning Plan setting out the health and social care services to be commissioned and the associated costs of delivery.

It is the responsibility of the Board, in cooperation with the Public Health Agency in the first instance, to assess health and care need, to identify ways in which this need might be met and to directly commission or otherwise put in place services and systems for the appropriate delivery of health and social care gain. In carrying out this responsibility, it is important that the Board engages with a wide range of stakeholders such as the public in general, patients, their relatives and carers, health and social care professionals, Trusts and other providers of health and care. It is our aim to ensure that services are appropriate and equitably distributed in line with service user expectations and that those services we commission are the subject of regular and ongoing performance appraisal and quality improvement.

It is within this context that the Board prepares the annual Commissioning Plan in partnership with the Public Health Agency. The Board and Agency take forward the regional commissioning agenda through a series of integrated service teams. The Board's commissioning processes are underpinned by the five LCGs which are committees of the Board and are responsible for ensuring that the health and social care needs of local populations across NI are addressed. (Each of the LCGs has produced its own local plan for 2011/12 which is appended to and should be read in conjunction with this document.) The Board has also established a network of Primary Care Partnerships to work in partnership with LCGs to effect change in primary care, and support the integration of primary, community and secondary care.

The Board's commissioning processes are underpinned by the five LCGs which are committees of the Board

The Board is accountable to the Department and the Minister for the achievement of Ministerial priorities, standards and targets and for ensuring that services are commissioned in accordance with statutory obligations, standards, departmental policy and strategy guidance and guidelines as well as agreed service frameworks Where a major change is proposed to an existing service, the change will require the endorsement of the Minister and the Department. Other decisions will be taken by the Board with support from the Agency as part of routine commissioning business, consistent with the respective roles and responsibilities of each organization.

This is the second Commissioning Plan to be produced by the Health and Social Care Board and Public Health Agency. It takes forward and builds upon the key themes set out in the Commissioning Plan 2010/11, in particular tackling health inequalities, reforming acute hospital services, reforming social care services and establishing Primary Care Partnerships.

This Plan takes full account of the financial parameters set by the Executive and DHSSPS, and is consistent with the direction and priorities set out in the Minister's Commissioning Direction.

While the capital budget is not within the responsibilities of the HSCB and is therefore not referenced directly in this Plan, clearly a number of the commissioning proposals set out in the Plan will have implications for the capital budget in terms of equipment and estate required.

Purpose

The core purpose of this Commissioning Plan is to provide a clear roadmap for the future development of health and social care services in 2011/12 and beyond. The Plan is driven primarily by the desire to improve safety, quality and the patient experience – rather than by money. It seeks to describe as simply as possible the issues and opportunities associated with the current arrangements, and to plot a clear and reasonable way forward that maximises benefit to patients and clients within available resources.

The Plan is driven primarily by the desire to improve safety, quality and the patient experience – rather than by money.

This Commissioning Plan sets out the level of service that the population of NI can expect to receive, and the changes that are necessary to existing services to secure this.

It is our aim that this Plan is straightforward and written in a manner which will encourage public engagement and understanding. We wish to show clearly how the commissioning task is to be approached and to signal the decisions necessary to ensure the maintenance of a health and social care system in Northern Ireland which responds to the population it serves.

Need to change the status quo

Health and Social Care in Northern Ireland is at a crossroads. The NI Budget settlement for the four-year period 2011 to 2015 provides health and social care with a 2% annual growth in resources over four years to £4.6b.[1] The forecast annual cost pressures of 6% would require £5.4b if the status quo is to be maintained.

Consequently, our choices are stark. As a system we can try to maintain existing arrangements for service delivery, but this will become increasingly difficult as the gap between available resources and the demands upon them grows. The inevitable outcome without change to the status quo will be an unplanned and unmanaged collapse in key health and social care services. This would almost certainly have a detrimental impact on patients and clients.

There is the opportunity even in a difficult financial environment to provide an excellent health and social care service to the population.

Or alternatively, we can begin now to radically reshape health and social care services in Northern Ireland. The objective is to maintain quality, deliver good outcomes and recognise that there is the opportunity even in a difficult financial environment to provide an excellent health and social care service to the population. In so doing the system would ensure that the still significant resources available are targeted towards providing care and support for those patients and clients most in need, and ensuring that these services are delivered efficiently and effectively consistent with best available evidence.

[1] In the 2011/12 allocation In the 2012/12 allocation letters to the HSCB and PHA.

This Commissioning Plan pursues the latter approach. The Plan signals significant change to both the range of health and social care services that will be provided in the future and where and how those services will be provided.

It is more important than ever, therefore, that we secure value for money through commissioning, ensuring that we achieve maximum benefit from all available resources. There are no neutral decisions: every decision will have consequences and opportunity costs for patients and clients. A failure to take action to maximise the cost-effectiveness in any one service area or location will simply translate into wasteful expenditure or lost opportunities to develop or improve services.

There are three key areas where change is most urgently required, both to free up resources for investment in new services and generate capacity within existing services to be able to deal with the increased levels of activity that will be required to meet the needs of our increasingly elderly population.

For a population of 1.8m, NI has too many acute hospitals.

The first key area for change is the transformation of how and where acute hospital services are provided. The simple fact is that, for a population of 1.8m, NI has too many acute hospitals. On the basis of widely accepted norms, a population the size of NI's requires between five and a maximum of seven acute hospitals, each serving a population of some 250,000 to 350,000. Currently we have 10 acute hospitals, most of which provide around-the-clock A&E, emergency surgery services, emergency medical services and obstetrics.

Trying to maintain acute services across this number of sites has been difficult from every perspective. Scarce staffing and other resources are spread too thinly, making it impossible to ensure that permanent senior medical cover for emergencies is available at all sites, 24/7/365. Instead, most sites – and not just the smaller ones – rely on a combination of junior doctors and temporary locums to provide much of the cover required, particularly out of hours. This inevitably impacts on quality and cost.

The relatively small size of many of NI's hospitals also means that economies of scale are lost, staff productivity is lower, and the cost of

any given treatment is higher than would otherwise be the case. Repeated reviews have demonstrated this fact. The required efficiency gains will be very difficult to achieve without hospital reshape. In addition, we admit more people and our lengths of stay for emergency and planned treatments are significantly longer than the best performing organisations in GB. This is often because if a hospital is there it is used and the alternatives to hospital are restricted because resources are committed to maintaining the hospital rather than to more effective community-based models of care. There are huge opportunity costs associated with our current model of acute hospital services – in terms of the cost effectiveness of the care provided and the lost opportunity to invest some of the resources currently locked into hospital care in other priority service areas.

Providing people with real choice about how their care is provided is the key objective.

The second key area for change is the reshaping of social care services for older people and other client groups. We need to review the way in which services are perceived and delivered to achieve a balance between meeting the needs of the most vulnerable and promoting independence and self determination. There is a need to significantly increase the proportion of people cared for at home rather than becoming overly reliant on residential or nursing home care. Providing people with real choice about how their care is provided is the key objective. In parallel we need to ensure best value is secured from the providers of residential and domiciliary care services. These changes are essential to ensure that health and social care is able to respond to the significant increases in the over 65 (+16%) and over 85 populations (+29%) by 2015. This will require a mixed economy of service provision, the introduction of new contractual arrangements for institutional care and much greater use of direct payments.

The third key area for area for change in 2011/12 is to reshape primary health and social care. Working through the LCGs, Primary Care Partnerships will increasingly have a role in demand management, redesigning care pathways and taking forward new opportunities to provide services in primary and community care settings. Within this context a priority for the Commissioner will be to take forward the commissioning of attached integrated teams of professionals aligned to individual practices and using the GP list as the primary building block for the development of services. A further

priority in 2011/12 will be the control of pharmacy expenditure, building on arrangements already in place. There will be a requirement to modernize reimbursement arrangements for the pharmacy industry, in line with the rest of the United Kingdom. There will also be a need to set demanding targets in relation to prescribing practice which can assure compliance with standards of evidence based best practice. The service will be expected to demonstrate delivery against both cost effectiveness and quality indicators which will be applied within commissioning arrangements

While significant improvements have been secured locally in the last year, NI continues to spend significantly more per head on prescription medicines than other countries in the UK; if our prescribing expenditure per head was the same as in Wales, we could save more than £50m each year. These resources must be freed up to allow investment in other areas that will provide greater benefit to the health and wellbeing of the population of NI. The expectation will be to close this gap by at least £30m by the end of 2011/12.

NI continues to spend significantly more per head on prescription medicines than other countries in the UK

The focus of medicines management will also include consideration on safety and quality issues and it is anticipated that through consideration of improved medicines management process there will be an opportunity to reduce the frequency of adverse events arising from medicines use.

Over- riding objectives

Our commissioning of health and social care services shall seek to achieve the following objectives within the resources available:

- To protect the most **vulnerable** and **disadvantaged**
- To ensure through our commissioning of health and social care services that we promote **equality of opportunity** and **human rights**
- To secure transformational improvement to the health and wellbeing of the population through both a reduction in health

inequalities and a general improvement in **health outcomes** for all

- To ensure that the services we commission are **evidence-based**, safe and of high quality, and deliver improved outcomes for patients and clients in line with our statutory duty under the Health and Personal Social Services Order 2003.
- To **avoid false choices** – patients and clients rightly expect their health and social care services to have a positive experience *and* a good outcome and our commissioning will reflect this
- To commission **compassionately**, ensuring that the individual and collective needs and expectations of patients and clients are at the centre of our thinking in all of our decision making
- To maintain or increase current volumes of activity, with cost pressures being absorbed as far as possible by provider organisations through increased **productivity** and new ways of working
- More generally, to secure **value for money**, maximize efficiency and effectiveness in service delivery and drive out waste
- To leverage, through the newly established **Primary Care Partnerships**, the essential knowledge and experience of GPs and other primary care practitioners as clinical gatekeepers in influencing system-wide change
- To support people to **live at home**, with services being reshaped to promote independence, recovery and rehabilitation
- To provide services as **locally** as possible, where this can be done safely, sustainably and cost-effectively. However significant change to the current pattern of acute hospital services is essential if standards of quality and safety are to be maintained or improved
- To ensure appropriate access to those existing **and new services and treatments** for which there is a clear evidence base to demonstrate cost-effectiveness and patient benefit, and which are affordable
- To maintain **reasonable waiting times** for all of the services we commission, consistent with the prioritised needs of patients and clients

- To create a working environment that enables the **committed** workforce to do their job **sensitively and effectively**.

In all of our commissioning activities we will be open, accessible and straightforward even if at times this requires 'uncomfortable' debate.

Where a commissioning decision is taken primarily to make a saving or service reduction, this will be explicitly stated.

Where we propose changes to existing services, or decide not to commission a new service, we shall do so transparently with a clear rationale for our decision. Where a commissioning decision is taken primarily to make a saving or service reduction, this will be explicitly stated.

While we fully recognise that our primary and direct line of accountability is to the Minister, as a public body we shall seek to work openly and effectively with the Assembly Health Committee and other elected representatives.

A key objective will be to ensure that effective arrangements are in place to allow us to engage and communicate with clinicians and other professionals, patients and clients, the public and their elected representatives at all stages in the commissioning process. In this regard, we have sought to reflect throughout this Plan the people's priorities identified recently by the Patient Client Council, namely:

- Ensuring that front line staff, particularly nurses, are protected
- Maintaining reasonable waiting times for hospital in-patients, outpatients, diagnostics and GP appointments
- Ensure effective arrangements to care for the elderly, including domiciliary care
- Ensuring effective mental health and learning disability services
- Maximising funding for health and social care services
- Ensuring local access to hospital services, including A&E and out-patients services
- Ensuring access to high quality GP services including out of hours services
- Ensuring access to high quality cancer care services
- Ensuring effective communication arrangements are in place

- Tackling the rising costs of prescription drugs.

Two Distinct Planning Periods – 2011/12 and 2012/13 to 2014/15

Financial break-even over this planning period will pose major challenges.

The trajectory of the budget settlement together with the lead time associated with many of the key strategic reforms requires a particular approach to be taken to commissioning for the 2011/12 financial year, distinct from the approach in the subsequent three years 2012/13 to 2014/15.

Financial break-even is a mandatory requirement for all parts of the HSC, although it is acknowledged that to do so over this planning period will pose major challenges. To appreciate the task it is necessary to provide context for 2010/11. Break-even last year was only achieved with substantial non-recurrent support. This came from workforce control, suspension of a range of planned investments and a relentless drive on efficiency. The financial base for the period 2011 to 2015 will require the temporary decisions taken in 2010/11 to become permanent. This means the £40 million achieved through temporary control of the workforce will become permanent; this is the equivalent to confirming a reduction in the total workforce of around 2,000.

Table 3 on page 44 shows the projected financial deficit for 2011/12. Substantial pressures have been eased by the work to date to provide a range of solutions. Despite every attempt to deliver £130m of savings in 2011/12, HSCB is currently projecting a deficit of £11m.

During 2011/12 we shall also plan and begin the implementation of the key strategic reforms necessary to ensure the integrity of the health and social care system in 2012/13 and beyond. Reforms in the three priority areas referred to above will be particularly important, namely:

i. The transformation of how and where acute services are provided to ensure the hospital system can respond safely, effectively and sustainably to the increasing needs of the population within a largely static resource base. This will require significant improvements in hospital productivity, throughput and effectiveness

ii. The reshaping of social care services with the introduction of the Re-ablement model and other measures to significantly increase the proportion of people cared for at home rather than in residential care

iii. The reshaping of primary health and social care including the implementation of more effective prescribing arrangements through the range of initiatives being progressed by LCGs and PCPs within a coherent regional framework.

These and other reforms must be substantially in place as a matter of urgency to ensure the continued integrity and financial viability of health and social care in 2012/13 and beyond. It is essential therefore that early decisions are taken on these key changes.

During the period 2012/13 to 2014/15 our focus will be on ensuring the full implementation of all elements of strategic reform some of which because of scale, the need for infrastructure investment or other factors will take some time to roll out. It will be essential throughout the four-year period 2011 to 2015 that appropriate support and assurance arrangements – including external support for the most critical reforms – are in place to ensure timely and effective implementation.

Summary of priority issues in 2011/12 (HSCB)

- *Reconfigure A&E and emergency surgery services*
- *Improve hospital efficiency creating additional capacity for future demand*
- *Maintain reasonable waiting times for planned services*
- *Expand diagnostics capacity ensuring full use of NIPAC*
- *Establish single site provision of elective care specialities in all Trusts*
- *Review arrangements for the provision of patient transport services*
- *Increase capacity of radiotherapy services in Belfast and prepare for the opening of the new unit in Londonderry*
- *Implement the recommendations of the DHSSPS maternity services review*
- *Undertake evaluations of the stand-alone midwifery units in Downpatrick (2011) and Lisburn (2012)*

- *Introduce new community-based teams for long term condition management*
- *Reshape social care services with the introduction of the Re-ablement model*
- *Improve value from social care services though a mixed economy of service provision, the introduction of new contractual arrangements and greater use of direct payments*
- *Develop capacity in Primary Care to ensure that local communities are engaged and that local providers have a shared understanding of new models of care and the impact of changes on their area and community*
- *Progress the development of Primary Care Partnerships*
- *Establish integrated multi-professional teams attached to GP practices*
- *To bring prescribing expenditure in line with other comparable parts of the UK*
- *To modernize reimbursement arrangements for the pharmacy industry*
- *Reconfigure inpatient mental health services*
- *Maintain momentum with the resettlement programme for mental health and learning disability patients*
- *Increase capacity and resilience of child protection services*
- *Promote health and wellbeing through commissioned services*
- *Implement the palliative and end of life strategy focusing on the care of the dying pathway in all care settings.*

Summary of priority issues in 2011/12 (PHA)

- *Introduce a cardiovascular risk factor management programme with HSCB*
- *Roll out the bowel cancer screening programme NI-wide and complete the preparatory work to introduce a new screening programme for abdominal aortic aneurysm (AAA)*
- *Introduce automated systems for existing screening programmes, specifically breast cancer and diabetic retinopathy programmes*
- *Support Trusts to achieve further reductions in Healthcare Associated Infections (HCAIs), specifically MRSA and C. Diff*
- *Ensure plans are in place to respond to seasonal flu and other emergency*

situations

- *Roll out the next phase of early years programmes to support children in schools and at home and strengthen antenatal care*
- *Expand programmes to tackle the determinants of health, including a rural poverty initiative with DARD*
- *Develop and implement a community development plan with HSCB and other partners*
- *Target stop smoking services to areas with high prevalence of smoking and introduce further programmes in FE Colleges, antenatal and pre-op assessment clinics and workplaces*
- *Implement actions within the regional Obesity Framework when published*
- *Implement the New Strategic Direction for alcohol and drugs*
- *Roll out community suicide response plans and target intensive interventions to areas with high rates of suicide and poor mental health*
- *Implement the sexual health action plan with the Sexual Health Network*
- *Develop an overarching quality and safety assurance framework, through the Quality & Safety Service Forum*
- *Develop a range of nursing and midwifery key performance indicators to further support the provision of safe and effective care.*
- *Introduce a regional initiative to gather 3,000 patient/clients stories to ensure that individual and collective needs and expectations of patients and clients are at the centre of all decision making.*
- *Adaptation and implementation of PPI strategy and implementation plan*
- *Reform and Modernisation of AHP services and the development regional standardized care pathways*
- *Delivery of the AHP commissioning intent projects including AHP input into children with special educational needs in mainstream and special schools.*
- *To ensure implementation of the RTNI contract and the provision of remote telemonitoring to 1,800 people during the 2011/12 year*
- *To commission an independent evaluation of the RTNI service*
- *To work with relevant stakeholders to develop a broad strategy for the development of connected health within the HSC*

Making the changes

This Commissioning Plan was approved by the boards of the Health and Social Care Board and the Public Health Agency in June 2011 and submitted to the Department for consideration. The final Commissioning Plan was approved by the new Minister in [November] 2011 and arrangements have now been put in place by the Health and Social Care Board, in partnership with the Public Health Agency, to oversee its delivery. These arrangements include:

- The translation of the Commissioning Plan into objectives within corporate and local commissioning plans that will be the subject of scrutiny through established performance review
- The agreement of detailed service and budget agreements with providers, including appropriate incentives and sanctions, supported by appropriate performance management regimes
- The development of detailed proposals from Local Commissioning Groups and Providers to give effect to the commissioning strategy in this Commissioning Plan for consideration, equality screening, consultation and implementation as appropriate.

Within this plan it is fully recognised that the shape of health and social care service will need to change in order to adapt to an ever changing, and increasingly difficult environment

In addition to the above arrangements, and consistent with their criticality to the integrity of the health and social care system in 2012/13 and beyond, we shall establish formal project management arrangements on a regional basis to ensure the delivery of the three key strategic reforms, namely, reforming acute hospital services, reforming social care services and reshaping primary health and social care including reducing prescribing expenditure. External support will be secured to help ensure that reform is implemented quickly, effectively, consistently and sustainably.

Within this plan it is fully recognised that the shape of health and social care service will need to change in order to adapt to an ever changing, and increasingly difficult environment. We have sought to

put in place arrangements that will deal specifically with these complex issues, while acknowledging that all final decisions will require the endorsement by the Minister and the Department.

As the Commissioning Plan is implemented we are committed to assessing potential effects on particular populations – including those identified under Section 75 of the Northern Ireland Act 1998 - in a rigorous way, through the conduct of equality and human rights screening and if necessary further equality impact assessments. Through this activity we believe that we can increase the probability that decisions will better promote equality of access and outcomes. We recognise however that in some instances an assessment of equality and human rights implications can be limited by lack of local data or evidence including the lack of disaggregated data. Data collection will therefore be a key consideration, as are our organisational efforts to embed equality and human rights in our commissioning activity; promote personal and public involvement and engagement; work in partnership with community, voluntary and other public sectors and increase the capacity of staff to use all the relevant evidence in decision making processes.

Our regular monitoring of progress on the implementation of the Commissioning Plan will inform us of how well we are doing this.

HSC Review

The Minister for Health, Social Services and Public Safety announced earlier this year his intention to undertake an external review of the Health and Social Care System, under the chairmanship of John Compton. The Review is due to be completed later in 2011 and as such will have limited impact on service plans for 2011/12.

The recommendations of the Review are likely to be significant however for the commissioning and delivery plans produced by the HSCB and Trusts respectively in 2012/13 and thereafter.

Dr Ian Clements
Chair, Health and Social Care Board

Mr John Compton
Chief Executive, Health and Social Care Board

Ms Mary McMahon
Chair, Public Health Agency

Dr Eddie Rooney, Chief Executive, Public Health Agency

Section One

Context and Key Themes

1 Strategic Context

This section sets out the key environmental factors influencing policy formulation and on the major policy imperatives which define the future direction of travel for service development and redesign.

1.1 Demographic Changes

Northern Ireland is becoming an older society. While the absolute size of our population is estimated to increase over the next 10 years, of greater significance to the demand for Health and Social Care is the likelihood that the average age of our population will also continue to increase at a faster rate. Specifically, estimates are that between 2008 and 2020:

- The Northern Ireland population will increase by 142,000 people (8%)
- The number of people over 75 years will increase by 40%.

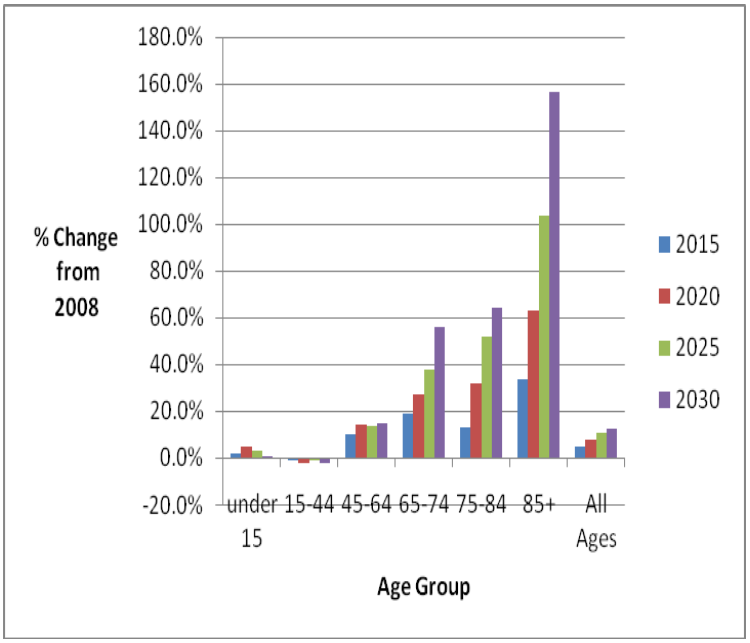


Figure 1: Changing Demography of Northern Ireland - % Change by 2015, 2020 and 2030 by age group.

Older people are major users of our Health and Social Care system. If systems remain unchanged by 2020 demand placed on our systems by an increasing elderly population mean that hospital admissions will have increased by 17% and beds used by 23%.

Older people tell us that they want care, support and treatment in or close to home (Health & Wellbeing Strategy for Older People 2006-16). Commissioning must therefore continue to reform and modernise the Health and Social Care system, responding to growing demand with an increased emphasis on community based services.

Older people tell us that they want care, support and treatment in or close to home.

An important element within this plan is to promote older people's health and wellbeing, through a further shift to supporting people at home and giving individuals, their family and local communities' greater control over the range and delivery of services. Major features will be positive health promotion, the active prioritisation of direct payment schemes, the focus on support for carers, the management of people with chronic diseases in their own homes with the help of technology, and the delivery of palliative care in the community.

1.2 Safe and Sustainable Services

The overall aim in commissioning is to ensure that the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. To maintain and to continue to achieve this standard of service will mean a re-profiling of the current pattern of services. To meet best clinical practice some services may have to be delivered on a national, regional or sub regional basis. This is not a new approach and we have demonstrated in the past – for example by consolidating cancer care into the major acute hospitals with streamlined access to a regional service – that we can provide evidence based practice standards and achieve improved outcomes for people with cancer.

Frequently these changes are simplistically portrayed as centralisation. The Commissioner will wish to secure local services for local people but simultaneously provide safe, sustainable services for the population at large.

The safety of services provided is paramount and we will progress strategies for reducing infection rates, reducing untoward events across all areas of practice, achieving real improvement in hygiene to improve outcomes and the patient/client experience.

Commissioning is about securing good outcomes and providing safe services. We recognise the importance of patient and client choice and the need for people to have confidence in how our services are provided. Choice will therefore be a major theme in driving commissioning but this must be realistic and consistent with the delivery of safe, effective care.

1.3 Modern Treatments

Since 1948 the nature of Health and Social Care services has been characterised by the need to respond to new demands, treatments and interventions. For example many surgical procedures previously requiring inpatient stays in hospital now happen safely on a day case basis allowing patients to return home on the same day as their treatment occurs.

In recent years, we have seen the day case rate as a percentage of total elective work increase in certain key service areas and there is now a requirement that all Trusts in Northern Ireland achieve and maintain a 75% day case rate across a basket of 24 specified procedures.

Treatment for cancer has been revolutionised over the past decade with survival rates improving across a range of cancers, although we still fall behind European survival rates in a number of cancers, so further work needs to be done.

As survival rates continue to increase the nature of caring for people with cancer will change.

Improved survival rates have occurred at a time of significant investment in improving access to cancer services including drug regimes. As survival rates continue to increase the nature of caring for people with cancer will change. More people will be living with cancer as a chronic illness and our services must evolve responsively to these needs.

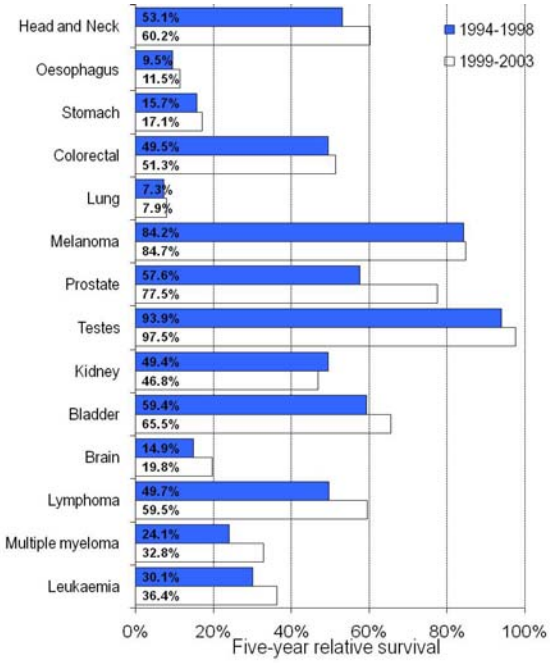


Figure 2: Changes in survival for male patient with cancer by cancer site, 1994 – 2003 (Five year relative survival by sex, cancer site and period of diagnosis. Source NI Cancer registry).

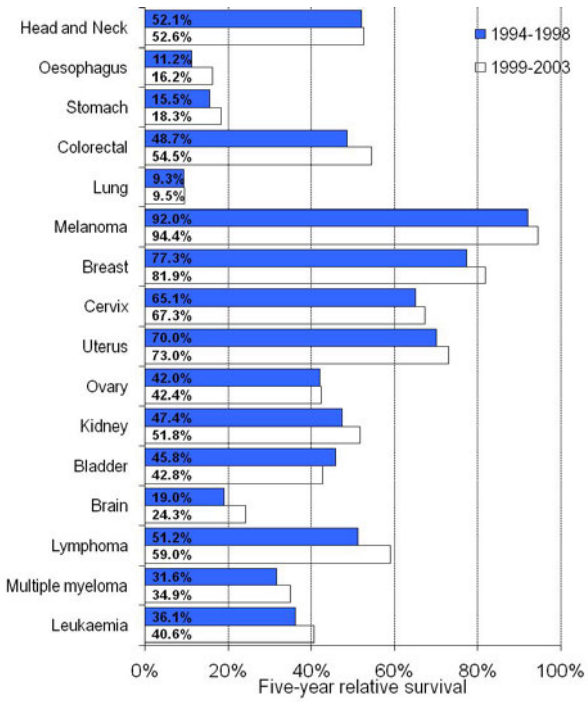


Figure 3: Changes in survival for female patient with cancer by cancer site, 1994 – 2003 (Five year relative survival by sex, cancer site and period of diagnosis. Source NI Cancer registry).

New drugs and treatment techniques for a wide range of healthcare needs are constantly being developed and their efficacy and value assessed by the National Institute for Clinical Excellence.

Traditional support supplied in children's residential care has been revolutionised by a much expanded and more skilled fostering service.

Home based treatment in mental health services has introduced a recovery model of treatment and led to major changes in how hospital care is provided.

Primary Care has been given the opportunity to provide more care and treatment in the community through locally enhanced services. The decision to introduce and implement these kinds of improvements and innovations is linked to how we use resources. Sometimes this will happen with new funding, or possibly the re-use of funding released by greater efficiency or a decision to change the priority of an existing service.

Home based treatment in mental health services has introduced a recovery model of treatment and led to major changes in how hospital care is provided.

The introduction of a service can also depend on the availability within Northern Ireland of staff with the appropriate expertise and skills. For example, with a local population of 1.8m it is difficult to support the full range of modern acute services. Some very specialist services for our population will either be commissioned outside Northern Ireland or will be jointly commissioned with other regions.

It is also essential to recognise that it will not always be possible to commission immediately every new service that is available, even where approved by the National Institute for Clinical Excellence. Commissioning in these areas will inevitably make for difficult choices.

Decisions about the introduction of new services will require scrutiny of the benefits and costs involved and the availability of resources. This will include the possibility of releasing and reinvesting resources from less effective services.

For example, we do not routinely commission bariatric surgery. There is no certainty that we will be in a position to commission this service in the immediate future and we may opt instead for prevention and support services as alternatives for those with obesity problems.

Similarly, there are a number of instances where users of social care services patients have been the subject of transfer to high cost facilities outside Northern Ireland. It will be important to scrutinise these and other similar future cases in order to determine whether appropriate alternatives can be supplied locally.

1.4 Resources

Discussion about money is always controversial. In the public perception, proposed changes or debates about money are frequently assumed to be about savings or perceived cuts. Where any commissioning decisions are primarily taken to make a saving or service reduction, this will be explicitly stated.

In fact many of the decisions to make change are not driven by money but by a desire to improve quality or effectiveness. Commissioners will not avoid such decisions but will seek to take them in an informed and sensitive manner that reflects the potential implications for individuals and communities. In the end however there are no neutral decisions. Unnecessary preservation of an existing pattern of service delivery will in all probability mean denial of new developments. Making choices is a reality for any commissioning system. This is vitally important to understand in the financial climate that commissioning is entering. For over a decade Health and Social Care has invested in one year and met the full cost from a growth in funding the following year. The period 2011-15 will not permit such a pattern. It is much more likely that the money currently in the Health and Social Care system is the most that will be available leading to a number of difficult years ahead. Whilst this represents a different climate the Health and Social Care system is likely to continue to spend nearly 40% of the Northern Ireland Block. We commit more than £10m every 24 hours to support the delivery of services to the population of Northern Ireland. Opportunities to develop new services remain but only if there is significant change and greater efficiency in the current service patterns.

Often when there is a debate in regards to resource, the problem is presented in terms of unnecessary bureaucracy. While it is important that administration and management costs are tightly controlled and represent value for money, this does not reflect where the real focus needs to be. Within Health and Social Care today we commit just over 4% of the commissioning resource to management costs. We need a properly managed system that is responsibly resourced. The real debate about resource is an understanding of the need for change and decisions about what can and cannot be provided. This Plan will not be distracted from this central issue. However, as Commissioners, we fully appreciate that final decisions require to be endorsed by

Unnecessary preservation of an existing pattern of service delivery will in all probability mean denial of new developments.

the Minister and the Department.

1.5 Workforce

Successful commissioning needs to have a keen appreciation of the workforce implications of what it wishes to see provided. This holds true for all types of grades and staff working in the sector. It also requires the Commissioner to have an appreciation of capacity within the delivery system. This interest spreads across both the statutory and independent sector. In 2010/11 some [£40m] was spent on locum doctors and nurses in Northern Ireland to support the existing hospital system. Such expenditure not only represents poor value for money but also impacts on the continuity and therefore the quality of care provided. Commissioning in 2011 and beyond will seek to reshape the hospital sector in a manner which minimises the need for such expenditure. This change is also required to respond to the implementation of the European Working Time Directive and take account of the actual medical workforce availability.

Such a change is driven principally by quality, and the interplay of quality, volume and value for money is at the core of this decision making process. Although there will be a requirement for rapid change it will be done in such a manner as to reflect the need to respond to capacity. Failure to acknowledge this would simply lead to unplanned service change or collapse and inappropriate commissioning which does not take account of responsible risk management.

1.6 Demand

Reference has already been made to demographic change and the effect this has on demand for services. During 2010/11, we have achieved significant success through the local commissioning arrangements in better understanding and managing demand. As might be expected, the pattern of demand for services in 2010 shows some variation to that experienced in 2009, depending on the nature of the service being sought; for example:

- Outpatient referrals to the acute hospital sector for specialist assessment have remained more or less constant between 2009 and 2010 at around 618,000.
- Referrals in family and child care services for children at most risk rose by just under 11% from 4,322 to 4,792

- The number of older people discharged from hospital with complex care needs rose by 2% from 11,920 to 12,176
- The number of care packages for those in residential accommodation rose by 2% from 9,485 to 9,677 while those in receipt of intensive care at home (domiciliary care) rose by over 10% from 5,619 to 6,217.

Further developing our understanding of these demand patterns and working with providers in primary, community and secondary care to ensure more effective management of demand will continue to be a central issue for commissioning in 2011/12 and beyond. The Local Commissioning Groups and the newly established PCPs provide us with an opportunity to engage with family practitioners, patients, carers and local care providers to examine both the nature of demand and the potential for local alternatives for appropriate assessment and treatment.

1.7 Developing Better Services

Written in 2002, this DHSSPS strategy addresses the future shape of hospital provision for Northern Ireland. Although time has moved on its core principles remain. Changes have occurred at Downpatrick, Lisburn, Enniskillen, Omagh, South Tyrone and most recently Magherafelt and Whiteabbey, and further changes in Lisburn with the introduction in February 2011 of a stand-alone midwife-led unit. In 2011/12 we will take forward the implementation of the final stages of this strategy so that transition to this model will be substantially completed by 2013.

Local Commissioning Groups and the newly established PCPs provide us with an opportunity to engage with family practitioners, patients, carers and local care providers

The principal driver remains the maintenance of quality of intervention and whilst local services and central delivery will be balanced in the commissioning process, safety, sustainability and outcome will be the key determinants.

1.8 The Bamford Report

The Bamford Report and the ‘Protect Life’ Strategy set out the vision for the reform and modernisation of Mental Health, Learning Disability and Child and Adolescent Mental Health Services over a 15-year horizon. Since the publication of the individual reports, further evidence based

models of service delivery have emerged and these will be integrated during the implementation of the Bamford recommendations.

The Health and Social Care Board and the Public Health Agency have established a number of core task groups to take this work forward and this will be led by the Bamford Project Board, chaired by the Health and Social Care Board's Chief Executive.

A core theme will be the need to promote mental health and wellbeing and to strengthen community services to promote a recovery based model of care provided predominantly in or close to people's homes. As outlined in "Delivering the Bamford Vision" (DHSSPS, 2009), key themes include:

A core theme will be the need to promote mental health and wellbeing and to strengthen community services.

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers
- Providing better public services to meet people's needs
- Providing structures and a legislative base to deliver the Bamford Vision.

1.9 Older People

The strategic direction for services for older people has been guided by the Minister's priorities and objectives as stated within the Commissioning Direction in recent years, with the focus being on a continuum of integrated primary and community care services, supporting independence and reducing inappropriate reliance on hospitals and other institutional care.

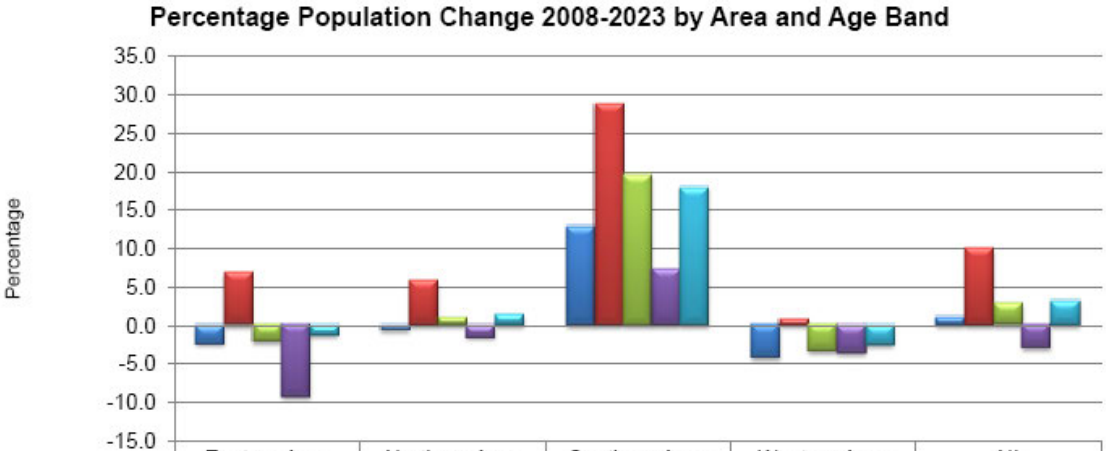
The anticipated Service Framework for Older People's Health and Wellbeing and the NI Dementia Strategy will form the future strategic direction for commissioning, with the agreement of evidence based standards, targets and measurable outcomes. Using this strategic base, commissioning will aim to ensure a balance of provision between disease prevention, health promotion and healthy ageing, and the required network of care and treatment services for those most at risk.

1.10 Children

It has been acknowledged by several independent authors that the level of investment in Children and Families Services in NI is approximately 30% less than in other parts of the United Kingdom. There are also examples of initiatives funded in other parts of the United Kingdom where there has been no direct read across to NI which has added to this imbalance.

It had been predicted that the number of births in Northern Ireland was to decline but this has proven not to be the case with birth rates remaining broadly static.

15-Year Population Projections by Age Band
Data Source: NISRA 2008 Population Projections



	Eastern Area	Northern Area	Southern Area	Western Area	NI
0 to 4 Years	-2.4	-0.6	12.8	-4.2	1.0
5 to 9 Years	6.8	5.8	28.7	0.8	10.0
10 to 14 Years	-2.2	0.9	19.6	-3.4	2.8
15 to 17 Years	-9.3	-1.6	7.3	-3.6	-3.0
0 to 17 Years	-1.3	1.3	17.9	-2.5	3.2

As Figure 4 above illustrates, percentage increases between geographical areas is variable but the overall increase leads to increased demand, particularly for family support services but also at the upper end of the continuum.

It is evident that the needs of children and families can only be addressed through multi-agency working and where partnership working is well established.

The strategic direction over the past few years has recognised the importance of early intervention

The fundamental principle of the Children (NI) Order 1995 is one of non intervention. In keeping with this

principle we recognise that considerable efforts should be made to maintain children within their family of origin. At the same time we need to recognise the lifelong damage which can be done to some children if left for too long within a highly dysfunctional family to the point where alternative care arrangements will always struggle to meaningfully engage with the young person.

The strategic direction over the past few years has recognised the importance of early intervention. There are a range of excellent examples operating in each of the Trust areas and being provided by the range of partners. This focus has been heightened even further with the publication of “Families Matter”, “Healthy Child – Healthy Future” and the “Family Nurse Partnership Initiative”. The concept of Family Support Hubs aligned with locality planning is developing and will be progressed. In addition the Family Support database, to be launched, should serve as an excellent resource to families, communities and professionals and be available to signpost families to support services at the earliest possible opportunity.

There is a need to consider the range of placements available for looked after children and those within CAMHS. This will include an exploration of the relative value of transfers to provision outside NI compared to that offered locally across the independent, statutory and voluntary sectors.

In the past year the Regional Quality Improvement Authority (RQIA) completed an inspection of Child and Adolescent Mental Health Services (CAMHS) and work will progress jointly with Trusts to progress the recommendations. The overall strategic direction continues to be as shaped by the Bamford Report.

The needs of children with a disability, including autism, remain a priority for the HSCB/ PHA and the various stakeholders involved in delivering services and working jointly with service users. The Regional Autism Spectrum Disorder Network (RASDN) has been seen to be an effective vehicle to engage users and take forward the agenda for children and adults with autism.

1.11 Disability

The Regional Strategy for People with Physical Disabilities and Sensory Impairment will be the strategic framework for services for this client group. The focus will continue to be on promoting health and wellbeing, independence and empowerment and improving the quality and

responsiveness of Health and Social Care services for people with disabilities and their carers. The Strategy will adopt a life cycle approach covering all age groups and will promote the importance of partnership working across community and independent sectors.

1.12 Reducing Inequalities and Promoting Health and Social Wellbeing

Commissioning, by definition, involves determining local health and social well-being requirements and commissioning services to meet these. We acknowledge at the outset of this commissioning plan that individuals and groups should have equality of opportunity to benefit from health and social care commissioned by the Health and Social Care Board and the Public Health Agency. But inequalities in health between different groups are well documented and long-standing. Evidence also suggests that health and social needs and outcomes are far from homogenous. There are different barriers to accessing services and there may be different obstacles for interventions consequently it is necessary that we understand each group's experiences.

In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women.

However, against this positive overall trend, inequalities are evident when mortality rates are compared across geographical areas. Many of the electoral wards which have the highest death rates are also those which have some of the highest levels of deprivation.

Relative deprivation in Northern Ireland is assessed by looking at income, employment, education, health, including disability and early death, local environment, crime and proximity of an area to services such as GP surgeries, hospitals or shops. Individual areas are ranked across Northern Ireland based on these. The 20% of most deprived areas represent nearly 340,000 people.

In Northern Ireland life expectancy increased between 2002-2009 from 74.5 years to 76.1 years for men and from 79.6 years to 81.1 years for women.

Some of the most common characteristics associated with being born into poverty rather than more affluent circumstances are:

- Lower life expectancy than the Northern Ireland average
- 23% higher rates of emergency admission to hospital
- 66% higher rates of respiratory mortality
- 65% higher rates of lung cancer
- 73% higher rates of suicide
- Self harm admissions at twice the Northern Ireland average
- 50% higher rates of smoking related deaths
- 120% higher rates of alcohol related deaths.

In addition, it is recognised that certain groups also experience disadvantage e.g. life expectancy for male Travellers is estimated at some 15 years less and Traveller women at some 10 years less than the adult population as a whole.

It is clear therefore that we need to do more to narrow the gap in health inequalities and improve the health and wellbeing of our population. This means working to address the determinants of ill health and reduce risk factors, including those associated with poverty and social exclusion.

The ability to positively impact on health and social inequalities cannot be exclusively addressed by the Public Health Agency and Health and Social Care Board. Meaningful partnerships and a common agenda need to be developed with our Trusts, our colleagues in local government, housing, education and the environment, and our communities if we are to effectively deliver on improving the health of our population. The Public Health Agency will have a key role in developing programmes to drive this agenda forward in the context of the review of the Investing for Health Strategy and the work that will be developed on a new Public Health Strategy for beyond 2012.

1.13 Performance Management

Strong performance management will be the key to achieving an outcome which is positive and publicly understood, and ensures compliance with standards, statutory obligations and targets set annually within the Commissioning Direction by the DHSSPS. In 2011/12 we will continue to develop the use and publication of a range of high level commissioning milestones as a benchmark of performance. While performance management of our care providers such as Trusts, General Practitioners and other primary care providers will be conducted in a

supportive manner, we will be clear our first obligation is to ensure safe, sustainable services which respond effectively to the population's needs and represent value for money.

1.14 Evidence Based Commissioning

Commissioning needs to be carried out within a framework of formal evidenced based guidance about the standards and outcomes we need to achieve.

Commissioning needs to be carried out within a framework of formal evidenced based guidance about the standards and outcomes we need to achieve. There are two key drivers in developing this approach:

Managed Clinical Networks

Managed Clinical Networks are a way of supporting the provision of high quality, sustainable, safe and effective services to our population. Integration and partnerships with clinical colleagues, either regionally, nationally or with the Republic of Ireland means that in Northern Ireland, despite our small population, we can be assured that our services are delivered to the highest possible standards. We already have some networks in place for paediatric cardiac surgery, adult intensive care, cancer and pathology services, and we will continue to develop these arrangements linking into our newly established regional commissioning teams.

Service Frameworks

Service Frameworks are sets of guidance on the highest quality of care and good practice spanning specific conditions or service areas. This guidance encompasses nationally supported evidence based standards, as well as the input of local clinical experts, in the development of recommendations applicable to our local services. Work is currently underway on the implementation of the Service Frameworks for Cardiovascular and Respiratory Services. Other Service Frameworks for Cancer, Mental Health and Wellbeing, Learning Disability, the Health and Wellbeing of Children and Young People and the Wellbeing of Older People are at various stages of development.

Service Frameworks are sets of guidance on the highest quality of care and good practice spanning specific conditions or service areas.

Commissioning will make progress with the implementation of these recommendations. However, there will be a need to balance how and when the recommendations can be fully

implemented with affordability, workforce skills and capital investment. Approaches in the near future are therefore likely to focus on standardisation of good practice and re-profiling of care systems in the first instance, rather than assuming that significant additional resources will be available for service development.

2 Ensuring Financial Stability and Effective Use of Resources

The key objective of the Commissioning Plan is to use all available resources to ensure the overall investment in services secures as broad a range as is practicable along with the best possible outcomes for local populations. In developing the Commissioning Plan the Health and Social Care Board, supported by the Public Health Agency, recognises that significant resources are available to support its successful delivery. In 2011/12 this will include access to £3, 941m of commissioning revenue resources.

The delivery of a successful Commissioning Plan requires the Board to be sensitive to the financial parameters within which commissioning operates. It is vitally important that we provide as much clarity as we can to the public in relation to the financial climate within which commissioning will operate during the current Budget period 2011-15.

The NI Executive allocations for DHSSPS represent a real terms reduction in current expenditure by 2014/15

The NI Executive allocations for DHSSPS represent a real terms reduction in current expenditure by 2014/15 with the result that the level of growth funds available in recent years will not be available in the period 2011-15.

The key challenge for HSCB and PHA is to ensure the delivery of the same or greater levels of activity currently being commissioned within a financial envelope which is reducing in real terms over the new spending review period. In 2011/12 this will involve both ensuring we achieve financial balance and also that we set the financial parameters for the rest of the spending review period which will underpin the longer term plans to reform and modernise health and social care.

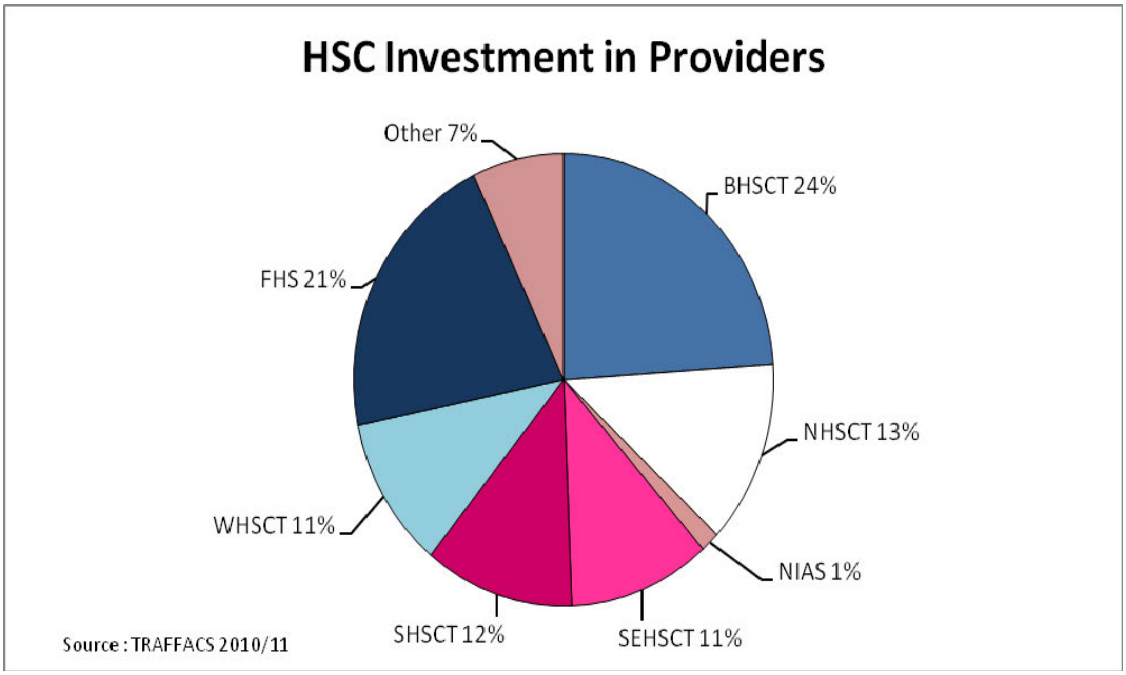
This section of the Commissioning Plan provides an overview of:

- The existing investment of Health and Social Care Board and Public Health Agency resources
- Financial performance in 2010/11
- The financial plan for 2011/12 and key financial targets
- The financial challenges for 2011-2015.

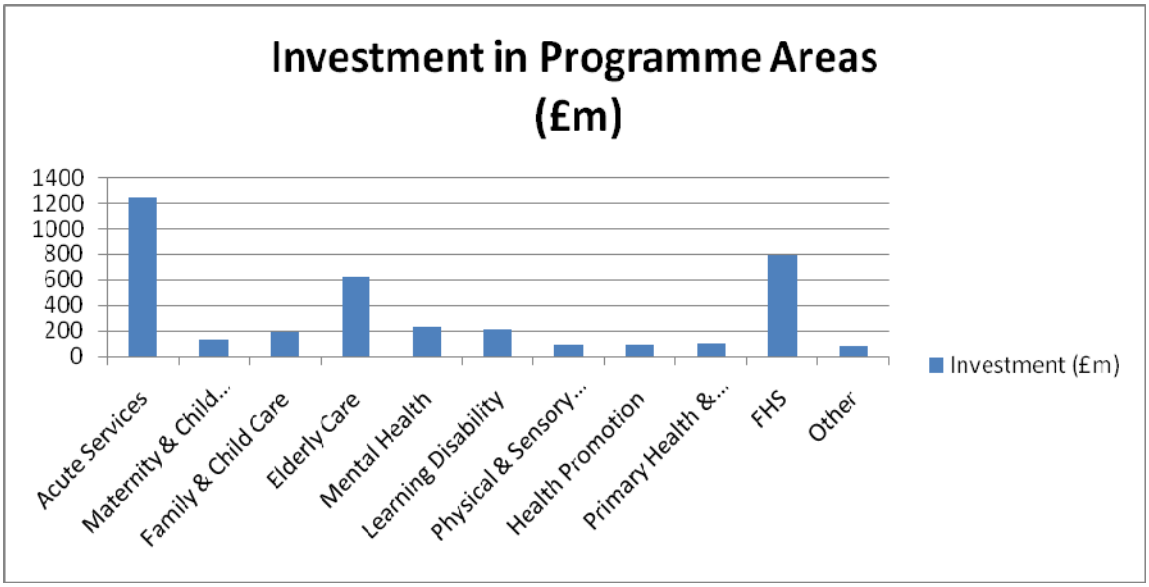
2.1 Existing Investment

The DHSSPS received an overall recurrent budget of £4.3bn in 2010/11. Of this, the Health and Social Care Board and Public Health Agency received some £3.8bn for commissioning Health and Social Care on behalf of Northern Ireland's 1.7m resident population. The DHSSPS utilise the remaining £0.5bn on NI Fire and Rescue Service i.e. Public Safety, Capital and other Agencies.

Of the £3.8bn received by HSCB and PHA, £2.7bn is deployed to the six provider Trusts and £1.1bn allocated across other providers of care such as voluntary organisations and General Practitioners in meet the health and social care needs of the population. Figure 5 illustrates the breakdown of the commissioning resources across providers.



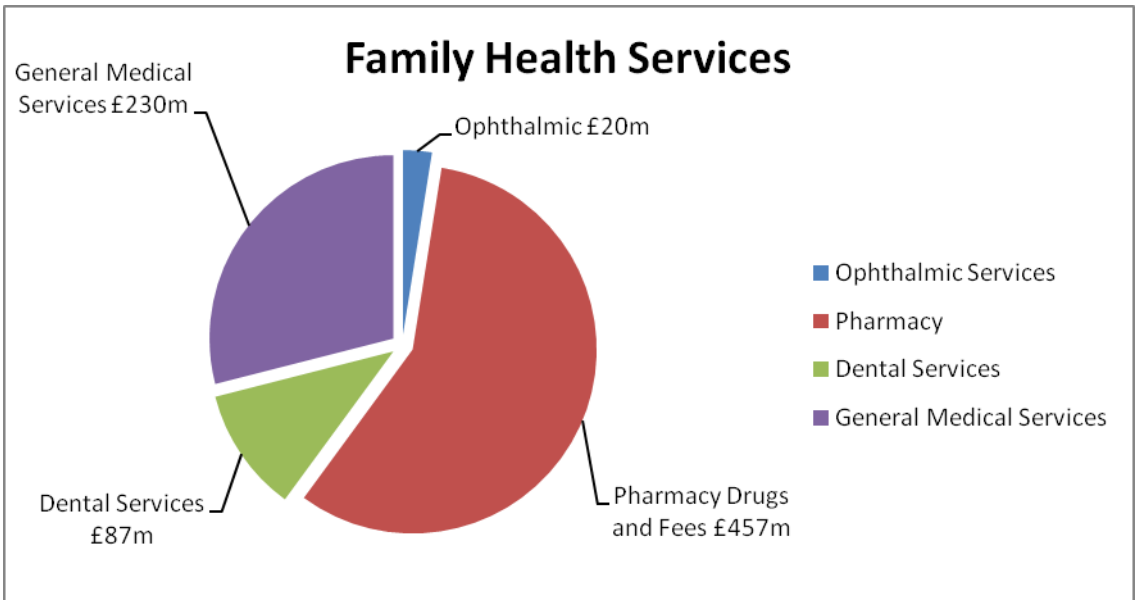
The PHA and HSCB invest £2.9bn across the 9 Programmes of Care areas and a further £0.8bn in Family Health Services (FHS) to meet the health and social care needs of local populations. The FHS funding was devolved to the HSCB from DHSSPS in 2010/11. Figure 6 (overleaf) illustrates how funding has been mapped to the Programme of Care areas.



In addition to Programme of Care funding, £0.8bn investment is made across the four areas of FHS which relates to the following services:

- General Medical Services
- Dental Services
- Pharmaceutical Services
- Ophthalmic Services

Figure 7



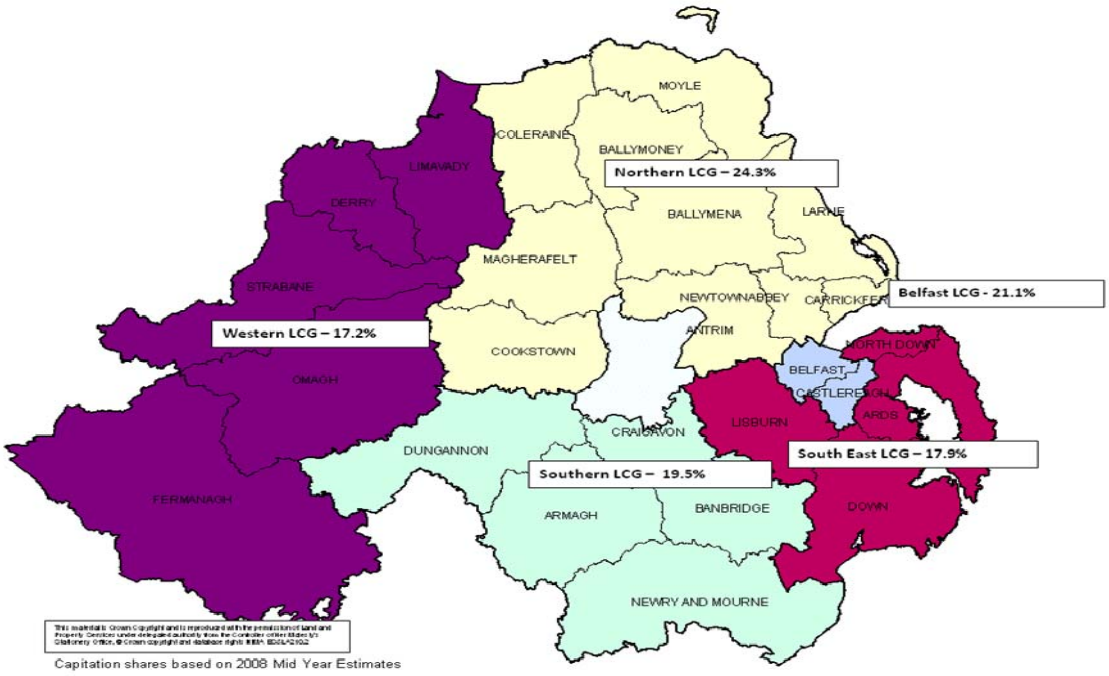
Ensuring these resources are fairly distributed across local populations is a core objective of the commissioning process.

Account must be taken of the population profile in a locality. Resources must be targeted to meet the diverse needs of populations based on its age and gender make up, for example, areas with a high number of elderly or very young are primary users of health care.

Also, the level of deprivation in an area is a key determinant in the requirement for health and social care in that area. Areas with high levels of deprivation require a higher than average investment in areas such as social care and health improvement.

The Health and Social Care Board uses a validated statistical resource allocation formula to inform its investment decisions made for the population in their localities. This is the "capitation formula". It reflects the different needs of the population based on age, gender and deprivation. Figure 8 shows the relevant capitation shares mapped to localities.

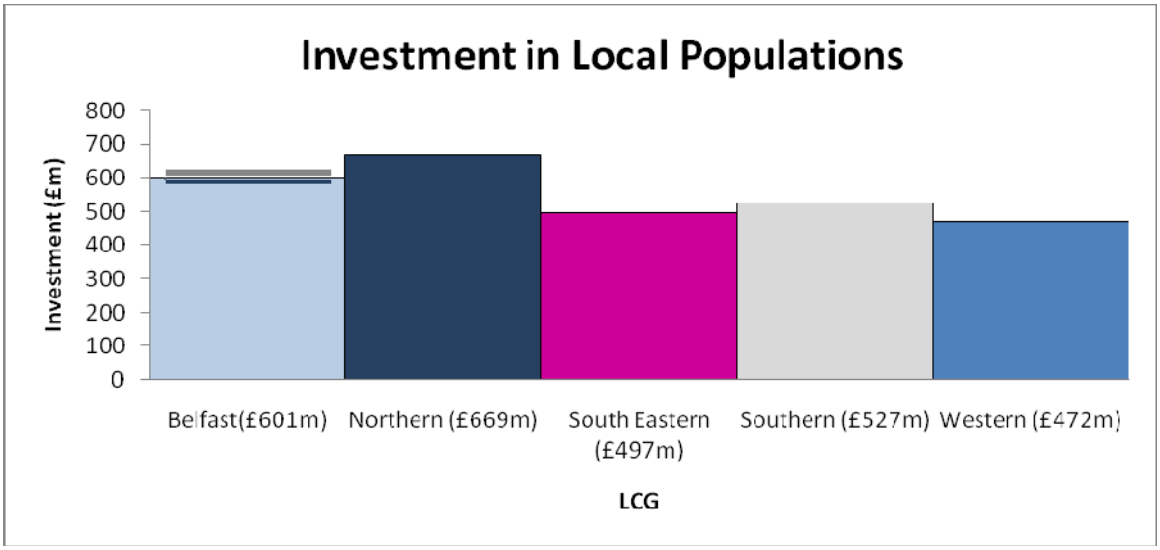
Capitation shares by LCG



There is a separate capitation formula for Family Health Services. It is based on GP practice list populations.

Figure 9 illustrates how existing resources are invested in localities.

Figure 9



Where localities funding levels are out of line with their capitation based entitlement, equity strategies are developed to address the inequities, over a manageable period of time.

However, it is also important to appreciate that services provided for and accessible by a population may not always be located in that geography e.g. regional services such as specialist residential care for children and cardiac surgery. This is to ensure that the population has a safe and sustainable service.

2.2 Overview of Financial Performance in 2010/11

In 2010/11 Health and Social Care was asked to deliver savings of £284m arising from:

- The third year of the Comprehensive Spending Review efficiency savings as agreed in 2008
- The additional reductions decided by the Northern Ireland Executive in 2010
- The need to cover elective care costs consistent with the Minister's priorities as set out within the Commissioning Direction.

Due to this financial position, the DHSSPS's commissioning direction of the Health and Social Care Board required it to plan for savings of £204m. The sources of funds identified are summarised in Table 1:

Table 1

Description	£m
Comprehensive Spending Review Year 3:	
Trust Payroll;	40
Strategic Service Redesign and efficiency	15
Additional Income	3
Deferral of funds associated with Maintaining Existing Services	42
Deferral of originally planned Service Developments	58
Family Health Services Pharmacy Control	46
Total	**204**

There were major and complex management challenges involved in meeting these financial pressures and these were addressed through the establishment of a Financial Stability Programme Board chaired by the Commissioner, with involvement from DHSSPS and the provider Trusts.

Close monitoring of the performance of each organisation against each of the savings targets outlined above, with appropriate management action and contingency planning, enabled the Health and Social Care system to achieve a financially stable position by March 2011.

2.3 Overview of Financial Plan 2011/12

Following the approval by the NI Assembly of the Budget for the period 2011-15 the DHSSPS has published resource plans for Health and Social Care spanning 2011/12-2014/15. These were approved by the Northern Ireland Executive.

The financial climate for Health and Social Care in 2011/12 is extremely challenging given the range of inescapable requirements that must be met from the approved allocations. The key objective remains the need to deliver safe and effective Health and Social Care in a way that ensures appropriate and equitable use of all available resources and effective and efficient service delivery across all areas in the context of increasing demand for services from a growing and ageing population. The approach to developing financial plan for 2011 was:

- To identify HSC-wide and HSCB/PHA specific inescapable pressures to enable the maintenance of existing activity levels
- To evaluate Trusts' financial positions for 2011/12
- To identify the potential solutions to address the 2011/12 savings requirement.

The key financial targets for 2011/12 remain financial breakeven and delivery of efficiency savings, therefore the commissioning system will expect all organisations to live within the resources allocated. To achieve this objective the financial aspects of the Commissioning Plan have robustly focused on ensuring there is a source of funds for all expenditure and prioritisation of inescapable funding requirements.

In relation to the level of bureaucracy within the Health and Social Care system, the Health and Social Care Board will always wish to drive down such costs and add to productivity. However, the notion that the financial constraints can be exclusively addressed as a consequence of these issues is not accurate and diverts from the real public debate that will be required on resources and its utilisation.

The key financial targets for 2011/12 remain financial breakeven and delivery of efficiency savings.

2.4 HSCB/PHA Resource Allocation 2011/12

The DHSSPS have allocated to HSCB/PHA for 2011/12 total revenue resources of £3,941m for the commissioning of HSC services and provision of Family Health Services.

The following table shows how the £3,941m has been planned to be allocated by Trust and locality.

Trust	HSCB	PHA	A&E	LCG Regional	LCG Belfast	LCG Northern	LCG South Eastern	LCG Southern	LCG Western	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Belfast Trust			20.60		554.46	143.15	130.30	76.12	44.23	968.86
Northern Trust			13.32		1.26	502.19	1.00	0.78	1.63	520.18
NIAS			56.05							56.05
South Eastern Trust			13.89	7.47	43.88	6.47	353.56	9.92	2.39	437.58
Southern Trust			16.67		0.32	3.44	1.17	435.64	1.25	458.49
Western Trust			9.70		0.14	6.83	0.11	3.19	415.06	435.03
ECRs *					6.39	7.19	5.30	3.68	6.11	28.66
Voluntaries *					9.71	2.70	5.87	1.58	4.31	24.17
Agencies *					2.10	2.70	1.90	1.94	0.09	8.73
Primary Care *					0.68	0.66	0.62	0.58	0.47	3.01
Not allocated to provider *					13.64	23.01	13.41	16.62	16.42	83.11
FHS *					192.00	193.00	134.00	153.00	144.00	816.00
Management and Admin	31.00	16.00								47.00
R&D / BSO / DIS *					12.00	13.00	10.00	10.00	9.00	54.00
Grand Total	**31.00**	**16.00**	**130.23**	**7.47**	**836.58**	**904.34**	**657.24**	**713.05**	**644.96**	**3,940.87**

* == Indicative Allocation By LCG Only

2.5 Inescapable Funding Pressures

The HSC faces a number of inescapable demands including:

- Demographic change
- Demand pressures
- Pay costs and pay inflation
- Goods and service inflation
- Completion and commissioning of new buildings

A review of the impact of the emerging 2011/12 HSC financial environment, taking account of the allocations confirmed in the approved budget outcome identified and quantified the range of inescapable pressures across the HSC. The HSCB/PHA element of these pressures is £226m, as set out in the table below:

Table 2

Area	Amount (£m)
Pay costs	45
National Insurance Contributions (NIC)	19
Non-pay inflation	23
Revenue Consequences on Capital Developments	7
Mental Health resettlement	3
Learning Disability resettlement	6
Demographics	26
Residual demand **	14
HSCB/PHA central pressures	9
NICE approved drug therapies	2
Pharmaceutical growth	40
Ministerial commitment	10
Elective care	15
Service developments revenue tail	7
Total	**226**

** Further details in Section 2.8*
*** Includes £3.4m monies to be redirected to other organisations*

2.6 Trusts' Financial Positions

Trusts will be expected to live within the resources allocated.

Trusts have continued to experience increasing financial difficulties during the course of 2010/11 with the requirement to initiate Contingency Plans, over and above the financial targets referred to in paragraph 2.2 above, in order to fulfil their statutory duty to financially breakeven. In the context of 2011/12, therefore, the Health and Social Care system anticipates that it will need to invest in maintaining existing services as well as developing new provision.

Trusts will be expected to live within the resources allocated. To achieve this objective Trusts will be required to implement robust plans to achieve a recurrent breakeven position by 31 March 2012. The Board will closely monitor progress against these plans via the Financial Stability Progress Board (FSPB).

2.7 Steps to address the 2011/12 savings target

For 2011/12 the HSCB/PHA has been tasked with addressing a savings target of £130m (3.2% of total revenue resources) in order that overall expenditure and the inescapable pressures are contained within approved budget allocations. The HSCB/PHA identified potential (recurrent and non-recurrent) solutions to contribute to alleviating this target, which resulted in a residual element of £41m remaining. After a secondary analysis of additional pressures and solutions, a final deficit position of £11m remains as detailed in Table 3 below. The HSCB/PHA will continue to review how this remaining savings deficit can be addressed in order to maintain the key target of financial balance whilst at the same time meeting Ministerial priorities and objectives within the Commissioning Direction.

Table 3

	£m	£m
Total Savings Target		**130**
Proposed Solutions:		
Pharmacy Savings	30	
Pay Pressures no longer required	13	
Cost Pressure Slippage	10	
Full Year Effect of 2010/11 Savings	36	
Total Proposed Solutions		**89**
Revised Deficit		**41**
Additional Pressures		
General Dental Services	5	**5**
Additional Solutions		
Pay	16	
Additional Savings required by DHSSPS	10	
PHA	2.5	
Others	6.5	
Total Additional Solutions		**35**
Final Deficit		**11**

2.8 Inescapable Funding Areas 2011/12

Key elements of new funding:

- Revenue consequences of capital £7.0m
- Revenue tail from 10/11 service developments £7.2m
- Ministerial commitments £9.2m
- Demography £19.8m (but £5m already committed)
- Residual demand £8.9m
- NICE £2.2m
- Community pharmacy growth £40m (gross)
- Specialist drugs £2.9m
- Non-recurrent funding for MH/LD resettlement (£9.2m) and elective care (£15m)

This section provides further detail on each of the identified areas in 2.5.

Pay costs
This includes a nationally agreed uplift for employees of £250 who earn an annual salary of less than £21k, employers' national insurance increases, outstanding Agenda for Change appeals and incremental progress.

National Insurance Contributions
This reflects the 1% increase on the employer's cost element of National Insurance Contributions for 2011/12.

Non-pay inflation
To cover goods and services inflationary increases.

Revenue Consequences of Capital Developments
This funding is to address the revenue consequences arising from capital projects committed to in previous years and to be committed in 2011/12.

Mental Health and Learning Disability resettlements
This non-recurrent funding will be used for resettlement of mental health and learning disability patients from hospital to community setting.

Demographics
This funding has been identified to cover the costs of demographic pressures arising from a growing and ageing population.

Residual demand
This funding is to address the growing demand for services caused by new drugs and technologies to deliver quality services**.**

NICE approved drug therapies
This funding has been identified to enable the implementation of relevant NICE approved treatments in Northern Ireland.

Ministerial Commitments
These resources have been identified to fund a range of areas where the Minister has made a prior commitment to resource e.g. the Regional Decontamination Strategy.

HSCB/PHA central pressures
Pressures arising with the HSCB/PHA in order to maintain existing services.

Elective care
Non-recurrent funding has been made available to assist in meeting elective care waiting time targets.

Service developments revenue tail
This is to fund the full year recurrent cost of service developments commenced during 2010/11 financial year.

Pharmaceutical growth
Resources identified for this area will be used primarily to cover anticipated growth within general prescribing. However this additional resource must be seen in the context of the material efficiency and savings required from this area.

2.9 Planning for the Future

The budget outcome for the period 2011-15 sets out a challenging position for Health and Social Care in the coming years. Whilst the financial plan outlined above will be required to deliver financial stability in 2011/12 it is clear that if the financial challenges continue as anticipated in 2012/13 and beyond, then it will be necessary to radically reform and modernise services if we are to continue to meet existing

activity levels and address new demographic pressures. We will be required to have a long term strategic financial plan. This may involve the following:

- Improvements in productivity
- Reviewing administrative costs
- Reconfiguration of Health and Social Care Services
- Bearing down of pay and price inflation
- Seeking greater contributions from service users.

The "Reshaping the System" document initiated by the HSCB will form a starting point for planning for the future.

It is essential that the Health and Social Care System begins to robustly plan for the future challenges during 2011/12 to ensure that it is in a position to maintain financial stability throughout this budget period and beyond. The "Reshaping the System" document initiated by the HSCB will form a starting point for planning for the future and the Board/PHA through the Commissioning Workstreams will play a fundamental role in this

3 Personal and Public Involvement

Personal and Public Involvement (PPI) is a legislative requirement for Health and Social Care Organisations as laid down in the Health & Social Services (Reform) Northern Ireland Act 2009. Departmental Guidance issued in 2007 sets out the core values and principles to which we are expected to adhere. PPI is core to the effective and efficient commissioning, design and delivery of Health and Social Care services. PPI means actively engaging with those who use our services and the public to discuss: their ideas, our plans; their experiences, our experiences; why services need to change; what people want from services; how to make the best use of resources; and how to listen to these views and therefore improve the quality and safety of services.

PPI is core to the effective and efficient commissioning, design and delivery of Health and Social Care services.

Whilst the term Personal and Public Involvement may be relatively new, the concept is not. Health and Social Care has long recognised the benefits of meaningful and effective engagement of service users, carers and the public. We have made considerable efforts in 2010/ 2011 to further embed Personal and Public Involvement in our everyday work.

Personal and Public Involvement work is happening throughout health and Social Care. It complements, enhances and sets the context for the ongoing engagement work being progressed through the Local Commissioning Groups which will contribute to the content of the 2011/12 Commissioning Plan.

A Regional HSC Personal and Public Involvement Forum have been established on a collaborative basis between the Health and Social Care Board and the Agency, under the chairmanship of the Director of Nursing, Public Health Agency. The Forum comprises senior representation from all Health and Social Care Organisations in Northern Ireland. Service Users, Carers and Community & Voluntary Organisations also form part of its membership. The Forum will:

- Undertake a training needs analysis and roll out a training and development programme
- Analyse information from engagement activity to inform priorities and future practice

- Develop impact assessment methods to evaluate the effectiveness of PPI.

The Forum will work to promote a whole system approach and reduce unnecessary duplication. In addition it will develop an agreed process for the reimbursement of expenses for service users and carers involved in engagement.

A specific aim will be to publish and implement approved Public and Personal Consultation Scheme by 31 March 2012. The PHA and HSCB have worked in partnership with this scheme. The pre consultation process included significant face to face events involving over 500 participants, including the voluntary and community sectors. Targeted approaches were used with the help of CDHN to ensure input was secured from marginalized and excluded groups.

An extensive process of engagement was undertaken on behalf of the Health and Social Care Board and Public Health Agency in respect of the development of a Draft Joint PPI Strategy. This included seeking the views on the preparation, content, purpose and goals of a PPI Strategy. A series of workshops were held in the second half of 2010 to inform the development of our Consultation Schemes and PPI Strategy. Amongst these were workshops with the Regional HSC PPI Forum and workshops held specifically with community and voluntary sector partners. These helped gain their insight into PPI, what it can deliver and how best Heath and Social Care can work with Service Users, Carers, the Community & Voluntary Sector and the wider public to embed PPI into our culture and practice. Further workshops were held in early 2011 throughout Northern Ireland aimed at further involving Health and Social Care staff, the community and voluntary sector, service users and the general public. Input was secured from marginalized and excluded groups by using targeted approaches; and one to one interviews were conducted with key Health and Social Care staff.

The engagement carried out to develop the draft Strategy has identified six key priority areas of work:

- Cultural Integration of Personal and Public Involvement
- Awareness and Understanding of Personal and Public Involvement
- Training and Skills Development
- Impact Measurement

- Stakeholder Support
- Communication and Co-ordination.

These key priority areas will be delivered through the work of a Joint Public Health Agency/Health and Social Care Board PPI Implementation Group which will encompass PPI Leads from each of the Directorates in both organisations. This Group will ensure the development of tailored Action Plans, specific to each organisation, which will assist us in delivering on the agreed strategic priority areas, ensuring more effective commissioning, service development and delivery. Opportunities for joint working will be identified and taken forward in the incoming year. Examples of tangible products will include:

- A framework of methods of engagement
- Development of a protocol for ensuring PPI responsibilities are adhered to before plans and or investment decisions are endorsed
- A PPI Training framework and roll out of appropriate training
- Development of a unified Expenses Reimbursement policy for services users and carers involved in engagement work.

Local Commissioning Groups continue to engage with service users, carers, the community and voluntary sectors and the wider public, to assist them in the development of their local priorities.

Consultation on the PPI Strategy was completed in October 2011 and it is planned that the final Strategy will be issued in January 2012.

The Health and Social Care Board and Public Health Agency will also work with the Patient and Client Council to explore the opportunities offered by their Membership Scheme to support the Personal and Public Involvement Strategy.

Local Commissioning Groups continue to engage with service users, carers, the community and voluntary sectors and the wider public, to assist them in the development of their local priorities. The Local Commissioning Groups intend to build on this process throughout 2011/12 and beyond, working with PPI Leads in both the Public Health Agency and the Health and Social Care Board.

The Health and Social Care Board, including its Local Commissioning Groups, and the Public Health Agency are committed to working in

partnership with the Patient and Client Council, other Health and Social Care Organisations and statutory bodies such as Local Councils, to promote Personal and Public Involvement and identify joint Public Involvement opportunities and reduce duplication.

We recognise Personal and Public Involvement as an integral process linking human rights and equality, patient and client experience, user involvement and community development. Section 75 of the Northern Ireland Act 1998 provides a legislative framework for the promotion of equality of opportunity and good relations.

We recognise Personal and Public Involvement as an integral process linking human rights and equality, patient and client experience, user involvement and community development.

The Commissioning Plan has the potential to impact on Section 75 categories and the categories under Good Relations. It also has the potential to impact on the human rights of individuals. In this context, substantial work has been undertaken to ensure that the development of our Personal and Public Involvement consultation schemes were in compliance with the requirements of Section 75 of the Northern Ireland Act (1998), the Human Rights Act (1988) and the Disability Discrimination Act (1995).

Once the Commissioning Plan has been approved by the DHSSPS and the Minister, appropriate arrangements will be put in place to ensure key elements of the Plan are equality screened and, where screening indicates the need for more thorough examination, an equality impact assessment will be considered.

4 Local Commissioning Groups

4.1 Background

The five Local Commissioning Groups have developed Local Commissioning Plans which echo and reflect the key themes in the Commissioning Plan for 2011/12. Each of the Regional Commissioning Service Teams has produced a statement of commissioning intent for 2011/12 which has been translated into a series of actions and priorities for each of the LCG plans, as appropriate. While progress against each of the key themes may vary depending on local circumstances, the underlying direction of travel will be consistent across all localities. As local expressions of the Health and Social Care Board, the LCGs are well placed to shape and steer the commissioning agenda in their respective areas.

Tackling Health Inequalities

The Commissioning Plan includes specific measures to address the determinants of health and reduce inequalities. LCGs are supportive of collaborative working with other partners and agencies to tackle the wide ranging causes of poor health and inequalities. Access to local intelligence will also help shape this agenda in going forward. LCGs are keen to commission upstream interventions to make a difference in outcomes longer term.

Primary Care Partnerships

One such agenda is the establishment of Primary Care Partnerships (PCPs). LCGs have been tasked with establishing PCPs to operate as networks of primary care providers rooted in geographical communities. Partnerships will include GP Practices, pharmacists, nurses and other providers of health and care in the area. Serving practice populations of circa 100,000, PCPs will be the main vehicle for taking forward key commissioning objectives in terms of service improvement and pathway redesign.

Significant progress has been made in driving this agenda forward with some 15 pathfinder projects completed. 2011/12 will be a landmark year in terms of bringing these models centre stage. This will be helped by the appointment of GP, pharmacy and nursing clinical leads for each PCP who will engage with peers and with secondary care clinicians and Trust management to implement regional strategic plans within a local health

economy. It will be important for PCPs to be underpinned by a cross – directorate team of Board and Agency staff in each local office working in concert to support the Clinical Leads and the wider PCP developmental agenda.

Reshaping Acute Hospital Services

The Commissioning Plan commits the Board and Agency to taking forward a comprehensive programme to reform and modernize acute hospital services. LCGs will also have a key role to play in the reshaping of acute hospital services and will want to ensure that acute hospital services for their resident populations are safe, sustainable and reliable. It will be important to maximize the potential offered by the network of local hospitals, especially in those areas with dispersed rural populations.

Living at Home

As one of the key themes of the Commissioning Plan, the focus in the LCG Plans is on promoting independence, recovery and rehabilitation to support as many people as possible to live in their own homes. The introduction of a re-ablement model has already shown its potential and will be rolled out across all LCGs in 2011/12. Key to the success of this initiative is the engagement with wider society on the merits of the new model. LCGs can play their part in helping raise awareness of the benefits of healthy ageing.

Quality and Safety

In keeping with the commitments in the Commissioning Plan agreed by the Board and Agency, LCGs will commission services underpinned by quality and safety considerations. As part of a programme of reviewing patient pathways, LCGs will want to ensure that patients receive the outcomes they expect and that care is delivered by staff with the requisite skills and experience. The focus will be on ensuring that patients are able to access safe services without unreasonable delays in environments conducive to the delivery of good quality care.

Patient/Client Experience

LCGs have listened and will continue to listen to local communities and the voluntary and community sector about the patient and client experience. Improving the experience enhances outcomes and facilitates

better communication between patients/clients and the wider HSC. Taking forward the PCP agenda, LCGs will embed patient experience within the reshaping of pathways and will link with the Patient and Client Council and other representative bodies in pursuit of this aim.

Value for Money

LCGs are keenly aware of the financial challenges ahead and the opportunities that this will present. In going forward, LCGs will seek to maximize the potential of PCPs to act as gatekeepers to secondary care services. Furthermore, LCGs will strive to provide services in community rather than hospital settings where it is safe and appropriate to do so. Commissioning of services will be evidence-based and make the best use of available resources along the entirety of the patient pathway.

Local Commissioning Group Chairs

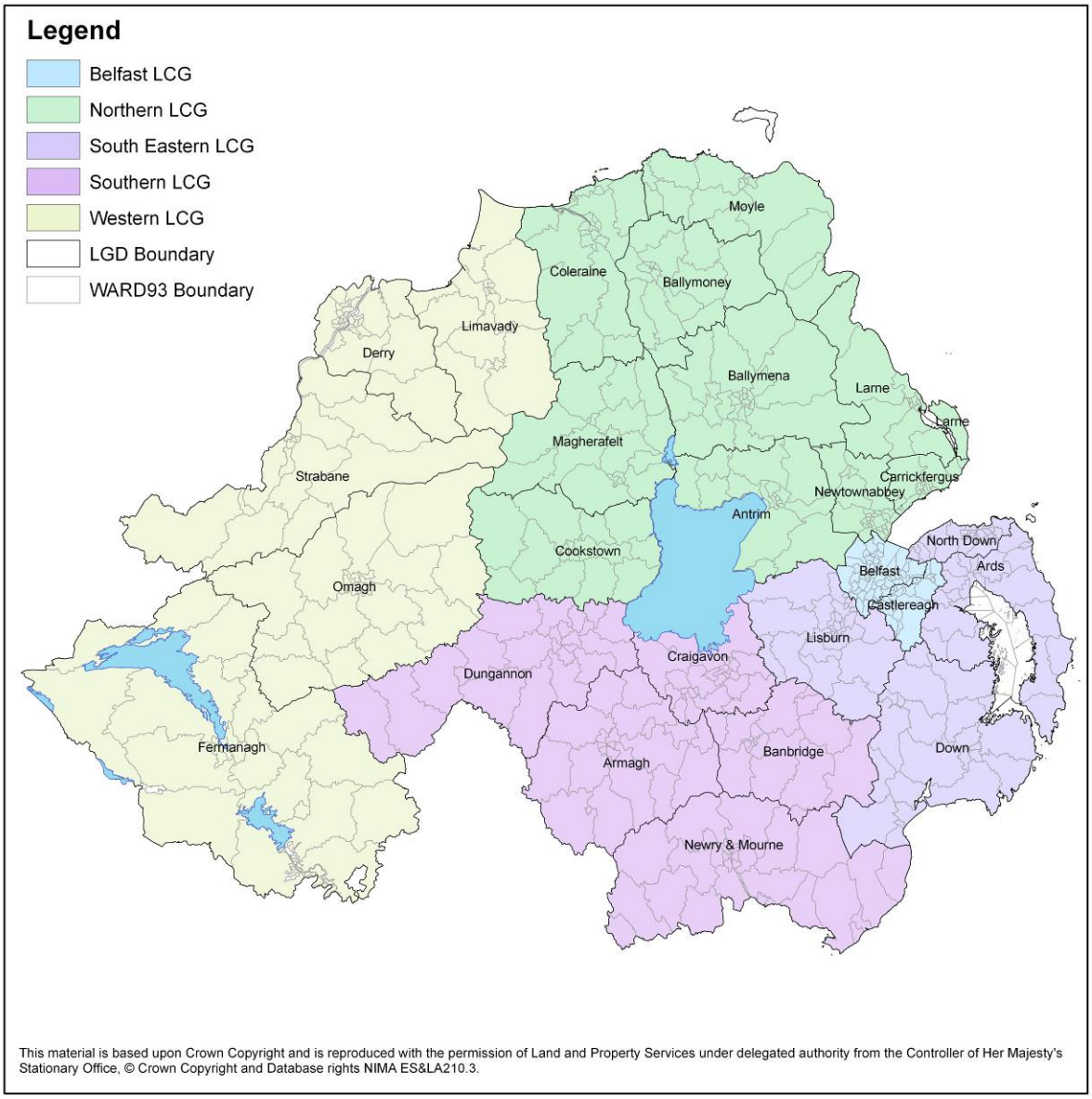
Dr G O Neill
Belfast

Dr N Campbell
South Eastern

Dr B O Hare
Western

Mr S McKeagney
Southern

Dr B Hunter,
Northern



Local Commissioning Area	Population
Belfast	335,000
South Eastern	340,000
Southern	348,700
Western	300,000
Northern	450,000

Overarching Themes

5.1 Introduction

This section details the key commissioning themes which provide the backdrop for much of the commissioning agenda in 2011-12 and beyond.

Progress with each of these themes has already been made in the last year. Maintaining this momentum will be essential to the delivery of safe, sustainable, high quality and affordable services for people of Northern Ireland.

5.2 Tackling Health Inequalities

This Commissioning Plan contains specific measures to address this challenging agenda, but it is equally important that health protection and improvement is actively considered as an integral part of all of our commissioning strategies.

Inequalities in health arise because of inequalities in society. Addressing inequality therefore requires coordinated action across many different sectors and government.

To address the determinants of health and reduce inequalities, concerted and co-ordinated action is required across many government departments and delivery organisations. Health and Social Care organisations can have a significant impact: firstly, by taking a leadership role in championing the issues and working collaboratively with other sectors to address the challenge; secondly by shifting resources, and commissioning 'upstream' interventions; and thirdly, by creating healthy workplaces using the entire health and social care workforce as an opportunity to improve their own and their families' health as well as using every interaction with the public to promote health and wellbeing. Critically, it requires active engagement with local communities. The PHA/HSCB will continue to support and further develop local level multiagency partnerships to improve health and wellbeing and reduce inequalities. These will be key vehicles for implementation of Investing for Health and other public health related strategies. In addition, PHA will continue to develop and implement action plans with local government. In 2011/12 these will primarily focus on the identified priorities of physical activity and obesity.

Disadvantaged communities are known to be disproportionately affected by infectious diseases, major disasters and their adverse consequences.

The recent strategic review of health inequalities in England by Professor Sir Michael Marmot provided advice to government on preventable ill health. The report argues that action to reduce health inequalities must start before birth and be followed through the life of the child, adopting a 'life course' approach. The PHA, taking into account this evidence and a range of other policy objectives, has adopted a framework of four Building Blocks to reduce inequalities and promote health and wellbeing:

- **Give Every Child and Young Person the best start in life –** invest more in a package of programmes to support children and families in the antenatal period, first 5 years, and through to adulthood

- **Ensure a decent standard of living for all** – work with others to tackle poverty, maximise benefits and income and use the power of the public sector to procure goods locally and where appropriate, through the social economy

- **Build sustainable communities** – work with local communities to develop capacity, increase community participation, and support community based approaches such as community gardens/ allotments with for those experiencing the greatest inequalities

- **Making Healthy Choices Easier –** provide information and create environments which make it easier for people to make healthy choices e.g. through public information campaigns.

Health Protection

Disadvantaged communities are known to be disproportionately affected by infectious diseases, major disasters and their adverse consequences. Key priorities for tackling Health Protection inequalities include the need to:

- Achieve good uptake rates for childhood immunisation in disadvantaged communities, including migrants

- Ensure equity of access to and uptake of services for the prevention, diagnosis and treatment of TB, HIV, Sexually Transmitted Infections, Hepatitis B and C

- Reduce the incidence of HCAIs which disproportionately affect the elderly and those with underlying health problems

- Ensure all Health and Social Care organisations have strong emergency preparedness plans which have been tested and cover major emergencies such as an influenza pandemic, and severe disruption to the drinking water supply.

Screening Programmes

Population screening is an important public health activity that focuses on the early detection of disease. This allows for earlier interventions contributing to improved outcomes. Work is ongoing to improve screening programme coverage in hard to reach groups, including those who are disadvantaged.

Screening policy is set by the DHSSPS on the advice of the UK National Screening Committee. Screening involves inviting people who have no symptoms of a particular disease, to be tested to see if they have the disease, or are at risk of getting it. Early detection and treatment can therefore result in better outcomes.

There are a number of issues and challenges relating to screening programmes. These include:

- The need to improve the performance of existing screening services to meet standards.
- The need to improve the performance of related diagnostic & treatment services to meet standards.
- The need to implement policy and current targets as outlined in the Commissioning Direction for new screening programmes and developments in existing programmes.

Screening is different from the usual type of health care in which a patient makes contact with the health service because he or she has symptoms or signs of disease. For this reason quality assurance is an integral part of screening programmes. This helps to ensure that

minimum standards are maintained and that the programmes are continually improved. In this way the benefits of screening can be maximized and harms (such as over diagnosis and overtreatment) minimized.

5.3 Ensuring Equity of Provision

Achieving equity in commissioning health and social care for our population is a key objective of the Commissioning Plan. In order to support the delivery of this objective the Health and Social Care Board (HSCB) will develop a strategy which will aim at ensuring all local populations have fair and equitable:

- access to services - dependent upon need;
- allocation of resources - dependent upon availability of funds;
- levels of high quality, safe and effective care in line with agreed standards and recommended best practice.

In order to develop its strategy the Board will draw on a range of information sources to allow it to identify measure and address equity gaps in the three areas above.

Capitation Formula

The HSCB will review and develop the regional Capitation Formula. This is a statistical formula which measures the relative need for available resources across local populations by taking account of the factors which most differentiate one areas need from another e.g. population size and age profile, socio economic factors such as different levels of deprivation. The results of the formula inform the Board about how its resources should be shared out fairly across its local commissioning group areas. These results can be compared to planned spend to identify any variances. These funding gaps will be addressed in a number of ways including:

- Family Practitioner Services resources will all be allocated on a capitation share basis;
- Additional/new commissioning funding will be allocated on a capitation fair share basis;
- Efficiency savings targets will be skewed across relevant local Trust areas.

Service and Budget Agreements – activity analysis

Service and Budget Agreements set out details of the services the Board will purchase from our local Trusts and what it will pay them for those services. These are currently under review to ensure efficiencies are maximised and, where possible, costs streamlined. The result of this work will have an impact on future activity and expenditure plans and resulting equity gap analysis. The population in Belfast is increasing at a significantly lower rate than other localities, particularly the South. There will, therefore, be a requirement to maximise utilisation of capacity in Belfast in the short term and, in the longer term, explore options to realign services with where people live by providing enhanced and more effective services in home and community settings.

High Level Summary of Services Commissioned from HSC Trusts: 2011/12

	Service	Belfast	SET	Northern	Southern	Western	Total
Acute Hospital Services	Inpatient	91491	34189	57941	44100	47268	274989
	Day Case	67815	42055	21349	22008	32351	185578
	Outpatient	709741	350758	311649	331033	337719	2040900
	Other	183049	99151	117599	200898	87905	688602
Community Services	Community Nursing	838390	775440	768993	1321734	576579	4281136
(contacts)	Allied Health Professions	361783	268877	472307	354078	188442	1645487
	Residential & Nursing Home	843547	929126	1248400	331661	731380	4084113.5
	Social Work	23032	22961	18188	15660	11864	76045
	Home Help / Domiciliary Care	3147654	2145240	389309	5759584	1860496	13302283
	Day Care	331634	207639	261384	113463	336353	1250473
NI Ambulance Service	A&E	34272	22683	33385	21370	19046	130756
(journeys)	Urgent	8914	7620	9105	5854	4577	36070
	Non-urgent	29623	16798	67901	52500	40367	207189

Quality and Safety

Section 5.6 details the Board's approach to ensuring safe, sustainable and high quality services for the people of Northern Ireland. Information obtained by the Board as it continues to pursue these objectives will seek to identify and address any differential in quality and safety of services in its localities.

Long Term Strategy

The Minister has commissioned a long-term review of the provision of health and social care services for the next decade. This will be led by the Chief Executive of the HSCB. A central issue to be taken account of in planning for the next decade will be the projected population shifts across the region.

5.4 Developing Capacity in Primary Care

As Health and Social Care enters a period of unprecedented system-wide change, an evermore pressing need exists to ensure that local communities are engaged and that local providers of health and care (HSC Trusts, independent contractors and the voluntary sector) have a shared understanding of new models of care and the impact of changes on their area and community.

It is envisaged that Primary Care Partnerships (PCPs) will be a critical enabler in establishing an integrated approach across primary, secondary and community care. They will help to enable changes to the way in which our health estate is used to deliver care more appropriately, and the development of a more community-based workforce.

Plans to reduce the HSC's dependency on hospital and institutional care will have consequences for community and primary care based services and enhanced capacity needs to be developed outside the hospital environment. Implementing service redesign safely demands a careful and considered approach, one which takes on board the views of local clinical and social care leaders from primary, community and secondary care settings.

It is envisaged that PCPs will be an important vehicle for taking forward service improvements, providing more effective services appropriate to patients' needs. Arrangements will recognise the essential knowledge and experience of GPs and other primary care practitioners as clinical gatekeepers in influencing system-wide change.

Integrated multi-professional teams attached to GP practices will be enabled, through the support of PCPs, to manage services transferring from the hospital to the community setting e.g.

- The monitoring of patients with long term conditions such as stroke, asthma and diabetes
- Improved access to diagnostic testing such as x-rays; ultrasound; cardiac investigations; blood tests

The Model

PCPs will be provider networks built around local communities – typically serving populations of c.100, 000 – and will include GP practices, pharmacists, nurses and other providers of health and care based in their area. The Partnerships will have a key and central relationship with the five Local Commissioning Groups and so will be in a position to provide a more local expression of need into the commissioning process. PCPs will be clinically led to ensure strong clinical governance and decision making and commissioners will ensure that they can contribute meaningfully to leading reform across all sectors of our health and social care services.

Primary care Partnerships (PCPs) will be a critical enabler in establishing an integrated approach across primary, secondary and community care.

As a new approach to managing change it is important at the outset to state the agreed rules governing engagement with PCPs. In this regard the HSCB will ensure that new investments and service changes in primary, community and secondary care are made with appropriate input from local representatives of the affected sectors. This fundamental principle recognises the system wide consequences of reform.

Proposals for change will be required to include: (i) a clear identification of the relevant clinical pathway (e.g. diabetic care) which will facilitate integration through multiprofessional input and ensure that social care, disease prevention and health promotion delivery are given equal status to clinical services delivery; and, (ii) analysis of local demand and existing service capacity, necessary if we are to invest efficiently in service change.

HSCB will continue to test PCPs as a concept and Local Commissioning Groups will be in the lead to ensure that, subject to evaluation, these fundamental principles are embedded going forward.

Progress and next steps

Following the Minister's launch of PCP pathfinder projects in November 2010, an external evaluation of their progress by the Beeches Management Centre reported in April 2011. The five LCGs have identified 17 PCP areas and, consistent with the recommendations of the Pathfinder review, will recruit clinical leads for each of their PCPs.

Fifteen LCG led pathfinders covered a range of areas including:

- Mental health (which will include working with SE LCG, PHA and local communities to develop a response to Suicide "clusters" which can be extended across Belfast and to other LCG areas) – Belfast LCG
- ENT pathway – Belfast LCG
- Prescribing demand – Western LCG
- Dermatology pathway – South Eastern LCG
- Online Guidelines for the Management of Dyspepsia – Southern LCG
- Accident & Emergency care pathway – Northern LCG

During 2011/12, informed by the outcome of the external evaluation, it is envisaged that PCPs will start work on:

- Identifying clinical leads – GPs, pharmacists and nurses
- Communicating with local providers, primary care, community and hospital based
- Agreeing plans with Trusts to establish 'wraparound' community services clustered around GP practices
- Mapping local clinical pathways which reflect the regional priorities set out in the Commissioning Plan 2011/12 e.g. urgent care services
- Using pathways as a basis for bringing forward proposals for change

- Facilitating local review of referral pathways and activity and practice prescribing action plans, required through the Quality and Outcomes Framework (GP Contract) performance indicators.

Subject to ongoing evaluation the HSCB will support these developments through providing the required investment, leadership development and administrative support to ensure that PCPs have the tools required to take forward what will be a demanding programme of reform.

5.5 Reshaping Acute Hospital Services

In commissioning acute hospital services, our primary consideration is to ensure appropriate services are in place to respond to the existing and emerging needs of the population in Northern Ireland. It is a given that services must be safe and effective. But they must also be *reliable*: patients should be confident of receiving the same high quality service regardless of location, the time of day or the day of the week.

Many of our services – and not just those provided in smaller units – are becoming more dependent on the use of locum cover.

The drive for change in how we commission and provide acute care is about making sure that all of our population, irrespective of where they live, has access to the same standard of high quality, safe clinical care, provided reliably and sustainably by appropriately qualified staff.

Developments in medical technology continue to provide exciting new opportunities to improve outcomes for patients through new arrangements for diagnosis and treatment. But new technologies can be expensive and require the skills of specially trained staff. To keep abreast of the pace of change, doctors, nurses and other clinical staff are being required to develop their expertise in increasingly narrow fields and specialisms. Clinical staff need to work in a different way, with access to a significant clinical infrastructure, sub-speciality expertise and larger teams of senior colleagues to discuss and to make decisions about the best treatment and care for patients.

For many years Health and Social Care has tried its best to secure the right clinical staffing profile to maintain acute services but this is becoming increasingly difficult. Many of our services – and not just those provided in smaller units – are becoming more dependent on the use of locum cover which by its nature

must impact on the continuity of care because we cannot attract or retain permanent specialist staff. All of our acute hospitals face challenges in ensuring that a sufficiently senior doctor is routinely available – that is, 24/7, 365 days a year – to assess and treat patients in an emergency. Where permanent senior cover is not available and there is a reliance on more junior staff and/or locums, it is inevitable that there is an impact on the quality of service provided to patients.

Workforce challenges also exist within a number of specialist regional acute services, including a number of specialist services for children. The nature of these services means that they are only provided at one centre in NI – typically in Belfast. But even with this centralization, the population of NI is simply too small to generate sufficient critical mass and allow Health and Social Care to safely sustain all existing services on a 'stand-alone' basis. As commissioners we will continue to support the development of network arrangements for specialist services with other providers in ROI or GB with a view to maintaining local provision. Our over-riding criteria will be safety and quality however, even where this may local provision to cease and patients to travel outside of NI for the very specialized care they require.

The drive for change in how we commission and provide acute care is about making sure that all of our population, irrespective of where they live, has access to the same standard of high quality, safe clinical care, provided reliably and sustainably by appropriately qualified staff. These issues – rather than money – are the over-riding drivers for change to the existing pattern of service in acute hospitals.

Changes to acute hospital services have already been happening. Over the last 10 years, cancer care has been consolidated into the major acute hospital sites with streamlined access to the regional cancer centre as needed and we are seeing better outcomes for patients as a result. A similar approach is being taken with the modernization of urology services, with specialist surgery being provided on fewer sites by specialist teams working across Trust boundaries.

The implementation of the 2002 DHSSPS Strategy "Developing Better Services" has resulted in changes to acute hospital care across Northern Ireland. In the last year there have been changes to the pattern of acute services in Magherafelt, Whiteabbey, Downpatrick and Lisburn.

Remote populations can be concerned about access to life-saving interventions in the event of an emergency. Proximity to an acute hospital is often perceived as the determining factor as to whether the local population's needs will be adequately provided for. Increasingly however it is not the distance to the appropriate facility that may determine the outcome for the patient but the timeliness of the initial clinical intervention and the ability to provide appropriate care for the patient during a transfer to the most appropriate destination. In our commissioning therefore we will seek to ensure appropriate supporting measures for dispersed rural communities are further developed, for example, including first responder schemes, improved ambulance services, etc. We will also seek to ensure the full establishment of the regional neonatal and paediatric transport service which was launched last year.

We will seek to ensure appropriate supporting measures for dispersed rural communities are further developed.

We want to maintain as much local access for local people as possible, where it is possible to do so safely, sustainably and cost-effectively.

Around 80% of hospital care is made up of diagnostics, outpatients, day care and ambulatory services. Therefore it becomes clear that, irrespective the changes that will have to happen for inpatient hospital care, there remains a very important and key role for smaller local hospitals where much of this activity takes place. We want to maintain as much local access for local people as possible, where it is possible to do so safely, sustainably and cost-effectively. The local hospital has a key role in refining the diagnosis for patients and referring them through the system as appropriate, with close linkages to local primary care practitioners. The role of local hospitals is particularly important in relation to the provision of services to more dispersed, rural communities that may be some distance from a large acute hospital. However, the value of such hospitals when located nearby to a large acute facility is less clear and there may be opportunities to secure greater cost-effectiveness by locating more services on the acute site, without significantly impacting on patient access.

Hospital services are dependent upon those delivering primary and community care services to ensure that people are not inappropriately referred to hospital services where there is a safe and effective means of caring for the patient in the community. Primary and community services must also respond to the needs of patients following discharge from

hospital to ensure patients have access to a range of services needed to support them in the community. We will seek to achieve a closer integration of primary, community and secondary care with the aim of delivering comprehensive treatment and care across a variety of care settings, with care providers operating collaboratively as an inter-dependent care network. Local Commissioning Groups through the new Primary Care Partnerships will play a lead role in taking forward this key agenda.

We will also seek to maximize the potential offered by ICT for improved communication with remote sites, between primary and secondary settings and transfer, in real time, of data, information and images. Radiology services in across Northern Ireland are now connected by the PACs system which allows digital radiology images to be sent electronically within and across Health and Social Care organizations. Technology is also in place or being introduced to allow specialist advice to be made available remotely to smaller institutions and even into patients' homes, contributing to enhanced care being delivered locally, enhancing the patient experience and avoiding many hospital visits and possibly hospital admissions.

During 2011/12 we will take forward a comprehensive programme to reform and modernise NI's acute hospitals. This programme will include:

- The full implementation of the outstanding elements of DBS by 2013
- The completion of the review of the existing pattern of A&E services to ensure the provision of safe and reliable emergency service in each Trust area delivered by senior medical staff, 24/7, 365 days a year
- The completion of the review of the current profile of inpatient emergency surgical services to support emerging sub-specialisation and appropriate staffing and expertise
- To review the arrangements for the provision of paediatric inpatient services taking account of the recommendations of the DHSSPS Maternity Review and other relevant considerations
- "Right Sizing" the number of acute medical inpatient beds for our population in line with national standards for lengths of stay, admission rates, daycase rates, etc to release resources for reinvestment in front line services

- Developing clinical partnerships with larger acute providers in the Republic of Ireland and GB as well as continuing with the programme for establishing local Clinical Networks to ensure our services are delivered to the highest possible standards
- Acknowledging that a population of 1.8m may be too small to sustain some highly specialised services, but securing new arrangements which make sure our population gets timely access to these services when they are needed
- Further investment in modern diagnostic services across the hospital network, and providing GPs through PCPs with direct access to appropriate services
- Further investment in ambulance services to ensure patients are receive timely access to life-saving care
- Review the existing arrangements for providing patient transport services
- The further development of the role and function of the local hospital network in providing access to diagnostics, outpatients, day and ambulatory care and establishing care pathways through the rest of the hospital system
- The review of the current profile of minor injuries and other local hospital services on those sites which are close to larger acute hospitals
- The implementation of the recommendations of the DHSSPS Review of Maternity Services
- The development of a portfolio of staffing ratios for the nursing workforce in all major specialities to support the provision of high quality care.

If Northern Ireland is to continue to have access to high quality services we must be able to respond to increasing professional standards and new and developing treatments and interventions while maintaining local services where appropriate. This may mean that some services will inevitably need to change, with some services provided locally and some on a national or regional basis. It also means that it will not always be possible to commission immediately every new service or treatment that is available.

Commissioning is about making difficult choices, ensuring that the population gets access to a high quality service within the resources available.

Commissioning is about making difficult choices, ensuring that the population gets access to a high quality service within the resources available underpinned by robust evidence, for example from NICE, Scottish Medicines Consortium and other sources. Through this plan and in our ongoing arrangements for engagement we will seek to provide an open and honest statement of what services can and cannot be delivered in local communities with clear explanation of the reason for this. Our commissioning decisions will be taken in a sensitive manner that reflects the potential implications for individuals and communities.

5.6 Living at Home

The overarching intention of community care is to help people to live at home with appropriate and timely support. Reshaping our services to promote independence, recovery and rehabilitation means that people may not need care and support long term. Rather there is more intensive support to help people to resume a more active and improved quality of life, at home and within their communities.

Of course we recognise that some people will require ongoing care and support on a long term basis. But currently we spend too much of our resources providing costly long term packages or purchasing beds in residential and nursing homes.

Government policies and strategies published in recent years have promoted this approach and we are beginning to see change. There are many community based services that are promoting these principles but we still have a greater reliance on residential type services than England, Scotland and Wales.

Delivering the Bamford Vision (2009) clearly set out the way in which services for people with mental health problems or a learning disability should be provided.

This is particularly true in relation to services for older people where increasing demand has stretched our ability to deliver community care packages. We intend to invest more money in this area but alongside this investment we have been exploring a Re-ablement Model to change the way we view older people and their needs.

This model has been rolled out in other parts of the UK. It promotes healthy ageing; provides a single contact point for information and access to services; stimulates the voluntary and community

sector to provide support services such as shopping, cleaning and befriending. It drives and promotes rehabilitation in all our services to sustain independence.

District nursing is ideally placed to delivery a flexible, high quality service that works in partnership with communities to place patients and their families at the centre of care delivery. The HSCB and PHA will seek to ensure that the recommendations of the DHSSPS Review of District Nursing Services are implemented in a timely fashion.

Delivering the Bamford Vision (2009) clearly set out the way in which services for people with mental health problems or a learning disability should be provided. We will continue to implement the recommendations of this report, consistent with available funding, with an emphasis on the development of community and primary care based services, thus moving services out of the hospital setting. The continued programme of resettlement of people from long stay hospitals to community living will be progressed ensuring that the alternatives meet the needs and wishes of the individual concerned and, as far as possible, their families.

We will continue to review the way in which we support children and families. Our main strategy is to provide earlier intervention to promote positive outcomes for children, using the six high level outcomes developed by Government.

This means providing more support to families in the early years of children's lives and in the early stages when difficulties and challenges arise.

The development of Family Support Hubs will help us to achieve this aim. These are local, community based centres, underpinned by a new web based database of family support services, which will help to direct people to the most appropriate support service without the need to always come through Social Services.

Where children and families require direct intervention and support from social services we will continue to ensure that this is provided to achieve the best outcome possible for children and young people. Where children cannot be looked after by their parents

Where children and families require direct intervention and support from social services we will continue to ensure that this is provided to achieve the best outcome possible for children and young people.

we will continue to make all efforts to ensure that they have experience of family life.

The changes outlined above require effective collaboration between the HSCB and PHA, the Local Commissioning Groups, Primary Care Partnerships, other statutory agencies, the voluntary sectors, communities and individuals who require our support. We are committed to a partnership approach that will help us to deliver this challenging agenda because we fully recognize that we cannot do this alone.

5.7 Quality and Safety

Everyone in Northern Ireland expects to be provided with high quality health and social services. They expect services to be safe, effective and reliable, that these services are able to respond to the needs of individuals and where possible, that these services are provided locally.

We will also work with patients, clients, carers, professional staff and organisations to define good practice for quality, safety and patient/client experience which will focus on what is important to those that use our services.

The public have told us that they want services to be provided in an environment that is safe and clean, delivered by staff with expert knowledge, compassionate in their work all within a service that treats each individual with respect and dignity.

Commissioning is about securing good outcomes and safe services. While considerable progress has been made in areas such as infection control and environmental hygiene, we will consolidate this progress and work with Trusts to reduce further rates of infection, maintain high standards of hygiene, and improve the experience each individual has while in our care.

We will collaborate with national and international experts to ensure that staff can access the best evidence for improvement, to help guide standards and improve practice and to help inform the public of the quality of care they can expect to receive. Organisations such as the HSC Safety Forum will work with Trusts to further develop staff capacity in leadership skills for quality.

We will also work with patients, clients, carers, professional staff and organisations to define good practice for quality, safety and patient/client experience which will focus on what is important to those that use our

services. This will include agreeing normative staffing levels for nursing and midwifery staff in all care areas.

If the public is to maintain their confidence in our service they need to be assured of the quality of services provided. Commissioners will scrutinize the quality of care and safety of our services, working with providers to share good practice and learn from serious incidents or service reviews. The aim is to further enhance transparency and openness enabling meaningful engagement with local communities during the planning, commissioning and delivery of service models.

During 2011/12 we will take forward a comprehensive quality and safety programme which will include:

- The collection and publication on a [quarterly] basis of standardized mortality rates for all HSC organization
- Ensuring that, by March 2012, Trusts achieve 95% compliance with all elements of the falls bundle across all in patient acute care settings, 95% compliance with all elements of the SKIN care bundle, and either zero pressure ulcers or at least 300 days between pressure ulcers
- Ensuring that satisfactory progress is made towards the full implementation of local approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection and the crash call rate
- By 31 March 2012, publish and implement the approved Public and Personal Consultation Scheme
- By October 2011, establish two new clinical quality improvement collaboratives in priority topics at least one of which should focus on primary care
- Monitoring readmission rates to hospital following appropriate elective and unscheduled admissions.

5.8 Patient/Client Experience

A key aim of this year's Plan will be to work alongside patients, families and carers in order to improve the experience of every individual when engaging with health and social care services in Northern Ireland. Through various surveys and work carried out by the Patient and Client

Council, commissioners are now fully aware of the expectations of those who access services, including those in a support capacity. Evidence shows that improving the patient/client experience and developing partnerships with patients are linked to improved health outcomes.

A real impact can be made upon the experience of those who use services by:

- Showing respect to every individual
- Displaying a positive attitude towards patients
- Maintaining professional and considerate behaviour at all times
- Communicate in a way which is sensitive to the needs of patients
- Protect the privacy and dignity of patients at all times.

These five high level standards will underpin every service provided within health and social care. In order to fulfil these standards, we will endeavour to take the following actions:

- In words and actions, communicate that the patient's safety and well being are the critical considerations guiding all decision making
- To treat patients and families as partners in care at every level, from decision making bodies to individuals delivering care.
- To ensure that sufficient staff are available with the tools and skills to deliver the care patients need, when they need it.
- To recruit staff and providers with the correct values and talent, support them for success, and hold them accountable for results individually and collectively
- Ensure the physical environment supports care and healing
- Ensure patients are able to access care without long and unreasonable waits and delays
- Provide care that is safe, ensure concerns are addressed, and, if standards are not met, that there is open communication and apology
- Patients receive the outcomes they expect.

In addition to other indicators of quality such as waiting times, it is our belief that the patient/client experience should be regarded as equally important. It is the role of the HSCB and PHA to set standards of excellence and make the necessary changes within the culture, habits, training and purpose of each service and of the organisation as a whole. Consistent with this prioritisation, during 2011/12 we will continue to monitor the outcome of the patient client experience standards in the settings agreed by the Agency and HSC Trusts in the formal work plan for 2011/12 and take forward an initiative which will systematically collect over 3,000 patient/client stories to help inform the commissioning of services.

It is the role of the HSCB and PHA to set standards of excellence and make the necessary changes within the culture, habits, training and purpose of each service and of the organisation as a whole.

5.9 Value for Money

In common with all other public services, Health and Social Care is entering a period of unprecedented financial challenge. It is more important than ever, therefore, that we secure value for money through commissioning, ensuring that we achieve maximum benefit from all available resources. There are no neutral decisions: every decision will have consequences and opportunity costs for patients. A failure to take action to maximize the cost-effectiveness in any one service area or location will simply translate into lost opportunities to develop or improve services.

We will seek to respond to the value for money challenge through the following means:

- Ensuring that all of the services we commission are evidence-based, providing real benefits to patients in terms of improved health and wellbeing, consistent with available resources
- Decommissioning treatments of limited clinical value
- Introducing thresholds for accessing certain treatments to ensure they are targeted at those patients likely to benefit most
- Ensuring robust arrangements with appropriate clinical involvement are in place to support the prioritization of new treatments and interventions

- Maximising opportunities through PCPs and other mechanisms to more effectively manage demand and provide services in community rather than residential settings
- From April 2011, ensure that Trusts achieve a level of performance that increases the level of prescribing of generic medicines to 66% by the end of March 2012
- Ensuring services are delivered efficiently and effectively consistent with the top 25% of performance in England
- Taking forward a programme of VFM studies across Health and Social Care to identify opportunities to improve efficiency and effectiveness and reduce waste both in relation to front-line services and supporting infrastructure, for example, procurement and estates. As part of the VFM programme for 2011/12 we will take forward a comprehensive review of management costs across HSC organisations
- HSC organisations will work with Centres of Procurement Excellence in health to agree timescales to ensure that;
    - 95% of project requirements over £20k in relation to supplies and £30k for construction to be publically advertised using eSourcingNI
    - 95% of contracts to include requirements for terms and conditions for sub-contracting.

Many of the services we recognise today will have to change in order to adapt to the changing needs of the population. We believe that through innovative ways of providing services this can be achieved. These changes should not be seen as a decline or reduction in qualitative and quantitative terms, but instead as an opportunity to redesign services that are tailored to the individual needs of service users. Although the financial restrictions imposed upon health and social care is inevitably one of the drivers of change, the creation of services which are reliable, sustainable and of sufficient quality will remain the primary driver. This aim is underlined by the desire to perform at a level comparable to that of best performing peers elsewhere.

To demonstrate this thinking, we will continue the journey of releasing frontline staff to use their expertise, creativity and skill to find innovative ways to improve quality of care for patients. By realigning funding to frontline services, staff and users will have greater input into where resources should be placed. However, commissioners will continue to

have an important role to play by providing the checks and balances which ensure that services are delivered to a standard that reflects the investment made.

It is the role of commissioners to determine priorities and levels of funding for services which may fall anywhere between public health prevention and the provision of treatment responses. Commissioners have this responsibility as they control the budgets for individual services as well as paying providers. We will be driven by the knowledge that these budgets are funded by the taxpayer, therefore reinforcing the need to look for better value for money, more efficiency, greater productivity and less bureaucracy. We will also challenge poor practice, give more emphasis to quality and safety underpinned by robust evidence, for example from NICE, Scottish Medicines Consortium and other sources and at all times push for innovation that is in the interest of patients and service users, placing their interests firmly at the centre of future health and social care plans.

Finally we will seek to ensure that our commissioning processes within the HSCB and PHA are as streamlined and cost-effective as possible. This process is already underway, and reviews of various elements of expenditure associated with commissioning will be taken forward over the next year to ensure value for money in all aspects of our work.

Section Two

Detailed Commissioning Intentions in 2011/12

Commissioning Intentions in 2011/12 – Summaries by Service Group

6.1 Introduction

This section is intended to provide detail on the Board's commissioning intentions in 2011/12 and beyond.

Commissioning discussions have in the past been structured around Programmes of Care. While this categorisation continues to be important in summarising the funding and/or resource reallocation process, the Board has restructured its commissioning groups to reflect key service areas. Commissioning proposals will therefore be presented within the following service areas:

1. Specialist Services
2. Unscheduled Care
3. Elective Care
4. Cancer Care
5. Palliative and End of Life Care
6. Long Term Conditions
7. Maternity and Child Health
8. Community Care, Older People and Physical Disability
9. Children and Families
10. Mental Health and Learning Disability
11. Prison Health
12. Health and Social Wellbeing Improvement

Each service area has a dedicated Service Team which is tasked with working together with stakeholders to identify and deliver on the commissioning priorities within their service area for the year.

Each Service Team has undergone training in relation to Equality and Human Rights and has been provided with detailed evidence on the health inequalities that exist within their service area. Each team has considered the inequalities across each of the Section 75 groupings within their service area and has sought to identify

priority actions to address those inequalities. Teams are also working to collect further data and evidence in those areas where the data is poor.

During the course of the year, teams will work up detailed plans which outline how the priorities will be met. It is anticipated that detailed equality screening and / or impact assessments may be required in relation to a number of the priorities identified and these will be completed in advance on any service changes being taken forward.

6.2 Specialist Services

Specialist Services for acute care include highly specialist tertiary services delivered through a single provider either in Northern Ireland or via a service level agreement with a tertiary centre in GB. They further include services which are in the process of evolving from a single provider model to provision in a number of local settings. High cost specialist drugs also fall within the remit of this branch of commissioning.

Due to our small population size, many of our more specialist services are becoming increasingly difficult to sustain as specialist teams are small, often delivering services with only 1 or 2 lead clinicians. Whilst this level of staffing is sufficient to meet the needs of the numbers of patients presenting, it is not a sustainable model in providing all year round availability of the service on the 24/7 basis that we need.

The nature of specialist care is also changing. Staff are working within an ever increasing clinically complex environment. To ensure that they can offer the best care for patients, senior clinical staff need access to significant clinical infrastructure, sub specialty expertise and larger teams of senior colleagues. The issue cannot be solved through investment in personnel as there are simply not enough patients presenting to maintain and develop their skills, and avoid future training issues.

We need to pursue opportunities to link our clinical teams to larger tertiary centres in GB and ROI. These network models will support our clinicians working in larger teams and offer access to the clinical infrastructure that we need, for care and training, supporting long term sustainability of services locally.

In the last 5 to 10 years the rate of development of new high cost specialist drugs has been phenomenal. In the last 3 years alone, Northern Ireland has invested over £34m of new monies to provide treatments for rheumatoid arthritis, bowel disease, cancer, sight threatening conditions and a range of other diseases. We need to be sure that we are securing the right levels of access to these regimes for the right patients. We also need to be clear that it is fully supporting the anticipated demand for specialist drugs in the current financial climate will be very difficult.

Very hard choices will need to be made in deciding the services which will receive investment, the services that won't and the services from which disinvestment will be made. This will involve difficult policy decisions being made even between the suite of NICE approved therapies to identify differential benefits between therapies.

In order to make progress with these issues we will need the expertise, support, engagement and input of our clinicians to successfully utilise funding to gain the highest levels of benefit in health terms for our population.

Processes to support how we make these decisions will need to be put in place. We must also ensure that we have robust arrangements in place to drive forward and implement guidance issued on services which are not proven to be effective.

Some conditions are so very rare that they will never be able to be able to have local services provided within Northern Ireland. We will continue to facilitate travel to tertiary centres of excellence for these patients. We are committed to working with colleagues in the Patient Client Council in line with the aspirations of the Rare Disease UK strategy 'Improving lives, Optimising Resources'.

Opportunities for early pre-emptive interventions or other forms of treatment as alternatives to acute care are limited due to the specialist nature of these services. However, there is potential within specialist care to direct resource to secure long term, highly effective benefits of treatment, for example supporting every opportunity for renal transplantation as an alternative to long term dialysis.

There are currently over 1,100 patients receiving various multiple sclerosis therapies supported by a level of investment of over £8m.

Services have been established in both the Western and Belfast Trusts to provide treatment for age related macular degeneration for the population of Northern Ireland. Resources have been made available to both Trusts to ensure that timely treatment is provided to preserve the sight of people affected by this condition in accordance with therapies and regimes approved by the National Institute for Clinical Excellence which recommends

Ranibizumab (Lucentis) as an option for the treatment of Wet AMD within specified clinical criteria.

The HSC Board and Public Health Agency recognise the clinical leadership demonstrated within both Trusts to ensure that patients are reviewed and treated within clinically appropriate timescales. This has been achieved through a process of service redesign including remodelling of the patient care pathway and despite the challenges that have been experienced in recruiting and retaining staff. The additional funding being made available in 2011/12 will ensure that both new and review patients can access this service.

Given the complexity of this service and the potential sense threatening implications arising from delays it is important to ensure that sufficient capacity can be established to meet the projected need. The HSC Board and Public Health Agency remain committed to working with the Western and Belfast Trusts towards establishing a robust and sustainable Wet AMD service for the Northern Ireland population.

In 2010/11, the Belfast Trust delivered 53 live donor transplantation procedures. In the last year, the Board and Agency have worked closely with transplant and nephrology staff to review the current service capacity with a view to securing robust arrangements for the future of this service. The key challenges in 2011/12 will be our ability to attract and recruit 2 additional consultant transplant surgeons to the Northern Ireland service.

Key Priorities

The priorities for specialist services are all expected to be progressed over the next 12 to 24 month period and can be summarised as follows:

Clinical Networks to sustain key specialist services

- To develop options to secure sustainability of key specialist services including the development of clinical networks with

providers in ROI and GB. In 2011/12 this will focus on highly specialist paediatric specialties and kidney transplantation**.**

Introduction of NICE guidance

- To agree processes to inform decision making on the introduction of NICE guidance in Northern Ireland. This will involve further scrutiny about the benefits and costs of immediately introducing every new service in an environment where even maintaining baseline capacity will be challenging. A key part of this process must also be about how we drive forward and implement guidance issued on services which are not proven to be effective. Where we can release resources from this approach, these should be secured for reinvestment in service priorities. This will be progressed by the regional specialist commissioning team supported by the HSCB Director of Commissioning and the Public Health Agency Director of Public Health.

Benchmarking Usage of High Cost Drugs

- To benchmark usage of relevant high-cost drugs against other areas of the UK. This will be progressed by the HSCB and PHA.

Individual Funding Requests

- To streamline arrangements for the management of exceptional funding requests and extra contractual referrals. These arrangements will require Trusts to ensure that submissions made have been subject to robust, internal scrutiny and supported at medical director level.

Rare Diseases

- To progress mapping and signposting for complex chronic and rare conditions in keeping with national protocols and strategies will be developed.

Transport Services

- Ensure full establishment of the regional neonatal and paediatric transport service which was launched last year.

Radiotherapy

- To commission additional radiotherapy capacity at the Belfast City Hospital and make preparations for the planned development at Altnagelvin Hospital.

Investment Proposals

Supporting the availability of high cost specialist drugs and therapies has never been purely about covering the costs of regime procurement. We recognise that investment also has to be made in maintaining the specialist infrastructure to ensure that patients are safely assessed for treatment and their subsequent care effectively managed by expert clinical staff.

In 2011/12 as well as supporting growth in specialist regimes for rheumatoid arthritis, inflammatory bowel disease, HIV care, cancer, Wet AMD, new NICE approved therapies, clinical genetics and high cost individual drug requests, we plan to invest in infrastructure to support:

- Biologic regimes for adults and children for inflammatory bowel disease and rheumatoid arthritis;
- Highly specialist regional paediatric services;
- Cancer services;
- Specialist adult congenital cardiology;
- Acute dialysis; and;
- GUM services.

Specific targets to be achieved for specialist services in 2011/12 are:

- From April 2011, the HSCB and PHA should ensure that Trusts achieve a performance level of no patient waiting longer than 9 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis

- From April 2011, the HSCB and PHA should ensure that Trusts achieve a performance level of no patient waiting longer than 13 weeks to commence NICE recommended therapies for multiple sclerosis (MS) or therapies approved under the UK Risk Sharing Scheme for disease modifying treatments for MS
- From April 2011, no patient waits longer than 9 weeks to commence specialist drug treatment for wet AMD for the first eye.
- From April 2011, the Belfast HSC Trust should deliver a minimum of 50 live donor transplants.

6.3 Unscheduled Care

The A&E department is the main gateway for emergency patients to unscheduled care, such as emergency medicine, emergency surgery, critical care and diagnostics. It is one of the principal contacts with hospital services for the public. Given the gateway role, A&E has a major impact on the rest of acute hospital services. Typically, patients of all types, e.g. people with minor injuries through to heart attack sufferers and cases of major trauma, arrive to the same service. Having one portal of entry means that staff have to stop working on the less seriously ill and injured to attend to emergency cases and this, in turn, contributes to longer waiting times.

Performance at a number of hospital sites has been significantly below the 4-hour minimum standard set by the Department. These standards are routinely achieved in England.

In the last five years, the total number of attendances per annum at emergency care departments has increased by 4% to almost 700,000 - on average; nearly 2,000 patients attend A&E each day in Northern Ireland. Of the patients who attend A&E, approximately one in four are admitted to a hospital bed. Rates of attendance and admission are both considerably higher than in England.

Northern Ireland has approximately a quarter more acute beds (per 100 population) than England. However, these beds are less intensively used and patients tend to stay in hospital for longer periods than the equivalent patient in England.

It is evident that the Health and Social Care system is experiencing challenging workforce issues which have and will continue to undermine commission intentions. Difficulties recruiting and retaining experienced medical staff have restricted a number of acute specialties, including emergency care and paediatrics. Emerging standards will place further challenges to have in place significant numbers of middle grade doctors to ensure quality and safety. Changes in training of junior doctors have also greatly impacted on services due to the European Working Time Directive.

Unscheduled care and admission to hospital for children varies across Northern Ireland. In some cases, children are admitted via a Children's A&E department but, in the majority of cases, they will be admitted via the general hospital Emergency Department. Some departments do not have a designated area for children. In a traditional model, children requiring a longer period of assessment are often admitted to wards, which results in a longer length of stay.

Unless the way services are provided is changed then the situation for patients and staff could deteriorate further with risks to quality, governance and performance.

Proposed Model

The Board recognises opportunities to redesign the Unscheduled Care pathway with a greater emphasis on offering alternatives to attending an Emergency Department through changing patient behaviour towards choosing which service to access. In some instances, self-care supported by community pharmacy will be most appropriate. Early access to a GP will often be important with use of out-of-hours GP services only where necessary. Use of emergency ambulance services should only be in an emergency and NIAS should increasingly treat non-emergency calls at the scene without the necessity to transport patients to hospital.

In the acute setting, the commissioning intention is to separate care for key patient groups so that instead of one portal of entry (i.e. A&E), patients are directed to reorganised services based around specific needs:

- Minor injuries and surgical
- Major injuries and patients requiring resuscitation
- Medical assessment and ambulatory care
- Dedicated children's assessment and treatment.

Medical Assessment Unit

We envisage moving to a position where all major 24/7 A&E departments are supported by a Medical Assessment Unit (MAU) and speciality beds An MAU is a short stay facility providing safe and efficient acute medical care. It should operate around the

clock and be staffed by a multidisciplinary clinical team. The HSC Board will be specifying ambulatory care activity as part of its new contract with HSC Trusts and the operation of an MAU facility will be essential for reforming that part of emergency care.

A key part of the model of care is that GP-referred medical and surgical patients would be directed to the MAU where clinically appropriate. Direct admissions would ensure that patients reach the appropriate setting quickly; waiting times for patients would also improve. (80% of all breaches in A&E are acute medical patients).

Paediatric Assessment Unit

We envisage moving to a position where all major 24/7 A&E departments are supported by a Paediatric Assessment Unit (PAU). This is a facility within which children with acute illnesses, injuries and other urgent referrals can be assessed, investigated, observed and treated without requirement for admission to inpatient facilities. The length of stay in a PAU can be tailored to the condition for which a child is being observed (4, 8 or 12 hours) leading to the more effective use of both medical staff and in-patient paediatric beds.

Conditions which are especially suitable for management within a PAU include breathing difficulties, fever, diarrhoea and vomiting, abdominal pain, seizures and rash, as well as head injury and non-intentional poisonings. These are some of the most common reasons for attendance in the Emergency Department.

Like MAU, GP-referred patients will go directly to the PAU, avoiding paediatric admission to A&E and the likelihood of in-patient admission and long lengths of stay in hospital which are unnecessarily costly. PAU will provide a more efficient clinical service for patients and will facilitate earlier discharge for patients. In general, it will result in more effective use of both the medical workforce and in-patient beds and lead to a significant reduction in costs due to reduced number of admissions.

It is anticipated that the PAU would be co-located with a paediatric ward and be run collaboratively by the Paediatric Department and Emergency Department or by the Emergency Department in a specialist paediatric hospital.

As well as the MAU and PAU, the proposed model for unscheduled care will include:

- Co-location GP Out of Hours (Urgent Primary Care) within A&E as many A&E attendances could be managed by Primary Care;
- Dedicated care pathways for children, older people and patients with long-term conditions, particularly heart and respiratory conditions; and
- Appraisal of ambulance services necessary to support reconfigured acute services.

Delivering the model for unscheduled care will be central to the commissioner's commitment to re-shape acute hospital services across Northern Ireland to create a service which is better able to respond safely and effectively to the needs and priorities of the population, taking account of the importance of addressing health inequalities. Moreover redesign will be in the context of a 'shift-left' approach which seeks to reduce the need for hospital care through investing in primary care and in health promotion and prevention. This will necessitate patient education on appropriate use of services, particularly A&E, GP urgent care and in-hours GP services. Improved access to diagnostics in primary, secondary and community care will also be the key.

In tandem with more appropriate use of hospital services, the commissioner will ensure a greater focus on rehabilitation following a period of hospitalisation and is committed to developing the Re-ablement approach evident in Britain.

Key Priorities

- To redesign the Unscheduled Care pathway with a view to offering greater alternatives to attendance at an Emergency Department and changing patient behaviour in relation to the most appropriate services to access, including self-care supported by Primary Care, GP services, and minor injuries units.

- To bring forward and implement appropriate changes to the provision of unscheduled care services, in particular A&E and emergency surgery, to improve safety, quality, sustainability and cost effectiveness
- To ensure that senior clinicians in A&E appropriately re-direct patients who do not require emergency care to other services, such as GP urgent care services and in-hours GP appointment
- To extend GP involvement in A&E departments
- To place an emphasis on ambulatory care, i.e. completing unscheduled care within 23 hours, including diagnostics and treatment, thereby avoiding unnecessary in-patient admission. This will be particularly important at larger acute hospitals with closely linked medical assessment units
- To reduce in-patient lengths of stay for unscheduled care, through an ambulatory care model and the involvement of senior clinicians in care planning and treatment
- To bring forward and implement new care pathways for key acute conditions, including stroke and heart attacks, based on best practice and evidence
- To put in place a paediatric assessment unit (PAU), co-located with a Paediatric ward and supported by the Emergency Department
- To further strengthen emergency ambulance provision, including extending treatment without the need to transfer to hospital where clinically appropriate

Specific targets to be achieved for acute and unscheduled care in 2011/12 are:

- From April 2011, 95% of patients attending any Types 1, 2 or 3 A&E departments are either treated and discharged home, or admitted, within four hours of their arrival in the department
- From April 2011, no patient attending any A&E department should wait longer than 12 hours either to be treated and discharged home, or admitted

- From April 2011, the HSC Board and NIAS should ensure an average of 72.5% of Category A (life-threatening) calls are responded to within eight minutes (and not less than 65 % in any LCG area)

6.4 Elective Care (including Diagnostics)

Each year nearly 600,000 people are referred to hospital for specialist assessment by their GPs or dentists. Every year around 450,000 people receive planned inpatient or day case operations. A substantial percentage of these operations (around 30% – 40% on average) are clinically urgent and should be carried out promptly and in the order of their clinical priority. The remainder are routine and generally speaking can be dealt with in date order.

The overarching priorities for the elective care system in Northern Ireland is to ensure that all urgent operations are completed in a timely manner and that patients waiting for routine assessment or treatment should wait no longer than the maximum times set by the Department.

The way we do this is by ensuring that;

- We have sufficient elective capacity to meet need;
- We work with General Practitioners and other referrers to agree appropriate referral pathways, including appropriate alternatives to acute assessment and treatment.
- We work with consultants, GPs and other clinicians to develop assessment and treatment protocols linked to effective use of resources policies.

Service redesign, coupled with further investment in services where needed, is therefore a key component of the reform and modernisation agenda.

Key Priorities

- Establish a Regional Trauma and Orthopaedics Advisory and Implementation Group to examine the systems and arrangements for Orthopaedic service delivery across the region, including the development of agreed regional pathways
- Ensure the agreed implementation of the Urology Review Recommendations

- Establish a process to review the existing Effective Use of Resources Policy and develop an agreed process for effective implementation
- Develop a Commissioning Framework for Procedures of Low Clinical Value (PLCV)
- Complete an analysis of the main reasons for referral and commence work to prioritise the development of regional pathways for these referrals
- Agree with Trusts, GPs and other stakeholders, criteria and guidance for the effective management of elective demand
- Complete an analysis of diagnostic services and develop a regional plan to improve diagnostic services. This will include plans to improve patient pathways and waiting times for endoscopy and radiological investigations
- Work with Trusts to improve the quality of data, in particular the focus will be on clinical coding and Theatre Management Systems
- Use the learning and good practice from the PCP projects to be incorporated into the regional pathways
- During 2011/12 the HSCB and PHA should ensure that Trusts achieve a level of performance that the number of excess bed days for the acute programme of care is reduced by 5%
- Take appropriate action to deliver, in cooperation with Trusts and other stakeholders, the following key targets and standards:

    - From April 2011, at least 50% of patients wait no longer than 9 weeks for a first outpatient appointment
    - From April 2011, all patients are seen for a first outpatient appointment within 21 weeks
    - From April 2011, at least 50% of inpatients and daycases are treated within 13 weeks
    - From April 2011, no patient waits longer than 36 weeks for treatment (inpatient / day cases)
    - All outpatient reviews are completed within the clinically indicated time
    - No patient should wait longer than 9 weeks for a diagnostic test

- All urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks
- No patient should wait longer than 9 weeks from referral to commencement of AHP treatment
- From April 2011, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures
- An overall day surgery rate of not less than 75% for the 'basket' of 24 procedures
- An overall admission rate on the day or surgery of not less than 75%.

- Continue to develop local Primary Care Projects linked to the improved management of patients in:

➢ Belfast LCG -	ENT Clinical Pathway Redesign
➢ Belfast LCG -	Elective pathway and referral management
➢ Western LCG -	Ultrasound access Altnagelvin
➢ Western LCG -	GP access to MRI
➢ Southern LCG -	Access to OGD
➢ South Eastern LCG -	Dermatology Clinical Pathway Redesign
➢ South Eastern LCG **-**	Medicines Management Review in Nursing Homes

6.5 Cancer Care

Cancer affects all of us. Over 10,000 people in Northern Ireland are diagnosed with cancer every year and nearly 4,000 people die from the disease.

While cancer survival rates have increased significantly over the past 10-15 years, we know that the NI survival rates for colorectal, lung and ovarian lag behind the best performing countries. We also know that even within Northern Ireland there is variation across the region with areas of highest deprivation experiencing cancer rates 2 - 3 to higher for some cancers, than more affluent areas; later diagnosis and poorer survival rates are also seen.

Early detection and treatment are key to supporting improvements in outcomes. We need to ensure that our clinical teams, both in the community and in secondary care are able to identify and distinguish symptoms as cancer related at as early a stage as possible. We also need to ensure the public are informed, in a balanced way, with key actionable messages, so that they know when to seek medical advice early.

Much has been done to standardise cancer care across NI, in line with evidence based guidelines. The DHSSPS Cancer Service Framework will also support this approach, as will care pathways which describe the clinical management of patients throughout investigation, treatment and follow-up.

As well as taking these actions forward, we also need to ensure that we systematically monitor and measure our performance on outcomes, quality of care provided and patient experience.

Patients with potential complications from chemotherapy will have access to a 24 hour telephone triage system which will assess their clinical status, provide advice or direct them to the most appropriate place for further assessment and treatment, (for example: direct admission to hospital, GP, Emergency Department, fast track oncology appointment). Those patients directed via the Helpline to A&E will be assessed by a nurse within 15 minutes, and where appropriate treated on a neutropenic sepsis pathway (i.e. one hour antibiotic treatment). Whilst those patients with potential complications from chemotherapy are in the Emergency Department, the Trusts will take action to limit the risk

of secondary infection in this group of patients from exposure to others.

To secure further improvements for everyone and to close the health inequality gap between NI and other countries, and between socioeconomic groups, we need to reduce smoking rates, tackle obesity, sun exposure and ensure high uptake of screening programmes in all areas, to enable early diagnosis of cancer and provide high quality care to all.

Key Priorities

- Promote stop smoking services in the areas with the highest smoking rates
- Develop appropriate messages and communication plans to increase public awareness of the signs and symptoms of suspected cancer
- Ensure active engagement and partnership working with patients and carers across cancer commissioning priorities
- Refine and implement care pathways for patients with colorectal, lung and ovarian cancer to ensure effective clinical management, care and support
- Review and prioritise implementation of key components of the Cancer Services Framework and submit an implementation plan to DHSSPS by December 2011
- Ensure Trusts complete a review of the care of patients who present to hospital with complications of cancer or its treatment by March 2012
- Explore opportunities for the strengthening of acute oncology services across NI
- Progress the implementation of the national Oncology/ Haematology 24 Hour triage toolkit for patients with complications
- Work with Trusts to identify practical solutions for the prioritisation of acute oncology patients who present at A&E
- Complete GAIN audit of Neutropenic Sepsis Pathway being implemented across region

- Ensure tailored information is offered to colorectal, lung and ovarian cancer patients and their carers in line with regionally agreed pathways
- Work in partnership with Macmillan (and other key stakeholders including voluntary sector) to transform follow-up pathways for cancer patients in line with Trust bids
- Develop mechanisms to measure clinical quality and patient experience to provide feedback to the colorectal, lung and ovarian multidisciplinary teams
- Identify an IT system for Oncology and Haematology to replace the current system
- Explore the opportunities for utilising C-PORT for chemotherapy capacity planning across the region
- Agree standardised regional chemotherapy protocols
- Work to develop pathways for Teenage and Young Adult (TYA) Cancer Services and raise awareness of the needs of this group of patients with professionals
- Work with the NI Cancer Registry to monitor cancer incidence and survival rates and health inequality gaps in cancer in NI
- Work with the Voluntary Sector and key stakeholders to explore opportunities for a cancer event
- Ensure all urgent breast cancer referrals should be seen within 14 days
- Ensure 98% of cancer patients commence treatment within 31 days of the decision to treat
- Ensure 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

6.6 Palliative and End of Life Care

The vision for palliative and end of life care is to improve quality of life and meet the patient/carer needs in the last year of life; meet the bereavement needs of families; and support patients' preference to die in their preferred place of death, usually their home.

Palliative Care is defined as: "the active, holistic care of patients with advanced progressive illness. Management of pain and other symptoms and provision of psychological, social and spiritual support is paramount. The goal of palliative care is to achieve the best quality of life for patients and their families. Many aspects of palliative care are also applicable earlier in the course of the illness in conjunction with other treatments". More latterly the importance of "early identification and impeccable assessment" has been added to this definition as it is thought that problems at the end of life can have their origins at an earlier time in the progression of the illness and should therefore be recognised and dealt with sooner.

Palliative Care and acute care can co-exist in the provision of care for many people as the last few months, weeks or days may not be possible to identify.

The Palliative Care approach has traditionally been used for people mainly with a cancer diagnosis. Services to these patients have not been equally developed across the country to provide a palliative care response for all cancer conditions. It is estimated that two thirds of all deaths in N. Ireland (9,570) would benefit from the palliative care approach in the last year of life, but do not receive it. This approach is appropriate also for those with chronic conditions such as respiratory disease, heart failure, neurological, renal and other degenerative conditions like dementia, and those elderly people approaching end of life, as reflected in the relevant Service Framework documents published to date. We would wish to enhance workforce skills and redesign pathways to ensure identification of palliative care needs across all conditions; and the development of care plans to meet these needs.

We would also seek to support people to die in their preferred place of care, usually their own home (including nursing and residential homes). Approximately 50% of all deaths and 50% of

all cancer deaths occur in hospital. We intend to develop pathways and services which support people to die at home when that is appropriate and their preferred place of death.

Work needs to be progressed in adapting the skills of our workforce; and core communication and network systems developed between primary, community, voluntary and secondary care to support service redesign.

Key Priorities

- Progress the development of information systems to measure progress on the implementation of the Palliative Care Strategy and to improve co-ordination between services
- Agree definitions for the implementation of palliative care provision
- Agree functions and support implementation of the key worker function
- Agree and support implementation of key prognostic indicators within respiratory, heart failure, cancer and renal secondary care specialties
- Agree/develop holistic assessment tools and advance care plans and support implementation
- Develop and support implementation of handover forms for OoH services
- Develop and support implementation of patient held passports
- Agree to use shared care notes in the home at the dying phase
- Develop disease specific care pathways, for heart failure, renal failure, Cystic Fibrosis and cancer.
- Support and progress the implementation of the Care of the Dying Pathway within acute hospitals and community services
- Develop palliative care guidelines for nursing homes
- Develop palliative care guidelines for GP services including Out of Hours

- Ensure advice and support contact points are in place in each LCG area for patients and carers out of hours through improved training, co-ordination and utilisation of existing services
- Work will be undertaken to co-ordinate services for Huntington's disease based on the Huntington's Disease Needs Assessment
- LCGs will measure baselines and develop plans in each area for the enhanced provision of a 24hr palliative care support service e.g. by reallocating resources from acute care particularly for patients with cancer who are currently admitted within 48 hours of death and for patients with cancer who wish to be discharged to die at home
- Local commissioners will develop plans to sustain palliative care co-ordinators beyond 2011/12 in each LCG area.

6.7 Long-Term Conditions

Long-term conditions (LTCs) refer to any condition that cannot, at present, be cured but can be controlled by medication and/or therapy. Our overall aim is to reduce the impact of long term conditions on individuals, families and the population, although there are a number of significant public health challenges in delivering this objective. These include:

- An increase in the percentage of children and adults who are overweight or obese
- An increase in the number of people with long term conditions, such as diabetes
- A higher frequency of risk factors for heart, stroke, vascular and respiratory diseases in more disadvantaged communities
- Higher death rates from conditions such as coronary heart disease, stroke, vascular and respiratory diseases in more disadvantaged communities.

For 2011/12 our focus will be on long-term conditions related to heart disease, vascular disease, respiratory disease, stroke, and diabetes in adults and children. This focus supports the implementation of the Cardiovascular Health & Wellbeing Framework and the Respiratory Health & Wellbeing Framework. Care including clinical care (where appropriate), should be provided close to home; with patients and their families being active participants in their care. They need to be supported by responsive secondary care services to deal with exacerbations or complications that cannot be managed at home.

Implementation of the Cardiovascular & the Respiratory Health & Wellbeing Service Frameworks, and developments such as:

- agreed, evidence-based care pathways that cover the entire patient journey;
- a cardiovascular managed clinical network;
- community disease management programmes;
- a familial hyperlipidaemia service; and
- telemonitoring

this will support public & patient involvement, primary & secondary disease prevention, the development of expert patients, patient self management, reduction in health inequities and inequalities; and the “shift left” (the move towards greater disease prevention and less hospital based care).

Key Priorities

- **Implementation of the Cardiovascular Health & Well-being Service Framework**

  The HSCB and PHA will want to see clear action plans from the Trusts regarding implementation of the Cardiovascular Framework.

- **Implementation of the Respiratory Health & Well-being Service Framework**

  The HSCB and PHA will want to see clear action plans from the Trusts regarding implementation of the Respiratory Framework.

- **Enhance primary care management of cardiovascular risk factors**

  The HSCB/ PHA will develop and test a programme of enhanced primary care management of cardiovascular risk factors, in collaboration with local communities. This will start in areas of deprivation and with practices with below average performance on QOF. The aim will be to address health inequalities. The first programmes will be in place by March 2012.

- **Enhance patient self-management**

  The HSCB/ PHA will review the impact of investments in patient education programmes to promote self management, remote monitoring and case/ disease management in people with diabetes, COPD, heart failure and stroke. This will be undertaken during 2011. The HSCB/ PHA will review the content and format of existing patient self-management programmes, learning from effective chronic disease management models elsewhere.

- **Develop care pathways**

  The HSCB / PHA will work with relevant stakeholders to facilitate the development of care pathways for COPD, stroke, heart failure, atrial fibrillation and diabetes (children & pre-pregnancy care). These care pathways will help to reduce variations in care; provide a framework for providing high quality care based on good evidence of effectiveness and facilitate improved communication between HSC staff and patients/ service users. These care pathways will be developed by March 2012.

- **Develop disease management programmes**

  During 2011/12, the HSCB/ PHA will work with Trusts and primary care to develop community disease management programmes, (in COPD, heart failure and atrial fibrillation), which aim to reduce acute unscheduled hospital activity. These programmes will have an emphasis on prevention, patient self-management, expert patient programmes and community development approaches to maximise health and well being.

- **Measure and improve clinical quality**

  The HSCB/ PHA will work with Trusts to develop/ revise existing systems to measure clinical quality routinely and use that information and patient experience information on a week to week basis to improve their service. This will be linked to the work on the Service Frameworks, including the recommendations of the Cardiovascular Framework Health Impact Assessment, and associated timescales. This approach will be introduced with three clinical teams in 2011/12.

- **Measure patient experience**

  The HSCB/ PHA will work with existing patient fora in Trusts, community/voluntary groups, clinical networks etc, and use standard tools to facilitate data collection and analysis. We will review the results with service providers and use the results to help in improving the quality of care. This work will be linked to the standards for communication and personal & public involvement in the service frameworks and associated timescales, with data collection starting during 2011.

- **Primary prevention – reduce obesity & smoking**

This will be taken forward through the Tobacco and Obesity action plans led by the PHA. However during 2011/12, the HSCB/ PHA will work with Trusts to enhance stop smoking support to outpatients and inpatients with cardiovascular and respiratory disease. The HSCB & PHA will want to see appropriate stop smoking support available to patients attending respiratory, cardiology and vascular outpatient clinics.

The Board and Agency will also want to ensure that relevant staff working in cardiology, respiratory, vascular and general medicine wards are trained and able to provide brief interventions to support smokers to quit.

- **Familial hypercholesterolaemia (FH)**

  The HSCB/ PHA will want Trusts to work collaboratively, and with primary care, to develop a model for the development of a familial hypercholesterolaemia service for Northern Ireland by March 2012. This should aim to ensure that all people with genetically linked high cholesterol (familial hypercholesterolaemia) can be identified and treated, and their names entered on a regional register so that other family members can be identified and measures introduced to prevent the development of cardiovascular disease.

- **Adult congenital heart disease (ConHD)**

  The HSCB/ PHA will work with adult and paediatric cardiologists, through the Cardiac Network, to ensure that adults with major congenital heart disease receive specialist care, including access to a consultant specialist and appropriate diagnostic services; as recommended by the Cardiovascular Service Framework. The new arrangements will be in place by March 2012.

- **Invasive Cardiology**

  The HSCB/ PHA will work with the Cardiac Network and service managers in all Trusts to review the allocation of resources for regional and local cardiac catheterisation services, with the aim of providing equitable and timely access to cost-effective interventional cardiology services. We will look carefully at the results of the primary angioplasty pilot in the Belfast HSC Trust, and other evidence, and work with the Cardiac Network to identify an equitable service

model for Northern Ireland. Review carried out, service model identified and action plan agreed by March 2012.

- **Insulin pumps**

  The HSCB/ PHA will identify the resources to enable investment in additional insulin pumps for children and adults beginning in 2011/12; and phased over the next three to five years.

- **Stroke Awareness, Treatment & Care**

  The PHA will launch a multimedia campaign "Act Fast" in 2011/12 to raise public awareness of the early signs and symptoms of stroke. The HSCB/ PHA and LCGs will work with trusts to ensure that patients with stroke and transient ischaemic attack (TIA) have access to treatment and care that meets national quality standards consistent with the recommendations of the review of stroke services in Northern Ireland. This work will be ongoing over the next 3 years.

- **Vascular Services**

  The HSCB/ PHA will work with relevant stakeholders to develop a Northern Ireland vascular network (as part of the Cardiovascular MCN) and agreed patient pathways and protocols for patients with vascular disease; beginning with a care pathway for people with abdominal aortic aneurysm (AAA). The network and the AAA care pathway will be developed by during 2011.

- **Development of Community Respiratory Services**

  The HSCB/ PHA will work with relevant stakeholders to develop community respiratory services in those areas where they currently are not available. This will include pulmonary rehabilitation, long term oxygen treatment assessment, early intervention and facilitated early hospital discharge services and palliative care.

  The HSCB / PHA will identify the resources required to develop screening and diagnostic services for TB, to reduce health inequalities, in accordance with identified need. A Service development plan will be in place by March 2012.

  The HSCB/PHA will identify the resources required to develop paediatric asthma and allergy services in accordance with identified need and the standards set in the

Respiratory Service Framework. A Service development plan will be in place by March 2012.

- **Diabetes Pilot Projects**

  The HSCB/ PHA will review the pilot projects on pre pregnancy care and structured patient education (SPE) programmes for children and adolescents being run by the five trusts. These run until 2013 and at that stage a decision about future funding will have to be made.

- **Telemonitoring**

  By March 2012, the HSCB/PHA will, together with Trusts, ensure that at least 1,800 people benefit from the provision of remote telemonitoring services.

- **Unplanned Admissions**

  By 31st March 2012 ensure that Trusts reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions compared to previous year

6.8 Maternity, Paediatrics and Child Health

There are currently nine consultant obstetric units in Northern Ireland. Three of these units have co-located midwife units, and there are a further two freestanding midwife units. In total these units deliver around 25,000 babies per annum. A DHSSPS review of maternity services is expected to report in 2011 which will provide key context and direction for the provision of maternity services in the future.

There are currently eight paediatric medical inpatient units in Northern Ireland. The only consultant obstetric unit that does not have a co-located paediatric inpatient unit is at the Mater Hospital in Belfast.

Our ability to provide the recommended level of staffing cover for intrapartum care and to sustain inpatient paediatric services across all existing sites presents challenges, particularly for smaller units. Future models of care which continue to support local access but with clear pathways to specialist support as necessary will need to be developed if we are to continue to meet quality and safety standards in these areas.

During 2011/12 and beyond, we shall seek to promote the normalisation of births, including securing a reduction in rates of caesarean section which vary considerably between units and are generally higher than in the rest of the UK. We shall also examine the continued appropriateness of existing arrangements for the transfer of obstetric emergencies from community settings.

We will also focus on the variance in pregnancy outcomes across socio economic groupings. Particular attention will be given to reducing the number of women who smoke during pregnancy, reducing levels of obesity in pregnant women, and increasing levels of breastfeeding. We will also seek to ensure that key recommendations from recent reports[2] published by the Centre for Maternal and Child Enquiries (CMACE)[3] are implemented.

[2] Saving Mothers' Lives (2011), Perinatal Mortality (2010 & 2011), Maternal Obesity in the UK (2010).
[3] Now Maternal, newborn and child health clinical outcome review programme.

Priority will also be given to services for pre-school and school aged children, and the recommendations of the regional review of health visiting and school nursing will be important in this regard.

The Family Nurse Partnership programme provides intensive support to vulnerable first time parents and has been shown to make a significant difference to children's' health and well being. During 2010-11 a pilot commenced in the Western Trust, and in 2011-12 the programme will be offered to up to 100 teenage mothers.

Finally, we shall ensure that Trusts have in place appropriate arrangements to enable users to have an input to improving maternity services.

Key priorities

- To establish appropriate arrangements to take forward the implementation of the recommendations of the regional review of maternity services
- To require each Trust to develop an action plan to promote the normalisation of birth
- To review arrangements for the management and transfer of obstetric emergencies occurring in the community
- Through action plans led by the PHA introduce appropriate measures to reduce maternal obesity, improve pre-conception and pregnancy care for obese women, reduce smoking in pregnancy and improve breastfeeding
- To ensure that key recommendations from recent CMACE reports are implemented
- By 31st December 2011, make arrangements for implementation of the Family Nurse Partnership a pilot programme for 100 pregnant mothers who will be recruited up to the 28th week of pregnancy at the first test site
- To develop a clear commissioning framework for health visiting services in support of the work being taken forward by the PHA to implement the recommendations of 'Healthy Futures' (the review of health visiting and school nursing)

- To evaluate the freestanding midwifery units in Downpatrick (2011) and Lisburn (2012)

6.9 Community Care, Older People and Physical Disability

Older People

Our population is ageing and this demographic change will have significant implications for health and social care as older people are major users of services;

- The number of people over 65 has increased by 16% since 1999 and will show a similar increase from the current figure of 255,000 by 2015
- This will include a rise of 29% in the number aged over 85
- The number of people over 65 with dementia will increase by 30% from the current figure of 15,400 people to almost 20,000 by 2017.

If we are to meet the challenge of demographic change and build on progress to date the way in which services are perceived and delivered needs to be reviewed in order to achieve a balance between meeting the needs of the most vulnerable and promoting independence and self determination. This will impact on how the 19% (£616m) of the budget allocated for older people's services is spent and the balance within it for major areas of expenditure such as residential and nursing home provision (£190m), hospital care (£115m) and domiciliary care (£138m).

Delivering these priorities will require radical change. It will need us to shift the emphasis of from traditional service models to a partnership approach; optimising inter-agency working, enhancing the capacity and role of voluntary and community organisations to support self management and improving safeguarding arrangements. The current model of delivery, with its emphasis on the provision of community care to and for people rather than supporting their own independence and abilities does not meet this demand nor is it financially supportable in the long term.

Each year additional funding has been required to provide community care packages for a growing aged population. The budget for the next four years will not provide the same level of increase so we will have to change the way in which we assess

people for care packages and more actively promote healthy ageing and self management. In Northern Ireland we have a relatively high proportion of people living in care homes. This is at odds with the demand for greater independence and needs to be reduced substantially. Other significant initiatives will be the implementation of the Northern Ireland Single Assessment Tool (NISAT) as a way of delivering needs led services alongside the further development of regional safeguarding arrangements to protect those at risk of abuse or exploitation.

Key Priorities

The Board and PHA would wish to progress the following priorities in relation to **Older People** in 2011/12.

- Incorporate Service Framework standards into Board commissioning and performance monitoring.
- Address the recommendations of the regional Dementia Strategy, in particular the needs of carers
- Introduce a Re-ablement model to promote rehabilitation, self care and independence.
- Increase access to targeted health and wellbeing improvement services, falls prevention services and action to reduce social isolation
- Extend the proportion of people cared for at home and reduce reliance on nursing home care by reviewing current assessment and discharge processes from hospital to home, patterns of demand and costs.
- From April 2011, older people with continuing care needs should have their needs assessment and the main components of their care needs met within 20 weeks of referral
- From April 2011, ensure that Trusts achieve the level of performance that no care management assessment should take longer than 8 weeks to complete; and the main component of the assessed care need – nursing home care, residential care or domiciliary care – will be delivered within 12 weeks of the assessment being completed

- To take forward the recommendations of the DHSSPS Review of District Nursing Services.

Physical Disability

It is estimated that between 17 – 21% of our population have a disability, affecting 37% of households. Recent research indicates that approximately 8,800 people have a visual impairment, 11,700 are hearing impaired and over 35,000 have a mobility problem. Whilst quite a small proportion of this population is in regular contact with HSC services, approximately 16,500 contacts are made with Trust disability services each year. 400 people are in nursing or residential care but the heaviest reliance is on community based day and domiciliary care, specialist equipment and therapeutic interventions. A high proportion (approx 32%) of the 1860 (at Jan 11) people receiving Direct Payments have a physical or sensory disability

A relatively small proportion of the Board's budget, 2.8% (£91m) is allocated to this programme. Domiciliary care accounts for 22% (£19m) of this figure, hospital care almost 15% (£13m) and residential/nursing care accounting for a similar expenditure (£14m). A significant proportion of this budget is spent on community staffing and support. Future funding pressures will be created by changing public expectations, technological advances, an increase in high cost care packages and transfer of budgetary responsibility to service users.

Until recently the reform agenda within disability services has been focused on specific services resulting in initiatives aimed at reforming Wheelchair services, prosthetics, brain injury services, sensory impairment provision and Thalidomide survivors. A more strategic approach will be adopted as a result of the new Regional Disability Strategy. The Board will work closely with service users and providers to consider how this will help to reshape services. It will be followed by the Report of the Joint Housing Adaptations Steering Group which is designed to improve joint working between HSC and Housing.

In relation to **People with a Physical Disability or Sensory Impairment** our priorities for 2011/12 are:

- Address the recommendations of the Physical Disability Strategy, in particular the needs of carers
- Work with DSD/NIHE to take forward the findings of the Joint Housing Adaptations Review.
- From April 2011, 95% of lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate
- From April 2011, a 13-week maximum waiting time for 95% of all wheelchairs including basic wheelchairs
- From April 2011, ensure that Trusts maintain a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment for acquired brain injury in 95% of cases.
- From April 2011, 95% of patients referred to the audiology department for hearing aids fitted within three months of the date of referral.
- Promote robust service re-design of regional brain injury provision.
- Introduce a Re-ablement model to promote rehabilitation self care and independence.

In relation to **both Programmes** we will also seek to take forward the following areas:

- Support Primary Care Partnerships and LCGs in local service redesign, including reducing inequalities of access and outcome
- Update Adult Protection procedures and review the effectiveness of current safeguarding arrangements.
- By 31 March 2012, ensure that Trusts increase the number of direct payment cases to 2,100 and other models of self directed support.
- Increase the availability of respite provision in support of service redesign and modernisation.
- Promote individualised care planning and improve the quality and coordination of assessment through implementation of the Northern Ireland Single Assessment Tool

- From April 2011 ensure that Trusts achieve a performance level of 90% of complex discharges from an acute hospital setting take place within 48 hours of decision to discharge; All non-complex discharges from an acute hospital setting take place within six hours of being declared medically fit (Standard 100%); and no discharge from an acute hospital setting takes longer than seven days (100% standard).
- From April 2011, that both care management assessments are completed and the main component of the assessed care need - nursing home care, residential care or domiciliary care - will be delivered within 20 weeks of the assessment being initiated
- The specific needs of those with impaired vision will be addressed in response to the draft Eye Care Strategy

6.10 Children and Families

This section relates primarily to services which are required through legislation and also considers circumstances where additional supports are required to assist families to care for their children.

The Service areas include:

- Family Support/ Early Years
- Child Protection
- Looked After Children including residential child care and foster care
- Adoption
- Leaving Care and After Care
- Children with a disability
- Child & Adolescent Mental Health Services (CAMHS)

The Board now leads a single integrated planning and commissioning process for services for children and young people across Northern Ireland, through a Chief Executive led partnership, the Children and Young People's Strategic Partnership (CYPSP). The CYPSP will provide an integrated plan, the Northern Ireland Children and Young People's Plan, setting out how Partnership member agencies will integrate their planning and commissioning in order to improve the lives of children and young people across Northern Ireland. The process is outcomes focused, with the joint outcomes being those set out in the NI Executive's Ten Year Strategy for Children and Young People, 'Our Children and Young People: Our Pledge'.

The CYCP will be framed within the context of the full range of statutory functions in respect of the HSCB and Trusts for Children's Services. In relation to the role of the HSCB as the 'authority' recognised within the Children Order, the associated Schemes for the Delegation of Statutory Functions to Trusts and the professional lines of accountability from the Trust to the HSCB to DHSSPS for these delegated statutory functions, these are taken into account within this overall multiagency process.

The Board will ensure that all of its commissioning decisions in relation to children and young people will contribute towards the Northern Ireland Children and Young People's Plan.

In addition, the CYPSP has decided that a key shared strategic objective is to focus efforts on early intervention. By this is meant addressing the needs of children and young people in the early years and at an early stage of any difficulty, at all ages. The Board's commissioning decisions in relation to children and young people will be consistent with this strategic objective. The CYPSP has identified the need to designate Northern Ireland as an early intervention region to ensure that strategies and funding streams for early intervention are used with more consistency and less duplication of effort. A priority for the CYPSP will be to work with DHSSPS towards this end.

There is an onus on all stakeholders involved in the lives of children and their families to demonstrate what difference/benefits are accruing as a result of the services being offered. Contract monitoring and monitoring against targets as outlined within the Commissioning Direction will inform on progress being made. The voice of the user is also integral to this agenda and remains to the fore. It will also be important to have close working relationships with the service team looking at Maternity and Child Health as there are mutual areas of concern, specifically for children with a disability but also in the consideration of support services for families.

It has been recognised by a number of independent reviews that, compared to other parts of the United Kingdom, there is approximately a thirty percent under investment in children's services within Northern Ireland.

Although the economic climate will pose very real challenges going forward, it will be important to ensure that children and young people who have been unable to be looked after by their parents have their needs fully met in families / settings which can best meet their assessed need. Of equal importance will be the need to maintain an emphasis on early years support and intervention if children's needs are to be recognised, assessed and addressed at the earliest possible stage.

The overarching principle spelt out within the Children (N.I.) Order 1995 that children are best cared for within the family of origin will continue to shape interventions and service delivery. There will also continue to be a small number of children for whom this is not achievable and, in these circumstances, it is critical that decisions on permanency are informed by robust assessment and effected in a timely fashion to avoid further damage to the children involved.

There will continue to be an emphasis on working collaboratively with all stakeholders to inform needs assessment, to assist with planning services and provide opportunity to monitor and, if required, reshape service delivery.

Key Priorities

- The Board will in conjunction with relevant stakeholders progress the development of the Regional Fostering and Adoption Recruitment and Training service. There will be a focus on securing placement as per assessed need and collaborative working
- The Board and PHA will progress a review of the Allied Health Profession Service in Special Schools to ensure equity of access and fit with the core service
- The Board will take forward a review of Trusts' Early Years Services to encompass the regulatory functions as well as the potential for skill mix and charging
- The HSCB/PHA will continue to progress the strategic direction as outlined within the Healthy Futures strategy
- The Board will conclude a Regional Review of Residential Child Care provision to provide greater differentiation. Account to be taken of Individual Funding Requests, some of which result in out of country placement
- The Board and PHA will undertake a review of the multi disciplinary teams for children with a disability. The review will focus on the quality and effectiveness of the teams and regional consistency
- The Board will progress the commissioning of an Inter-country Adoption Service within one lead Trust and explore the feasibility of this service being self financing

- The Children and Families Team will support RASDN, the Bamford Task Group and the Regional Acquired Brain Injury Groups to deliver on actions relating to children. This will include a review of the Family Trauma Centre
- The Board, in collaboration with other stakeholders, will progress a regional review of accommodation needs of Care Leavers and Young Homeless
- The Board and PHA will review the availability of provision for children with life limiting illness to consider hospice, children's community nursing and respite services.
- The Board and PHA recognise the importance of early intervention to provide much needed support when it matters most and will take cognisance of this in pursuing any review or service development
- The Board and PHA will take appropriate action to deliver, in cooperation with Trusts and other stakeholders, the following key targets and standards:

  - Ensure that at least 70% of all care leavers aged 19 are in education, training, or employment
  - Ensure children admitted to residential care have, prior to their admission: (i) been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process
  - Ensure that for every child taken into care, a plan for permanence and associated timescale is developed within six months and formally agreed at the first six-monthly LAC review
  - Provide family support interventions to 3,000 children in vulnerable families
  - From April 2011, all child protection referrals should be allocated within 24 hours of receipt of the referral
  - All child protection referrals should be investigated and an initial assessment completed within 10 working days from the date of the original referral being received
  - From April 2011, following the completion of the initial assessment, a child protection case conference should

be held within 15 working days of the original referral being received

- From April 2011, an initial assessment should be completed within 10 working days from the date of a child becoming looked after
- From April 2011, 90% of family support referrals should be allocated to a social worker within 20 working days for initial assessment
- From April 2011, all family support referrals should be investigated and an initial assessment completed within 10 working days from the date the original referral was allocated to the social worker
- From April 2011, on completion of the initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days.
- Ensure that at least 225 care leavers aged 18+ are living with their former foster carers or supported family.

6.11 Mental Health and Learning Disability

This section proposes the significant reform, modernisation and standardisation of mental health and learning disability services beginning in 2011 and extending across the current Comprehensive Spending Review period.

To take forward the recommendations and actions arising from the Bamford Review ('Delivering the Bamford Vision, DHSSPS 2009) the Board and Agency, in partnership with Trusts, established a range of working groups across the region in partnership with Local Commissioning Groups. Within the Taskforce service users and carers have been incorporated as equal partners; this is reflected across the range of working groups.

Key in-patient service delivery areas in Mental Health are Acute Assessment and Treatment, Psychiatric Intensive Care beds, Low Secure/Forensic beds and Addiction beds. Key community service delivery areas are primary care based assessments and therapies such as structured counselling, Primary Care facing Psychological therapies e.g. Cognitive Behaviour Therapy. People with more acute needs are now increasingly having these met by crisis response/home treatment/community mental health resource services which aim to minimise admissions to hospital and promote recovery.

It is also agreed that there must both be a better access to primary care based services to reduce dependence on secondary care and work is also needed to implement more consistent and standardised service models across Trust areas.

Within Learning Disability services include assessment and treatment beds, multi-disciplinary community teams, supporting living options/residential and nursing homes and day opportunities to help support people live independent and inclusive lives.

The key focus for service delivery and modernisation in 2011-2012 will be the continuation and promotion of inclusion and independence in line with "Equal Lives". This will support people with a learning disability in the areas of housing, training, further education and employment opportunities.

People with a learning disability should be supported to live as independent a lifestyle as possible. At present there are still too many people living within hospitals in N.Ireland.

Too often the physical health of those with a learning disability falls below that enjoyed by the general population. People with a learning disability still can't access the full range of educational, training and vocational opportunities accessed by the wider population.

At the heart of the 'Bamford Vision' are the following key themes:

- Promoting positive health, wellbeing and early intervention
- Supporting people to lead independent lives
- Supporting carers
- Providing better public services to meet people's needs
- Providing structures and a legislative base to deliver the Bamford Vision.

Some of the additional strategic drivers include

- 'Protect Life', Suicide Prevention and Promoting Mental Health and Wellbeing strategy
- New Strategic Direction for Drugs and Alcohol
- Psychological Therapies Strategy
- Personality Disorder Strategy
- Autism Action Plan.

In terms of improving health and social care services there is a need to improve access to community based services which allow people to live independently, address inequalities and promote citizenship, recovery and inclusion.

The Mental Health Service Framework was launched across the HSC in October 2011. The Framework sets out expects standards of care across mental health services and also within the community/primary care settings. During 2011/12 work will be undertaken to scope out baseline service performance - this work will encompass the views of service user and carers.

Targets and Priorities

Trusts must work in partnership with the Commissioner to deliver a major programme of reform, modernisation and standardisation.

Within **Mental Health** services, the key five core strands will be:

- Stepped Care model – implement the agreed model of care
- Progressing Mental Health Promotion and Protect Life strategy implementation
- Crisis Resolution/Home Treatment – identify an evidence based high fidelity service model
- Acute inpatient care services – secure agreement regarding the overall configuration and size of Acute and PICU inpatient services
- Resettlement – all long stay patients in Mental Health hospitals will be resettled by 2014/15.

Within **Learning Disability** services, the key strands will be:

- Resettlement - all long stay patients in Learning Disability Hospitals will be resettled by 2014/15
- Day Services - continue to develop and implement a consistent model of provision
- Improved Physical and Mental Health - implementation of the Directed Enhanced Service for Learning Disability which provides annual physical and mental health checks in primary care for all adults with a Learning Disability in Northern Ireland
- Family Support - supporting families and carers who care for someone with a learning disability to live in the community.

The Board/PHA will work with Trusts and other stakeholders to ensure that the following targets and standards are delivered in 2011/12:

- No patient waits longer than 13 weeks to assessment and commencement of treatment (including psychological therapies)

- From April 2011, 75% of patients admitted as mental health or learning disability inpatients for assessment and treatment should be discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days
- By 31 March 2012, resettle at least an additional 45 long stay patients from learning disability to appropriate places in the community compared to the end March 2011 figure
- By 31 March 2012, resettle 45 long-stay patients from mental health hospitals to appropriate places in the community compared to the end March 2011 figure
- From April 2011, no children should wait longer than 13 weeks for assessment for autism following referral and a further 13 weeks for commencement of specialised intervention.

Local Priorities

The above regional priorities will be incorporated into LCG commissioning plans within the context of taking forward locally based service improvement. In addition, LCGs will also take forward the following priorities:

Mental Health

- Northern LCG – to consider the strategic outline business case for the replacement of Holywell Hospital in partnership with Northern Trust
- Southern LCG – take forward and progress the further development of the Bluestone in-patient unit, i.e. additional new ward facilities;
- Belfast LCG – to consider proposals for the development of new build mental health in-patient services within a single site configuration based on the existing business case
- Western LCG - to develop proposals for the appropriate model of acute in-patient service provision for the Western area

- South Eastern LCG – to take forward and progress the existing business case for the development of acute in-patient services based at Lagan Valley hospital.

Learning Disability

- Belfast/Northern/Southern Eastern LCGs - the development of plans for the resettlement of the remaining long stay population from the Muckamore Abbey Hospital site.
- Southern LCG - develop plans for the resettlement of the remaining long stay population from Longstone Hospital in Armagh. In addition, the development of new acute admission and treatment facilities in the Southern area.
- Southern / South Eastern LCG – consider plans for the development of new adult resource centres to replace existing centres.
- All LCGs - The development of a better understanding of the capacity of existing resources to deal with the needs of ageing carers. In addition, development of local community support options in partnership with local housing, employment, further education and leisure providers.

6.12 Prison Health Services

From 1st April 2008 the DHSSPS has had responsibility for Prison Health Services. The commissioning of Prison Health Services is now the function of the HSCB and the management of Prison Health Systems the responsibility of the South Eastern Health and Social Care Trust. A Prison Health Partnership Board has been set up to coordinate prison health strategies and policies and to take forward the aims of the Prison Health Partnership Agreement.

Healthcare services in Northern Ireland are delivered within three prison establishments: HMP Maghaberry with a branch at Crumlin Road Working - Out Unit; HMP YOC Hydebank Wood and HMP Magilligan. There are approximately 5,000 committals annually and approximately 1,500 prisoners placed within the prison estate at any point in time.

Prisoners receive a full range of healthcare services. The majority of services provided within the prison are primary care services. Access to secondary care services are usually provided in acute hospitals through normal referral processes.

There are particular challenges in delivering health care in an environment whose principal purpose is security.

A considerable amount of research has been carried out on the prevalence of personality disorders in prisons. It is estimated that 60-80% of male prisoners and 50% of female prisoners have a personality disorder compared with 6-15% of the general population.

Offenders have very high rates of mental ill health; recent estimates suggest that up to 90% of all those in custody will have some form of mental health need (OMHCP, 2005), with both sexes similarly affected. The offender population is at much greater risk of depression, psychosis, suicide, self harm or a plurality of such illnesses.

Many of those with a mental health illness also have addiction problems. Evidence would suggest that as many as 3 in 5 prisoners may have an addiction problem.

New sentencing arrangements introduced in May 2008 have the potential to increase the prison population from 1480 prisoners (January 2010) to approximately 2000 prisoners by 2015.

The transfer of responsibility for Prison Health Systems is relatively recent and in many ways existing health structures represent systems in transition. Although many prison health staff are employed by the NIPS it is our expectation that the percentage employed directly by Health and Social Care will increase over time. This mixed model of provision does however give rise to potential governance issues and to the need to clarify lines of responsibility to facilitate good governance and the quality assurance of systems.

The overarching aims for Prison Healthcare are to:

- Ensure that prisoners have at least the equivalent standard of healthcare as would be received in the community
- Ensure services are delivered to high quality standards and are in line with HSC standards and best practice
- Ensure services are delivered in line with the assessed needs of the prison population
- Promote health and social wellbeing in order to reduce or mitigate the effects of unhealthy or high-risk behaviours
- Promote effective links with health and social services in the community to improve continuity of care
- Ensure best value for money is secured.

Key Priorities

- Agreeing with the South Eastern Trust the appropriate numbers of qualified staff taking into consideration the need for specialist therapists in respect of all aspects of care and the transfer of staff to HSC and that future recruitment is to HSC
- Ensuring that the Trust has appropriate information systems and that there is improved healthcare information flows from prison to the community and vice versa

- Progressing the development of medical services and chronic disease management in line with the principal of equivalence
- The development of care pathways in and out of prison
- Improving the committal process for people with complex needs; including substance misuse, diabetes and epilepsy
- Through the implementation of the learning disability screening questionnaire the South Eastern Trust will identify the number of prisoners with a learning disability currently in the prison system and develop appropriate care pathways for the client group.
- The introduction of the stepped care model within prisons to address mental health problems both at acute and sub-acute levels by providing a range of therapies to meet the differing needs of prisoners.
- Further development and implementation of a personality disorder service to prisoners and linkages with community personality disorder services developed

- The development of a Health Promotion Strategy
- Initiating work with the criminal justice system and prison health partners to ensure the identification of people with mental health problems and/or a learning disability early in the criminal justice system

6.13 Health and Social Wellbeing Improvement, Health Protection and Screening

Health and Social Wellbeing Improvement

The focus of this section is on the broader public health agenda. Improving health and reducing inequality requires coordinated action across many different sections of government and delivery organisations. Such action also requires:

i. Health and social wellbeing improvement to be embedded in the commissioning of services and;

ii. Development of effective partnerships with other sectors that can influence the wider determinants of health.

Prevention of ill health and the promotion and maintenance of health and wellbeing is essential. This presents something of a paradox; as financial pressures will undoubtedly increase within health and social care budgets, the need to spend more on prevention becomes clearer, yet also more difficult because of the pressure on service delivery. It is also likely to be compounded by financial pressures experienced by other government departments whose policies will impact on the development of health. There is now good evidence that promoting good health and preventing ill health does save money[4]. Further, there are significant costs in not tackling health inequalities, estimated in England to be £31 – 33 billion loss in productivity, £20 – 32 billion in lost taxes and higher welfare payments and some £5.5 billion in additional NHS health care costs [1]. In Northern Ireland the Chief Medical officer estimated the total annual inpatient costs as a result of smoking to health and social services to be £22 million in 2000[5]. The total costs of hospital treatment for smoking - related diseases in Northern Ireland were estimated at £119 million per annum in 2008/09[6]. Some £24.5 million were estimated to have been spent on prescribed anti-diabetic medication alone in 2009[7].

[3] Using NICE guidance to cut costs in the downturn, NICE 2009
[5] The Health of the Public in Northern Ireland: Report of the Chief Medical Officer 2000. DHSSPS 2000
[6] RCP (2000) Nicotine Addiction in Britain: A report of the Tobacco Advisory Group of the RCP applied to 2008/09 HRG costs. In: Ten Year Tobacco Control Strategy for Northern Ireland Consultation Document
[7] N. Gallagher, Presentation QUB Centre of Excellence 2011, Source BSO

The downturn in the economy is in itself likely to have an impact on health and wellbeing, for example there is clear evidence of the link between unemployment and poor health with every 1% increase in unemployment met with 0.8% increase in suicide.

The impact of financial pressures in other government departments' funding plans are likely to impact on protective programmes such as those at neighbourhood level. The development of effective partnerships offers the opportunity for making most of the public expenditure, building synergy of action at a local level. However, the lack of progress with the Review of Public Administration in other sectors has made partnerships working particularly difficult over the past number of years with the lack of certainty impacting negatively on clear direction and shared goals.

It is significant that throughout this period of change, partnerships aiming to improve health and wellbeing have continued to develop and deliver on this challenging agenda. The multisectoral Investing for Health partnerships involving statutory, community, voluntary and private sector interests remain a key mechanism for securing 'joined up' solutions at a local level. Collaboration among partners, including local and central government departments, has brought innovative practice and better outcomes. The focus of these efforts has been on tackling health inequalities at both strategic and operational levels. At operational level for example, work areas have been taken forward in partnership with Local Government including the implementation of Community Response Plans in response to suspected suicide clusters. At a strategic level, in Belfast for example, a new strategic partnership for the city has been established with a clear remit to reduce life inequalities. The Partnership is supported by the Belfast Health Development Unit where staff from the PHA, Belfast H&SC Trust and Belfast City Council are working to a programme of agreed joint action. Similar partnerships are in place across Northern Ireland.

Joint working with local government has also been given renewed emphasis with the establishment of the formal joint working arrangements with seven clusters of local councils. Strategic collaboration has been focused on working with local communities as well as progressing thematic approaches such as increasing levels of physical activity, addressing poverty and reducing alcohol

misuse. In addition, an important range of partnerships drive action on specific issues such as smoking, suicide prevention, alcohol and drug misuse and sexual health. All of this delivery relies on the effective use of our collective resources.

In 2011/12, the action plans agreed within Investing for Health, local government and other partnerships will be implemented. Research is essential in developing effective practice at both regional and local levels. For example, in the field of mental health and suicide prevention significant work has been undertaken to evaluate the impact of public information campaigns, suicide awareness training to a range of sectors and disciplines and of the Lifeline service itself. Forthcoming evaluation will focus on the regional and local delivery of the overall Protect Life strategy, the 'Card Before You Leave' scheme, ongoing service delivery as well as mapping mental health and suicide prevention services.

Several major studies are also underway- the geodemographic factors associated with deliberate self harm and death by suicide: a within and between neighbourhoods analysis with Professor Brendan Bunting, University of Ulster; an examination of Suicide in Northern Ireland: service use and needs in urban and rural settings with Dr Gerard Leavey, NI Association for Mental Health; Providing Meaningful Care Learning for experiences of suicidal men to inform mental health services with QUB / UU; and the recently launched Confidential Inquiry by Prof Louis Appleby. All of this work is informing the direction of future efforts to tackle the distressing issue of suicide.

Finally, a further significant challenge is halting the rise in the proportion of the population who are overweight or obese, 59% of all adults measured were either overweight (35%) or obese (24%).[8]The impact of this increase is now being experienced in different areas of service provision e.g. complications in pregnancy, increase in type 2 diabetes, coronary heart disease, stroke and a number of cancers. It is also known that obese children are more likely to become obese adults. A key goal is to improve health and wellbeing and reduce the gap between more affluent and less affluent groups and those communities known to be at increased risk in our society. It is essential therefore that we:

[8] NI Health and Social Wellbeing Survey 2005/2006, Information and Analysis Directorate, DHSSPS

- Influence the environment positively so that healthier choices become easier
- Increase knowledge, skills and behaviours that promote health and wellbeing
- Develop models of effective practice that inform future direction, including the shape of health and social care services
- Develop partnership models which empower communities and which seek to address with others the determinants of health
- Contribute to, and improve understanding about, health inequalities and effective interventions
- Promote and inform health and social care staff (and others) about their role in promoting health and wellbeing

Targets and Priorities

In addition to specific actions identified across the commissioning teams, the PHA/HSCB will progress priorities within the PHA Health Improvement framework as follows:

Give Every Child and Young Person the Best Start in Life

- Implement the Family Nurse Partnership Programme
- Ensure that 'Healthy Child, Healthy Future' is offered to children and families across Northern Ireland
- Develop evidence based breast feeding programmes in identified areas of low uptake and among young mothers
- Support HSC Trusts and Sure Start programmes to achieve and maintain UNICEF UK Baby Friendly Initiative accreditation
- Develop effective breast feeding coordination in each HSC Trust as recommended by NICE to the level of at least one full time equivalent post for every 3000 births
- Implement the Alcohol Hidden Harm Action Plan
- Extend the Roots of Empathy programme to a minimum of ten primary schools in the remaining three HSC Trusts

- Develop models of parents active participation in their children's education

Ensure a decent standard of living

- Expand programmes which tackle poverty (including fuel poverty) and maximise access to a range of services and support
- Ensure current health and wellbeing programmes are tailored and focused to meet the needs of those at risk of poverty, including Travellers, Looked After Children, lone parents and homeless people
- Continue to implement the RAFAEL programme to increase the proportion of fresh, local and sustainable food procured into healthcare settings, supporting local economy, sustainability in healthcare and increasing the nutritional content of food on patient and staff menus
- Work with Health and Social Care organisations and a wide range of community and voluntary networks to support skills development
- Continue to develop effective working with the education sector using the school as a setting for holistic development

Build Sustainable Communities

- Develop an integrated action plan for user and carer involvement and community engagement in health and social care organisations
- Health and Social Care organisations will implement the Community Development Strategy and Action Plan. A performance management framework will be incorporated into all PHA and HSCB plans
- Extend joint working with community networks, including rural support networks, to increase community participation in health and social wellbeing improvement
- Develop together with other services food cooperatives, community gardens/allotments at local level
- Support a wide range of programmes at local community level to improve health and wellbeing

Travellers and Migrant communities

- Develop the newly established NI Travellers Health Forum, including implementation of the recommendations of the All Ireland Traveller Health Study
- Develop an integrated Action Plan to meet the needs of Travellers
- Establish a Migrant Health and Wellbeing Network as an information and good practice sharing forum for health and social care professionals
- Develop a clear action plan to meet the health needs of migrant communities Northern Ireland

Lesbian, Gay, Bisexual and Transgender communities

- Ensure that health and social care services are accessible and sensitive to the needs of LGBT people
- Ensure programmes are in place for LGBT training and awareness for staff working across health and social care sector
- Continue to work with LGBT sector to identify health needs and appropriate responses

Make Healthy Choices Easier

Tobacco

- Develop a public information campaign targeted towards 16-24 year olds.
- Rerun existing public information campaigns at an intense, sustained level.
- Ensure smoking cessation services continue to be developed and provided to areas and populations with higher rates of smoking. A particular focus will be given to pregnant women and patients prior to elective surgery.
- As a minimum, maintain 2010/11 quit rates for people completing Cessation Programmes.
- Maintain the number of adults from areas of deprivation (bottom quintile) completing smoking cessation programmes and, at the least, maintain 2010/11 quit rates for people completing cessation programmes.

Promoting healthy weight and physical activity

- Promote healthier eating and policy change with different sectors across a wide range of settings
- Expand the implementation of the community based nutrition education programme “Cook It”
- Implement the physical activity guidance at local level and in particular the physical activity referral programme and walking for health programmes
- Develop a consistent approach to providing weight management advice and support for young people (and their families) that are found to be obese during annual BMI assessment for year 8 pupils
- Review and develop enhanced support programmes for women in the preparation for, and during pregnancy

Alcohol and Drug Misuse

- Contribute to the implementation of Phase 2 of the New Strategic Direction on Alcohol and Drugs 2011-2016
- Roll out the use of the Regional Initial Assessment Tool to improve consistent assessment and referral processes in relation to young peoples substance misuse
- Expand the development of brief intervention training programmes in primary care settings informed by the pilot programme to ensure that a minimum of 80 health and social care professionals will be trained in delivering brief interventions.
- Undertake a review of workforce education and training.
- Ensure drug and alcohol programmes are in place through multi-sectoral action at local level
- Consider the findings from the evaluation of the pilot one stop shop services and further development if appropriate.
- Benchmark, lobby and raise awareness of the need for a minimum price for a unit of alcohol

Mental Health and Wellbeing and Prevention of Suicide

- Support the development of the new regional mental and emotional wellbeing strategy and work with key partners to develop an implementation plan
- PHA, HSCB and HSC Trusts will work together to ensure suicide cluster response plans are in place for each Trust/LCG area.
- Develop a new public information campaign and maintain existing programmes.
- Develop and implement new contract for 'Lifeline' crisis response and post intervention service.
- The Deliberate Self Harm Register will be extended to all five HSC Trust areas and by 31 March 2012 the PHA and HSCB will ensure that 100% of new people, with injuries as a result of self harm, presenting to A&E Departments are being added to the deliberate self harm registry.
- PHA, HSCB will ensure that Trusts and partners have delivered 100 'gatekeeper' suicide awareness prevention training sessions across the 5 Trust areas to a minimum of 1000 people.
- The PHA and HSCB will ensure that there is a 30% unprompted awareness of the Lifeline service.

Teenage Pregnancy and Sexual Health

- Consolidate support programmes offered to young women during pregnancy and after birth.
- Implement the sexual health promoting strategy and in particular access to and delivery of sexual health services.
- Ensure health improvement programmes to promote good sexual health and reduce teenage pregnancy are in place in a range of arenas including school and youth settings
- Continue support and education programmes for Looked After Children
- By March 2012, as part of the implementation by the Public Health Agency of the Family Nurse Partnership pilot programme, the programme will be delivered to 100 teenage mothers who will be recruited up to the 28th week of pregnancy at the first test site

Accident Prevention

- Development and implementation of the accident prevention action plan with a focus on home, workplace (including farms) and road. Falls prevention will be particularly important in relation to older people

Settings

A coordinated approach will be developed to take forward health improvement in a number of settings including the workplace:

- Review the regional “Work Well” initiative
- Develop a comprehensive workplace health improvement model with a wide range of public, private, voluntary and community organisations
- Promote the health and social wellbeing of staff in health and social care organisations

Local Priorities

Priorities at a local level will involve a local interpretation of regional priorities alongside meeting the specific needs of localities. In addition, action will be taken forward to:

- Asset map with communities – in the most disadvantaged areas as well as with specific groups such as LGBT, older people.
- Develop innovative use of green space with communities
- Develop programmes of community led activity
- Develop partnership approaches across a wide range of agencies and Influence the environment positively so that healthier choices become easier
- Communities to address local needs

Health Protection

Health Protection includes Public Health Activities intended to protect individuals, groups and populations from infectious diseases or environmental hazards. It includes the need to have

robust, tested emergency plans to respond to health protection emergencies.

Health Protection Service PHA

The Health Protection Service in the Public Health Agency has a frontline role in protecting the Northern Ireland population from infectious diseases and environmental hazards and does this through:

i. Surveillance and monitoring of infectious diseases.
ii. Operational support and advice to a range of Health professionals/other stakeholders throughout the health and social care system.
iii. Response to all adverse health protection incidents including outbreaks.
iv. Education, Training and Research.

Health Protection is the first point of call in hours and out of hours for all Health Protection emergencies. In hours this service is provided from the Public Health Agency Duty Room and out of hours by an on call rota.

Health Protection – Work Programmes

Immunisation programmes

Immunisation against serious infectious diseases is one of the most effective Public Health interventions ever, in terms of preventing disease and prolonging life expectancy. The childhood immunisation programme and the influenza immunisation programme in Northern Ireland are the most successful in the United Kingdom. The Health Protection Service PHA has overall leadership responsibility for the implementation of immunisation policy across Trusts and Primary Care.

Healthcare Associated Infections (HCAIs)

Prevention of HCAIs is a priority and a patient safety issue. DHSSPS set targets for Trusts to achieve reductions in Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile.

HCAIs cause morbidity and mortality, particularly for elderly people and those with at risk medical conditions. HCAIs are associated with increased lengths of stay in hospital and negatively impact on the health economy.

Tuberculosis

There are approximately 70 cases of Tuberculosis in Northern Ireland each year. The management of a Tuberculosis case requires a coordinated approach across Public Health, Primary Care and Trusts. Trusts need to have facilities for diagnosis and treatment of these patients and appropriate infection control facilities available.

Blood-borne viruses and sexually transmitted infections

Prevention and control of sexually transmitted infections and blood borne viruses requires work across Public Health services, Primary Care and Trusts. Trusts need to ensure they have services for diagnosis and treatment of sexually transmitted infections. Although numbers of HIV infection in Northern Ireland are low compared to the rest of the United Kingdom, we still see cases every year which require care by Trusts. New therapies for HIV have resulted in increased drug costs. The Hepatitis B (HBV) immunisation programme in Trusts is delivered for occupational health reasons, for immunisation of newborn babies who are born with or at risk from Hepatitis B infection and in GUM clinics. Appropriate services for diagnosis and treatment of Hepatitis C infection are also required.

Emergency Preparedness

All Health and Social Care organisations in Northern Ireland are required to have robust and up to date tested emergency preparedness plans in place which cover major emergencies such as an influenza pandemic. A key aspect of these plans is business continuity planning to ensure that vital elements of service are preserved during the response to an acute emergency.

Health Protection Targets for Trusts

- Achieve 20% uptake rate of the seasonal flu vaccine by frontline Health and Social Care workers by 31 March 2012.

- Achieve 40% uptake of seasonal flu vaccine by pregnant women by 31 March 2012.

- From April 2011, the Public Health Agency and Trusts should secure a further reduction of 14% in MRSA and C. Difficile infections compared to the position in 2010-11.

Key Priorities

- Work with Primary Care and Trusts to achieve good uptake for all immunisation programmes. In particular, ensure a strong focus on protecting the health of minorities and migrants from vaccine preventable diseases, and those in disadvantaged communities.
- Implement any changes to the childhood immunisation programme in 2011/12 and achieve high uptake levels.
- Ensure the mandatory Trust requirements for clearance of health care workers for serious communicable diseases are met. Roll out of the MMR immunisation programme for healthcare workers to continue.
- Trusts to ensure services in place for the diagnosis and management of HIV, Hepatitis B, Hepatitis C and Sexually Transmitted infections.
- Trusts to ensure the 4 dose programme for HBV Immunisation of babies born to HBV infected mothers.
- Trusts to ensure access to laboratory services for diagnosis of TB (IGRA and VNTR) as per NICE recommendations.
- Trusts to ensure services for assessment for post exposure prophylaxis for HIV occur within 72 hours of exposure -HSS (MD) 23/2010).
- Implementation of the Regional Tuberculosis Action Plan due to be published by PHA July 2011.
- Trust services for TB to meet the standards in the NICE Guidance, Respiratory Framework and DHSSPS HSS (MD) 22/2009.

- Trusts to meet the requirements of DHSSPS Policy in Changing the Culture 2010 and DHSSPS Controls Assurance Standards http://www.dhsspsni.gov.uk/governance-controls.
- Clostridium Difficile Infection (CDI) - the ribotyping programme, delivered through NI Ribotyping Service in Belfast Trust to be reviewed.
- The CDI testing protocol to be reviewed second half of 2011, informed by publication of findings of UK study of optimal testing protocols. PHA and Trusts to agree future CDI testing arrangements for Jan 2012.
- Trusts to deliver the Intensive Care Unit (ICU) Infection Surveillance and the CDI & MRSA/MSSA Surveillance programmes.
- Development of a regional action plan on for Antimicrobial Resistance.
- Trusts to develop and implement a programme of Antimicrobial stewardship.
- All HSC organisations to have in place up to date and tested outbreak and emergency preparedness plans.
- Undertake Seasonal Flu planning, including for an increase in admission of patients with seasonal flu or flu like/related illness during winter of 2011/12.
- Trusts to ensure laboratory reporting of organisms of public health interest to the Health Protection Agency (HPA England) is in line with HPA published guidelines for surveillance purposes/public health action and their associated targets –www.hpa.org.uk
- Trusts to provide the necessary supports for outbreak investigation, including - microbiological input, laboratory resources and community staff to assist the PHA in outbreaks which could involve community facilities and schools.
- Maintain the capability and capacity of the Hazardous Area Response Team in NIAS.

Screening Programmes

Screening is an important public health function that involves Health & Social Care inviting members of the public, who have no symptoms of a particular disease, to be tested to see if they have the disease, or are at risk of getting it. This is different from the usual type of health care in which a patient makes contact with the health service because he or she has symptoms or signs of disease.

Screening is a programme, not just a test. Screening programmes are subject to strict quality assurance and control. In this way the benefits of screening can be maximised and harms (such as false positive and false negative results) minimised. The elements of a screening programme include:

- Policy setting;
- Equipment procurement;
- Staff training;
- Workforce planning;
- Quality assurance;
- Identifying and inviting all eligible people;
- Information management;
- Public and professional communication;
- Taking and reading tests;
- Follow-up and failsafe;
- Diagnosis; and
- Interventions.

Most screening tests are not diagnostic tests and further diagnostic testing is required to establish the diagnosis. Screening tests sort a population of people into two groups – those who might have the disease being looked for and those who probably don't.

There are a number of issues and challenges relating to screening programmes. These include:

- The need to improve the performance of existing screening services to meet standards.

- The need to improve the performance of related diagnostic & treatment services to meet standards.
- The need to implement policy and current targets as outlined within the Commissioning Direction for new screening programmes and developments in existing programmes.

Key Priorities

Breast cancer screening

- Prepare for the introduction of digital mammography.
- Plan for the NI Breast Screening Programme to undertake surveillance of women at high risk of breast cancer, in accordance with guidance to be issued by the NHS Breast Screening Programme.

Cervical screening

- Improve laboratory ‘smear to result’ turnaround times.
- Introduction of HPV triage into screening pathway (policy awaited) - will reduce number of repeat smears but may increase colposcopy referrals
- Improve uptake and coverage particularly in hard to reach groups.
- Establish direct referral from screening labs to colposcopy – timelier follow-up and improves failsafe.

Bowel cancer screening

- Maintain timely access to diagnostic colonoscopy services for screen positive (asymptomatic) patients and to diagnostic endoscopy services for symptomatic patients.
- Complete roll out of the bowel cancer screening programme by March 2012.
- Introduction of polyp surveillance programme.
- Improve uptake and coverage particularly in hard to reach groups.
- Establish QA structures & monitoring processes.

Cancer screening

- Develop a strategy to improve uptake and coverage in the 3 cancer screening programmes; particularly in hard to reach groups.

Diabetic retinopathy

- Review capacity of Diabetic Retinopathy Screening Programme within BHSCT
- Development of direct referral mechanism from screening services to ophthalmology.
- Monitor growth in diabetes cases and impact on services.

Abdominal aortic aneurysm (AAA) screening

- Prepare for implementation of AAA screening in 2012.

Antenatal infection

- Implementation of DHSSPS 2011 standards (implications for labs).
- Ensure specialist assessment for hepatitis B positive women within 6 wks of diagnosis.
- Ensure hepatitis B vaccination for all infants of hepatitis B positive mothers.
- Improve failsafe for the identification and follow up of missing screening results.

Newborn blood spot

- Implementation of sickle cell screening.
- Improve a timely sample despatch & avoidable repeats.
- Address sustainability of regional services for follow-up of infants screen positive for PKU, CHT, CF & MCADD.

Newborn hearing

- Establish QA structures & monitoring processes

GLOSSARY

Glossary of Terms

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Quality Outcomes Framework – a system under which the effectiveness of schemes and measures to improve health is measured against a set of agreed targets.

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Chronic conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and need regular treatment and medication.

Palliative Care – services for people who are typically in their last year of life and who suffer from conditions such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

National Institute for Clinical Excellence – an expert organisation based in London that guides health care organisations across the UK on the effectiveness of new treatments, new drugs and other innovations.

Bariatric Surgery – a new type of hospital operation that enables some chronically obese people to reduce their weight by extensive surgery on their abdomen and digestive organs.

Northern Ireland Block – the total amount of financial support given to Northern Ireland by the Treasury in London.

Locum doctors – doctors whose work is based upon short term or temporary contracts.

Local Commissioning Groups – committees of the regional Health and Social Care Board that are comprised of GPs, professional health and social care staff such as dentists and social workers and community and elected representatives. Their role is to help the Board arrange or commission health and social care services at local level.

The Bamford Report – a major study commissioned by the Department of Health in Northern Ireland to provide a long term strategic plan for the development of mental health services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Evidence Based Commissioning – the provision of health and social care services based upon proven evidence of their value.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff.

Board Membership

Health and Social Care Board Membership

Dr Ian Clements – Chair
Mr John Compton – Chief Executive
Non Executive Directors
Mr Robert Gilmore
Mrs Elizabeth Kerr
Mr Stephen Leach
Dr Melissa McCullough
Mr Brendan McKeever
Mr John Mone
Dr Robert Thompson
Executive Directors
Ms Fionnuala McAndrew, Director of Social Services
Mr Paul Cummings, Director of Finance
Mr Dean Sullivan, Director of Commissioning
Ms Louise McMahon, Director, Performance Management and Service Improvement

Public Health Agency Board Membership

Ms Mary McMahon – Chair
Dr Eddie Rooney – Chief Executive
Non Executive Directors
Ms Julie Erskine
Dr Jeremy Harbinson
Ms Miriam Karp
Mr Thomas Mahaffy
Councillor Cathal Mullaghan
Councillor Stephen Nicholl
Mr Ronnie Orr
Executive Directors
Dr Carolyn Harper, Executive Medical Director/Director of Public Health
Mr Ed McClean, Director of Operations
Mrs Mary Hinds, Director of Nursing and Allied Health Professions

Local Commissioning Groups

Belfast Local Commissioning Group

Dr George O'Neill (Chair)
Mr Iain Deboys, Commissioning Lead
Cllr. Tim Attwood
Ms Gerry Bleakney
Dr Grainne Bonner
Mr Gerry Burns
Ms Pat Cullen
Dr Jenny Gingles
Alderman Michael Henderson
Cllr. Mervyn Jones
Dr Terry Maguire
Ms Joyce McKee
Mr Danni Power
Alderman Gerry Rice
Ms Catriona Rooney
Mrs Irene Sloan
Dr Alan Stout
Mr Mike Townsend

Western Local Commissioning Group

Dr Brendan O'Hare (Chair)
Mr Paul Cavanagh, Commissioning Lead
Dr Kieran Deeny
Dr Eugene Deeny
Cllr Robert Irvine
Mrs Jenny Irvine
Dr Jackie McCall
Dr Martin McCloskey
Mr Seamus McErlean
Mrs Clare McGartland
Mrs Siobhan McIntyre
Ms Loretto McManus
Mr Eamon O'Kane
Mr Martin Quinn
Mr Graham Robinson
Cllr Bernice Swift

Northern Local Commissioning Group

Dr Brian Hunter (Chair)
Mrs Bride Harkin, Commissioning Lead
Cllr. David Barbour
Dr Ian Buchanan
Mrs Linda Clements
Cllr. Adrian Cochrane-Watson
Dr Fiona Kennedy
Dr Una Lernihan
Mr Laurence O'Kane
Dr Terry McGowan
Cllr. Thomas Nicholl
Ms Sharon Sinclair
Dr Turlough Tracey
Mrs Corrina Grimes

South Eastern Local Commissioning Group

Dr Nigel Campbell (Chair)
Mr Paul Turley, Commissioning Lead
Ms Oriel Brown
Cllr. Angus Carson
Cllr. Dermot Curran
Dr Paul Darragh
Mr Donal Diffin
Mr John Duffy
Cllr. Andrew Ewing
Dr Colin Fitzpatrick
Mr Brendan Forde
Mr David Heron
Dr Garth Logan
Ms Louise McCormick
Dr Paul Megarrity
Mrs Heather Monteverde
Mr Peter Mullan

Southern Local Commissioning Group

Mr Sheelin McKeagney (Chair)
Mrs Lyn Donnelly, Commissioning Lead
Dr Walter Boyd
Mrs Beverly Burns
Dr Sean Digney
Mr Iolo Eilian
Mrs Mary Emerson
Dr Brid Farrell
Mr Paul Maguire
Mr Miceal McCoy
Mrs Janis McCulla
Cllr. Sean McGuigan
Cllr. Sylvia McRoberts
Mr Kieran McShane
Dr Tom O'Leary

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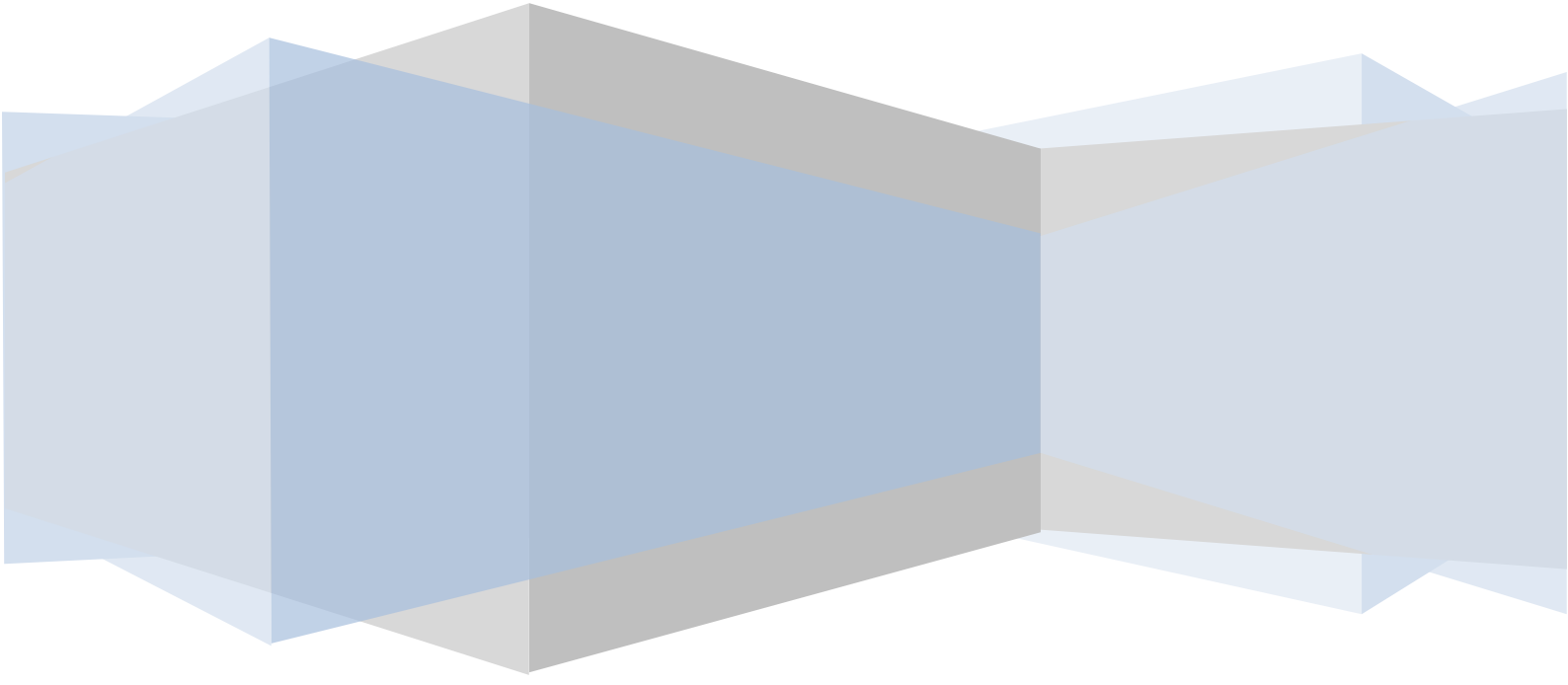
Health and Social Care Board

Public Health Agency

Commissioning Plan 2015/16



Contents

Foreword

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

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

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

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

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

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

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

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

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

1.0 Introduction

1.1 The Purpose of the Plan

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

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

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

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

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

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

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

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

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

1.2 Placing communities at the centre of commissioning

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

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

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

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

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

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

1.3 Monitoring Performance

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

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

2.0 Summary of Key Demographic Changes

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

N Ireland Resident Populations by Local Commissioning Group

Table 1

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

Source: NISRA, 2013 MYEs

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

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

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

3.0 Delivering on Key Policies, Strategies and Initiatives

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

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

3.1 Programme for Government

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

3.2 Quality 2020

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

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

- Develop HSC Trust Annual Quality Reports

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

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

3.3 Institute of Healthcare Improvement Liaison

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

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

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

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

3.4 HSC Safety Forum

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

During 2015/2016 the key deliverables will include:

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

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

3.5 Workforce Planning & Development

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

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

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

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

This includes:

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

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

These include:

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

3.6 Delivering Care: Nurse Staffing in Northern Ireland

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

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

3.7 Service Frameworks

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

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

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

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

3.8 Primary & Community Care Infrastructure

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

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

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

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

3.9 Palliative and End of Life Care

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

During 2015/2016 the key deliverables will include:

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

3.10 Maternity Strategy

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

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

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

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

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

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

3.11 Physical and Sensory Disability Strategy

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

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

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

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

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

3.12 Community planning

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

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

3.13 E–Health

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

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

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

4.0 Ensuring Financial Stability & Effective Use of Resources

4.1 Introduction

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

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

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

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

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

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

Summary of 2015/16 Financial Plan

Table 2

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

* includes savings from Pharmaceutical Price Regulation Scheme (PPRS)

4.2 Producing the Financial Plan

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

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

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

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

HSCB – Opening Position

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

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

2014/15 Carried Forward Service Commitments

Table 3

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

Trust Opening Position - Carried Forward Pressures

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

4.2.2 Planned additional investment 2015/16

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

Total new pressures 2015/16

Table 4

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

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

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

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

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

Demography by Programme of Care

Table 5

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

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

FHS Pressures

Table 6

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

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

Primary care investment

Table 7

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

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

Inescapable Service Pressures

Table 8

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

Pressures for which no funding is available

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

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

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

Income 2015/16

Table 9

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

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

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

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

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

Efficiency Savings 2015/16

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

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

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

Efficiency Savings 2015/16

Table 10

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

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

Staff Productivity

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

Non Pay Opportunities

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

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

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

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

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

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

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

4.2.4 Options to Ensure Financial Stability

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

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

Potential in year funding solutions

Table 11

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

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

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

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

Total Planned Spend by Organisation

Figure 1

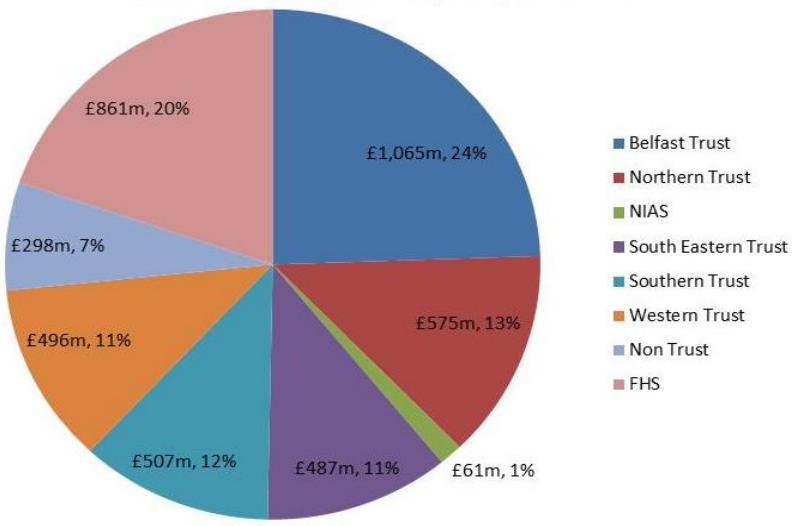


Table 12 sets out how the total resources are planned to be spent across the Programmes of Care and Family Health Services.

Planned Expenditure by Programme of Care

Table 12

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

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

Resources by LCG

Table 13

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

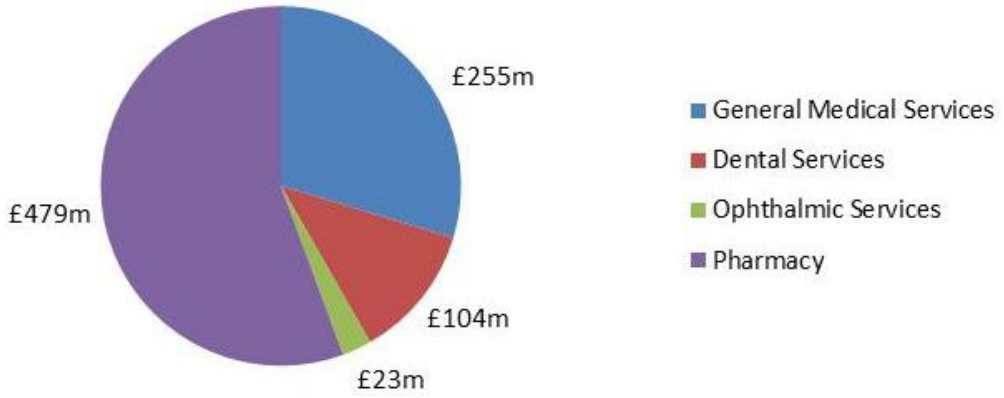
* Includes Mgmt & Admin, BSO, DIS
** Non Trust includes voluntaries and Extra Contractual Referrals

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

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

Planned Spend for Family Health Services

Figure 2



4.2.6 Equity

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

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

Capitation Formula

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

Expenditure

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

Impact of 2015/16 Plan Compared to Capitation Share

Table 14

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

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

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

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

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

4.3.1 Effecting the shift

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

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

Integrated Care Partnerships (ICPs)

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

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

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

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

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

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

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

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

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

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

Learning disability & mental health resettlement programmes

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

Recurrent Investment in Reform

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

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

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

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

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

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

4.3.2 Monitoring the Delivery of Financial Shift Left

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

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

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

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

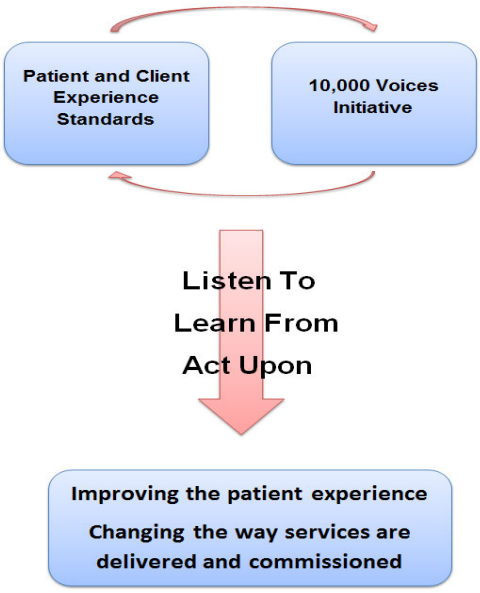
5.0 Listening to Patient and Client experience and learning from Personal and Public Involvement

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

5.1 Patient Client Experience Standards & 10,000 Voices

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

Figure 3



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

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

5.2 Patient Client Council (PCC) Peoples' Priorities 2014

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

Table 16

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

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

5.3 Personal and Public Involvement

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

Standards for PPI

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

Involving Patients and Clients in the Commissioning of Services

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

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

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

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

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

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

The HSCB has:

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

6.0 Regional Commissioning – Overarching Themes

6.1 Improving & Protecting Population Health & Reducing Inequalities

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

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

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

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

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

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

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

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

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

6.1.1 Giving every child the best start

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

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

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

6.1.2 Tackling poverty

Specific Commissioning Intentions for 2015/16 will include:

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

6.1.3 Sustainable communities

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

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

6.1.4 Supporting healthier choices

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

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

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

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

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

6.1.5 Screening & Health Protection

Screening

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

During 2015/2016 the key deliverables will include:

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

Health Protection

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

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

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

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

Commissioning priorities for 2015/16 include:

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

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

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

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

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

6.2 Providing care closer to home

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

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

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

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

6.2.1 Commission acute care closer to home

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

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

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

6.2.2 Ensure effective community nursing and AHP interventions

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

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

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

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

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

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

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

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

6.2.3 More appropriate targeting of domiciliary care services

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

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

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

Key actions during 2015/16 will include:

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

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

6.2.4 Statutory Residential Homes

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

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

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

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

6.3 High quality, safe & effective care

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

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

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

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

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

6.3.1 Quality Improvement Plans (QIPs)

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

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

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

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

6.3.2 Unscheduled Care Services

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

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

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

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

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

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

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

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

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

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

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

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

6.3.3 Acute reform

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

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

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

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

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

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

6.3.4 Delivering Care

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

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

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

6.3.5 Managing Long-Term Conditions

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

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

Emergency Admissions to hospital for Long Term Conditions

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

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

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

Source: PAS Data Warehouse

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

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

6.3.6 Addressing known shortfalls in capacity/quality concerns

Improving Cancer Services

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

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

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

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

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

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

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

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

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

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

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

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

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

Improving Fracture Services

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

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

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

Improving Imaging Services

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

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

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

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

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

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

6.4 Promoting independence and choice

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

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

6.4.1 Reablement

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

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

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

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

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

6.4.2 Promotion of direct payments / self-directed support

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

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

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

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

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

6.4.3 Carer support

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

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

Key priorities for 2015/16 include:

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

6.4.4 Implementation of Learning Disabilities Day Opportunities Model

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

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

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

6.5 Safeguarding the most vulnerable

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

6.5.1 Dementia strategy

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

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

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

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

6.5.2 Investing in mental health/learning disability community infrastructure

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

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

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

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

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

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

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

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

6.5.3 Safeguarding services

Safeguarding children

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

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

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

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

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

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

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

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

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

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

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

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

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

Adult Safeguarding

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

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

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

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

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

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

6.6 Efficiency & Value for Money

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

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

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

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

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

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

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

6.6.1 Procurement from Alternative Providers

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

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

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

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

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

GP Federations

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

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

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

6.6.2 Delivery of Contracted Volumes

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

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

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

7.0 Regional Commissioning

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

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

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

7.1 Family & Childcare Services

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

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

Family and Childcare– Key Commissioning Priorities 2015/16

Needs and Assessment

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

Services to be commissioned

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

Securing Service Delivery

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

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

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

Family and Childcare– Values and Volumes

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

Table 18

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

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

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

7.2 Specialist Services

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

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

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

Specialist Services – Key Commissioning Priorities 2015/16

Needs and Assessment

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

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

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

Services to be Commissioned

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

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

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

Securing Service Delivery

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

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

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

Needs and Assessment

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

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

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

Services to be Commissioned

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

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

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

Securing Service Delivery

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

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

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

Needs and Assessment

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

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

Services to be Commissioned

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

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

Securing Service Delivery

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

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

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

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

Specialist Services – Values and Volumes

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

Table 19

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

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

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

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

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

Access to NICE Treatments

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

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

7.3 Prisoner Health

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

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

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

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

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

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

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

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

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

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

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

Prisoner Health – Key Commissioning Priorities 2015/16

Needs and Assessment

1. Chronic disease management systems and services within prisons are currently not equivalent to those available for the general population
2. Needs assessment reveals higher rates of mental health issues within the prisoner population
3. There are issues associated with the misuse of prescribed medicines and the supply of illicit drugs within prisons
4. Needs assessments demonstrate that there are higher rates of risky health behaviours within the prison populations (e.g. smoking, addiction)

Services to be commissioned

HSCB to work with provider to:

1. Continue to progress development of equivalent chronic disease management services informed by a profile of prisoner population by chronic disease category produced as per Quality and Outcomes Framework
2. Further develop services in line with Bamford to include: the development of the recovery ethos within mental health services and increased provision of psychological therapies
3. Make improvements in medicines management, with a particular emphasis on the safe use of prescription medications
4. To produce an Action Plan to implement new health improvement initiatives, programmes and resources within the prison environment

Securing Service Delivery

SET will:

1. Provide prisoners with chronic disease management in line with community provision
2. Ensure provision of the Stepped Care Model and maintain registers for addiction, personality disorder and learning disability across prison sites
3. Revise and monitor medicines management policies, ensure that GP prescribing is in line with accepted regional standards and implement improvements in medicines management with an emphasis on safer use
4. Implement evidence based health improvement programmes: mental health promotion, smoking, healthy eating & nutrition, healthy lifestyles, including sexual health and relationships, and substance misuse

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Owers Review, Joint Healthcare and Criminal Justice Strategy

Prisoner Health – Values and Volumes

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

Table 20

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

7.4 Northern Ireland Ambulance Service

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

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

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

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

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

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

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

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

NIAS– Key Commissioning Priorities 2015/16

Needs and Assessment

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

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

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

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

Services to be Commissioned

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

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

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

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

Securing Service Delivery

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

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

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

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

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

NIAS – Values and Volumes

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

Table 21

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

7.5 Family Practitioner Services

Family practitioner Services comprise the following four key areas:

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

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

7.5.1 General Medical Practitioners Services

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

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

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

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

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

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

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

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

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

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

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

7.5.2 General Ophthalmology Services

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

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

Commissioning Priorities 2015/16

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

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

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

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

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

7.5.3 General Dental Services

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

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

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

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

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

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

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

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

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

7.5.4 Community Pharmacy and Medicines Management

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

General Pharmaceutical Services

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

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

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

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

Medicines Management

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

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

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

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

Medicines Safety

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

During 2015/2016 the key deliverables will include:

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

8.0 Achievement of Ministerial Targets

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

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

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

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

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

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

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

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

Progress was made in a number of areas including:

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

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

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

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

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

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

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

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

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

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

Unscheduled Care: From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.
The number of patients who have waited longer than 12 hours in Emergency Departments has been reducing steadily over the past number of years – from over 10,000 in 2011/12 to 3,100 in 2013/14. Unvalidated figures for 2014/15 indicate a slight increase to 3,175. Eliminating breaches of the 12-hour standard and significantly improving the percentage of patients attending an Emergency Department who are treated and discharged, or admitted within four hours of arrival will continue to be a top priority for the HSC in 2015/16.

During 2015/16 the HSCB will provide additional recurrent funding to enable Trusts to implement plans to ensure that key services (diagnostics, AHPs, social care, pharmacy etc.), at the five main hospital sites in the first instance, are delivered on a seven-day basis thereby improving patient flow at weekends.
The HSCB Unscheduled Care Team and LCGs will also work with Trusts during 2015/16 to develop plans to support twice daily senior decision making for all inpatients, and to ensure patients with the highest clinical priority are seen first during hospital ward rounds followed by patients potentially fit for discharge to facilitate early discharge and improve patient flow.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.0 Belfast Local Commissioning Plan

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

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

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

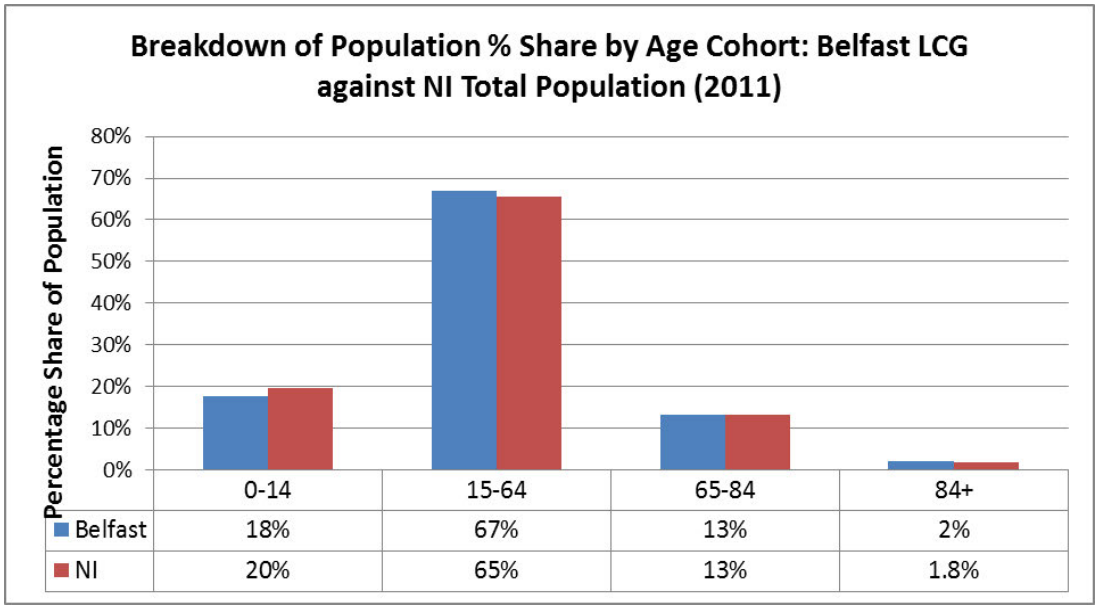
9.1 Overarching assessment of need and inequalities for LCG population

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

9.1.1 Demographic changes / pressures

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

Figure 4



Source: NISRA 2012

Demography

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

Belfast LCG population changes

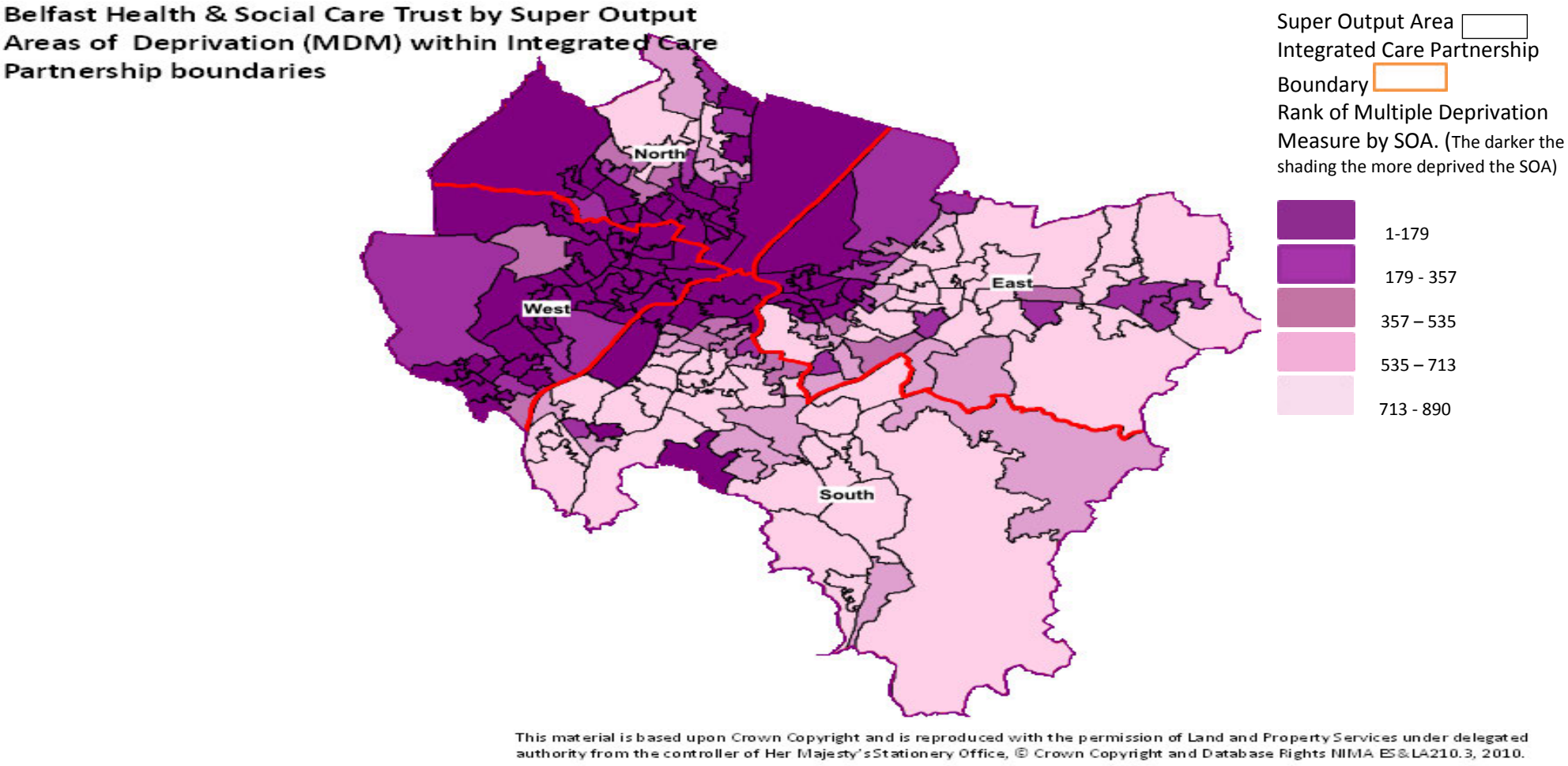
Table 22

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

Deprivation

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

Figure 5

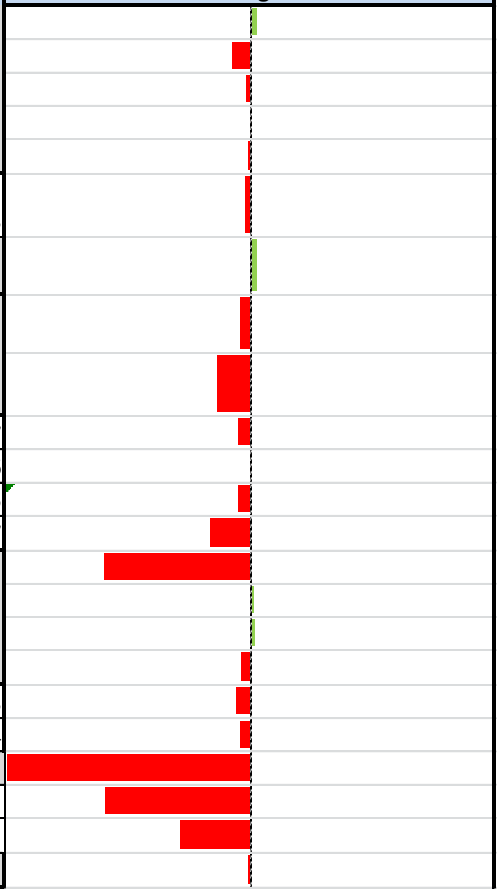


Health Summary

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

Table 23

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



Higher than NI Average

Lower than NI Average

9.1.2 Personal and Public Involvement

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

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

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

9.1.3 Summary of key challenges

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

9.2 LCG Finance

Use of Resources

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

Table 24

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

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

Table 25

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

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

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

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

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

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

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

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

Trust Savings Plan

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

Community Information Exercise

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

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

9.3.1 POC 1: Acute – Elective Care

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

Local Needs and Assessment

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

Services to be commissioned

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

Securing Service Delivery

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

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

9.3.2 POC 1: Acute – Unscheduled Care

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

Local Needs and Assessment

1. The number of patients admitted as emergencies for less than 48 hours is increasing, in line with national trends.
2. Variation in demand for urgent care by hour of day and day of week is not matched by appropriate service responses in hospital or in the community, leading to delays in the delivery of care and requiring expansion of capacity in specific areas.
3. Around 46,000 people attend Emergency Departments for minor illnesses or injuries which could be addressed more appropriately within primary care or by self-care.

Services to be commissioned

1. The LCG will commission 7-day Acute Care at Home and Community Respiratory services to avoid unnecessary short stay admissions of the frail elderly and COPD patients to hospital.
2. The LCG will commission a new Emergency Department and supporting services at the RVH which match the pattern of attendances at this hospital. The LCG will commission 7 day services which support the Emergency Department and avoid unnecessary short stay admissions and delays.
3. The LCG will commission integrated Minor Injury, Minor Illness, Out of Hours and Primary Care services, supported by community and voluntary resources.

Securing Service Delivery

1. The Belfast ICPs should continue to implement the ICP Respiratory team and bring forward proposals to extend Acute Care at Home to 7 days.
2. The Belfast Trust should ensure that: the new RVH ED has sufficient support from hospital services to meet Ministerial targets for waiting times; senior decision-makers are able to assess and discharge rather than admit, where this is clinically appropriate, and the frequency of ward rounds is increased to ensure no unnecessary delays in discharging patients. Excess days in hospital should be reduced in line with best practice in the NHS.
3. The ICPs should bring forward proposals for minor illness/injury services based on the LCG specification.

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

POC1 Values and Volumes

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

Table 26

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

9.3.3 POC 2: Maternity and Child Health Services

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

Local Needs and Assessment

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

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

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

Services to be commissioned

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

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

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

Securing Service Delivery

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

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

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

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

POC2 Values and Volumes

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

Table 27

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

9.3.4 POC 4: Older People

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

Local Needs and Assessment

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

Services to be commissioned

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

Securing Service Delivery

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

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

POC4 Values and Volumes

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

Table 28

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

9.3.5 POC 5: Mental Health

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

Local Needs and Assessment

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

Services to be commissioned

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

Securing service delivery

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

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

POC5 Values and Volumes

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

Table 29

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

9.3.6 POC 6: Learning Disability

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

Local Needs and Assessment

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

Services to be commissioned

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

Securing Service Delivery

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

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

POC 6 Values and Volumes

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

Table 30

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

9.3.7 POC 7: Physical Disability and Sensory Impairment

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

Local Needs and Assessment

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

Services to be commissioned

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

Securing Service Delivery

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

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

POC 7 Values and Volumes

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

Table 31

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

9.3.8 POC 8: Health Promotion

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

Local Needs Assessment

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

Services to be commissioned

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

Securing Service Delivery

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

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

9.3.9 POC 9: Primary Health and Adult Community

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

Local Needs and Assessment

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

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

Commissioning Requirements

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

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

Securing Service Delivery

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

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

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

10.0 Northern Local Commissioning Plan

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

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

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

10.1 Overarching assessment of need and inequalities for LCG population

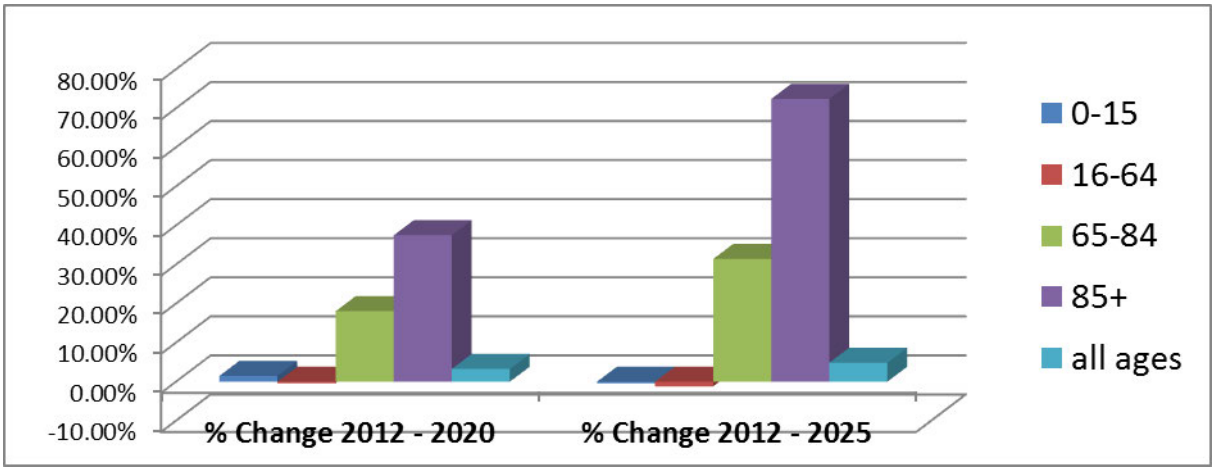
This section provides an overview of the assessed needs of the populations of the Northern Local Commissioning Group (NLCG). A range of information and analyses have been used to identify the challenges facing the NLCG in 2015/16 and beyond.

10.1.1 Demographic changes / pressures

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

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

Figure 6



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

Source: NISRA, 2012

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

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

Table 32

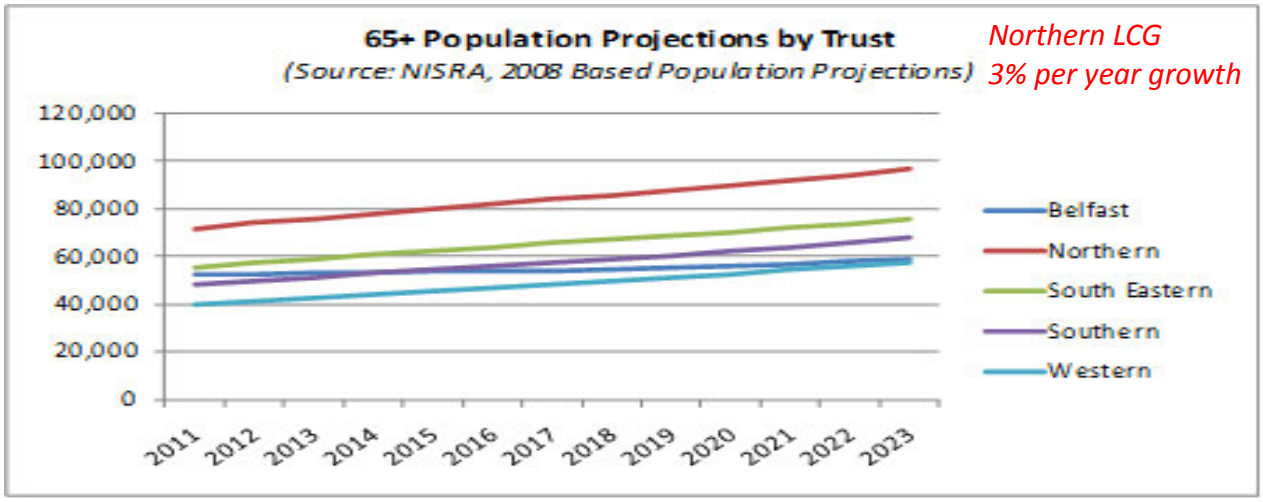
LGD	65-74	75-84	85+	Total 65+
Antrim	4,549	2,347	798	7,694
Ballymena	6,117	3,707	1,393	11,217
Ballymoney	2,751	1,570	570	4,891

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

Source: NISRA, Mid-Year Estimates 2013

Current >65 Population

Figure 7

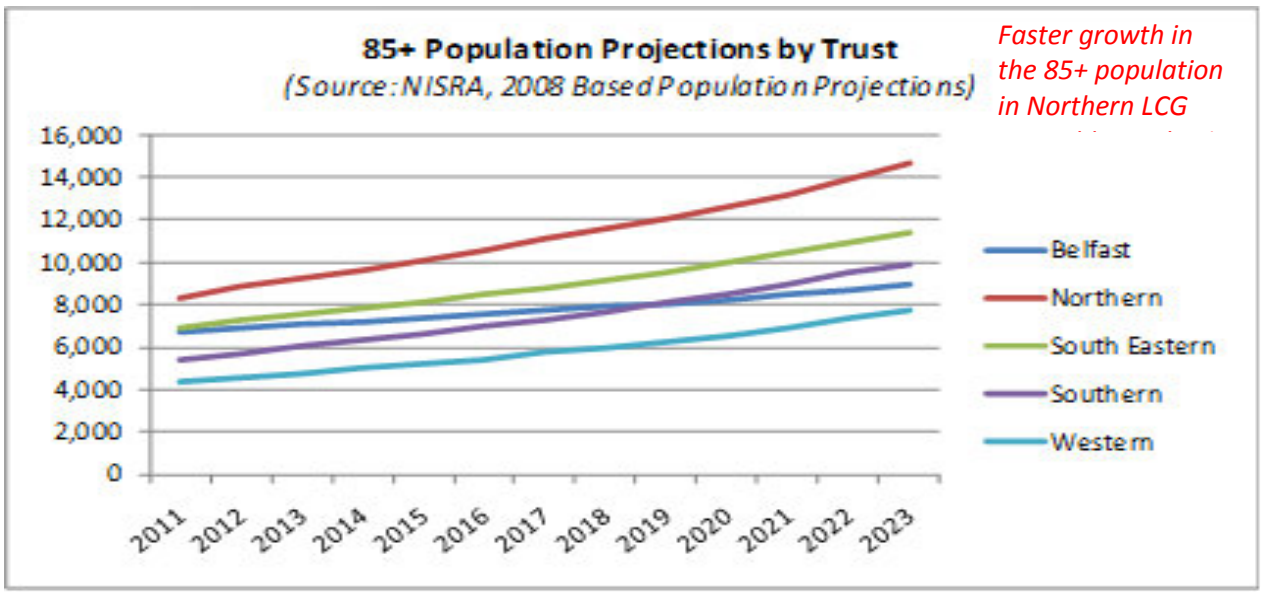


Year:	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
65+ Pop	71,527	73,876	75,912	77,834	79,785	81,725	83,706
	2018	**2019**	**2020**	**2021**	**2022**	**2023**	
65+ Pop	85,693	87,661	89,630	91,777	94,024	96,386	

Source: NISRA, 2008 Population Projections

Current Over 85 Population

Figure 8



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

Source: NISRA, 2008 Population Projections

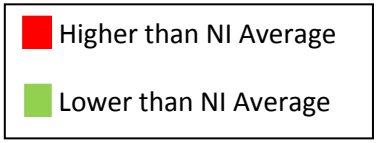
The table below highlights the greater prevalence of certain conditions in the Northern LCG area namely: cancer, stroke, atrial fibrillation, coronary heart disease, hypertension and diabetes.

Health Summary

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

Table 33

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



10.1.2 Personal and Public Involvement

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

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

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

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

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

10.1.3 Summary of Key Challenges

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

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

10.2 LCG Finance

Use of Resources

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

Table 34

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

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

Table 35

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

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

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

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

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

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

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

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

Trust Savings Plan

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

Community Information Exercise

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

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

10.3.1 POC 1: Acute – Elective Care

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

Local Needs and Assessment

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

Commissioning Requirements

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

Securing Service Delivery

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

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

10.3.2 POC 1: Acute – Unscheduled Care

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

Local Needs and Assessment

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

Commissioning Requirements

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

Securing Service Delivery

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

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

POC1 Values and Volumes

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

Table 36

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	8,127	260	8,387
		Daycases	23,552	2450	26,002
		New Outpatients	109,881	6100	115,981
		Review Outpatients	110,769		110,769
	Unscheduled	Non Elective admissions - all	36,645	2000	38,645
		ED Attendances	133,088	250	133,338
		Planned investment in 2015-16		£1.5m	

10.3.3 POC 2: Maternity and Child Health Services

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

Local Needs and Assessment

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

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

Services to be commissioned

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

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

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

Securing Service Delivery

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

Progress of the APNP will be monitored.

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

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

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

POC2 Values and Volumes

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

Table 37

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

10.3.4 POC 4: Older People

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

Local Needs and Assessment

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

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

Services to be Commissioned

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

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

Securing Service Delivery

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

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

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

POC4 Values and Volumes

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

Table 38

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

10.3.5 POC 5: Mental Health Services

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

Local Needs and assessment

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

Services to be Commissioned

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

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

Securing Service Delivery

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

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

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

POC5 Values and Volumes

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

Table 39

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

10.3.6 POC 6: Learning Disability Services

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

Local Needs and Assessment

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

Services to be Commissioned

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

Securing Service Delivery

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

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

POC6 Values and Volumes

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

Table 40

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

10.3.7 POC 7: Physical Disability and Sensory Impairment Services

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

Local Needs and Assessment

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

Services to be Commissioned

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

Securing Service Delivery

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

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

POC7 Values and Volumes

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

Table 41

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

10.3.8 POC 8: Health Promotion

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

Local Needs and Assessment

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

Services to be commissioned

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

Securing Service Delivery

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

   NHSCT should be smoke free by No Smoking Day 2016.

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

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

10.3.9 POC 9: Primary Health and Adult Community

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

Local Needs and Assessment

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

Services to be Commissioned

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

Securing Service Delivery

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

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

11.0 South Eastern Local Commissioning Plan

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

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

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

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

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

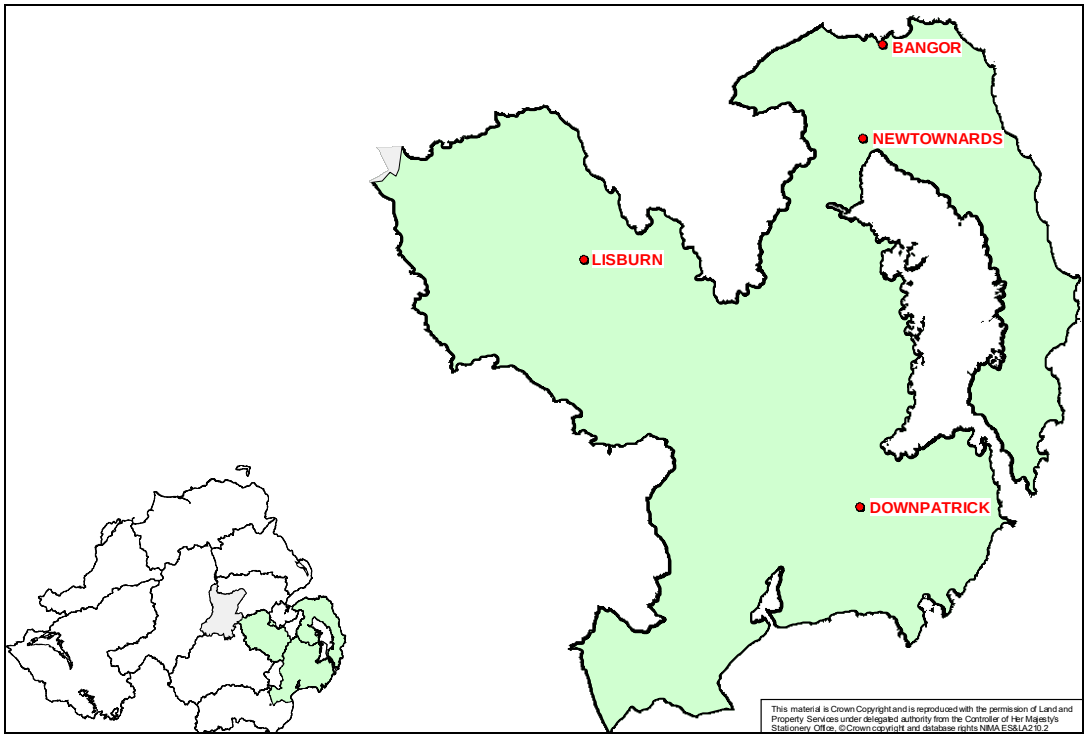
11.1 Overarching assessment of need and inequalities for LCG population

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

Geography and Communities

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

Figure 9: Population Centres in SELCG area



11.1.1 Demographic changes / pressures

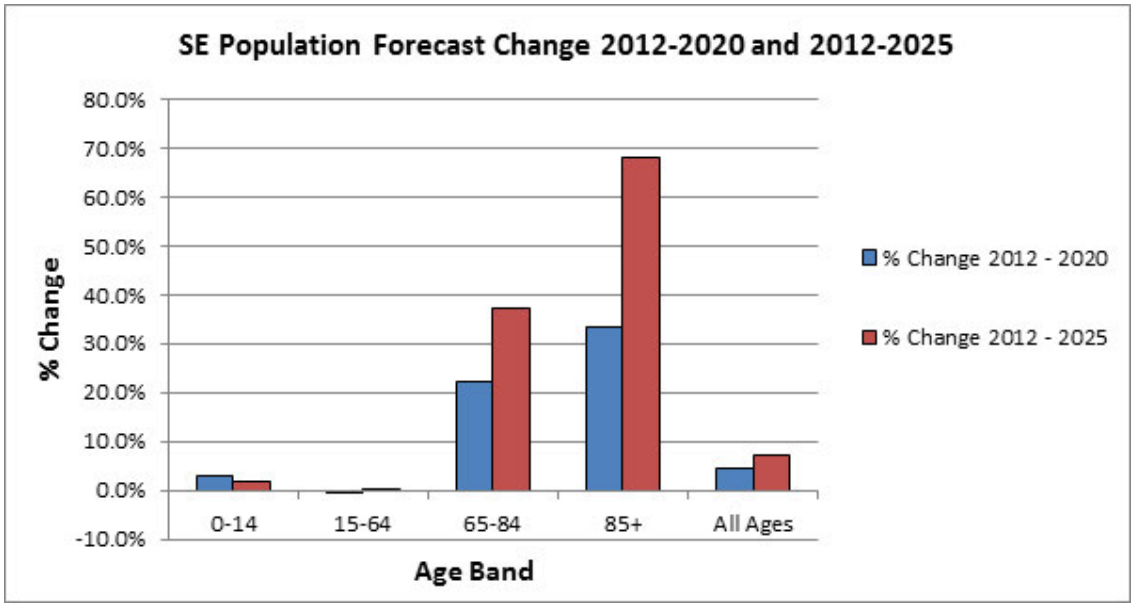
This section gives a general overview of the population within the LCG area, describing the age structure, general health and income of the resident population.

Demography

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

Population Forecast Change

Figure 10



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

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

Population Projections

Table 42

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

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

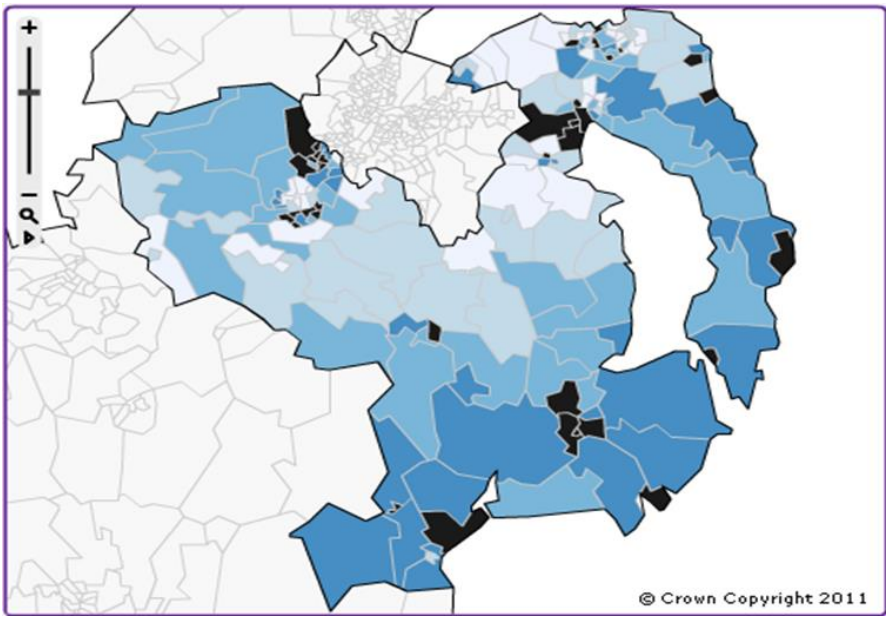
Deprivation

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

Life expectancy for males within the most deprived areas of the south east at 2010-12 was 3.4 years lower than the overall figure for the area, and 2.5 years lower than N. Ireland as a whole. Female life expectancy within the most deprived areas over the same period was 1.6 years lower, and 1.2 years lower than N.Ireland as a whole.

Deprivation Mapping

Figure 11



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

Percentage of Population in NI Deprivation Quintiles
Figure 12

Source: PMSI South East Local Area Health Profile

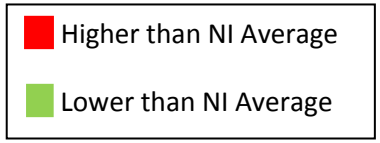
Work produced by the N. Ireland Health and Social Care Inequalities Monitoring System (HSCIMS) sub regional inequalities (2015) has been helpful in identifying, across a range of domains, inequalities across the south east in comparison to the N. Ireland average. The general picture shows that within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

Health Summary

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

Table 43

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



11.1.2 Personal and Public Involvement

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

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

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

11.1.3 Summary of Key Challenges

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

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

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

Equality and Human Rights

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

11.2 LCG Finance

Use of Resources

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

Table 44

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

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

Table 45

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

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

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

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

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

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

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

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

Trust Savings Plan

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

Community Information Exercise

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

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

11.3.1 POC 1: Acute (Elective)

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

Local Needs and Assessment

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

Commissioning Requirements

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

Securing Service Delivery

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

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

11.3.2 POC 1: Acute (Non-Elective)

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

Local Needs and Assessment

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

Commissioning Requirements

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

Securing Service Delivery

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

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

POC 1 Values and Volumes

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

Table 46

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

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

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

[8] UHD, Downe, LVH sites only

[9] UHD, Downe, LVH sites only

11.3.3 POC 2: Maternity and Child Health Services

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

Local Needs and Assessment

1. There has been an increase in births above the commissioned capacity (4,941 in 14/15). In particular, there has been an increase in births at the Ulster Hospital (UH). This has put pressure on both inpatient and outpatient provision.

   The prevalence of mothers with higher BMIs and births where diabetes was identified as a maternal risk factor is increasing.

2. The incidence of asthma and allergies among children has increased in recent years and there is currently no paediatric consultant in place in the SE with an interest in Epilepsy.

   Medical cover in paediatrics – there are fewer consultant paediatricians serving the locality than in other LCG areas despite having the second largest childhood population.

3. There are a small number of children with complex needs requiring specialised, high cost care.

Services to be Commissioned

1. Core baseline funding will be reviewed due to sustained increase in births above commissioned capacity. The LCG will commission additional resource to make labour rooms 6 and 7 operational at the UH.

   The LCG will also seek to address capacity issues within the UH's maternity outpatient area to deal with the volume of Gynae, fertility and other maternity clinics, to include diabetes clinics. The LCG will also review neonatal services at the Ulster Hospital following the publication of the Neonatal Review.

2. The LCG will explore with the SET, a new paediatric model, to include a consultant with an interest in epilepsy and will work with the SET to support improved access to paediatric services at the Ulster Hospital.

3. The LCG will continue to work with SET to address pressures associated with complex care packages at home.

Securing Service Delivery

1. The LCG will seek to commission an evaluation of Downe and Lagan Valley Midwifery Led Units in conjunction with the Leadership Centre.

   SET should continue to ensure that the model of care in place is in line with the Maternity Strategy and participate in projects led by the HSCB/PHA to implement other key priorities.

   SET should relocate gynae and speciality outpatient clinics from the UH maternity unit to community hubs (or other appropriate sites) where it is safe to do so.

   SET should ensure that all eligible pregnant women, aged 18 years or over, with a BMI of 40 or more at booking are offered the 'Weight to a Healthy Pregnancy Programme', with an uptake of at least 65% of those invited.

2. SET to provide a paediatric epilepsy service subject to funding.

3. SET to increase access to paediatric services by extending the opening hours of the paediatric short stay assessment unit at the UH.

Regional Priorities (see appendix A): Tackling Obesity (MT2), Patient Safety (MT25)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC 2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 47:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,941		4,941
	Health Visiting	Contacts	24,430		24,430
		Planned investment in 2015-16		Nil	

11.3.5 POC 4: Older People

Strategic Context: The elderly population (65+) of the south eastern locality is growing faster than any other age group. With an ageing population, gains in life expectancy often present challenges in the context of higher prevalence rates of long term conditions such as COPD, diabetes, heart failure and stroke. Population ageing means that overall health and social care need has risen. This holds new responsibilities and challenges for us to commission services that help older people to stay healthy, independent and active for as long as possible

Local Needs and Assessment

1. SE LCG locality has, and into the future is projected to have, the highest number of 65+ older people in NI as a % of its population (18.3% of SELCG population by 2017). By 2023, 11,418 people will be 85+, a rise of 57.8%.

   This is leading to increased demand on both acute and community services including, unscheduled care, domiciliary care, dementia care, psychiatry of old age, safeguarding and provision of end of life care.
2. SE LCG the highest prevalence of Stroke and TIA in Northern Ireland and it continues to rise. (Source GP QoF)
3. As the population ages, the LCG area has an increased number of people providing unpaid care. Evidence shows that caring impacts negatively on both the mental and physical wellbeing of the carer.

Services to be Commissioned

1. To meet the increasing demands the LCG will commission:
   - additional domiciliary care hours
   - additional community equipment
   - appropriate care at home as an alternative to ED and acute hospital admission where clinically appropriate for elderly patients.
   - a 'Safe and Well 'model of community support.

   The SELCG will also work with PHA to develop and commission preventive services to include falls prevention, social inclusion and the promotion of active and healthy lifestyles
2. A new stroke model for the SE will be designed.
3. The LCG will commission additional short break provision for carers of older people.

Securing Service Delivery

1. SET will provide additional hours of domiciliary care for older people through a mix of statutory and independent domiciliary care provision and implement a 'Safe and Well' model.

   The ICP will:
   - implement a Care at Home initiative in North Down in 15/16.
   - develop initiatives to support older people to remain at home e.g. Falls programme.
   - progress actions coming from the Transforming Your Palliative and End of Life Care initiative to support people to die in their preferred place of death.
2. A new stroke model will be delivered by the ICP.
3. SET will provide additional short break provision for carers of older people.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC 4 Values & Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 48

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,048	58,700	2,316,748
	Residential and Nursing Home Care	Occupied bed days	730,804		730,804
	Community Nursing	Contacts	206,704	6,400	213,104
		Planned investment in 2015-16		£4.2m	

11.3.6 POC 5: Mental Health Services

Strategic Context: The LCG will continue to work with the Regional Bamford Team to develop services for those with mild, moderate or severe mental illness, placing an emphasis on recovery through the Stepped Care Model which supports people to live as independently as possible. Focus should also be on people who have significant life events and/or stressors that increase the threshold of harm. The LCG will also work to develop access as appropriate to community voluntary or specialist support by targeting clients at an earlier stage to prevent crisis intervention.

Local Needs and Assessment

1. Clients are waiting longer than 13 weeks for psychological therapy within the secondary care service.

   There is an over dependency in the SE area on prescription drugs for those with mental health issues.
2. Current hospital admissions and length of stay for acute patients are currently higher in NI compared to England and could be further reduced with greater use of Crisis Response/Home Treatment and a new acute MH in-patient model.
3. Carers continue to provide vital support to family members with mental health issues. Carers have reported to the LCG poorer mental and physical health as a consequence of their caring role.

Services to be Commissioned

1. The LCG will commission additional psychological therapies within primary care at levels 1 and 2 of the Stepped Care Model; and within secondary care at Level 3.
2. The LCG will commission a reprofiling of Crisis Response Home Treatment with the inclusion of a skill mix based staffing complement and the opportunity to develop a new MH centre of excellence.
3. The LCG will commission additional carers assessments and support to include short breaks in addition to uplifting nursing and residential home places.

Securing Service Delivery

1. SET will establish a Primary Care Mental Health and Well-Being Hub pilot site in Dunmurry. The evaluation of this pilot will influence further commissioning intent in other sectors.

   SET will also deliver the additional commissioned capacity within secondary care for psychological therapies.
2. SET will further develop and extend access to the Crisis Response Home Treatment service in accordance with the commissioner specification.
3. LCG will monitor provision of short breaks.

Regional Priorities (see appendix A): Unplanned Admissions (MT6), Carers' Assessments (MT7), Mental Health Services (MT22), Excess Bed days (MT27)
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC 5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 49:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	39,273	0	39,273
	Residential and Nursing Home Care	Occupied Bed days	41,808	720	42,528
	Domiciliary Care	Hours	13,042	2,612	15,654
		Planned investment in 2015-16		£0.43m	

11.3.7 POC 6: Learning Disability Services

Strategic Context: The key aims of Learning Disability services are to promote independence for people with a learning disability in inclusive community environments which promote their health and wellbeing and provide appropriate support for their families who care for children and adults with learning disabilities.

Local Needs and Assessment

1. A small number of LD clients remain to be resettled from Muckamore Abbey Hospital.
2. There is a need to reduce the number of LD clients presenting at EDs.
3. There is also a need to extend supported living schemes for LD clients.
4. A number of children with learning disability and complex health needs are transitioning to adult services in 2015/16.
5. There is a need to continue the delivery of Day Services in line with the Regional Day Opportunities model.

Services to be Commissioned

1. The LCG will respond to plans for resettlement to finalise the arrangements for the remaining LD clients in Muckamore Abbey.
2. The LCG will commission a pilot Crisis Response Home Treatment service for people with LD.
3. The LCG will continue to develop supported living schemes under South Eastern Area Supporting People Partnership.
4. The LCG will commission services for those young people with LD and complex health needs who are transitioning to adult services.
5. The LCG will commission the delivery of additional Day Services subject to budgetary constraints.

Securing Service Delivery

1. SET will be required to report on the progress of the remaining LD clients. If needed, appropriate funding will be made available to facilitate this process.
2. SET will pilot the Crisis Response Home Treatment service.
3. LCG will monitor provision of supported living places in line with need.
4. SET will be commissioned to provide a number of services for those young people with LD and complex health needs who are transitioning to adult services.
5. SET will provide additional Day Services for LD clients.

Regional Priorities (see appendix A): Delivering Transformation (MT29)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 - Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 50

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	108,582	4,000	112,582
	Residential & Nursing Home Care	Occupied bed days	116,456		116,456
		Planned investment in 2015-16		£0.13m	

11.3.8 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: SELCG will continue to the implementation of the Physical and Sensory Disability (P&SD) Action Plan and Transforming Your Care (TYC) recommendations to support people to live independently in their own homes as long as possible. We will continue to invest in additional neuro-rehabilitation services to support the increasing number of people being discharged from hospital with complex care needs.

Local Needs and Assessment

1. As of September 2014 there were 489 physical and sensory disabled clients in receipt of a domiciliary care package. Of these, 193 are receiving intensive domiciliary care. The number of people with complex needs is increasing and these people require significant packages of care.
2. Wait times for access to audiology services do not meet with regional guidelines
3. Over 5% of the SELCG population provide 20 hours or more of unpaid care per week.
4. It is anticipated that there will be increased pressure to discharge from secondary care those patients who suffer from brain injury and who are clinically appropriate for discharge to an alternative facility best placed to meet their longer term needs.

Services to be Commissioned

1. The LCG will commission an appropriate mix of domiciliary care and direct payments via a mix of statutory and Independent providers and additional Nursing Homes for P&SD clients.
2. The LCG will commission additional audiology capacity for those with a hearing impairment.
3. The LCG will commission short break provision for Carers of People with Physical and Sensory Disabilities.
4. The HSCB will commission additional bed days in Thompson House to support the brain injury pathway.

Securing Service Delivery

1. SET will ensure delivery of additional domiciliary hours and nursing home beds.
2. SET to appoint an additional audiologist and ensure improvements in audiology access.
3. SET will provide the required number of short breaks.
4. SET will ensure provision of the neuro-rehabilitation additional bed days and consultant sessions.

Regional Priorities (see appendix A): Carers' Assessments (MT7), Direct Payments (MT8), Allied Health (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC 7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 51

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	342,870	500	343,370
	Residential & Nursing Home Care	Occupied bed days	27,192	80	27,272
		Planned investment in 2015-16		£0.08m	

11.3.9 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing health inequalities are key priorities for the SELCG and the PHA. In line with the new public health strategy 'Making Life Better' and the Marmot Review 2010 and 2012, action will focus on strengthening coordination and collaboration across organisations and communities, and with the community planning function of the new councils, to ensure children and young people get the best start in life, people are supported to make healthy choices and together with partners we seek to ensure structural, economic, environmental and social conditions are conducive to health.

Local Needs and Assessment

1. In the SE area 20% of the population continue to smoke (NI 22%), 37% of adults are overweight (NI 37%), 26% are obese (NI 25%) and 18% of adults drink above recommended weekly limits (NI 16%).
2. Communities experiencing higher levels of deprivation continue to experience lower levels of life expectancy and higher levels of disability and poor health.
3. There is a high rate of suicides and self-harm among the south east population.
4. Local Councils now have a lead role in developing Community Plans which include Health and Wellbeing.

Services to be Commissioned

1. The LCG/PHA will commission programmes to encourage changes in behaviour related to physical activity, healthy eating, alcohol and drug use, cancer prevention, sexual health and smoking.
2. The LCG/PHA will commission evidence based parenting programmes to ensure accessible and equitable family support services & programmes across the area.
3. The LCG/PHA will commission programmes to promote mental and emotional wellbeing and prevent suicides and self-harm.
4. The LCG/PHA will engage with the new Councils in the development of Community Plans.

Securing Service Delivery

1. The LCG with PHA will continue to invest in the work of the SET Health Improvement Service to provide effective operational leadership, coordination and support across all communities and organisations contributing to health and wellbeing improvement.
2. Early Years Intervention communities to deliver programmes in Colin, Lisburn, Downpatrick, Ards/North Down .
3. ICPs, Primary Care Teams & SET to deliver commissioned mental health support programmes.
4. New Partnerships through Local Councils should deliver and support improved health outcomes.

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

12.3.10 POC 9: Primary Health and Adult Community

Strategic Context: This programme of care includes all work, except screening, carried out by General Medical Practitioners, Out of Hours, General Ophthalmic, Dental, and Pharmacists as well as community based AHPs and nursing services. The GP practice population for the SELCG is 315,664 (overall population is circa 350,000). The SELCG will continue to commission primary care led services for the frail elderly and people with long term conditions, such as coronary heart disease, diabetes, respiratory conditions and TIAs/strokes.

Local Needs and Assessment

1. There are increasing numbers of adults being referred to ED and admitted to hospital. Many of these people could be alternatively treated at home or in the community.
2. SELCG population has higher than average prevalence of cancer, stroke, coronary heart disease, hypertension, asthma, diabetes and chronic pain.
3. Along with the rest of N.Ireland, reliance on prescription medication remains high within the population.
4. Prevalence rates of sexually transmitted infections are higher than the NI average.

Services to be Commissioned

1. LCG will continue to commission services in relation to the 'Care at Home' model of care and Frail Elderly LES.
2. LCG will invest in ICP developed care pathways. Subject to funding, Arthritis Care NI will be commissioned to provide a Peer Education Pain Management Programme for patients with chronic pain.
3. LCG will continue to invest in Practice Based Pharmacists to facilitate efficient medicines management and further reduction of prescribed medication costs.
4. LCG will commission the roll out of Asymptomatic STI testing in Primary Care to the Down and Ards localities with a view to developing a fully integrated sexual and reproductive (family planning) service.

Securing Service Delivery

1. SE ICP will implement the Care at Home initiative in the North Down locality in 2015/16.
2. ICPs will implement new care pathways for respiratory disease and diabetes.
3. The SELCG will continue to monitor prescribing practice and costs within south east locality.
4. SET Sexual Health service will build the Primary Care Asymptomatic STI testing service LCG wide and will seek to redesign and integrate the FP service.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Pharmaceutical Clinical Effectiveness Programme (MT30)

12.0 Southern Local Commissioning Plan

This plan sets out what the LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines on a Programme of Care (PoC) basis, what our local needs are, what we will commission in year in response to that need and how we intend to ensure deliver either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

12.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Southern LCG. A range of information and analyses have been used to identify the challenges facing the LCG in 2015/16 and beyond.

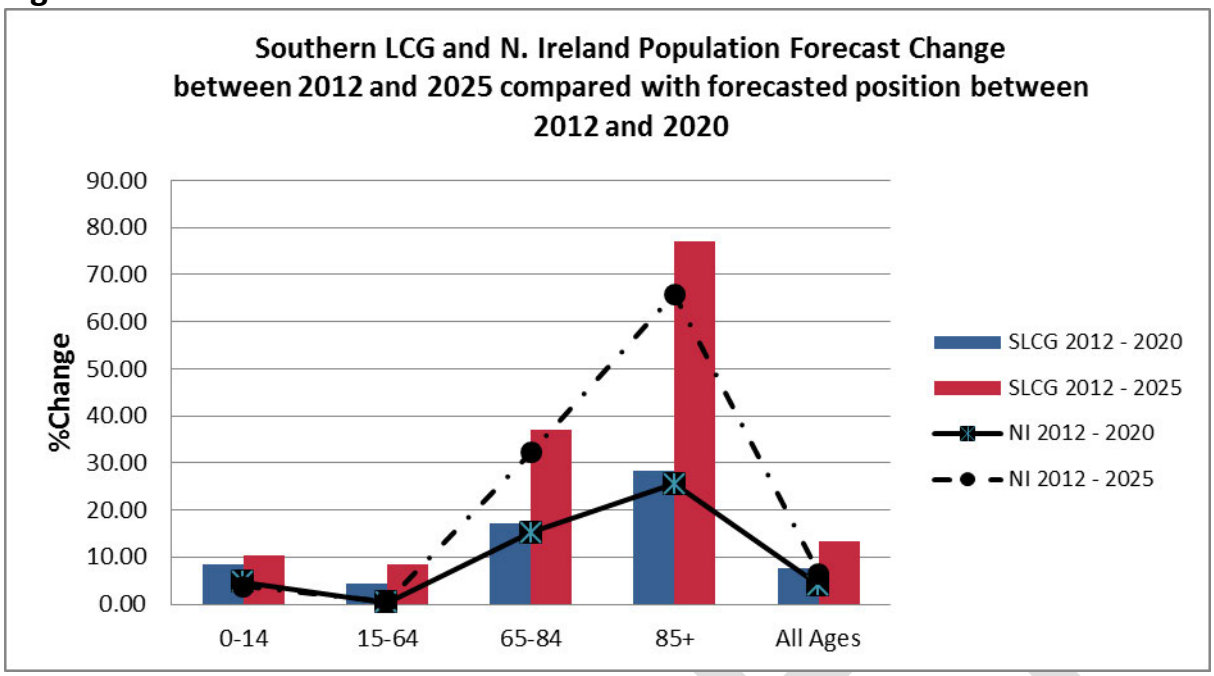
12.1.1 Demographic changes / pressures

This section gives a general overview of the population which the Southern LCG serves, describing the age structure, general health and income of the resident population.

Demography

The Southern LCG currently has a population of 365,712, representing 20.0% of the overall N. Ireland population. 93,595 SLCG residents aged 0-17 years account for 25.5% of the total SLCG population. 60.5% are aged 18-64 years, and 14% make up 65 years and over SLCG population.

Figure 13



The large increases forecast in the elderly, and particularly the very elderly, have significant implications for health care over the next five to ten years. Even if the general levels of health in these age groups can continue to improve, the shape and structure of health services will need to change to meet the needs of this growing group. Investment in the "Acute Care at Home" model and District Nursing will be pivotal in meeting this need.

Migration

The Southern LCG area has experienced a high influx of foreign nationals, between July 2004 and June 2013 the 5 Local Government Districts within the Southern LCG area experienced a net international migration population of 20,233 which accounts for 68% of the overall N. Ireland total. In addition, 4 of the 5 SLCG LGDs fell within the highest net figures across N. Ireland, with Dungannon LGD accounting for 22% of the NI total.[10]

[10] NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 52

NISRA Estimated Net International Migration, by LGD (July 2004 – June 2013)

Table 4.3: Estimated Net International Migration, by Age and Gender (July 2012 - June 2013) - N. Ireland, Trust and SLCG LGD

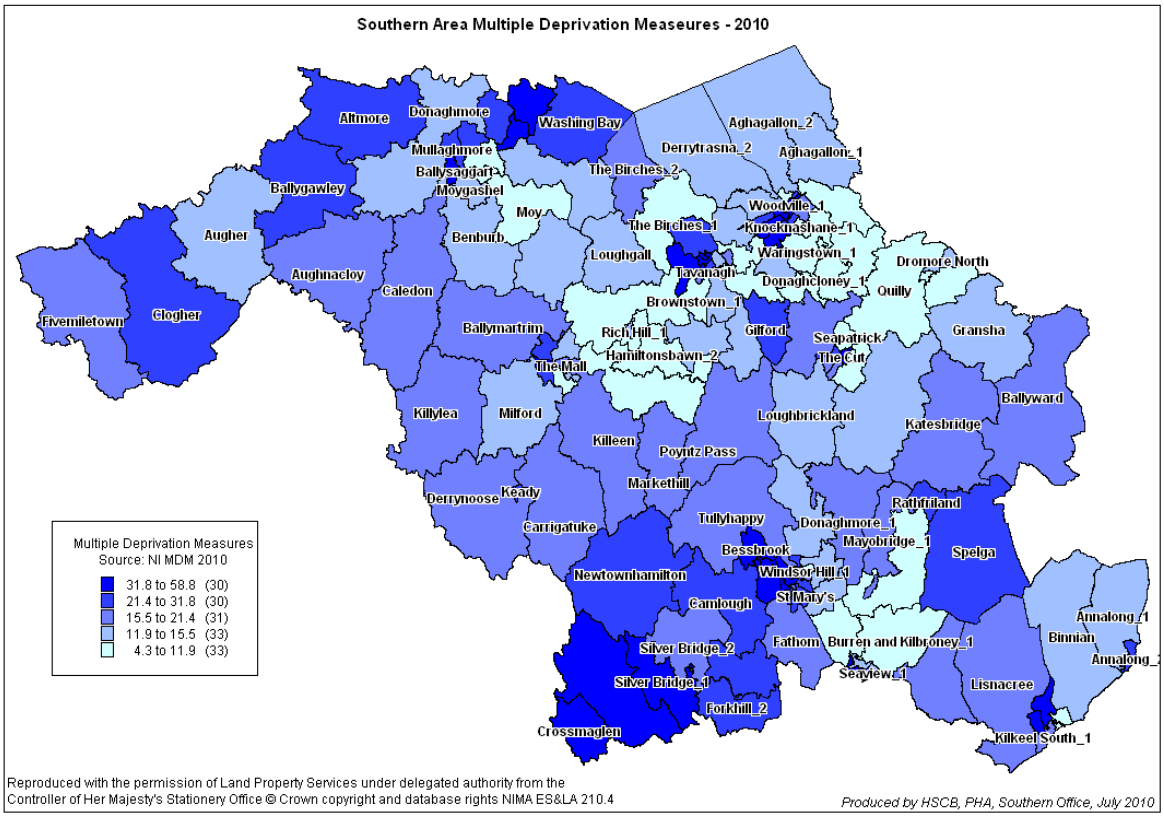
Gender / Age	Estimated Net International Migration	BHSCT	NHSCT	SEHSCT	SHSCT	WHSCT	Armagh	Banbridge	Craigavon	Dungannon	Newry and Mourne
Male	**-547**	**-756**	**-89**	**-124**	**527**	**-105**	**86**	**-9**	**207**	**156**	**87**
Less than 18 years	263	52	49	-20	158	24	27	0	44	60	27
18-24	216	-168	51	28	314	-9	28	-2	113	109	66
25-34	-529	-386	-125	-17	23	-24	21	-5	40	-19	-14
35-44	-331	-182	-61	-59	34	-63	12	1	6	0	15
45-54	-32	-12	8	-33	15	-10	6	-2	10	-3	4
55-64	-69	-29	-10	-10	-9	-11	-2	3	-3	1	-8
65 years and over	-65	-31	-1	-13	-8	-12	-6	-4	-3	8	-3
Female	**-340**	**-367**	**-202**	**-56**	**493**	**-208**	**55**	**7**	**205**	**126**	**100**
Less than 18 years	421	132	42	27	178	42	18	8	42	58	52
18-24	225	-22	-19	32	236	-2	19	9	77	73	58
25-34	-652	-322	-173	-54	25	-128	6	1	33	-3	-12
35-44	-254	-125	-44	-39	-6	-40	-1	-14	24	0	-15
45-54	-44	-24	-15	-17	35	-23	6	2	20	-2	9
55-64	-1	15	-1	0	9	-24	-1	-1	1	1	9
65 years and over	-35	-21	8	-5	16	-33	8	2	8	-1	-1
Total	**-887**	**-1,123**	**-291**	**-180**	**1,020**	**-313**	**141**	**-2**	**412**	**282**	**187**

Source: NISRA (June 2014)

Deprivation

- Using the Multiple Deprivation Measure, the most deprived Super Output Area across the Southern area is Drumnamoe_1 (Craigavon LGD) whilst the least deprived is Waringstown_2, (Craigavon LGD).
- Using Multiple Deprivation, Drumnamoe_1 is ranked 16 out of 890 and Waringstown_2 is ranked 830 out of 890 across Northern Ireland.
- *Summary Measures* - using the Extent score (% of an area's population living in the most deprived SOAs in NI); the highest % in the Southern area is within Craigavon LGD, 21%. This LGD ranks 4th across NI using this score.
- The summary measures also indicate that almost 30,000 people or 29% of the total population in Newry/Mourne LGD are considered income deprived (ranked 3rd in NI).

Southern Area Multiple Deprivation Measures (2010)
Figure 14

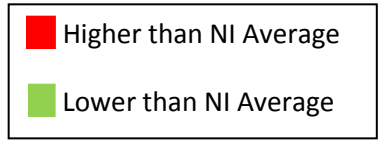


Health Summary

The table below shows the health of the Southern LCG population in comparison to Northern Ireland as a whole.

Table 53

Domain	Indicator	Descriptor	SLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.61	19.12	
	COPD	Prevalance per 1000	15.82	18.56	
	Stroke	Prevalance per 1000	15.86	17.94	
	Atrial Fibrillation	Prevalance per 1000	13.45	15.12	
	Coronary Heart Disease	Prevalance per 1000	35.59	38.81	
	Hypertension	Prevalance per 1000	124.32	130.5	
	Diabetes	Prevalance per 1000	38.47	42.61	
	Asthma	Prevalance per 1000	55.35	60.48	
	Dementia	Prevalance per 1000	5.8	6.67	
	Learning Disability	Prevalance per 1000	5.35	5.33	
	Bowel Cancer Screening	Programme Uptake	47.76	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	7.66	8.54	
	Crude Suicide Rates	All Persons	15.2	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012-2013)	22	24	
	Obese or overweight	% of population (2012-2013)	61	62	
	Meeting Physical activity levels	% of population (2012-2013)	51	53	
	Pain or Discomfort	% of population (2012-2013)	34	35	
	Anxious Depressed	% of population (2012-2013)	23	26	
Maternal and Child Health	Children in Need	Rate per 100,000	45.64	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	2.57	3.86	
	Births to unmarried mothers	Percentage 2013	53.44	42.46	
	Births to Mothers from outside NI	Percentage 2013	20.98	17.88	
Life Expectancy	Male	Age (2009-11)	77.5	77.5	
	Female	Age (2009-11)	82.11	82	
	Neonatal	Death Rate (2013)	0.2	0.3	
	Infant Mortality	Death Rate (2013)	3.5	4.6	
	Lung Cancer	STD Death Rate	58.8	66.5	
	Female Breast Cancer	STD Death Rate	42.2	38.1	
Carers	Unpaid Care (2011)	50+ Hours provided	3	3.1	



12.1.2 Personal and Public Involvement

The Southern LCG has over the past year initiated, faciliated and supported a range of opportunities to engage directly with patients, service users and the public on both their experiences of using health and social care services in the southern area and their views on how these could be commissioned and provided in the future to improve outcomes for patients. Specific engagement events[11] have been held on:

- Integrated Care Partnerships and their role in the delivery of health and social care at a local level
- The views of carers and carers representatives on the provision of short breaks
- Urgent Care, as provided by emergency departments, minor injuries units and the GP Out of Hours services

In addition and as a consequence of the second event above, the LCG has established a carers group of 10 local carers who will work directly with the LCG to contribute to and support its commission decisions. Already and in response to carers input, the LCG has invested in support for carers in a number of programmes of care and intends to continue this support in year.

The LCG has also recognised that the voice of adults with a physical disability and /or sensory impairment is often not heard and so has set up a User Panel to seek the views of individuals who have experienced these services to improve the outcomes for service users.

The LCG has also extensively engaged with public representatives on a range of issues and has and will continue to offer community and voluntary groups the opportunity to come to meet LCG members. Groups have used these opportunities to share what they are doing to improve outcomes for individuals, families and communities at both a service and / or geographical level.

[11] Full reports on the events can be found at www.hscboard.hscni.net in the Southern LCG section

Following all these events and processes, a number of key themes have emerged which the SLCG is committed to taking forward, namely:

- **Improved communication with service users**: The SLCG will continue to hold 3-4 engagement events annually.
- **Continued support for carers**: The SLCG has identified this as a commissioning priority in Programmes 4, 6 and 7.
- **Need for more flexible services which respond to real life situations, especially at weekends**: The SLCG is committed to working toward extended day and /or 7 day services where possible

12.1.3 Summary of key challenges:

- A growing population of elderly people with increased care needs and increasing prevalence of disease;
- Higher proportion of people living with long term illness;
- Highest proportion of individuals using prescribed medication for mood and anxiety disorders
- An over-reliance on hospital care, with activity exceeding current funds;
- Services which are fragmented and lack integration;
- Health and quality of life generally worse than the rest of NI

12.2 LCG Finance

Use of Resources

The Southern LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £562m. As detailed in the table below, this investment will be across each of the nine Programmes of Care, through a range of service providers.

Table 54

Programme of Care	£m	%
Acute Services	205.6	36.50%
Maternity & Child Health	27.3	4.85%
Family & Child Care	38.8	6.89%
Older People	128.2	22.79%
Mental Health	48.4	8.60%
Learning Disability	54.3	9.65%
Physical and Sensory Disability	18.8	3.34%
Health Promotion	19.5	3.46%
Primary Health & Adult Community	21.1	3.93%
POC Total	**562.0**	**100%**

This investment will be made through a range of service providers as follows:

Table 55

Provider	£m	%
BHSCT	49.1	8.69%
NHSCT	0.1	0.02%
SEHSCT	5.3	0.93%
SHSCT	463.1	82.32%
WHSCT	3.7	0.65%
Non-Trust	40.7	7.39%
Provider Total	**562.0**	**100.00%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Southern Trust is in the region of £15.7m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Southern area and additional investment in the therapeutic growth of services.

12.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Southern Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

12.3.1 POC 1: Non Specialist Acute – Elective Care

Strategic Context: The LCG, working with key providers, will address the demand on elective and non-elective services to ensure Ministerial targets, extant standards and response times are improved, as per priorities below. Key to this approach will, in 15/16, be exploring opportunities to commission from Integrated Care Partnership, GP Federations and other new providers, for safe and viable services to complement secondary care.

Local Needs and Assessment

1. Demand for imaging exceeds capacity and it is recognised that this needs to be addressed.
2. Demand for Endoscopies exceeds commissioned capacity by 3352 per year.
3. Demand exceeds service capacity by 11,820 outpatient consultations, 972 inpatient and 1,046 day case treatments
4. There is no longer a local Consultant Ophthalmology service in the Southern area and this gap needs to be addressed.

Services to be Commissioned

1. The LCG will commission an additional 1324 MRI Scans, 7364 CTs, 10,545 Non-Obstetric Ultrasounds and 37,675 plain film
2. Referrals for endoscopy will be scored on a JAG accredited points system to ensure more effective use of clinical capacity.
3. The LCG will support initiatives in Primary care to manage demand for Neurology, Dermatology, ENT, General Surgery, Urology and Gynaecology.
4. The LCG will work with the Trust to agree the future configuration of BHSCT Ophthalmology outreach clinics and the possible provision of clinics in the WHSCT in order to meet demand

Securing Service Delivery

1. The Trust should fully develop the potential for Nurse-led Endoscopy and introduce an agreed points system to increase capacity.
2. Demand management will be sought from primary care contractors where these can be shown to reduce the need to refer to Trust Consultant-led services.
3. The Trust should seek to recruit to funded capacity particularly where recent investments have been made to further enhance the service. This is particularly relevant to T&O, Rheumatology, Obs & Gynae and to ENT
4. BHSCT and WHSCT to deliver the agreed service model.

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Cancer services (MT11), Elective Care (MT15, 16, 17),

12.3.2 POC 1: Non Specialist Acute – Unscheduled Care

Strategic Context: The SLCG aim is to ensure that there is a fully integrated care system in place in the Southern area where patients know who to contact in an urgent care situation, receive appropriate care and treatment as close to home as possible, move through the patient pathway in a seamless manner and where outcomes, as per the regional priorities identified below.

Local Needs and Assessment

1. The number of new and unplanned ED attendances at all SHSCT emergency departments is expected to increase by 8% this year compared to last

   Performance against the 4 hour target has reduced in recent years, currently averaging 85%

   Conversion from attendance to admission is low, (24%) with discharges spread evenly Monday to Friday but less at weekends

2. Baseline position for the Regional Unscheduled Care Task Force's 5 identified key tasks has identified gaps in AHP, Social Care, Nursing and Pharmacy input to EDs and wards

Services to be Commissioned

1. Subject to a satisfactory evaluation of the current Phase 1 of the Acute Care at Home model, the LCG will consider further roll out of this to support and manage patient flow within the Trust.

   The LCG will commission integrated Minor Injury, Minor Illness, Out of Hours and Primary Care services, supported by community and voluntary resources.

2. The LCG will take forward the implementation of the recommendations in the unscheduled care plan to address 5 identified key tasks including additional capacity for CAH ED

Securing Service Delivery

1. The Trust should provide evidence of improved discharges at weekend, reducing transfers after 7pm and increased use of minor injury streams at CAH

2. The Trust will implement the agreed recommendations of the Unscheduled Care Plan with defined activity agreed in SBA

Regional Priorities (see appendix A): Unscheduled Care (MT12), Excess Bed Days (MT27)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 56

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	6,947		6,947
		Daycases	23,573		23,573
		New Outpatients	78,976		78,976
		Review Outpatients	132,485		132,485
	Unscheduled	Non Elective admissions	33,108	1,236	34,653
		ED Attendances	129,961	4,548	134,509
		Planned investment in 2015-16		£1.9m	

12.3.3 POC 2: Maternity and Child Health Services

Strategic Context: The SLCG is committed to commissioning high quality, safe, effective and sustainable maternity services for women and babies in line with the objectives of the "Strategy for Maternity Care in Northern Ireland 2012 -2018". The forthcoming Departmental Paediatric Review, NICE guidance and the recommendations arising from the regional Review of Neonatal Services will focus the SLCG in its commissioning of efficient and value for money networked neonatal and paediatric acute services at both CAH and DHH and the supporting primary and community services to give the best outcomes for mothers, babies and children.

Local Needs and Assessment

1. Projected number of increased births until 2017 /2018 (circa total 6000 births per annum)

   Increased number of complex pregnancies are circa 105 multiple births annually, 20% mothers present with a BMI over 30 and 4% of mothers present with Diabetes, all of whom require more frequent clinic visits in an ambulatory care setting

   Caesarean sections rates are significantly higher than NI average (34%v29%)

2. A 29% increase in birth rate in the decade from 2002, has resulted in a growing child population in SLCG with associated rising demand for child health services, including universal services provided by Health Visitors i.e. Healthy Child Healthy Futures.

Services to be commissioned

1. The LCG will work with the Trust to achieve an increase in midwife led births and promoting midwife as first point of contact, particularly in DHH. Commissioning requirements for the neonatal services at both CAH and DHH will be clarified following the publication of the Neonatal Review recommendations

   The Treating Obesity in Pregnancy programme will be commissioned by the PHA

2. The LCG will issue a commissioner specification for paediatric ambulatory care will be issued in 2015/2016 outlining required performance and monitoring standards to be delivered.

   In paediatric care, a planned programme of investments will continue in 2015 / 2016 to ensure that appropriate paediatric medical and nursing capacity is provided and that ambulatory paediatric care is available to the standard outlined in the commissioner specification

Securing Service Delivery

1. Monitoring of consultant and midwife births along with intervention rates will continue, including full implementation of the Trust's normalisation of birth action plan on both sites

   The Trust should put in place additional consultant obstetric capacity to monitor and support mothers with identified risk factors, including multiple pregnancies and complex risk factors in line with NICE and other relevant guidance

   Midwifery and Health Visiting capacity will continue to be monitored.

   The Trust will implement the Treating Obesity in Pregnancy Programme. At least 139 women per year will receive this additional support.

2. Universal child health programmes will provide data on the state of health of children in the SLCG area informing targeting of initiatives, such as FNP, at those sub-populations with poorer health outcomes

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 57

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	5995		5995
	Health Visiting	Contacts	116,073		116,073
		Planned investment in 2015-16		Nil	

12.3.4 POC 4: Older People

Strategic Context: The SLCG is committed to promoting independence and choice and securing care closer to home, with an appropriate range of inpatient services for those who require it. We will work with providers including Integrated Care Partnerships to commission a range of services to meet the needs of our frail elderly population. Our commissioning intent will underpin the principles of TYC, the Regional Dementia Strategy and the Older People's Service Framework.

Local Needs and Assessment

1. 2012 Population Estimates would suggest that there are 48,922 people aged 65 and over living in the Southern LCG area, over 5,500 of these are aged 85 and over. Every year our older population increases by 3% (almost 1,500 persons).

2. Alzheimer's Society suggests that 1 in 14 people over the age of 65 have dementia. This number rises to 1 in 6 over the age of 80. Currently 2,234 patients are registered with the Southern Trust as living with dementia. Application of prevalence rates would indicate that there could up to 3,490 people in the SLCG area currently living with dementia, rising to as many as 4,435 people by 2020.

3. Demand for nursing home beds has increased Currently 1,360 beds are used by older people in the SLCG area.

Services to be Commissioned

1. The LCG will continue to commission phase 1 of the Acute Care at Home model and will conduct a detailed evaluation of the service during 2015/16, the outcome of which will inform its further development. The LCG will continue to support the ICP through commissioning extended hours and pharmacy input to this service.

   The SLCG will explore the potential to implement a crisis response model to address the urgent needs of people with dementia and their carers. An OT-led cognitive model will also be considered.

2. The LCG will commission additional care packages in line with assessed need and demographic growth. The reablement model will be extended to the full LCG area during 2015/16.

3. The LCG will work with the Southern Trust to assess the demand and capacity within district nursing services. This may require additional investment to ensure a 24/7 DN service which is GP aligned

Securing Service Delivery

1. The SHSCT should report against agreed KPIs to demonstrate the activity of the Acute Care at Home team, taking account of patient outcomes impact on unscheduled/urgent care services and stakeholder feedback.
   Investments in dementia should be implemented and the SHSCT should report on demand/capacity of the memory service which commenced in 2014/15.

2. The LCG will continue monitoring of domiciliary care provision against SBA volumes. This will include assessment of the impact of extended reablement services.

3. The SHSCT will comply with data requests on community nursing activity through community indicators, ensuring consistent ECAT's implementation across the Trust.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Carers' Assessments (MT7), Emergency readmissions (MT14)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 58:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	2,258,781	35,000	2,293,781
	Residential and Nursing Home Care	Occupied bed days	662,160	17,549	679,709
	Community Nursing	Contacts	207,073	6,187	213,260
		Planned investment in 2015-16		£4m	

12.3.5 POC 5: Mental Health Services

Strategic Context: Bamford Strategy, Regional Psychological Therapies Strategy, Mental Health Services Framework and NICE guidance, all outline the need for a focus on improving access to psychological therapies. The SLCG is committed to securing local services which focus on prevention and early intervention to improve and protect the mental health and wellbeing of our population. We believe that through this we can reduce unnecessary demand for secondary care services, protecting access to more specialist services for those most in need.

Local Needs and Assessment

1. During 2012/13, within the SLCG there were 308 mental health compulsory admissions which represented the highest number across NI accounting for 28.7% of the NI total for 2012/13
2. SLCG GP registers indicate that 3,040 patients are registered as having schizophrenia, bipolar affective disorder and other psychoses or are on lithium therapy
3. During 2009/10, the Southern Trust received 2,460 referrals to the community addictions service (686 per 100,000 people against the NI average of 665 per 100,000 people). There has been a significant increase in the gap between the least and most deprived areas in the SLCG in terms of the standardised death rate relating to, alcohol and standardised admission rates relating to drugs, alcohol and self-harm (DHSSPSNI Sub Regional Health Inequalities).

Services to be Commissioned

1. The SLCG will seek assurance that there are adequate levels of staff to support complex patients in local inpatient units. The SLCG will monitor use of the regional addiction beds by Southern residents during 2015/16 to ensure fair access.

   The LCG will commission the first talking therapies hub in the Southern area to support people with low level mental health needs resident in the Armagh and Dungannon locality.
2. The LCG will seek to invest in additional staff to support community addictions services during 2015/16.
3. The SLCG will consider local capacity to support the diagnosis of adults with ASD.

Securing Service Delivery

1. SHSCT should ensure that local addictions staffing is in line with regionally recommended levels.
2. The Trust should progress against the action plan for implementation of psychological therapies primary care hubs.
3. The Trust will closely monitor short breaks and day opportunities investment in 2014/15 will be measured during 2015/16.

   SHSCT to implement the alcohol liaison 7 day service during 2015/16.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22),
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 59

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	34,230		34,230
	Residential and Nursing Home Care	Occupied Bed days	64,119		64,119
	Domiciliary Care	Hours	120,505	2000	122,505
		Planned investment in 2015-16		£0.66m	

12.3.6 POC 6: Learning Disability Services

Strategic Context: People with learning disabilities have a variable range of health and social care needs and often experience greater health and wellbeing inequalities than the general population and can experience difficulty in accessing services. They are also at risk of social exclusion, affecting their quality of life through exclusion from employment, relationships and other life opportunities. Both TYC and the DHSSPS Learning Disability Service Framework highlight the needs of the increasing numbers of young people with complex needs surviving into adulthood and the importance of the right support at transition stage.

Local Needs and Assessment

1. In 2013/14 there were 2,123 people identified on Southern LCG GP Practice registers for learning disability. Uptake of day opportunities has increased in line with the regional direction - an increase from 274 persons in 2012 to 359 by 2014.
2. It is expected that there will be at least 50 young people who will transition into adult learning disability services during 2015/16.
3. The regional caseload review audit as part of the learning disability service framework suggests a need for an increased focus on carer's assessments, recording of service user satisfaction levels and the documentation of person centred plans.
4. There are 536 adult carers known to the learning disability programme in the Southern area, representing 23% of the NI total for this programme.

Services to be Commissioned

1. The SLCG will commission the development of additional day opportunities for people with learning disabilities.
2. The SLCG will invest further to support the additional needs of young people transitioning into adult services, including enhancement of the transitions team.
3. Following on from investment in 2014/15, the LCG will provide further support to carers, particularly older carers
4. The SHSCT will be required to produce health action plans for people with learning disabilities.

Securing Service Delivery

1. The Trust should develop a menu of day opportunities across a range of sectors, continuing to engage with service users/carers and monitor uptake and change in demand patterns for day care.

2. The LCG will develop and implement a monitoring proforma for high cost packages in transition to adult services.

3. The Trust should continue to deliver the required complex caseloads and conduct ensure following on from the caseload review audit improved outcomes

4. The LCG will monitor the use of health action plans to ensure equity of outcomes for people with a learning disability.

Regional Priorities (see appendix A): Carers' Assessments (MT7),
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 60:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	276,991	2100	279,091
	Residential & Nursing Home Care	Occupied bed days	113,740	800	114,540
		Planned investment in 2015-16		£0.36m	

12.3.7 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: In support of the strategic direction to provide as much support and care close to home as possible, the SLCG are aware of a sharp increase in the number of people with complex disabilities being cared for in hospital settings who require discharge. In addition, demand for services to support people with a brain injury is increasing. The LCG will work within the Physical and Sensory Disability Strategy to ensure the provision of safe, high quality and effective services which are person-centred, promoting independence, choice and control.

Local Needs and Assessment

1. The Physical Disability Strategy estimates that 21% of adults in Northern Ireland live with a physical or sensory disability. In terms of the adult population of the Southern area, this would equate to around 54,781 people (based on an adult population of 260,860 people - 2011 Census persons aged 19+).
2. The SHSCT provided details on 25 complex hospital discharges requiring significant care packages.
3. Population growth in the Southern LCG area, including a significant growth in the child population, has resulted in increased demand for hearing aids.
4. Headway UK state that 661 persons per 100,000 sustained an acquired brain injury in 2011-12 in NI, the highest rate in the UK. Pro rata to the Southern area, this would equate to 2,379 persons. There were 6,943 finished episodes in NI hospitals relating to head

Services to be Commissioned

1. The SLCG will commission an appropriate mix of care to meet the needs of persons with complex disability upon discharge from hospital. This will require investment across a range of community service such as domiciliary care, short breaks and care homes.
2. A monitoring template will be developed to enable to LCG to capture information on the ongoing care needs of complex hospital discharges.
3. The LCG will invest further in equipment to support both children and adults with sensory disabilities, including audiology services and hearing aids.
4. The existing service agreements with community and voluntary sector organisations should be reviewed to ensure that people with a brain injury across the southern area are able to avail of a range of supports to meet their needs.

Securing Service Delivery

1. The Trust should continue to move towards increased uptake of direct payments and self-directed support.
2. Trust to put in place arrangements to address the outcomes of the LCG monitoring process
3. The Trust should ensure that there is appropriate access to audiology services including hearing aids.
4. The SHSCT should report to the LCG on plans to re-procure community and voluntary sector supports for people with a brain injury.

Regional Priorities (see appendix A): Direct Payments (MT8)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 61

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	365,130	5200	370,330
	Residential & Nursing Home Care	Occupied bed days	20,805	259	21,064
		Planned investment in 2015-16		£0.22m	

12.3.8 POC 8: Health Promotion

Strategic Context: Improving & protecting population health and reducing inequalities: Making Life Better was launched by the DHSSPS in 2014. This public health strategy builds on the learning from the Investing for Health Strategy and the Marmot Review 2010 and 2012 update. In 2015/16 Community Planning will be introduced and the SLCG/PHA will work with Councils and others to ensure the maximisation of opportunities to promote health and wellbeing for all citizens.

Local Needs and Assessment - SLCG

1. 17% of babies born are to mothers who themselves were born outside of the UK or ROI. Approximately one fifth of the population live in relative poverty, including 22% of children.
2. 20% of adults smoke cigarettes and 13% drink in excess of weekly recommended alcohol limits. 57% of adults and 17% of boys and 24% of girls in P1 are overweight or obese. In 2012 an estimated 656 people died prematurely of potentially avoidable causes
3. Uptake for screening programmes in 13/14 was 78% cervical; 76% breast; 49% bowel; 82% AAA and 79% diabetic retinopathy.

Services to be Commissioned

1. Family Nurse Partnership, Roots of Empathy and a suite of evidenced based parenting programmes will be made available.
2. The LCG will commission a range of health promotion services will be available on smoking; healthy eating; physical activity; alcohol; drugs; mental health and suicide prevention.
3. The LCG will commission a range of screening programmes including the Be Cancer Aware Programme

Securing Service Delivery

1. The Early Years/Early Interventions Officer will support this work. These services will link with the existing Family Support Hubs and the EITP.
2. Trusts should ensure that services commissioned meet specified quality standards which are monitored i.e. Stop Smoking Services; Drugs and Alcohol; Mental Health and Emotional Wellbeing
3. Performance targets for all programmes commissioned are specified and monitored quarterly.

Regional Priorities (see appendix A): Bowel Cancer Screening (MT1)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

12.3.9 *POC 9: Primary Health and Adult Community*

Strategic Context: Enabling people to maintain their independence, live at home and receive care at or as close to home as possible remains a key strategic and local commissioning priority. Ensuring effective community nursing and therapeutic interventions, 7 day working and developing work with Integrated Care Partnerships and the emerging GP Federations will assist in addressing known shortfalls in capacity and quality concern of service users.

Local Needs and Assessment

1. NI Quality and Outcomes Framework (QOF) 2013 registers indicate that there are 6,012 patients registered in Southern LCG GP practices as having Chronic Obstructive Pulmonary Disease (COPD) and 6,068 registered as having survived a stroke. During 2012/13, there were 528 people admitted to hospital in the Southern area following a stroke.

2. In the NI Diabetes Inpatient Audit (2013 Draft Report), the Southern Trust performance was below that of other NI hospitals and also suggested there were lower levels of specialist nursing investment in NI compared to the rest of UK.

3. The LCG has seen a higher increase than the NI average in both cost 2.5% compared to 1.9%) and volume of prescribed drugs (1.7% to 1.5%).

Services to be Commissioned

1. The LCG will work with the SHSCT to assess the demand and capacity within district nursing services which may require additional investment to ensure a 24/7 DN service which is GP aligned

The LCG will consider enhanced specialist nursing input to diabetes services to improve patient care, specifically inpatients.

2. Through the Southern ICPs, the LCG will continue to develop pathways and commission services to deliver on ICP specifications

3. The LCG will work closely with primary and secondary care to ensure efficient and effective prescribing in line with the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Proposals for the allocation of the SLCG prescribing budget will be brought forward in early 2015/16.

Securing Service Delivery

1. The Southern Trust should contribute to community indicators data to monitor activities of community nurses. The Trust should also ensure eCAT is implemented consistently throughout the Trust.

2. The SLCG will continue to monitor the progress of the Southern ICPs in delivering on the agreed specifications for priority groups – frail elderly, diabetes, respiratory and stroke.

3. Primary and Secondary Care should ensure that the prescribing budget is brought into line with the requirements of the Pharmaceutical Clinical Effectiveness Programme (PCEP).

Regional Priorities (see appendix A): Pharmaceutical Clinical Effectiveness Programme (MT30)

13.0 Western Local Commissioning Plan

This plan sets out what Western LCG will commission during 2015/16 in order to respond to the identified health and social care needs and inequalities within its population, taking account of feedback from patients, clients and carers and community and voluntary organisations.

The plan outlines, on a Programme of Care (PoC) basis, what our local needs are, what we will commission in-year in response to that need and how we intend to ensure delivery either through a Trust, ICP or other provider or through direct monitoring of progress by the HSCB or PHA. The Plan reflects the themes identified at regional level, with a focus on how we can transform our services while delivering efficiency and value for money.

The LCG will work closely with its community partners in the delivery of the plan, in particular seeking to take advantage of the opportunities that community planning with local government presents.

13.1 Overarching assessment of need and inequalities for LCG population

This section provides an overview of the assessed needs of the populations of the Western LCG, covering the council areas of Derry and Strabane District; Fermanagh and Omagh District; and the former Limavady Borough now within Causeway Coast and Glens.

13.1.1 Demographic changes / pressures

On Census Day (27 March 2011), the resident population of the Western LCG area was 294,417 persons accounting for 16.26% of the NI total. Mid-Year Estimates (2013) show projected increase in population to 296,883 persons.

The age profile on Census Day includes:

- 22.1% were aged under 16 years and 13.1% were aged 65 and over;
- 49.6% of the usually resident population were male and 50.4% were female; and

- 36 years was the average (median) age of the population

The older people population is lower proportionately than the NI average (13.1% and 14.6% respectively) although the Western area is projected to see the greatest increase in 65+ persons in the next ten years, i.e. 40.1% increase compared to 29.7% for NI as a whole. There were 3,951 births to Western families during 2013/14.

Deprivation

One in four people (25.3%) residing within the Western area in 2013 were living within the most deprived of the Northern Ireland deprivation quintiles. Across Northern Ireland, 18.8% of the population live in the most deprived quintile.

Key Indicators of Health and Wellbeing

Table 74 below provides an overview of key indicators of health and wellbeing. Despite high levels of deprivation, Western population shows better health outcomes than the NI average, apart from for respiratory conditions, i.e. asthma and chronic obstructive pulmonary disease (COPD). Mental health however is considerable worse, particularly due to anxiety and depression. There is higher rate of children in need.

Health Summary

The table below shows the health of the Western LCG population in comparison to Northern Ireland as a whole.

Table 62

Domain	Indicator	Descriptor	WLCG	NI Average	LCG Position vs NI Average
Disease and Poor Health	Cancer	Prevalance per 1000	18.49	19.12	
	COPD	Prevalance per 1000	20.36	18.56	
	Stroke	Prevalance per 1000	17.33	17.94	
	Atrial Fibrillation	Prevalance per 1000	15.11	15.12	
	Coronary Heart Disease	Prevalance per 1000	36.08	38.81	
	Hypertension	Prevalance per 1000	128.91	130.5	
	Diabetes	Prevalance per 1000	41.45	42.61	
	Asthma	Prevalance per 1000	61.62	60.48	
	Dementia	Prevalance per 1000	6.02	6.67	
	Learning Disability	Prevalance per 1000	6.34	5.33	
	Bowel Cancer Screening	Prevalance per 1000	50.22	49.8	
Emotional Heath and Wellbeing	Mental Health	Prevalance per 1000	9.12	8.54	
	Crude Suicide Rates	All Persons	16.7	15.8	
	LGBT Emotional Wellbeing	*WEMWBS Mean Score	46.7	46.23	
Risk Factors	Smoking- current smoker	% of population (2012 - 13)	28	24	
	Obese or overweight	% of population (2012-13)	60	62	
	Meeting Physical activity levels	% of population (2012-13)	51	53	
	Pain or discomfort	% of population (2012-13)	39	35	
	Anxious Depressed	% of population (2012-13)	28	26	
Maternal and Child Health	Children in Need	Rate per 100,000	85.51	60.18	
	Diabetes in Pregnancy			3.6	
	Obesity in Pregnancy	BMI >30		19.3	
	Smoking in Pregnancy			15.93	
	Births to Teenage Mothers	Percentage 2013	3.34	3.86	
	Births to unmarried mothers	Percentage 2013	43.79	42.46	
	Births to Mothers from outside NI	Percentage 2013	15.58	17.88	
Life Expectancy	Male	Age (2009-11)	77.23	77.5	
	Female	Age (2009-11)	81.84	82	
	Neonatal	Death Rate (2013)	0.4	0.3	
	Infant Mortality	Death Rate (2013)	4.9	4.6	
	Lung Cancer	STD Death Rate	67.9	66.5	
	Female Breast Cancer	STD Death Rate	37.4	38.1	
Carers	Unpaid Care	% of population 50+ Hours provided	3.1	3.1	

13.1.2 Personal and Public Involvement

In 2014, Western LCG undertook a flagship engagement programme, *Voice of Older People*, which engaged with 1,050 older people between January and March. The LCG worked with a range of Community Networks who undertook semi-structured interviews in line with an LCG brief to ascertain the views of older people from across the West on using Primary Care, Secondary Care and Community Care; on Transforming Your Care; and their expectations of future services.

The Networks engaged with older people in places which they routinely used, such as Luncheon clubs, Community Centres, Healthy Living Centres Community Theatre, Art Groups, Drop in Clubs, Exercise Classes, Singing Groups, Smoking Cessation Groups, Diabetes and Podiatry clinics in Healthy Living Centres to ascertain their views on the services they receive and use through the health service. The views of older people who did not attend community activities/centres or did not access local Voluntary and Community groups, and who are harder to reach were also sought through the Networks contacts and member organisations. Participants ranged from 65 to 90 years. Each participant completed.

Providers nominated one “Champion”, an older person who had participated in the exercise, from each area who attended the Local Commissioning Group meeting in May 2014. There was an opportunity for LCG members to hear initial findings and to engage directly with the Champions on issues of interest and concern. The LCG gave an undertaking to convene feedback sessions to inform and discuss with participants the outcomes and findings of the engagement process. The undertaking to feedback to stakeholders is a crucial element in getting the Networks to agree to accept the commission as it showed the HSCB’s commitment.

Key issues from the engagement initiatives:

- Need for more joined up approach in tackling health inequalities;

- Need for greater communication with older people regarding the services available;
- Need to tackle anxiety experienced by older people when attending the Emergency Department;
- Importance of transport in accessing health and social care services and alignment of appointments to transport schedules;
- Need for more support to carers; and
- More services delivered in local health centres, such as Physiotherapy, Minor injuries

LCG has committed to feedback sessions in response to issues raised and has published a report on the engagement programme.

The LCG also held a conference on health and social care in rural communities, in partnership with five local Community Networks, in Enniskillen on 3rd April 2014. The conference focused on:

- Rural issues of poverty, isolation, transport and access to services;
- Mental Health Services, promoting positive mental health; and
- Community planning, access and influencing key agencies

82 participants attended this event, largely comprising service users and carers living in rural areas across the Western area. Representatives from Rural Community Network, community and voluntary sector organisations, local Government, HSCB, WHSCT, NIAS and PHA also attended to hear participant views on services and related issues.

13.1.3 Summary of Key Challenges

Key challenges for the LCG in 2015/16 include:

- Fulfilling the potential of Western Integrated Care Partnerships in driving the *Transforming Your Care* agenda through integrated care pathways;
- Extending Pain Management programmes;

- Delivering the proposed Primary Care Infrastructure programme for the Western area, in line with agreed priorities;
- Further enhancing carers support and short breaks opportunities;
- Progressing plans towards having in place appropriate 24-hour community nursing services, including Acute Care at Home;
- Meeting domiciliary long-term care demand supported by the roll-out of reablement model;
- Tackling impact of alcohol on HSC services, particularly Emergency Services;
- Ensuring provision of Older People's Mental Health Services;
- Putting in place across key acute specialties processes to allow GPs to gain consultant and specialist professional advice which might prevent the need for referrals and improve management of patients in primary care;
- Maximising utilisation of hospital theatres and in-patient beds; and
- Identification of opportunities to consolidate the provision of intermediate and acute beds and/or sites.

13.2 LCG Finance

Use of Resources

The WLCG's funding to commission services in meeting the Health and Social Care needs of their population in 2015/16 is £519.1m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers.

Table 63

Programme of Care	£m	%
Acute Services	196.8	37.85%
Maternity & Child Health	25.2	4.84%
Family & Child Care	42.1	8.09%
Older People	114.9	22.10%
Mental Health	47.3	9.10%
Learning Disability	39.2	7.53%
Physical and Sensory Disability	15.5	2.98%
Health Promotion	17.0	3.28%
Primary Health & Adult Community	21.1	4.22%
POC Total	**519.1**	**100%**

This investment will be made through a range of service providers as follows:

Table 64

Provider	£m	%
BHSCT	26.2	5.05%
NHSCT	1.1	0.21%
SEHSCT	0.2	0.03%
SHSCT	1.9	0.38%
WHSCT	450.4	86.60%
Non-Trust	39.3	7.73%
Provider Total	**519.1**	**100%**

The above investment excludes the recurrent funding for Primary Care services and the FHS.

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2015/16 in respect of Emergency Care by the Western Trust is in the region of £12.7m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2015/16 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price Inflation, additional funding to take account of the demographic changes in the population of the Western area and additional investment in the therapeutic growth of services.

13.3 Commissioning Priorities 2015/16 by Programme of Care (PoC)

This section provides further detail on local commissioning priorities by Programme of Care. For each PoC it details the issues arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery. It also takes into consideration the overarching regional themes of:

- Improving and Protecting Population Health and Reducing Inequalities
- Providing Care Closer to Home
- High Quality, Safe and Effective Care
- Promoting Independence and Choice
- Safeguarding
- Efficiency and Value for Money

Trust Savings Plan

The commissioning priorities identified in this section also take into account the efficiencies highlighted within the Western Trust's Saving Plan for 2015/16.

Community Information Exercise

It has been agreed by the Regional Information Group that the provision of more timely, consistent and accurate information on Community Information Services is a key HSC priority.

As this work will be ongoing throughout 2015/16, the accompanying values and volumes as set out against relevant PoCs may not fully reflect the totality of activity delivered and will be subject to change throughout the year.

13.3.1 POC 1: Non-Specialist Acute Services

Strategic Context: Growing demand for hospital care, coupled with challenges recruiting and retaining medical and other staff, remain a key feature for Western services. Alternative pathways, designed to reduce demand, have been championed by LCG and ICPs and further opportunities exist in light of emerging GP Federations. The prerogative to extend Acute Care at Home, building on enhanced community nursing services adds an important dimension to transformation of care.

Local Needs and Assessment

1. Demand for OP assessment in the West currently outstrips capacity by around 6,000 patients per year, with referral rates continuing to rise annually.
2. Unscheduled care patient flow at Altnagelvin Hospital remains challenging. In 14/15, there were 25 12-hours breaches of Emergency Dept standards across WHSCT; 4-hour performance fell below 95%; and delayed discharges were a feature of pressures through the winter months.
3. Older Persons Assessment and Liaison Services in Altnagelvin demonstrated that through comprehensive geriatric assessment that a 4-day reduction in length of stay was achievable
4. Demand for neurology services exceeds commissioned capacity by 750 outpatients per year and demand for Orthopaedics exceeds commissioned capacity by 1,100 outpatients and resulting conversions.

Services to be Commissioned

1. The LCG, working with ICPs, will seek the introduction of GP request for advice across acute specialities, including extension of virtual clinics and direct GP access to hospital diagnostics
2. The HSCB approved 5 key commissioning priorities to improve patient flow. The LCG, supported by the Unscheduled Care Team, will prepare costed proposals for Altnagelvin Hospital for implementation.
3. The LCG will ensure the introduction of the commissioned Older People's Assessment and Liaison Services at South-West Acute Hospital with the provision of a multi-disciplinary assessment for all patients admitted to hospital, leading to reduced length of stay of 4 days for over 75 year olds
4. LCG will commission additional capacity in neurology and orthopaedics services to meet demand

Securing Service Delivery

1. Demand management initiatives will be sought from Integrated Care Partnerships where these can be shown to reduce the need to refer to Trust Consultant-led services.

2. The Trust will take forward the 5 key commissioning priorities, including delivering additional multi-disciplinary access and activity 7 / 7; extended senior clinical decision making; and a seven day dedicated minor injury stream in ED.

3. The Trust should implement Older Persons Assessment and Liaison Services in the South West Acute Hospital.

4. The Trust should bring forward proposals to close the elective gaps for neurology and orthopaedics.

14.3.1 POC 1: Non-Specialist Acute Services (continued)

Local Needs and Assessment

5. Increased annual demand on elective surgery, unscheduled admissions and GP surgical assessments.
6. Acute Care at Home (POC 1&4) can provide active treatment by health care professionals in the patients home avoiding unnecessary inpatient care.
7. The Western area has the largest increase in prevalence rates for stroke between 2007 (13.8/1000 population) and 2014 (17.3/1000 population) at 25%. RQIA recommends clear definition of a stroke unit, accessible thrombolysis service and TIA assessment and treatment at weekends for high risk cases.
8. In Western hospitals, there were 25,024 hospital cancelled outpatient appointments in 2014/15

Services to be Commissioned

5. The LCG will review the Elective Day of Surgery Unit and Surgical Assessment Area pilot with a view to mainstreaming if successful in reducing length of stay and admissions.
6. The LCG will commission a proportionate 24-hour community nursing service, building on district nursing, Rapid Response nursing and Treatment Room services which prevents unnecessary hospital admissions and supports the introduction of Acute Care at Home.
7. The LCG will consider the redesign of stroke services in line with regional model of care, including creation of a specialist acute unit and appropriate rehabilitation in hospital and at home.
8. The LCG will seek assurances that hospital cancelled appointments are minimised and appropriate and in line with Departmental requirements, i.e. reduced by 20% by March 2016.

Securing Service Delivery

5. The Trust should complete an evaluation of the Elective Day of Surgery Unit and Surgical Assessment Area.
6. The Trust should implement a phased Acute Care at Home model, building on commissioned expansion within Community nursing with Demographics investment in 15/16 focused to enhance the delivery of the 24/7 Community Nursing Model aligned to GPs, pathway development for >65years frail elderly Disease Specialist Nursing and an Acute Care at Home Team.
7. The LCG will work with the Trust to review existing medical, nursing and AHP capacity with a view to agreeing a new stroke service model later 2015.
8. By June 2015, the Trust will provide a plan to reduce cancelled consultant-led hospital appointments by March 2016

Regional Priorities (see appendix A): Allied Health Professionals (MT9), Hip fractures (MT10), Unscheduled Care (MT12), Elective Care (MT15, 16, 17) Stroke (MT19)

POC1 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 65

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Acute	**Elective**	Inpatients	11,302		11,302
		Daycases	31,915		31,915
		New Outpatients	115,379		115,379
		Review Outpatients	150,756		150,756
	Unscheduled	Non Elective admissions	37,053		37,053
		ED Attendances	100,733		100,733
		Planned investment in 2015-16		£1.4m	

13.3.2 POC 2: Maternity and Child Health Services

Strategic Context: Normalisation of birth remains the imperative in line with the Maternity Strategy. There have been fewer births in Western hospitals in recent years although there is some evidence of increased complexity, particularly a marked increase of mothers with a diabetes risk. Medical staffing challenges continue and are exacerbated by moves to extend cover of middle and senior obstetrician and paediatricians at South West Acute Hospital in the face of safety concerns regionally.

Local Needs and Assessment

1. WHSCT SBA outturn in 2013/14 outstripped the legacy SBA volume across a number of POCs with an increase in demand for health visiting 1,446 contacts within maternity & child health.
2. There are typically 3,600 medical admissions to paediatric wards in Altnagelvin, with requirement for escalation beds every year over the winter period.
3. While 27% of births were by caesarean section (elective & non elective), 2.1% below the NI average, caesarean section rates at SWAH have increased steadily and were 0.7% higher than the NI average in 2013/14
4. The pilot weight management programme for pregnancy women, "Weigh to a Healthy Pregnancy" is underway offering a lifestyle intervention to all pregnant women with a

Services to be Commissioned

1. In the context of on-going regional review, LCG will review capacity and demand for health visiting services (across PoCs) with a view to closing any gap and in line with normative nursing levels.
2. The LCG will review the pilot of the Paediatric Assessment Unit (PAU). If successfully evaluated, the LCG will consider commissioning recurrently, leading to reduction of admissions by 20%.
3. The LCG will work with Western Trust to promote normalisation of births in line with Maternity Strategy 2012-18.
4. The LCG, working with PHA, will seek to mainstream "Weigh to a Healthy Pregnancy", drawing on the learning of the pilot programme.

Securing Service Delivery

1. The LCG in collaboration with PHA will realign the WHSCT Health Visiting SBA 15/16 to reflect current service and modernisation reform that has been undertaken in line with normative nursing.
2. The Trust will carry out an evaluation of the PAU by July 2015 and LCG will consider the findings in due course.
3. The Trust will take steps to reduce Caesarean section rates to NI average within 12 months.
4. The Trust will bring forward proposals to continue "Weigh to a Healthy Pregnancy" programme.

Regional Priorities (see appendix A): Tackling Obesity (MT2)
Key Strategies: Maternity Strategy, Paediatric Reviews and Neonatal reviews, NICE CGs (62, 63,110,129,132), MBRRACE report 'Saving Lives Improving Mothers' Care' (Dec 2014) Regional Perinatal Mortality Report (2013)

POC 2 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 66:

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Maternity and Child Health	**Obstetrics**	Births	4,009		4,009
	Health Visiting	Contacts	67,633		67,633
		Planned investment in 2015-16		Nil	

13.3.3 POC 4: Older People's Services

Strategic Context: In the face of rapid growth of the older population and in light of *Transforming Your Care*, it is imperative that services for older people change and grow. The priority will be to provide support to enable all older people to remain independent and living in their own home for as long as possible.

Local Needs and Assessment

1. The number of over 65 years continues to grow in the LCG area; increasing demand on domiciliary care and among people with mental health difficulties and those with disabilities.
2. The demand for domiciliary care service has increased by 23% (2010-2014 estimated contact hours). Reablement services provide considerable benefit to patients with reduction in care requirements following period of intervention.
3. Older people with mental health challenges, particularly dementia continue to increase.
4. From April to September 2014, 1,168 people over 65 years attended Altnagelvin ED due to a fall. 82% of these falls were at the home.

Services to be Commissioned

1. The LCG will seek to increase the number of Domiciliary Care hours although this may be reduced by initiatives, such as the roll-out of Reablement.
2. The LCG will commission the further roll-out of Reablement across the Western area with a view to realising 45% reduction in referral rates to long term caseloads during 2015/16.
3. The LCG will review older people's mental health services, including dementia care, to ensure recent investments have proven successful and need is appropriately met.
4. The LCG will support ICP initiative to coordinate falls prevention through integrated care pathways supported by GPs, Western Trust, NIAS and voluntary sector agencies.

Securing Service Delivery

1. The Trust will deliver the required domiciliary care hours and other initiatives as specified by the commissioner.
2. The Trust should complete the roll-out of Reablement to the Southern sector to include an OT led Reablement Team and Contact and Information Centre covering the whole Western area, leading to 45% of discharges requiring no on-going care.
3. In collaboration with the Trust, LCG will produce a needs assessment of older people's mental health by October 2015, taking into account ICP plans to develop an integrated dementia care pathway.
4. ICPs will lead in building on GP pathway to Stepping On programmes and developing a Western wide falls prevention service.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6)
Key Strategies: Service Framework for Older People, Dementia Strategy

POC4 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 67

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Older People	**Domiciliary Care**	Hours	1,606,351	38,624	1,644,975
	Residential and Nursing Home Care	Occupied bed days	511,947		511,947
	Community Nursing	Contacts	162,488	7,000	169,488
		Planned investment in 2015-16		£2.8m	

13.3.4 POC 5: Mental Health Services

Strategic Context: In line with *Transforming Your Care* and taking forward the *Bamford Review*, the importance of maintaining mental health and intervening early in Primary Care remains the priority. A focus on Recovery Approaches in line with *Transforming Your Care* which states that "At the core of independence and personalisation is a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives."

Local Needs and Assessment

1. Mental health in NI is poor compared to GB. 25% of those surveyed in the West for NI Health Survey in 13/14 reported being anxious or depressed; higher than the NI average.
2. Patients on the Mental Health Register have risen by almost 10% in the 5 years to 2012.
3. HSCB has reviewed in-patient addiction services which recommends a regional model for detoxification and stabilisation care and rehabilitation.
4. The number of patients waiting longer than 13 weeks for a first appointment with psychological therapies service has increased through 2014.

Services to be Commissioned

1. The LCG will commission the introduction of Primary Care Talking Therapies, with support from ICPs to put in place clear GP referral pathway and appropriate access protocols.
2. The LCG will seek a consistent model of Primary Care Liaison and Crisis Response Home Treatment services across the Western area.
3. The LCG will support regional plans to have in place a 7-day in-patient addiction treatment service, including 8-beds in the Western area.
4. The LCG will review demand and capacity in psychological therapies required to deliver 13 weeks waiting times for first appointment.

Securing Service Delivery

1. The Trust will provide 400 talking therapy sessions through community and voluntary sector providers in 2015/16. The LCG will work with the Trust to ensure roll-out across the entire Western area during 2016.
2. The Trust will ensure consistent access to these services, particularly in the Southern Sector, leading to further reductions of acute mental health beds.
3. The Trust will ensure appropriate staffing levels are in place in line with investment.
4. The Trust will ensure that additional capacity is made available, in line with the commissioner requirements.

Regional Priorities (see appendix A): Substance Misuse (MT3), Mental Health Services (MT22),
Key Strategies: Bamford Action Plan, Mental Health Service Framework, Protect Life Strategy, Psychological Therapies Strategy

POC5 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 68

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Mental Health	**Hospital**	Occupied Bed days	38,759		38,759
	Residential and Nursing Home Care	Occupied Bed days	30,086	210	30,296
	Domiciliary Care	Hours	29,294	250	29,544
		Planned investment in 2015-16		£0.26m	

13.3.5 POC 6: Learning Disability Services

Strategic Context: The population of people with a learning disability is continuing to rise in line with the very welcome increase in the average lifespan. Consequently, there are greater numbers of people with a learning disability reaching adulthood and requiring day opportunities and appropriate community support. As adults reach old age in greater numbers, planning is required for their future long term care and housing and support for carers, in particular older carers, is crucial.

Local Needs and Assessment

1. The LCG area has the highest prevalence in NI of people with learning disabilities (6.17 per 1,000 people) and the number of people with a severe learning disability has increased by 30% since 2000.
2. For adult carers of LD clients, availability of alternatives to traditional forms of respite (day and residential care) is very limited.
3. Transition from children's to adult services is a challenging time for young adults with a learning disability and their families. Collaborative work between Education and Health sectors seeks to manage smooth transition and ensure individual needs are addressed through a coherent transition plan.

Services to be Commissioned

1. The LCG will seek to keep pace with growing demand for day opportunities to adults with learning disabilities, including providing support to up to 50 school leavers and meeting the needs of older adults.
2. The LCG will extend innovation fund for Adult carer recipients of short break hours in line with SDS approaches. Further short break options will be tested to extend the range of choice and flexibility for carers.
3. Given anticipated transition of up to 50 school leavers in 15/16; continued pressures on adult services and the emphasis on day opportunities, the LCG will seek assurance that the current transition process is effective in supporting individuals.

Securing Service Delivery

1. The LCG will continue to work with Western Trust to extend day opportunities and meet the needs of school leavers in 2015 as a priority, in line with emerging self-directed support model.
2. The Trust will provide additional innovative short breaks hours based on the outcomes of an LCG workshop in April 2015
3. The LCG and Trust will review the transition process and identified needs leading to any gaps in service.

Regional Priorities (see appendix A): Carers' Assessments (MT7)
Key Strategies: Bamford Action Plan, Learning Disability Service Framework

POC 6 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 69

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Learning Disability	**Domiciliary Care**	Hours	92,760		92,670
	Residential & Nursing Home Care	Occupied bed days	135,520		135,520
		Planned investment in 2015-16		Nil	

13.3.6 POC 7: Physical Disability and Sensory Impairment Services

Strategic Context: Developments in services for people with Physical and Sensory Disabilities have received a renewed impetus with the recent publication of Departmental and OFMDFM strategies. Implementation has benefited from the involvement of voluntary sector partners and emphasis on the participation of service users.

Local Needs and Assessment

1. In September 2014, 70 adults were awaiting a multi-disciplinary assessment for autistic spectrum disorder, most in excess of 13 weeks. 85 adults with a learning disability also required ASD assessment and support.
2. Western Trust figures show there are 279 deaf service users in the Western area, 127 of whom have no speech. Some have significant mental health and developmental difficulties and at risk behaviours in later life.
3. There is an increasing number of people with physical disabilities which are more complex including service users requiring high cost care packages and young people transitioning to adult services.

Services to be Commissioned

1. The LCG is investing in development of assessment and support service for adults with autism spectrum disorder leading to no one waiting longer than 13 weeks for an assessment by March 2016.
2. The LCG will commission community-based flexible service model of enablement, communication and skills development, providing 7 places in 15/16.
3. The LCG, working with regional colleagues, will consider a review of physical disability services, taking account of Trust reported pressures; the move to self-directed support; and population needs.

Securing Service Delivery

1. The multi-disciplinary Adult ASD service will provide integrated care plans for all young people transitioning to adult services; 30 adults supported by dedicated psychologist; 40 adults supported by dedicated Speech & Language Therapist and 40 adults supported by a dedicated Occupational Therapist.
2. The Trust will provide the commissioned service through Action for Hearing Loss.
3. The LCG will seek the input of Western Trust and relevant voluntary organisations in reviewing current services and evident gaps against regional standards.

Regional Priorities (see appendix A): Allied Health Professionals (MT9)
Key Strategies: Bamford Action Plan, Physical Disability and Sensory Impairment Strategy

POC7 Values and Volumes

The table below reflects the current spend within the PoC, the indicative planned investment during 2015/16 and the indicative additional volumes that the investment should purchase (based on the agreed demography allocations). Any volumes described below may be adjusted by the LCG throughout 2015/16 to address identified needs within the local population. The total value of the investment also includes other goods or services which cannot be quantified as additional volumes.

Table 70

Programme of Care	Service Description	Currency	2015/16 Baseline	Indicative Additionality 2015/16	Total indicative commissioned Volumes 2015/16
Physical Disability and Sensory impairment	**Domiciliary Care**	Hours	298,781	1,200	299,981
	Residential & Nursing Home Care	Occupied bed days	24,283		24,283
		Planned investment in 2015-16		£0.06m	

13.3.7 POC 8: Health Promotion

Strategic Context: NI Executive published Making Life Better in 2014, a whole systematic strategic framework for public health which sets out clearly the action required to address the determinants of health alongside a life course approach. The health and social care system will play a full part through embedding health improvement and health inequalities in planning, commissioning and delivery processes.

Local Needs and Assessment

1. Hospital attendances and admissions continue to disproportionately relate to substance misuse and in particular alcohol.
2. 11% of Travellers live in Derry City Council area. The 2009 All Ireland Travellers Health Study has highlighted the huge disparities in life expectancy and other health outcomes for Travellers.
3. The number of older people who rely on HSC services is increasing. Initiatives to build or restore self-confidence and self-reliance among older people, providing practical support to help them achieve their aspirations and reduce dependency are required

Services to be Commissioned

1. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days
2. The LCG will continue to support development of structured brief intervention programmes, in line with the drive to provide consistent services in hospitals across 7-days
3. The LCG, in collaboration with ICPs, will pilot the Social Prescribing scheme which seeks to offer alternatives to medicine prescription and overcome social isolation and loss.

Securing Service Delivery

1. The LCG, PHA and Trust will review the progress in the brief intervention and alcohol liaison service relating to both acute hospitals with a view to having in place a development plan by October 2015.
2. The LCG is co-funding support workers who will scope needs and services leading to an Action Plan, including health improvement programmes and improve access to HSC services.
3. ICPs have appointed a voluntary organisation to pilot the Social Prescribing Scheme with a number of GP Practices. Review will be undertaken in Autumn 2015 to inform decisions on mainstreaming in 2016/17.

Regional Priorities (see appendix A): Substance Misuse (MT3)
Key Strategies: Making Life Better Strategy, Early Interventions, Transformation Programme, Service Frameworks

13.3.8 POC 9: Primary Health and Adult Community Services

Strategic Context: Integrating primary and secondary care is central in the drive for Health and Social Care reform. Integrated Care Partnerships are established to be a key driver in this with their emphasis on integrated care pathways focused developing the role of primary care. Challenges in developing the necessary physical infrastructure in terms of primary care hubs and spokes; appropriate hospital accommodation; and IT systems are of critical importance. Engagement with service users and staff to ensure services meet their needs remain the strategic priority.

Local Needs and Assessment

1. An innovative partnership with community networks across the West elicited the views of over 1,000 older people, with older person champions raising their concerns directly with the LCG.
2. Chronic pain is estimated to affect approximately 20% of people in Northern Ireland. 35% of people in the West, surveyed as part of the NI Health Survey 2012/13, reported having pain or discomfort. Demand for pain management service outstrips commissioned capacity.
3. Clinical Interventions centres (CICs) reducing avoidable hospital admissions, facilitates early hospital discharge, reduces ALOS

Services to be Commissioned

1. During 2015, LCG will provide feedback on the issues raised during engagement projects in 2014, highlighting progress in addressing issues raised and will engage with community networks to elicit the views of HSC services from 1,000 adults in the Western area.
2. The LCG will commission a Pain Management Programme in the Northern sector of the Trust to reduce demand on assessment and treatments.
3. The LCG will commission Clinical Intervention Centres at Enniskillen Health Centre and Strabane Health Centre

Securing Service Delivery

1. LCG will engage with 5 local community networks who will each undertake at least 200 semi-structured interviews in a council area, including the involvement of Section 75 groups. LCG will engage with older person champions and network representatives to provide feedback on issues raised during engagement projects in 2014.
2. The Trust should bring forward proposals to expand the Pain Management Programme Trust wide
3. The Trust will provide an ambulatory service for patients in the community in Enniskillen and Strabane CICs in an ambulatory setting when it is safe and effective to do so

POC 9: Primary Health and Adult Community Services (continued)

Local Needs and Assessment

4. There is a need to put in place Primary Care Infrastructure (PCI) capital projects within primary care to support wider system change and the implementation of the recommendations of Transforming Your Care (TYC)

5. Altnagelvin's Emergency Department is not fit for purpose to meet the needs of its annual 58,000 patients. Outpatient demand also continues to rise placing considerable pressure on existing clinic space. There is also anticipated pressure on ICU/HDU.

6. The Transforming Your Palliative and End of Life Care Programme is supporting the redesign and delivery of coordinated services to enable people across Northern Ireland with palliative and end of life care needs to have choice in their preferred place of care.

Services to be Commissioned

4. The LCG will commission the opening of Omagh Local Enhanced Hospital, expansion of Enniskillen Health Centre and Lisnaskea Primary Care Centre as hubs in line with the HSCB's Primary Care Infrastructure programme and continue to progress hubs in Cityside, Limavady and Strabane

5. LCG judges that the completion of Phase 5.1 in 2017 leading to reduction of theatre capacity by 25% means it is imperative that 5.2 progresses as soon as possible. Improved accommodation for the Emergency Department and clinical adjacencies will also considerable improve patient flow and clinical decision-making.

6. LCG, working closely with Western ICPs, will commission 8 initiatives agreed within programme.

Securing Service Delivery

4. LCG in collaboration with WHSCT and Primary Care GPs deliver development of relevant Tranches of PCI programme for Western locality

5. The Trust will bring forward an Outline Business Case for the proposed Altnagelvin Hospital Phase 5.2.

6. The Programme is being delivered by the HSCB/PHA in partnership with Marie Curie working with statutory, voluntary and independent sector providers.

Regional Priorities (see appendix A): Unplanned Admissions (MT5, 6), Emergency Readmissions (MT14), Excess bed days (MT27)

Appendix 1 - Programme of Care Definitions

Acute Services (POC 1)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in an acute specialty. It also includes all activity, and resources used, by a hospital consultant in an acute specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

Acute specialties are all hospital specialties with the exception of the following (specialty codes in brackets); Geriatric Medicine (430), Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), GP Maternity (610) and mental health specialties (710 to 715).

Maternity and Child Health (POC 2)
Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Obstetrics (501), Obstetrics Ante Natal (510), Obstetrics Post Natal (520), Well Babies Obstetric (540), Well Babies Paediatric (550), and GP Maternity (610). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts by any health professional where the primary reason for the contact was maternity or child health reasons. All community contacts to children under 16 are included as long as the contact was not in relation to mental health, learning disability or physical and sensory disability.

Family and Child Care (POC 3)
This programme is mainly concerned with activity and resources relating to the provision of social services support for families and/or children. This includes

Children in Care; Child Protection; Child Abuse; Adoption; Fostering; Day Care; Women's Hostels / Shelters and Family Centres. This is not a definitive list of the type of support which may be offered under this programme. This programme includes community contacts by any health professional where the primary reason for the contact is because of family or child care issues.

Elderly Care (POC 4)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Geriatric Medicine (430), Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts with those aged 65 and over except where the reason for the contact was because of mental illness or learning disability. All community contacts where the reason for the contact was dementia are also included, regardless of the patient's age, as well as all work relating to homes for the elderly, including those for the Elderly Mentally Infirm.

Mental Health (POC 5)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in one of the following specialties; Mental Illness (710), Child & Adolescent Psychiatry (711), Forensic Psychiatry (712) and Old Age Psychiatry (715). It also includes all activity, and resources used, by a hospital consultant in one of the above specialties, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to mental health. If the reason for contact is that the patient has dementia, the activity is allocated to the Elderly Care programme of care.

Learning Disability (POC 6)

Includes all activity, and resources used, by any health professional, relating to an inpatient episode where the consultant in charge of the patient is a specialist in the Learning Disability specialty (710). It also includes all activity, and resources used, by a hospital consultant in this specialty, in relation to an outpatient episode, day case, regular day admission, regular night admission or day care.

In addition, this programme includes all community contacts where the primary reason for the contact was due to learning disability. All community contacts with Down's Syndrome patients who develop dementia, for any dementia related care or treatment are included as are all contacts in learning disability homes and units.

Physical and Sensory Disability (POC 7)

This programme includes all community contacts by any health professional where the primary reason for the contact is physical and/or sensory disability. All patients and clients aged 65 and over are excluded. These contacts should be allocated to the Elderly Care programme.

Health Promotion and Disease Prevention (POC 8)

This programme includes all community and GP based activity relating to health promotion and disease prevention. This includes all screening, well women/men clinics, child health surveillance, school health clinics, family planning clinics, health education and promotion clinics, vaccination and immunisation and community dental screening and prevention work.

Primary Health and Adult Community (POC 9)

This programme includes all work, except screening, carried out by General Medical Practitioners, General Dental Practitioners, General Ophthalmic Practitioners and Pharmacists. It includes contacts by any health professional with community patients aged between 16 and 64, for whom the primary reason for the contact is other than mental illness, learning disability or physical and sensory disability.

Appendix 2 - Ministerial Priorities & Targets

Ministerial Theme:

To improve and protect population health and wellbeing and reduce health inequalities

Standards and Targets

Bowel cancer screening

1. By March 2016, complete the rollout of the Bowel Cancer Screening Programme to the 60-74 age group, by inviting 50% of all eligible men and women, with an uptake of at least 55% of those invited.

Tackling obesity

2. From April 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.

Substance misuse

3. During 2015/16, the HSC should build on existing service developments to work towards the provision of seven day integrated and co-ordinated substance misuse liaison services in appropriate acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention Programmes.

Family Nurse Partnership

4. By March 2016, complete the rollout of the Family Nurse Partnership Programme across Northern Ireland and ensure that all eligible mothers are offered a place on the programme.

Ministerial Theme:

To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.

Standards and Targets

Unplanned admissions

5. By March 2016, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions, including those within the ICP priority areas.

6. During 2015/16, ensure that unplanned admissions to hospital for acute conditions which should normally be managed in the primary or community setting, do not exceed 2013/14 levels.

Carers' assessments

7. By March 2016, secure a 10% increase in the number of carers' assessments offered.

Direct payments

8. By March 2016, secure a 10% increase in the number of direct payments across all programmes of care.

Allied Health Professionals (AHP)

9. From April 2015, no patient waits longer than 13 weeks from referral to commencement of AHP treatment.

Hip fractures

10. From April 2015, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

Cancer services

11. From April 2015, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of

patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Unscheduled care

12. From April 2015, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours.

13. By March 2016, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area.

Emergency readmissions

14. By March 2016, secure a 5% reduction in the number of emergency readmissions within 30 days.

Elective care – outpatients / diagnostics/ inpatients

15. From April 2015, at least 60% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 18 weeks.

16. From April 2015, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken.

17. From April 2015, at least 65% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks.

Organ transplants

18. By March 2016, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors.

Stroke patients

19. From April 2015, ensure that at least 13% of patients with confirmed ischaemic stroke receive thrombolysis.

Healthcare acquired infections

20. By March 2016 secure a reduction of x% in MRSA and *Clostridium difficile* infections compared to 2014/15. **[x to be available in April/May 2015 following analysis of 2014/15 performance and benchmarking process.]**

Patient discharge

21. From April 2015, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

Mental health services

22. From April 2015, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Children in care

23. From April 2015, ensure that the number of children in care for 12 months or longer with no placement change is at least 85%.

24. By March 2016, ensure a three year time frame for 90% of children who are adopted from care

Patient safety

25. From April 2015, ensure that the death rate of unplanned weekend admissions does not exceed the death rate of unplanned weekday admissions by more than 0.1 percentage points.

Normative staffing

26. By March 2016, implement the normative nursing range for all specialist and acute medicine and surgical inpatient units.

Ministerial Theme:

To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.

Standards and Targets

Excess bed days

27. By March 2016, reduce the number of excess bed days for the acute programme of care by 10%.

Cancelled appointments

28. By March 2016, reduce by 20% the number of hospital cancelled consultant-led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment.

Delivering transformation

29. By March 2016, complete the safe transfer of £83m from hospital/ institutional based care into primary, community and social care services, dependent on the availability of appropriate transitional funding to implement the new service model.

Pharmaceutical Clinical Effectiveness Programme

30. By March 2016, attain efficiencies totalling at least £20m through the Regional Board's Pharmacy Efficiency Programme separate from PPRS receipts.

Appendix 3 - Summary of Unfunded Service Pressures

As indicated within the Commissioning Plan the funding position for 2015/16 means that a range of key service developments cannot be progressed or can only be taken forward at a significantly reduced scale and/or pace. These service areas are listed below along with the location of relevant information.

Service Area	Section	Page
Maternity services	3.10	15
Physical and sensory disability services	3.11	16
Implementation of the regional reform programme	4.3.2	38
Health Protection Services	6.1.5	48
Services for older people	6.2.3	53
Unscheduled care waiting times	6.3.2	58
Services for people with long-term conditions	6.3.5	61
Cancer services	6.3.6	63
Mental Health services	6.5.2	71
Learning Disability services	6.5.2	71
Family & Childcare Services	7.1	82
Specialist acute services	7.2	87
Access to NICE treatments	7.2	87
Ambulance response times	7.4	94
Primary care and adult community services	7.5.1	98
Elective care waiting times	8.0	108

Steps are being taken, where possible, to mitigate risk and HSCB will continuously review commitments to ensure best use of all available resources.

In addition the HSCB have supported the DHSSPS in preparing bids for June Monitoring amounting to £89m –the bids remain subject to approval.

Bid	Amount £m
Learning Disability Resettlement	6.0
Public Health	4.0
Unscheduled care/Patient Flow	6.0
Revenue Consequences of Capital	7.0
Elective Care/Diagnostics	45.0
Specialist Services	7.5
Mental Health and Learning Disability	4.0
Children's Services	2.0
Transforming Your Care	5.0
Other Departmental Priorities	2.5
	89

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the DHSSPS in N Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / longterm conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the HSCB and PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction – A document published by the Minister on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not publicly funded. Also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

Cord blood is blood that remains in the placenta and in the attached umbilical cord after childbirth. Cord blood is collected from the umbilical cord because it contains cells called stem cells, which can be used to treat some blood and genetic disorders.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Directed cord blood donations - These are collected from the umbilical cord of new born siblings of children with a condition such as acute leukaemia (sometimes referred to as saviour sibling donations). They are arranged with the haematologist treating the affected child.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a

range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, pharmacists, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector as well as service users and carers.

Lesbian, Gay, Bisexual & Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the HSCB arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Neoplasm – Any new and abnormal growth of tissue. Usually a cancer.

Palliative Care – The active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of N Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) – these pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Reablement - range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Service Framework - a document which contains explicit standards underpinned by evidence and legislative requirements. Service Frameworks set standards, specific timeframes and expected outcomes

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Transforming Your Care – Published in 2011 the Review of Health and Social Care in Northern Ireland "Transforming Your Care", sets out a model of care for health and social care which makes recommendations about how we change our services to enhance prevention, early intervention, care closer to home, and greater choice and access. The HSCB is taking forward the implementation of around 70 of the 99 proposals sets out in the TYC Report.

Trust Delivery Plans – In response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Ministerial targets, key themes and objectives outlined for the year ahead.

Unrelated cord blood donations - Also known as undirected or public donations, these are altruistic donations of blood taken from volunteers' umbilical cords at the time of delivery. They are processed and typed for storage in a public cord bank. Registers of public cord banks can be searched internationally to provide the best match for a stem cell transplant.

PRIORITIES FOR ACTION

2010/11

19 May 2010

CONTENTS

Section

INTRODUCTION

The overall aim of the Department of Health, Social Services and Public Safety is to improve the health and well being of the people of Northern Ireland. In pursuing this aim through the health and social care (HSC) system, the key objective of the Department is to improve outcomes through a reduction in preventable disease and ill health by providing effective and high quality interventions and services, equitably and efficiently, to the whole population.

Consistent with this aim and objective the Minister's expectation, for 2010-11 and beyond, is that – as far as possible within the resources made available by the Executive – the public will see continuing improvements to services across six key priority areas, namely:

- Priority Area 1: Improve the health status of the population and reduce health inequalities
- Priority Area 2: Ensure services are safe and sustainable, accessible and patient-centred
- Priority Area 3: Integrate primary, community and secondary care services
- Priority Area 4: Help older people to live independently
- Priority Area 5: Improve children's health and well-being
- Priority Area 6: Improve mental health services and services for people with disabilities.

In addition, Priorities for Action 2010/11 includes a seventh priority area which, particularly in the current financial context is critical, namely:

- Priority Area 7: Ensure financial stability and the effective use of resources.

It is inevitable that the substantial reduction in resources available for service developments as a result of the Executive's cut in the budget for health and social care will severely limit the progress that can be made across a number of the key PfA themes in 2010/11. However this document should nonetheless be taken as a clear signal to HSC organisations of the direction of travel in the short to medium term. It is more important than ever for commissioners and providers to ensure that every penny of the funding available to the HSC is spent economically, efficiently and effectively in pursuit of the Department's aim and objective as stated above. At the same time it must be acknowledged that within the funding available for health and

social care in Northern Ireland it will not always be possible to provide the local population with access to every new service that becomes available.

The remainder of this document sets out the strategic direction for HSC organisations across the seven key priority areas including the particular outputs and outcomes sought.

PRIORITY AREA 1: IMPROVE THE HEALTH STATUS OF THE POPULATION AND REDUCE HEALTH INEQUALITIES

Aim: to improve the health status of the entire population and reduce inequalities in health status between population groups and geographical areas.

Improving health and wellbeing status remains one of the most fundamental ways of improving people's quality of life in Northern Ireland. The Department's aim is to maintain and improve the health status of the entire population and to reduce inequalities in health status between population groups and geographical areas.

With healthcare costs continuing to rise and chronic care consuming an ever increasing share of spending, it is essential that a step-change improvement is secured in relation to prevention and health improvement activities and interventions, leveraging all opportunities within the health and social care service and beyond to promote key public health messages. The Public Health Agency should ensure that all key stakeholder organisations and individuals – within the HSC family, other statutory sectors and the community and voluntary sector – are fully and appropriately involved and working in partnership to improve public health and address inequalities. All stakeholders must be clear about their respective roles and responsibilities and the Agency should establish appropriate oversight arrangements to ensure timely and effective delivery of real improvements.

Addressing lifestyle factors such as smoking, alcohol, diet and physical activity can both reduce the incidence of chronic disease and prevent premature death. The HSC must offer advice and support to help people to stay healthy by tackling these issues, and also help older people remain independent; there should be a particular focus on the early years of life, from conception to the age of three. Individuals should also be encouraged to take more responsibility both for their own health and the health of their children and must understand the impact of their behaviours, especially in terms of rising rates of chronic diseases such as diabetes, cancer and cardiovascular disease.

Tackling inequalities

A key priority for the Department is to reduce inequalities in health status between population groups and geographical areas. This will require the social determinants of ill-health (employment, housing, education, poverty (including fuel poverty), etc) to be addressed, and social capital to be built within communities, through partnership working with key stakeholders.

The Department will continue to work with other Government Departments to promote the use of health impact assessment to ensure their policies and strategies help address the social determinants of health and well being. The Department will also work towards the integration of planning, transport, environmental and health policies to address the social determinants of health. In 2011-12 the Department will publish its new Investing for Health Strategy.

In addressing health inequalities, including in due course taking forward the recommendations of the review of the Investing for Health Strategy, the Public Health Agency should, working with other HSC organisations and through wider partnership arrangements, provide support to evidence-based local initiatives to empower communities and individuals, encourage regeneration and reduce social isolation. In addition, the Agency should work with NIHE, local councils and other statutory and voluntary organisations to ensure the best use of public funds in relation to reducing fuel poverty.

Tobacco

The prevalence of smoking in Northern Ireland has fallen only marginally in recent years, with little real improvement following the initial impact of the smoking ban in 2007. The Department's aim is to re-energise the drive to reduce smoking across Northern Ireland through a multi-component policy, community and societal level prevention approach. Particular focus will be given to those geographical areas with the highest rates of prevalence, and on pregnant women, manual workers and young people.

During 2010-11 and beyond, the Department will take forward a range of key actions to ensure an appropriate policy context for reducing the prevalence of smoking. Legislation will be introduced banning retail displays of tobacco products and the sale of tobacco products from cigarette vending machines, preventing point-of sales advertising for tobacco products.

During 2010-11 the Public Health Agency should introduce and sustain an intense, targeted public information campaign on smoking prevention and cessation. Working with Trusts, primary care and other providers the Agency should ensure accessible, effective smoking cessation services are provided, particularly targeting geographical areas with the highest smoking rates, pregnant women who smoke, manual workers and young people. The Agency will also be expected to work with local government to encourage effective local enforcement of smoking legislation. Finally the Agency should seek to involve communities identified as having high rates of smoking in reducing these rates and should engage with education partners to re-examine educational approaches with young people.

Alcohol and drugs

Tacking the harm from alcohol and drug misuse will continue to be a key priority in 2010-11 and beyond. During 2011 the Department will review and update its strategy document – a New Strategic Direction for Alcohol and Drugs – focussing on a number of existing and emerging issues including the misuse of prescribed drugs, misuse of legal highs, reducing general alcohol consumption (not just binge drinking), encouraging recovery amongst clients, addressing cocaine misuse, and delivering support and information to parents and carers.

During 2010-11 the Public Health Agency should work in partnership with Trusts, primary care and other providers to expand training for professionals for brief intervention, to further develop specialist services and treatments, to ensure effective media campaigns and to take forward relevant actions within the New Strategic Direction for Alcohol and Drugs, the Young People's Drinking Action Plan and the Hidden Harm Action Plan.

The Agency should also work in wider partnerships with statutory, community and voluntary sector organisations to develop community-based programmes to address illicit drug use and problem alcohol consumption, and increase social capital.

Obesity

Addressing obesity in children and adults remains a significant challenge. By October 2010 the Department will develop and publish a comprehensive framework to

prevent and address overweight and obesity across the whole life course. The framework will contain actions to improve nutritional intake, increase participation in physical activity, and improve the evidence base. The level of resources available to address this issue, along with the buy-in and support of key partners to address the obesity issues, will have a direct impact on the framework's effectiveness. The Public Health Agency should lead on the development and implementation of a comprehensive action plan to deliver the framework.

During 2010-11 the Department will continue to work with all Government Departments to address the obesogenic environment, including active travel, healthy schools and the built environment.

During 2010-11 the Public Health Agency should continue to promote and support breastfeeding by working with statutory, voluntary and community sector partners. The Agency should also seek to increase breastfeeding rates, by particularly targeting those least likely to breastfeed. The Agency should also continue to ensure that data are collected in schools on overweight and obese children and support provided for children identified through this process.

Working with other HSC organisations, the Agency should ensure the commissioning of effective services for the treatment and support of people who are overweight or obese. The Agency should also seek to promote Healthy Workplaces in HSC settings and promote physical activity and good nutrition for clients in different care settings e.g. long-term care.

In addition the Agency should continue to address adult and children obesity with actions and initiatives which cover food, nutrition and physical activity. This should include working with a wide range of partners and across all appropriate settings.

Mental health and suicide

The Department's aim is to promote improved emotional well-being and reduce deaths by suicides by: building resilience within individuals and communities; reducing stigma; promoting the early recognition of signs of mental ill health; providing appropriate training (for HSC and non-HSC staff) and sign-posting to appropriate referral pathways; and, providing a range of high quality, responsive

services which are both available and accessible (including preventive initiatives and support for bereaved, both community-based and statutory).

During 2010-11 the Department will publish a new Mental Health and Wellbeing Promotion Strategy. This will place significant emphasis on early-years interventions to secure life-long improvement in mental wellbeing. The Public Health Agency will be expected to work with relevant statutory, voluntary and community partners to take forward this and the new Investing for Health Strategy in 2011-12.

During 2010-11 the Public Health Agency will also be expected to manage effectively the Lifeline Contract. The Agency should ensure effective linkages between regional and local suicide prevention arrangements – with tailored interventions for those areas with particularly high suicide rates, and that local research into the causes of suicide and deliberate self harm is undertaken. Finally, following the refresh of the Protect Life Strategy, the Agency should work with local suicide prevention implementation bodies to develop and deliver local Protect Life Action Plans.

Sexual health and teenage pregnancy

The promotion of good sexual health and wellbeing, and further reducing the overall rate of teenage pregnancy and variations in local teenage pregnancy rates are key priorities.

During 2010-11 the Public Health Agency should undertake further analysis of local data and evaluation of local interventions to identify and implement appropriate ways of delivering accessible and high quality contraception and sexual health services in primary and community settings. These services should be underpinned by an effective, targeted information campaign. During 2010-11, the Agency, working with the Sexual Health Improvement Network, should also take forward the implementation of the Sexual Health Promotion Strategy, to include co-ordinated actions to address teenage pregnancy and parenthood.

Screening

Screening plays a vital role in preventing illness before symptoms appear. A new screening programme for bowel cancer will be introduced on a phased basis during 2010-11 for men and women aged 60 to 69. The Public Health Agency, working with

the HSC Board, Trusts and other relevant organisations should ensure that this programme is implemented in a manner that is cost effective and meets quality assurance requirements. During 2010-11 the Public Health Agency should work with the HSC Board and Trusts to commence preparatory work for the phased introduction of screening arrangements for abdominal aortic aneurysm.

In the context of available funding, it will not now be possible during 2010-11 to proceed with the planned extension to the scope of antenatal screening for foetal anomalies. This and other new screening programmes will be looked at again for introduction in 2011-12, in the context of available funding and on the basis of recommendations from the UK National Screening Committee.

Emergency preparedness

The purpose of planning for emergencies in the HSC is to ensure preparedness for an effective response to any emergency and to ensure that organisations fully recover to normal services as quickly as possible.

The Public Health Agency, the HSC Board, the Business Service Organisation, HSC Trusts, NIBTS and NIGALA should review, test and update their emergency plans, including building on the lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments for pandemic flu preparedness.

Business Continuity Planning

Both emergency and business continuity plans are essential components of each HSC organisation's planning, commissioning and delivery of HSC services to the wider population. Each HSC organisation must have the appropriate structures and mechanisms in place to continue to meet its core objectives even whilst under sudden or sustained pressure, whether as a result of factors outside or within the organisation. Putting in place plans and testing and validating these arrangements in order to ensure an effective response to threats and hazards can be delivered needs to be given high priority.

All HSC organisations should ensure that they have a fully tested and operational Business Continuity Plan in place.

Standards, targets and actions

The specific standards, targets and actions to be achieved in 2010-11 are as follows:

- **Life Expectancy (linked to PSA 1.1):** by March 2011, the Public Health Agency should implement agreed actions contained in its Health Improvement Plan to address inequalities at regional and local level, including any actions arising from the Investing for Health Review.

- **Smoking (linked to PSA 1.2):** by March 2012, reduce to not more than 22% and 28% respectively the proportion of adults and manual workers who smoke. Consistent with the achievement of these outcomes, by September 2010 the Agency should take forward its action plan to improve access to smoking cessation services for manual workers. By September 2010, the Agency should also have in place arrangements for obtaining enforcement activity reports from local government and for analysing and reporting this information (including views on value for money) at least twice yearly to the Department. And by December 2010 the Agency and Trusts should establish additional support arrangements for pregnant women to help them to stop smoking.

- **Obesity (linked to PSA 1.3):** by March 2012, reduce to not more than 9% the proportion of children that are obese. Consistent with the achievement of this outcome, the Agency should throughout 2010-11 ensure timely and effective arrangements are in place in each Trust area to provide targeted support to children identified through the ongoing BMI monitoring process in schools. By February 2011, the Agency should produce an integrated action plan to take forward the obesity prevention strategic framework to address overweight and obesity across the whole life course.

- **Reducing the harm related to Alcohol and Drug Misuse (linked to PSA 1.4, 1.5, 1.6, and 1.7):** by March 2012, reduce to 29% the proportion of adults who binge drink, reduce to 27% the proportion of young people who report

getting drunk, and reduce to 5.5% the proportion of young people taking illegal drugs. Consistent with the achievement of these outcomes, the Agency should from April 2010 further develop and evaluate the brief intervention pilot designed to support primary care to undertake screening and brief intervention on alcohol misuse. By December 2010, the Agency should produce an effective training methodology and determine the feasibility of rolling this out across GP practices. And, from April 2010 the Agency in partnership with the HSC Board should, through the implementation of the joint Hidden Harm Action Plan, increase awareness of relevant services and ensure that more young people affected by parental substance misuse are effectively signposted to existing services.

- **Suicide (linked to PSA 1.8):** by March 2012, ensure that the suicide rate is reduced below 14.5 deaths per 100,000. Consistent with the achievement of this outcome, by September 2010 the Public Health Agency should ensure that a Deliberate Self Harm Registry pilot is established in the Belfast HSC Trust, and a first draft report produced by March 2011. By September 2010, the Agency should produce an action plan to implement recommendations arising from Mental Health Promotion / Suicide Prevention Training in Northern Ireland.

- **Mental Wellbeing (linked to PSA 1.8):** by March 2011, the Public Health Agency should produce an action plan to take forward the relevant regional and local elements contained within the Mental Health and Wellbeing Promotion Strategy.

- **Early years' intervention:** by March 2011, the Public Health Agency and Trusts should ensure that the updated child health promotion programme is fully implemented. The impact of the programme will be measured through the Child Health System and the introduction of a new schedule of visits to be undertaken by health visitors.

- **Births to teenage mothers (linked to PSA 1.9):** by March 2012, the Public Health Agency should ensure that the rate of births to teenage mothers under 17 is reduced to not more than 2.7 births per 1,000. Consistent with the achievement of this outcome, by December 2010 the Agency should

complete a review of the latest evidence of effective intervention for reducing teenage pregnancy, take forward agreed actions to secure further reductions in the rates of teenage pregnancy linked to the Sexual Health Promotion Action Plan.

- **Bowel cancer screening (PSA 1.11):** during 2010-11, the Public Health Agency, Health and Social Care Board and Trusts should establish on a phased basis a bowel screening programme for those aged 60 – 69 (to include appropriate arrangements for follow up treatment).

- **Screening for abdominal aortic aneurysm:** during 2010-11, the Public Health Agency should work with the HSC Board and Trusts to commence preparatory work for the phased introduction of screening arrangements for abdominal aortic aneurysm.

- **Emergency Preparedness:** by March 2011, all relevant HSC organisations should review, test and update their emergency plans, including building on the lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments for pandemic flu preparedness.

- **Business Continuity Planning: –** by March 2011, each HSC organisation should ensure it has a fully tested and operational Business Continuity Plan in place.

PRIORITY AREA 2: ENSURE SERVICES ARE SAFE & SUSTAINABLE, ACCESSIBLE & PATIENT-CENTRED

Aim: to ensure that patients and clients have timely access to high quality services responsive to their particular needs and delivered locally where this can be done safely, sustainably and cost-effectively.

Quality and safety

The first dimension of quality must be that we do no harm to patients or clients.

A strengthened system of regulation and robust standards of care and treatment have been established through linkages with NICE and SCIE. Commissioners and Trusts must ensure that services are delivered to common agreed standards, and that there is no inappropriate variation in the care and treatment that people are receiving. Clinicians and practitioners will be expected to look closely at their own practice and ensure that it is fully in line with current best practice. Within the context of available resources, it is expected that patients will continue to have access to the majority of NICE approved drugs and technologies and approved vaccines.

During 2010-11, Commissioners and Trusts should ensure that appropriate clinical and social care governance structures are in place to ensure satisfactory progress is made towards the full implementation of all endorsed best practice guidance (NICE, SCIE, NPSA, GAIN). Trusts should evidence that they are participating in Safety Forum collaboratives and develop action plans for any learning sets.

A significant programme of work has been established to develop Service Frameworks for the major causes of ill health and disability. This programme has been assigned a high priority and the Service Frameworks implemented are expected to fundamentally underpin the commissioning and delivery of services across the HSC for the future.

Service Frameworks for Cardiovascular Health and Wellbeing and Respiratory Health and Wellbeing have been published for implementation whilst Service Frameworks for cancer, mental health and wellbeing, learning disability, the health

and wellbeing of children and young people and the health and wellbeing of older people are at various stages of development. HSC organisations are expected to continue to contribute to the development and implementation of this programme of work as a means of ensuring that services are commissioned and delivered to standards of quality that are evidence-based, safe and sustainable. Commissioners should ensure that the structures and processes for joint commissioning facilitate the timely and effective implementation of service frameworks.

It is also important that we learn from mistakes and minimise the risk of untoward events. *Safety First: A Framework for Sustainable Improvement in the HPSS* set an early strategic direction for Quality and Safety in the HSC, with a strong emphasis on robust incident reporting arrangements. Completion of this work has laid strong foundations in terms of quality, learning and patient/client safety in particular. In building for the future, all parts of the HSC are contributing to the development of a quality strategy for the next 10 years that will focus on three key components, namely safety, standards and the patient/client experience (with the latter embracing personal and public involvement). During 2010-11 the Public Health Agency in partnership with the HSC Board should establish effective arrangements to ensure that lessons learnt from adverse events are taken forward by Trusts, primary care and other providers.

During 2010-11, Trusts should continue to ensure satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash call rate, the prevention of venous thromboembolism and mental health inpatient care. Trusts should also during 2010-11 prepare quality improvement plans to implement WHO Surgical Checklists in 80% of cases by March 2011 and, in collaboration with the HSC Safety Forum, to promote initiatives aimed at reducing the incidence of falls and medication errors.

The Department also wishes to see evidence of improving clinical outcomes such as mortality and survival rates. From September 2010, Trusts will be expected to put in place arrangements to routinely review their standardised mortality rates, both over time and against comparator organisations in NI and GB. Trust review arrangements should include consideration at Trust board level.

It is also important to ensure that the healthcare environment is safe and clean and issues such as healthcare infection are tackled. *Changing the Culture 2010* aims to eliminate the occurrence of preventable, healthcare associated infections (HCAIs) in all HSC settings. To date, work has focussed on secondary care; the main challenge for the medium term will be to tackle HCAIs in the community. The Department expects to see year-on-year improvements in performance as measured by infection rates, infection numbers and other criteria; the infection-control performance of NI hospitals should be as good as high-performing comparable hospitals elsewhere in the UK.

General standards of hygiene and cleanliness are also essential to ensure public confidence. Trusts should ensure that effective arrangements are in place to provide ongoing assurance that the patient environment and levels of hygiene and cleanliness are meeting prevailing standards, as updated by the current review process being taken forward by the Department and Public Health Agency.

Ensuring effective decontamination of medical devices also forms an important part of protecting patients from infection risk: during 2010-11 Trusts should continue to take forward implementation of the regional decontamination strategy in accordance with agreed timescales.

Accessibility

Ensuring that the population has timely access to high quality healthcare remains a key priority.

Significant improvement in waiting times had been achieved in recent years, but performance has slipped back in 2009-10 in a number of specialties. It will be a key priority for the HSC Board and Trusts in 2010-11 to ensure that, within available resources, in-house capacity is increased and as many specialties as possible are brought into recurrent balance, with the independent sector only being used in exceptional circumstances, and then only with the prior approval of the HSC Board. By March 2011 it is expected that all outpatients will be seen within nine weeks following GP referral; it is recognised that the current 13-week standard for treatment is not achievable across all specialties within the resources available in 2010-11, but nonetheless Trusts should ensure that maximum treatment waiting times are – at worst – maintained at March 2010 levels for all specialties being brought into

recurrent balance in 2010-11, and in the small number of remaining specialties, waiting times for treatment do not exceed the maximums stated later in this section.

Trusts should also ensure in 2010-11 that effective steps are taken to address the current delays in appointments for review patients.

Similarly, A&E performance against the 4-hour and 12-hour standards has been weak at nearly all larger hospital sites in 2009-10 and commissioners and Trusts must ensure that the achievement of these standards is given the highest priority in 2010-11.

In delivering timely access to elective and emergency care services, Trusts will be expected to further embed the reform agenda, including the improvement of hospital booking processes, reducing cancelled appointments and improving hospital utilisation. To drive up both quality and productivity and to improve care and outcomes for patients, it is vital that clinicians are actively engaged in determining the best clinical care pathway redesign processes that deliver improved outcomes. This applies equally to clinicians in primary, community or secondary care. The HSC Board and Public Health Agency should ensure that effective clinical engagement is a central plank of their commissioning processes.

In meeting all challenges faced by the service, the primary issue is how health and social care services are best configured to respond safely and effectively to the emerging needs of the individuals and populations they serve. As those needs and the technology to meet those needs develop, it may be right to provide some services on single sites or have them provided on a regional basis while other services may continue to be provided at local hospitals or in primary care. At all levels of care the goal must be to ensure that the services provided are safe and of a high quality, delivering effective outcomes for patients. Timeliness and ease of access remain as important issues and service planners and providers should recognise the need to consider the particular issues faced by the most vulnerable and disadvantaged service users with regard to accessing appropriate care.

Commissioner and Trust plans should outline the action to be taken to identify where and in what way services may need to be modernised or reconfigured to achieve higher quality and better outcomes. Services should continue to be delivered locally where this can be done safely, sustainably and cost effectively.

Remote populations remain concerned about access to life saving interventions in the event of a sudden emergency. Often proximity to acute facilities is perceived as the determining factor as to whether the local health and social care services will adequately provide for a population's needs. Increasingly however it is not the distance to the appropriate facility that may determine the outcome for the patient but the timeliness of the initial clinical intervention and the ability to provide appropriate care for the patient during a transfer to the most appropriate destination.

Commissioner and Trust plans should reflect the steps required to put in place supporting measures, for dispersed rural communities, for example, first responder schemes, improved ambulance services, etc. Plans should also reflect the further actions required to ensure effective arrangements are in place for the regional neonatal and paediatric transport service.

Hospital services are dependent upon those delivering primary and community care services to ensure that people are not inappropriately referred to hospital services where there is a safe and effective means of caring for the patient in the community. Primary and community services must also respond to the needs of patients following discharge from hospital to ensure patients have access to a range of services needed to support them in the community. The HSC should seek to achieve a closer integration of primary, community and secondary care with the aim of delivering comprehensive treatment and care across a variety of care settings, with care providers operating collaboratively as an inter-dependent care network. This is developed further under Priority 3 – Integrate Primary, Community and Secondary Care.

Other developments include the potential offered by ICT for improved communication with remote sites, between primary and secondary settings and transfer, in real time, of data, information and images. These developments in turn facilitate the establishment of managed clinical networks, provide for specialist advice to be made available remotely to smaller institutions, and contribute to enhanced care being delivered locally, enhancing the patient experience and avoiding many hospital visits and possibly hospital admissions.

Commissioners and Trusts must ensure NIPAC is fully implemented and utilised and should continue to support its development.

Ensuring services are person-centred

Personal and Public Involvement (PPI) is about giving people and communities a say in the planning, commissioning and delivery of their health and social care services. Person-centred care means organising services around the needs of the individual patient, meeting their clinical needs, working in partnership and treating them with dignity and respect. It means providing timely and convenient services that help prevent – as well as treat ill-health.

Service users have a right to be treated with dignity and respect; they should be involved in discussions and decisions about their own healthcare and also in the development and consideration of proposals for changes to the way in which services are provided. Commissioners and Trusts should actively engage with those who use health and social care services, their carers and the wider public to discuss: their ideas, our plans; their experiences, our experiences; why services sometimes need to change; what people want from their services; how to make the best use of available resources; and how to improve the quality and safety of services.

To be effective, PPI must be seen as part of the job of all those involved in HSC organisations, integral and not incidental to their daily work. HSC organisations should therefore ensure that they comply with the requirements of Departmental guidance on PPI, and should continue to take forward appropriate actions at strategic and local level to ensure that PPI is mainstreamed within their organisation.

Standards and Targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Specialist drug therapies for arthritis (PSA 2.2):** from April 2010, the HSC Board and Trusts should ensure no patient waits longer than nine months to commence specialist drug therapies for the treatment of severe arthritis.
- **Elective care (consultant-led) (PSA 2.3):** by March 2011, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks for a first outpatient appointment and 9 weeks for a diagnostic test, the majority of inpatients and daycases treated within 13 weeks and no patient waits longer than 36 weeks for treatment. During 2010-11, Trusts should take steps to

ensure review patients are seen in a more timely fashion; from March 2012, all reviews should be completed within the clinically indicated time.

- **Diagnostic reporting:** from April 2010, the HSC Board and Trusts should ensure all urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.
- **Elective care (AHP):** from April 2010, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks from referral to commencement of AHP treatment.
- **Fractures (PSA 2.4):** from April 2010, the HSC Board and Trusts should ensure 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.
- **Cancer (PSA 2.5):** from April 2010, the HSC Board and Trusts should ensure all urgent breast cancer referrals are seen within 14 days, 98% of cancer patients commence treatment within 31 days of the decision to treat, and 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.
- **A&E:** from April 2010, HSC Board and Trusts should ensure 95% of patients attending any A&E department are either treated and discharged home, or admitted, within four hours of their arrival in the department. No patient should wait longer than 12 hours.
- **Stroke services (PSA 2.6):** by March 2011, the HSC Board and Trusts should ensure 24/7 access to thrombolysis and that high risk transient ischemic attacks are assessed and treated within 24 hours. Trusts should also work towards a door to needle time of 60 minutes for thrombolysis by March 2011.
- **Renal services (PSA 2.7):** from April 2010, the HSC Board and Trusts should ensure all patients should continue to have timely access to dialysis services. From April 2010, at least 60% of patients should receive dialysis via a fistula. By March 2011, the Belfast HSC Trust should deliver a minimum of 50 live donor transplants.
- **Ambulance services (PSA 2.8):** from April 2010, the HSC Board and NIAS should ensure an average of 72.5% of Category A (life-threatening) calls are

responded to within eight minutes, increasing to an average of 75% by March 2011 (and not less than 67.5 % in any LCG area).

- **Healthcare associated infections (PSA 2.1):** in the year to March 2011, the Public Health Agency and Trusts should secure a further reduction of 20% in MRSA and C.difficile infections compared to the position in 2009-10.
- **Hygiene and cleanliness:** from September 2010, each of the five HSC Trusts should put in place arrangements to routinely review compliance with updated and consolidated regional standards of hygiene and cleanliness. Trust review arrangements should include consideration at Trust board.
- **Mortality:** from September 2010, each of the five HSC Trusts should put in place arrangements to routinely review the Trust's standardised mortality rates, both over time and against comparator organisations in NI and GB. Trust review arrangements should include consideration at Trust board.
- **Trust quality initiatives:** from April 2010, the Public Health Agency and Trusts should continue to ensure satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust-specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash call rate, the prevention of venous thromboembolism and mental health inpatient care. By July 2010, Trusts should submit to the Public Health Agency, for approval and monitoring, quality improvement plans to implement WHO Surgical Checklists in 80% of cases by March 2011, and in collaboration with the HSC Safety Forum promote initiatives aimed at reducing the incidence of falls and medication errors.
- **Patient Experience:** following the adoption of the Patient and Client Experience standards in 2009, Trusts should extend the clinical care areas monitored and increase the range of monitoring tools, and ensure appropriate reporting and follow-up, consistent with direction from the Public Health Agency.
- **Patient involvement:** by March 2011, the Public Health Agency in partnership with the HSC Board should: establish a regional Health and Social Care forum, with appropriate Patient and Client Council and public representation, to drive the PPI agenda; develop and implement a regional Health and Social Care Action Plan for PPI including arrangements to

promote and evidence active PPI; arrange for the publication of an annual summary of PPI activity across Health and Social Care Organisations.

- **Service Frameworks:** by March 2011, Commissioners and Trusts should have action plans in place to ensure the implementation of agreed standards from the Cancer Framework in accordance with guidance to be issued by the Department in October 2010.

PRIORITY AREA 3: INTEGRATE PRIMARY, COMMUNITY AND SECONDARY CARE SERVICES

Aim: to ensure greater engagement between secondary and primary care clinicians and practitioners to agree clinical pathways which reduce the use of hospital services and increase the capability of primary care to manage patients more locally.

Ever increasing demands are being placed on hospitals. Patient flows must be more effectively managed so that patients are seen, diagnosed and treated in the right setting by the right person at the right time. Much of the care provided in hospital or other institutional settings could be delivered in community settings. Many referrals and unplanned admissions to hospital, outpatient appointments and diagnostic tests could be more appropriately managed in the community. Moving care from hospitals to community settings and patients' own homes should not only improve efficiency but should also drive improvements in quality.

A reduction in the use of acute services including mental health should lead to a managed reconfiguration of these services which focus on specialised interventions in support of enhanced locally based integrated care.

During 2010-11 Commissioners and Trusts should continue to build a continuum of responsive, integrated primary and community care that promotes good health, prevents ill health and focuses on people at risk, supporting them to live independent lives and reducing unnecessary and inappropriate reliance on hospitals and other institutional care.

The Department wishes to see greater engagement between secondary and primary care clinicians and practitioners to agree integrated clinical pathways which reduce the use of hospital services, increase the capability of primary care to manage patients more locally and ensure effective communication across organisational, professional and geographical boundaries. A good example of such an initiative is the current work on the development of an integrated pathway for the management of people with glaucoma. Trusts should support their clinicians and practitioners in facilitating the integration of primary, community and secondary care services.

During 2010-11, Commissioners should establish partnerships in primary care involving groupings of GPs and other health and social care providers, which incorporate integration along clinical care pathways and address the wider determinants of health. In particular, the partnerships should look at the potential for improvement in the care and support for patients with long term conditions, mental health problems, palliative care, families and children. In developing these partnerships, Commissioners should ensure that due regard is given to existing services provided by the voluntary/ community sectors and by other partners such as Councils, housing and education. Commissioners should also engage fully with PCC and service users to ensure proposed service models are responsive to client needs.

As part of this programme, and building on work in 2009-10, Commissioners and Trusts should continue to identify people with long term health conditions as early as possible and provide person centred care plans tailored to individual needs and wishes, supported through a case management approach that will improve the quality of local care and support available to users and their carers and enable people to better manage their conditions.

As medicines constitute a key aspect of care management, every effort must be made to optimise their safe, effective and economic use, including actions to secure further improvement in generic prescribing and the extension of repeat dispensing in line with the Pharmaceutical Effectiveness Programme. Commissioners should ensure that effective arrangements are in place for medicines management, including the introduction during 2010-11 of a NI medicines formulary and potentially expanding the role of community pharmacists within the primary care team.

During 2010-11, in developing partnerships in primary care, Commissioners should also explore the opportunities for primary care out-of-hours services to more effectively integrate with A&E and ambulance services in the provision of unscheduled care services, to include the physical co-location of out-of-hours services with A&E, single point triage, and the streamlining of management arrangements to maximise value from the complementary skill-sets and capacities and offer a more efficient, cost-effective service for patients. During 2010-11 Commissioners should also continue to progress work on the development of a regional out of hours service.

GPs are now expanding the services they provide and in some instances gaining more specialist expertise and training in specific areas. Subsequently the range and scope of healthcare that can and will be provided in local communities is likely to expand. Commissioners, working in partnership with relevant training agencies and other stakeholders, should facilitate specialisation, skills development and education in primary care. Commissioners should also explore the potential to use primary care information more effectively to proactively identify patients and families at risk of ill health and plan for their care.

Integrated care will require joint training as well as new skills to manage patients effectively along clinical pathways. Training agencies should be considering this and looking at ways of providing this. Agencies should also consider the generic skills and roles required at local levels to support integrated care. Commissioners should encourage the use of lay health workers to deliver healthcare in local communities.

Direct Payments also play an important role in facilitating independent living as they offer service users flexibility, choice and control over the purchase and delivery of the social care services that best support them. Trusts should continue to promote the use of Direct Payments as an alternative to traditional social care provision.

Consistent with the recently launched Departmental strategy, providers should ensure that each person identified as needing palliative care or end of life care is supported by a multi-disciplinary team on a 24/7 basis, which is proactive in working with private sector care home providers and carers to be able to offer people the choice of dying at home with dignity. These should be considered in the context of the Gold Standards Framework, (integrated) Care Pathway for the Dying and the best standards of multi-professional education as outlined in the Framework for Generalist and Specialist Palliative and End of Life Care Competency.

Standards and Targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Pathway management:** by March 2011, the HSC Board should establish: (i) models of integrated care in community settings which incorporate integration along clinical care pathways and address the wider determinants of health; and (ii) models of unscheduled care in hospital settings which integrate primary care out-of-hours services with ambulance and A&E services.

- **Hospital discharges (PSA 3.1):** from April 2010, the HSC Board and Trusts should ensure that 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days. All other patients should be discharged within six hours of being declared medically fit.
- **Unplanned admissions (PSA 3.2):** by March 2011, the HSC Board and Trusts should further develop early intervention approaches to support identified patients with severe chronic diseases (e.g. heart disease and respiratory conditions) so that exacerbations of their disease which would otherwise lead to unplanned hospital admissions are reduced by 50%.
- **Direct payments:** by March 2011, the HSC Board and Trusts should increase the number of direct payment cases to 1,750.
- **Palliative care:** by March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.
- **Primary care access:** from April 2010, the HSC Board should ensure 70% of patients receive an appointment within two working days with a GP or appropriate practice based primary care practitioner, increasing to 80% from April 2011.
- **Medicines management:** by March 2011, the HSC Board should introduce a NI medicines formulary.

PRIORITY AREA 4: HELP OLDER PEOPLE TO LIVE INDEPENDENTLY

Aim: to ensure that older people are able to remain independent in their own homes and communities with a good quality of life for as long as possible.

With life expectancy increasing, it is important that the HSC supports people to remain healthy both physically and mentally for as long as possible. During 2010-11 Commissioners and Trusts should continue to provide support to help older people live independent lives through ensuring local access to day care and respite services, together with the provision of targeted domiciliary care support, and effective management of long term conditions and end of life care.

Effective partnership arrangements should be established with DSD, local councils, voluntary, community and independent sector organisations to provide support to older people including initiatives to reduce social isolation, promote healthy life styles, develop more flexible transport arrangements and reduce fuel poverty. Commissioners and Trusts should continue to support this multi-agency approach.

Trusts should ensure that patients discharged from hospital are offered where appropriate active rehabilitation that reduces the need for residential care or domiciliary care. Planning for discharge should begin on admission and plans should be agreed with local integrated teams. Assessment of ongoing needs should take place at home or in intermediate care settings rather than in hospital. Consideration should be given to the needs of carers as part of the assessment process.

Providers should ensure that decisions on patients' long term care needs are made by all relevant professionals within the framework defined in the NI Single Assessment Tool to ensure that a consistent, comprehensive approach is taken in all cases. Patients, clients and carers should be appropriately involved in decisions being made about their community based health and social care. All patients should be provided with a copy of their individual care plan to enable them and their carers to understand the level of care to be provided and who to contact if difficulties arise with care package arrangements.

The vital role of carers and the contributions they make as expert partners and the support they need to fulfil this role should be recognised within care plans. Providers should ensure that carers are aware that they have a statutory right to an assessment of their own needs, and the Carer's Support and Needs Assessment component of NISAT provides an effective and consistent framework for this. Commissioners should plan for services to carers on the basis of the joint *Review of Support Provision for Carers* published in December 2009.

Standards and Targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Supporting people at home (PSA 4.1):** from April 2010, the HSC Board and Trusts should ensure at least 45% of people in care management have their assessed care needs met in a domiciliary setting.
- **Assessment and treatment of older people (PSA 4.2):** from April 2010, the HSC Board and Trusts should ensure older people with continuing care needs wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.
- **Individualised Care Plans:** from December 2010, the HSC Board and Trusts should ensure any patient receiving a new care package at home is provided with a copy of their individual care plan to enable them to understand the level of care to be provided and who to contact if difficulties arise with care package arrangements.

PRIORITY AREA 5: IMPROVE CHILDREN'S HEALTH AND WELL-BEING

Aim: to improve the health and wellbeing of children, to protect vulnerable children, to help families stay together and to improve outcomes for children and young people including those leaving care.

The Department's key policy priorities are set out in Families Matter and Care Matters both of which have now been approved by the Executive. The emphasis is on early intervention and prevention to help all families and parents to be confident and responsible in helping their children reach their full potential and reduce the number of children who have to be taken into care. The two strategies provide a continuum of support with Families Matter focusing on universal and targeted support and Care Matters focussing on higher level need.

During 2010-11, Trusts should continue to increase the use of family-friendly approaches such as family group conferencing and mediation and identify family-specific support packages to meet families' needs. The HSC Board and Public Health Agency, working with Trusts, should commission family support services in partnership with other key stakeholders, such as voluntary sector organisations.

Safeguarding vulnerable children

The need for robust structures and systems to support safeguarding children practice has been repeatedly emphasised in child death inquiry reports, case management reviews, the DHSSPS Inspection Report, Our Children and Young People – Our Shared Responsibility and in recent RQIA inspection reports into child protection services. Over the next year, a key safeguarding priority will be to complete the transition from Area Child protection Committee arrangements, building on the establishment of the Regional Child protection Committee and laying the groundwork for a statutory and independently chaired Safeguarding Board for Northern Ireland.

The Safeguarding Board will have responsibility for broadening the approach to safeguarding children beyond child protection into a wider child welfare agenda. The Safeguarding Board will have three main objectives: to secure effective coordination of what is done to safeguard and promote the welfare of children by each person and agency represented on the Board; to ensure the effectiveness of what is done by

each agency and person for that purpose; and, to communicate the need to safeguard and promote the welfare of children to the wider community.

During 2010-11, the Department will update the Co-operating to Safeguard Children guidance in preparation for the planned establishment of the Safeguarding Board. The revised guidance will take account of structural challenges in the delivery of services to children and families brought about by the reform of public administration alongside the introduction of the Safeguarding Board and new Safeguarding Vulnerable Groups arrangements. The guidance will also reflect the work being taken forward on the promotion of infant and child mental health and wellbeing.

Trusts should continue to ensure the effectiveness of child protection arrangements and services to families through the operation of gateway teams and the production of high quality assessments of need using the UNOCINI single assessment tool. Trusts should also continue to ensure that supervision standards, information sharing protocols and recording standards are complied with on a consistent basis. Further work is needed to align other assessment tools with the UNOCINI framework and to develop existing IT systems to underpin the functioning of Gateway and Family Intervention Teams and the referral and assessment process. Commissioners and Trusts should also continue to work positively with police colleagues to play their full part in the operation of statutory public protection arrangements introduced by the NIO in October 2009.

The Department has recently issued new guidance on the use of child protection procedures for looked-after children; Trusts should apply this guidance from April 2010 onwards.

The Department expect the Reform Implementation Team – established in 2006 to drive forward a comprehensive change agenda for child protection services in NI in partnership across Commissioners, Trusts, police and education – to continue to progress key initiatives in 2010-11 including: the implementation of the public law outline; the development of a caseload management model; the development of policies and procedures for residential care; and, the development of an audit process to underpin RIT products.

Vetting

The Department is implementing a new Vetting and Barring Scheme, which is being put in place under the Safeguarding Vulnerable Groups (NI) Order 2007. The new scheme extends to those who work with children in both paid and voluntary capacities and for the first time will establish a register of those who work with both children and vulnerable adults. Trusts should take steps to ensure that their employment and recruitment practice complies with the requirements of the scheme as it is fully implemented including taking steps to prepare for the phasing in of their existing workforce into the scheme over the following five years.

Looked-after children

While the best place for children and young people is nearly always with their families, sometimes the best interests of the child are served by their being looked after by health and social care services. At any one time, 2,500 children are looked after. The greater number of these young people live with a foster family with around 12% in residential care.

When health and social care services take on parental responsibility for children every effort must be made to provide them with stability, protect them from further harm and be ambitious for their futures. Trusts should work to achieve greater permanence for children in care – primarily through long-term foster/ residential care, returning children home or through adoption. All children in care should have a plan for permanence by the time they have been in care for six months.

During 2010-11, Trusts should also implement Departmental guidance on delegated authority (issued in January 2010) with a view to giving more children in care the opportunity to live their lives without bureaucracy unnecessarily impacting negatively on routine, day-to-day decision making. Similarly, Trusts should make further progress in developing and implementing new arrangements to recruit more kinship foster carers. All Trusts should have dedicated kinship foster carer teams or dedicated kinship foster carers workers within their fostering teams. And all Trusts should prepare for the implementation of new and separate approval processes for kinship foster carers which will be in place by September 2010.

In relation to adoption, all Trusts should eliminate unnecessary delays in progressing adoptions and provide better support to all parties involved including birth families,

adopters and children and young people themselves. The Department expects to see significant progress in the year ahead in the move towards a lead regional Trust for a Regional Adoption Service.

Improved outcomes for care leavers

During 2010-11, the Department expects to see improvements in outcomes for children and young people in care or on leaving care. Trusts should ensure that young people in care from age 13 are able to participate in an accredited preparation for adulthood programme. Trusts should also encourage more young people in care and care leavers to seek and attain employment, education and training opportunities, working in partnership with other agencies such as the careers service. And Trusts should also ensure adequate provision is made for those young people who wish to have the opportunity to continue living in their foster home until they are aged at least 21, taking steps to improve therapeutic support to residential children's homes.

These initiatives are intended to underpin a longer term strategic focus on improved outcomes for 18-21 year old care leavers in line with the Care Matters agenda. All Trusts should now have Through-care Transition Teams in place as an essential mechanism to ensure the provision of dedicated support services and to provide a gateway to other key services. A range of other collaborative initiatives are also being progressed to support this objective, including the development of guidance and protocols on the accommodation needs of care leavers, employability schemes, and the prospective introduction of delegated authority for foster carers and kinship care. Trusts should support the relevant Departments and agencies in the development and implementation of these initiatives to provide a strong foundation for 2010-11. This will include the piloting of new standards for facilities accommodating care leavers aged 16-21 and some older children in care.

There has been considerable co-operation between the Department, the HSC Board, Trusts, DSD and the Housing Executive on the development of joint accommodation provision to provide housing and support for care leavers aged 16-21. Trusts should continue to ensure that they fully discharge their statutory responsibilities towards young people living within jointly commissioned accommodation. They should also continue to work in partnership with housing colleagues to meet the needs of homeless young people and ensure that they assess the needs of this population.

Standards and Targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Children in care:** from April 2010, the HSC Board and Trusts should ensure children admitted to residential care have, prior to their admission: (i) been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process. For every child taken into care, a plan for permanence and associated timescale should be developed within six months and formally agreed at the first six-monthly LAC review.
- **Family support interventions (PSA 5.1):** by March 2011, the HSC Board and Trusts should provide family support interventions to 3,000 children in vulnerable families each year. By this date, Trusts should also have updated the Regional Information System with details of family support services which they provide.
- **Care leavers in education, training or employment (PSA 5.2):** from April 2010, the HSC Board and Trusts should ensure that at least 70% of all care leavers aged 19 are in education, training or employment.
- **Care leavers living with former foster carers or supported families (PSA 5.3):** by March 2011, the HSC Board and Trusts should ensure that at least 200 care leavers aged 18+ are living with their former foster carers or supported family.
- **Looked-after children on the child protection register (PSA 5.4):** by March 2011, the HSC Board and Trusts should ensure that the child protection status of all looked-after children on the current register is reviewed in line with Departmental guidance issued in April 2010.
- **Family group conferencing:** during 2010/11, the HSC Board and Trusts should ensure that at least 500 children and young people participate in a family group conference.
- **Assessment of children at risk and in need:** from April 2010, the HSC Board and Trusts should ensure the following:
    - Child protection (allocation of referrals) – all child protection referrals are allocated within 24 hours of receipt of the referral

- Child protection (initial assessment) – all child protection referrals are investigated and an initial assessment completed within 10 working days from the date of the original referral being received
- Child protection (pathway assessment) – following the completion of the initial assessment, a child protection case conference is held within 15 working days of the original referral being received
- Looked-after children (initial assessment) – an initial assessment is completed within 10 working days from the date of the child becoming looked after
- Family support (family support referral) – 90% of family support referrals are allocated to a social worker within 20 working days for initial assessment
- Family support (initial assessment) – all family support referrals are investigated and an initial assessment completed within 10 working days from the date the original referral was allocated to the social worker
- Family support (pathway assessment) – on completion of the initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days.

PRIORITY AREA 6: IMPROVE MENTAL HEALTH SERVICES AND SERVICES FOR PEOPLE WITH DISABILITIES

Aim: to improve the mental health of the population and to respond effectively to the needs of individuals with a mental health condition or a learning disability or physical/ sensory disability, and to support them to lead fulfilling lives in their own home and communities.

Mental health services

One in four people will suffer a mental health condition at some stage in their lives. Not only does this impact on the individual but also has a potential to have a profound social and economic impact on our society and on the lives of children and families.

The focus on mental health services should include the promotion of mental wellbeing and prevention of mental health conditions, where possible. During 2010-11, Commissioners and Trusts should ensure that the provision of services to people with a mental health need should be through a stepped care approach, recognising that the majority of services should be delivered in primary and community care settings through multidisciplinary and cost-effective approaches. Improving access to psychological therapies should be an integral part of a modern service and be incorporated within the stepped care approach. Inappropriate admission to hospital must be avoided and, where admission is necessary, a focus on access to therapeutic interventions is essential, and early discharge must be facilitated.

The key driver will be the Executive-approved Bamford Action Plan (October 2009). Bamford recognised the need for change – both societal and service change – with a focus on the creation of an emotionally resilient society, early intervention and a recovery ethos, where possible. For those with severe and enduring mental health conditions, there remains a need to provide specialist support and multiagency action. Strategic drivers will include the soon-to-be published Personality Disorder Strategy and Psychological Therapies Strategy, in addition to the recently published consultation on the Dementia Strategy. All of these documents will set strategic direction for future service developments recognising, of course, that enhanced

service provision will take some time to achieve. Such an approach is consistent with Bamford which identified that sustained development will be required over at least 15 years.

Mental health legislation is also an important driver for societal and service change. Preliminary Executive approval has been given to proceed with legislative change through the development of policy on a single Bill, encompassing mental capacity and mental health which, subject to Executive approval, will be enacted in 2012-13. Within this legal framework, change is needed to deliver a broader range of interventions and treatments. The legal framework will also include personality disorder in the definition of a mental disorder. In addition, the importance of advocacy for service users and carers will be recognised.

Risk assessment and management is a core element of mental health services and regional guidance in this regard has been issued, with piloting of supporting tools and associated training. Commissioners and Trusts should ensure this guidance is adopted during 2010-11 including implementation of supporting tools.

Regional principles to guide the provision of services for those in crisis and at risk of suicide or serious harm were published in January 2010. These principles should be taken into account by Commissioners and Trusts when developing crisis intervention services.

During 2010-11 and beyond, Commissioners and Trusts should ensure that progress is made in the following areas to improve mental health services and enhance mental wellbeing of the population:

- Promotion of early interventions including psychological therapies
- Strengthening of multidisciplinary community services, including crisis intervention services aligned to stated DHSSPS principles
- Continued development of the stepped care model across all appropriate mental health services
- Reconfiguration of acute inpatient facilities with a reduction in overall acute provision supported by step-up and step-down facilities
- Continued resettlement of long stay patients from hospital into the community

- Staged development of specialist services – including personality disorder services, and forensic mental health and learning disability services
- Development of regional low secure inpatient provision based on the Department's scoping paper
- Focus on early intervention for women and children with the development of an integrated pathway for peri-natal mental health services and promotion of infant and family mental health and wellbeing
- Development of HSC workforce plans for mental health services, building on the recommendations of the Workforce Report commissioned by the Department, with particular reference to the need for enhanced skills in the community, and development of specialist skills to deliver a range of therapeutic interventions for those with severe and enduring mental ill health
- Commencement of implementation of the Dementia Strategy and associated action plan to be published later in 2010
- Development of a regional approach to the reduction of extra-contractual referrals in both mental health and challenging behaviour
- Further development of a regional approach to eating disorder services recognising the need for specialist provision, and a commitment to reduce the number of extra-contractual referrals
- Ensure full and appropriate involvement of social services staff in Multi-Agency Risk Assessment Conferences (MARACs) to reduce the risk of domestic violence
- Reduce the trauma of sexual violence by securing the establishment of the regional Sexual Assessment and Resource Centre, to be operational by early 2012
- Subject to Executive approval, commence preparations for a single Bill encompassing mental capacity and mental health to be enacted from 2012 onwards.

Learning disability services

The focus for learning disability will be a "whole life approach" to early intervention, assessment, diagnosis, treatment, care planning and support. This requires a multi-agency approach at local and regional levels. The Department expects a greater

focus on “purposeful lives” which supports the individual to live as independently as possible. Changing demographics and improvements in treatment and care mean that not only will there be an ageing population of individuals with a learning disability but also an increasing number of people with more severe learning disabilities. At the same time the average age of those caring for them is also increasing. In developing community services, Commissioners and Trusts should ensure a co-ordinated whole life approach that values individuals as welcome members of society.

The aim for both learning and physical/sensory disability services will be to provide person-centred, seamless community-based services, informed by the views of service users and their carers. It is vital that people are supported to live in the community and that inappropriate admission to hospital is avoided. Where admission is necessary, Commissioners and Trusts must facilitate timely discharge.

Carers have an important role to play in providing community support. Innovative approaches to respite care should be adopted by Commissioners and Trusts as part of service redesign to promote “purposeful days” and social inclusion for the individuals with learning disabilities and support for carers.

Local and fully inclusive access to services for patients with a learning disability must also be increasingly available; people should be provided with services close to their own home and should not be excluded from mainstream services.

The improvement of services for people of all ages affected by autism is a key priority fro the Department; the strategic direction for the next three years is set out in the ASD Strategic Action Plan published in June 2009. Implementation should proceed through the regional ASD network which should report progress via the HSC Bamford Taskforce.

During 2010-11 and beyond, Commissioners and Trusts should ensure that progress is made in the following areas to improve access to health and care, and to enhance outcomes for individuals with a learning disability and their carers:

- Continued resettlement of the long stay population and the development of innovative approaches to prevent delayed discharges
- Redesign of community infrastructure to care and support individuals to live fuller lives

- Development of holistic approaches to care planning using appropriate assessment tools for both individuals and carers
- Promotion of “purposeful respite” that encourages social inclusion and support for carers
- Delivery of innovative, multiagency approaches to supported living in the community
- Development of a stepped care approach to the delivery of learning disability services in the community, with particular reference to care in the community
- Implementation of a regional bed protocol for those patients requiring acute hospital admission, to be published later in 2010
- Development of HSC workforce plans for learning disability, building on the recommendations of the Workforce Report commissioned by the Department; with particular reference to the need for enhanced skills in the community
- Enhancement of autism spectrum disorder services with particular reference to multiagency approaches to support early intervention, diagnosis, treatment and care and promote the timely delivery of services to children and adults.

Physical and sensory disability

The key driver for physical and sensory disability services will be the forthcoming disability strategy which will be issued for consultation in late-2010. This will be complemented by the soon-to-be- published Acquired Brain Injury Action Plan and consultation on a new Speech and Language Therapy Action Plan for children. All of these documents will set strategic direction for future years recognising, of course, that implementation will take some time to achieve.

Key themes for the disability strategy covering both adults and children will include:

- Promoting health and wellbeing, early intervention and social inclusion
- Supporting people to live independent lives
- Supporting carers and families
- Providing better services to meet the need of the individual
- Development of the infrastructure to implement change.

During 2010-11 and beyond, Commissioners and Trusts should ensure that progress is made in the following areas to improve access to health and care, and to enhance outcomes for individuals with a physical and/or sensory disability and their carers:

- Development of an integrated care planning approach to those with physical and/or sensory disability
- Service innovation and redesign to enhance the provision of respite for individuals and carers that focuses on age appropriate interventions to support social inclusion and purposeful living
- Improved access to wheelchair services especially for those requiring specialist wheelchairs, through service redesign and innovative approaches
- Implementation of NI contribution to *UK Vision Strategy* and recommendations contained in "*Challenge and Change*" report for sensory disability, including an agreed approach to the identification and use of established sensory equipment budgets
- Commencement of implementation of the speech and language therapy action plan for children to support early intervention and co-ordinated care
- Implementation of the acquired brain injury action plan due to be published soon, and especially the delivery of co-ordinated services in the community for those with complex conditions
- Focus on multi-agency arrangements to support those with acquired brain injury to live purposeful lives and to reduce the need for extra-contractual referrals
- Take forward the provision of assessments required to allocate the additional support for Thalidomide survivors generated by provision of additional resources which have been made available by the Department to the Thalidomide Trust.

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Standards and targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Unplanned admissions (PSA 6.1):** by March 2011, the HSC Board and Trusts should take steps to reduce the number of admissions to acute mental health hospitals by 10%.

- **Assessment and treatment (PSA 6.3):** from April 2010, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental heath issues with the exception of psychological therapies for which no patient should wait longer than 13 weeks.
- **Card before you leave:** from April 2010, the HSC Board and Trusts should ensure that all adults and children who self harm and present for assessment at A&E are offered a follow-up appointment with appropriate mental health services within 24 hours.
- **Resettlement of learning disability patients (PSA 6.4):** by March 2011, the HSC Board and Trusts should resettle 120 long stay patients from learning disability hospitals to appropriate places in the community compared to the March 2006 total. (Note: PSA target 6.2 for the resettlement of mental health patients has already been achieved.)
- **Discharge (both mental health and those with a learning or physical/sensory disability):** from April 2010, the HSC Board and Trusts should ensure that 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. All mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge.
- **Eating Disorders.** Further enhancement of a regional approach to eating disorder services recognising the need for specialist provision, and at least a 10% reduction in extra contractual referrals.
- **Respite – learning disability (PSA 6.7):** during 2010-11, the HSC Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 125 additional respite packages by March 2011 compared to the March 2008 total.
- **Respite – dementia:** during 2010-11, the HSC Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 1,200 additional dementia respite places by March 2011 compared to the March 2008 total.

- **Respite – physical/sensory disability (PSA 6.5):** during 2010-11, the HSC Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 110 additional respite packages compared to the March 2008 total.
- **Wheelchairs (PSA 6.6):** by March 2011, the HSC Board and Trusts should ensure a 13-week maximum waiting time for all wheelchairs, including specialised wheelchairs.
- **Housing adaptations:** from April 2010, the HSC Board and Trusts should ensure all lifts and ceiling track hoists are installed within 22 weeks of the OT assessment and options appraisal as appropriate, and all urgent minor housing adaptations to be completed within 10 working days.
- **Autism:** from April 2010, the PHA, HSC Board and Trusts should continue to progress the ASD action plan, ensuring that all children wait no longer than 13 weeks for assessment following referral and a further 13 weeks for commencement of specialised intervention.
- **Acquired Brain Injury:** from April 2010, the HSC Board and Trusts should ensure a 13-week maximum waiting time from referral to assessment and commencement of specialised treatment.
- **Domestic violence:** during 2010-11, each Trust should ensure that appropriate social services staff have participated in at least 95% of the Multi-Agency Risk Assessment Conferences (MARACs) held in their area during the year.

PRIORITY AREA 7: ENSURE FINANCIAL STABILITY AND THE EFFECTIVE USE OF RESOURCES

Aim – to ensure that all of the resources available to the NI health and social care service are used appropriately and effectively to improve the health and wellbeing of the NI population and to provide better treatment and care, and that the service lives within available resources.

Finance and productivity

The scale of the financial challenge facing the Department and the HSC in 2010-11 is unprecedented. Under existing CSR07 plans the HSC had been already required to deliver cumulative savings of £249m by the end of 2010-11; this requirement was recently increased by a further £105m following the Executive's decision to cut the planned 2010-11 budget for health and social care.

During 2010-11 Commissioners and Trust must protect and improve frontline services – consistent with the policy direction detailed earlier in this document – while at the same time making further productivity gains and taking forward key reforms. It is essential that the HSC ensures the best possible use of available resources and maintains strong financial control; this will be vital to the continued provision of high quality health and social care.

The focus should be on securing value for money for every pound invested, prioritising the most effective treatments, reducing errors and waste and keeping people healthy and independent for as long as possible. This will require innovation and radical thinking, as well as consistent sharing of best practice and the rolling out of the best examples of providing routine healthcare that is efficient and effective. As far as possible, reforms should be taken forward on a robust, consistent, co-ordinated basis across the HSC.

Continuing and further improved collaborative working is essential and advice should be taken from across HSC, including the views of staff, senior clinicians, patients and managers. This will complement more detailed local planning to put in place patterns of services that are sustainable, and delivers to the values and key priorities set out in this document. All organisations and individuals need to work together, to look at

own practice to ensure that it is fully in line with best practice, and to take responsibility for the best possible care along the whole pathway.

Further to this there needs to be a commitment to innovation and the promotion and conduct of research to improve the current and future health and care of the population. In the more challenging financial environment, research and innovation is even more important in identifying new ways of preventing, diagnosing and treating disease that are essential if we are to continue to increase both the quality and productivity of services into the future.

It is expected that further improvements in productivity, as expressed in both throughput and effectiveness of care, resulting from the changed professional working practices will be delivered across all programmes of care.

To deliver the required savings and efficiency improvements and deliver contracted activity levels in 2010-11, and secure break-even in March 2011, it is essential that the HSC Board and Trusts have effective programme planning arrangements in place.

Workforce

HSC services are delivered by people: over two thirds of HSC costs are staff-related. The Department and HSC are fully committed to staff engagement and working in partnership with Trade Union Side ensuring that organisational expectations are met and that staff at all levels are equipped with the resources and skills required to deliver.

It is essential that Commissioners and Trusts take full account of workforce implications in the development of their commissioning and delivery plans. Plans should include a robust risk assessment to identify any potential workforce capacity and capability issues, including the need to comply with the European Working Time Directive. Commissioners should offer constructive challenge to providers about the workforce assumptions in their delivery plans.

Developing staff, ensuring they are equipped with the skills they need to support changes and improvements in patient and client care and enabling them to progress in their careers is essential to the ambition of providing high quality patient centred

services in addition to underpinning successful organisational performance. All Trusts should have in place comprehensive learning and development plans, aligned with the Department's Workforce Learning Strategy, setting out a development programme for staff across all professional groups and at all levels.

Trust learning and development plans should have clear priorities – including the widening of access and increased participation in learning – supported by appropriate policies and an implementation plan. Plans should ensure sufficient investment to support the redeployment of staff into new ways of working, especially those moving to new roles and settings. Plans should also ensure all staff undertaking managerial roles have appropriate training for the role, and that managers undertake responsibility for development of their staff

Commissioners and Trusts will be expected to encourage multi-professional development through making the best use of current multi-disciplinary fora and, where necessary, the development of new processes to ensure all undergraduate and post graduate healthcare and social work students participate in multi-disciplinary working.

Commissioners and Trusts should also prepare for the introduction of medical revalidation in 2011 to help organisations deliver better quality of care and patient safety by ensuring that doctors remain up to date throughout their career. Commissioners should be seeking assurance that the clinical workforce is appropriately regulated to ensure patient safety. In tandem, Trusts should ensure that the necessary processes have been developed to ensure that appraisals are carried out on doctors in line with Trusts appraisal cycles to support the revalidation of medical staff.

All HSC organisations should support staff health and wellbeing by providing effective, targeted support for staff who present with ill health, being proactive in tackling the causes of ill health (both work and lifestyle related) and where there are clear benefits, providing early intervention services. HSC organisations will be expected to put in place organisational health and wellbeing strategies including being pro-active in improving the quality of and speeding up access to occupational health services, and strengthening board accountability for the management of sickness and absence.

Estate and equipment

A high quality service demands modern, fit for purpose facilities and equipment. Within the available resources, action is underway to renew or replace significant elements of the health and social care infrastructure across NI. In parallel with this major new-build capital programme, it is essential that Trusts have effective ongoing arrangements for identifying and responding to emerging risks to the current infrastructure to ensure that adherence to minimum statutory requirements and to reasonable expectations of patients, the public and HSC staff.

During 2010-11 the Department, working with Commissioners and Trusts will undertake a review of capital priorities. The resulting capital plan will complement and support the strategic direction set out in this document, will provide value for money and will be affordable in terms of both capital budgets and associated revenue requirements. Work will continue in 2010-11 on rationalisation of the existing estate with a view to delivering efficiencies and releasing surplus assets.

Standards and targets

The specific standards and targets to be achieved in 2010-11 are as follows:

- **Financial Breakeven (PSA 7.1):** during 2010-11, the Department and all HSC organisations should live within the resources allocated and achieve in-year financial breakeven and establish a medium and longer-term financially sustainable position.
- **Efficiency savings (PSA 7.1):** from April 2010, the HSC Board and Trusts should establish effective arrangements to ensure the full delivery of agreed efficiency savings during 2010-11.
- **Hospital productivity (PSA 7.2):** each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.
- **Daycase rate (PSA 7.2):** each Trust should secure improvements in daycase rates for a defined range of procedures in accordance with Departmental targets for March 2011.

- **Pre-operative length of stay (PSA 7.2):** each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2011.
- **Absenteeism (PSA 7.2):** each Trust should reduce its level of absenteeism to no more than 5.2% in the year to March 2011.
- **Greater use of generic drugs (PSA 7.2):** the HSC Board should ensure the level of dispensing of generic drugs increases to at least 64% by March 2011.
- **Cancelled operations:** from April 2010, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.
- **Staff health and wellbeing:** all HSC organisations should put in place organisational health and well being strategies including being pro-active in improving the quality of and speeding up access to occupational health services, and strengthen board accountability for the management of sickness and absence.

ANNEX 1 – PSA TARGETS

PFA Priority 1: Improve the health status of the population and reduce health inequalities – Related PSA Targets 2008-11

1.1 By March 2012, increase average life expectancy by 2 and 3 years for women and men respectively, and facilitate a 50% reduction in the life expectancy differential between the most disadvantaged areas and the NI average.

1.2 By March 2011, reduce to 21% and 25% respectively the proportion of adults and manual worker subset who smoke.

1.3 By March 2010, halt the rise in obesity.

1.4 By March 2010, ensure a 5% reduction in the proportion of adults who binge drink.

1.5 By March 2010, ensure a 10% reduction in the proportion of young people who drink and who report getting drunk.

1.6 By March 2010, ensure a 5% reduction in the proportion of young adults taking illegal drugs.

1.7 By March 2011, ensure a 10% reduction in the number of children at risk from parental alcohol and/ or drug dependency.

1.8 By March 2011, achieve a reduction of at least 15% in the suicide rate.

1.9 By March 2010, achieve a 40% reduction in the rate of births to mothers under 17.

1.10 By September 2008, ensure that a comprehensive HPV immunisation programme is in place, with a view to achieving a long term reduction of 70% in incidence of cervical cancer.

1.11 By December 2009, ensure that a comprehensive bowel screening programme for those aged 60-69 is in place, with a view to achieving a 10% reduction in mortality from bowel cancer by 2011.

1.12 By March 2009, extend the regional breast cancer screening programme to cover those aged 65-70.

PFA Priority 2: Ensure services are safe & sustainable, accessible & patient-centred – Related PSA Targets 2008-11

2.1 By 2009, ensure a 10% reduction in the number of hospital patients with staphylococcus aureus bloodstream infections (including MRSA), and a 20% reduction in cases of clostridium difficile infections.

2.2 By March 2011, ensure a 21-week waiting time for drug therapies for treatment of severe arthritis.

2.3 By March 2009, no patient will wait longer than 9 weeks for a first outpatient appointment, 9 weeks for a diagnostic test, and 17 weeks for inpatient or day case treatment, working towards a total journey time of 25 weeks by March 2011.

2.4 By March 2009, 95% of patients will, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.

2.5 By March 2009, 98% of cancer patients will commence treatment within 31 days of decision to treat, and 95% of patients urgently referred with suspected cancer will begin treatment within 62 days.

2.6 By March 2011, ensure a 10% reduction in mortality and disability from stroke

2.7 By March 2009, at least 50% of patients (rising to 60% by 2010) should receive dialysis via a fistula, and no patient should wait longer than nine months for a live donor transplant (six months by 2010).

2.8 By March 2011, NIAS to respond to 75% of life-threatening calls within eight minutes.

PFA Priority 3: Integrate primary, community and secondary care services – Related PSA Targets 2008-11

3.1 From April 2008, 90% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being declared medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support. All other patients will, from April 2008, be discharged from hospital within six hours of being declared medically fit.

3.2 By 2011, 50% reduction in unplanned hospital admissions for case managed patients with severe chronic diseases (e.g. heart disease and respiratory conditions).

PFA Priority 4 – Help older people to live independently – Related PSA Targets 2008-11

4.1 By 2010, 45% of people with assessed community care needs supported at home.

4.2 From April 2008, no older person with continuing care needs will wait more than eight weeks for a completed assessment, with the main components of care met within a further 12 weeks.

PFA Priority 5: Improve children's health and well-being – Related PSA Targets 2008-11

5.1 By 2011, provide family support interventions to 3,500 children in vulnerable families each year.

5.2 By 2011, increase by 50% the proportion of care leavers in education, training, or employment at age 19.

5.3 By 2011, increase by 25% the number of care leavers aged 18-20 living with their former foster carers or supported family.

5.4 By 2011, reduce by 12% the number of children requiring to be placed on the child protection register.

PFA Priority 6: Improve mental health services and services for people with disabilities – Related PSA Targets 2008-11

6.1 By 2011, ensure a 10% reduction in admissions to mental health hospitals.

6.2 By 2011, ensure a 10% reduction in the number of long-stay patients in mental health hospitals.

6.3 By 2009, ensure a 13-week maximum waiting time for defined psychotherapy services.

6.4 By 2011, ensure a 25% reduction in the number of long-stay patients in learning disability institutions.

6.5 By 2011, improve access to physical/sensory disability care by providing an additional 200 respite packages a year.

6.6 By 2011, ensure a 13-week maximum waiting time for specialised wheelchairs.

6.7 By 2011, improve access to learning disability care by providing an additional 200 respite packages a year

PFA Priority 7: Ensure financial stability and the effective use of resources – Related PSA Targets 2008-11

7.1 By 2011, reduce administration costs within the health and social care system by £53m a year.

7.2 Improve productivity, efficiency and effectiveness in the HSC as measured by such indicators as:

- Patient throughput per bed
- Ratio of day cases to inpatient cases
- Use of more effective drug therapies
- Greater use of generic drugs
- Improved procurement practices
- Proportion of people with community care needs supported at home
- Staff absenteeism.

7.3 Ensure the timely modernisation of the HSC infrastructure to include:

- By 2009, Downe Enhanced Local Hospital due to be completed.
- By 2010, Ulster Hospital Phase A due to be completed.
- By 2011, first stage of Altnagelvin Phase 3 due to be completed.
- By 2011, Royal Phase 2 B due to be completed
- By 2008, Craigavon Crisis Resource Centre due to be completed
- By 2009, Castlereagh Community Treatment and Care Centre due to be competed
- By 2010, Portadown Health & Care Centre due to be competed
- By 2010, Gransha Mental Health Crisis Centre due to be competed
- By 2010, Regional Adolescent Psychiatric Unit & Child and Family Centre due to be completed
- By 2011, Health & Wellbeing Centres Phase 2 due to be completed

- By 2011, delivery of PACS to be completed.

DIRECTION

2013 No. 13

The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by sections 6 and 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(a):

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014 and shall come into operation on 13 November 2013.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission for the period 1st April 2014 to 31st March 2015, for consideration and approval by the Minister. In doing so, it shall include the underpinning financial plan, and detail how commissioning will serve to deliver the planned transformation of services, including *Transforming Your Care* (TYC), and meet the standards and targets set out in the Schedule.

(2) The Commissioning Plan shall provide details of indicative commissioning intentions and associated indicative financial commitments for the period 1st April 2015 to 31st March 2016.

(3) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board and the underpinning financial plan align with and support the delivery of the Executive's Programme for Government (PFG) commitments and associated milestones, its Economic Strategy and its Investment Strategy; the Minister's vision and priorities for health and social care; extant statutory obligations, including Equality duties under the Northern Ireland Act 1998(b), the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); the standards, policies and strategies set by the Department; the agreed transformation of health and social care services including TYC; and Departmental guidance and guidelines.

(4) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board will deliver safe, effective and high quality care in the most appropriate

(a) 2009 c.1 (N.I.)
(b) 1998 c.47

setting, represent an equitable use of the resources made available for health and social care to the Northern Ireland population, based on relative need, and support the implementation of the agreed service delivery changes arising from planned transformation. In doing so the Commissioning Plan must:

(a) include the Strategic Context – the environmental factors and drivers for change influencing commissioning intentions and future service development and design, taking account of the strategic policies and priorities set by the Department;

(b) include the five LCG Commissioning Plans as part of the Commissioning Plan. These should reflect the use of an evidence-based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCG's target fair share, and the actual resources deployed for the respective populations;

(c) for all regional services and for each of the five Local Commissioning Groups, set out fully the services to be commissioned with details of specific commissioning intentions designed to deliver on the targets, standards and strategic priorities in this Direction for the year 1st April 2014 to 31st March 2015. This should include the values and volumes of services to be commissioned at LCG level and how they relate directly to meeting the assessed needs of the population and the delivery of standards and targets. The Plan should also provide indicative commissioning intentions for the year 1st April 2015 to 31st March 2016, to include a high level assessment of values and volumes of services to be commissioned;

(d) set out clear timescales and milestones for the delivery of the commissioning plan and underpinning financial plan as appropriate, and for the implementation of agreed service delivery changes arising from TYC;

(e) demonstrate how commissioning intentions take account of existing performance, and detail how performance management of HSC Trusts and other providers is used to ensure that assessed needs are met and targets and standards are being delivered through the effective and efficient use of the available resources. The Plan should explain how the Regional Board, in consultation with the Regional Agency as appropriate, will address significant under-performance against requirements by providers; and

(f) include specific commissioning intentions designed to support the six PFG commitments led by DHSSPS and the achievement of PFG milestones.

3.—(1) The Commissioning Plan shall demonstrate how the commissioning proposals deliver on the following key strategic priorities and statutory obligations:

(a) *To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion, anticipation and earlier intervention*;

The Commissioning Plan must demonstrate how the services to be commissioned support the aims and outcomes of the Public Health Strategic Framework 2013-23 and related population health strategies, and are conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland to fulfil the requirements of Section 2(3) (g) of the Act. There should be a strong focus in the Plan on how the services to be commissioned will prevent ill-health, anticipate the needs of local populations, and promote health and well-being. The Plan should also detail the early intervention measures being taken by the Regional Board and Regional Agency, where appropriate working in partnership with other organisations, and should demonstrate a commitment to address the wider determinants of health through, for example, the use of social clauses in procurement and service contracts where appropriate, and to maintaining and developing grassroots community and voluntary organisations.

(b) *To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting*;

The Commissioning Plan must demonstrate how the services to be commissioned will fulfil the statutory duty on the Regional Board under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(**a**); reflect the principles, values and standards set out in the Quality 2020 Strategy; improve the safety and effectiveness of services to deliver safe, high quality care that meets recognised standards, including those set out in Service Frameworks; and improve the patient and client experience, including implementation of the regional priorities identified in the PHA annual report (2013/14) on the Patient Experience Standards. The Plan must explain the outcomes which will be delivered for patients, clients and carers and outline how the Regional Board will take account of the views of patients, clients and carers in the commissioning of services. The Plan should also demonstrate that the design and delivery of services to be commissioned is based on the best available robust, research-informed evidence, in accordance with the objectives of the Department's strategy for Health and Social Care Research and Development.

(c) *To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions*;

The Commissioning Plan must demonstrate how the services commissioned will improve access to treatment, care and support closer to home, and facilitate people to live as independently as possible in their own community. This should include preventing people unnecessarily entering hospital and enabling them to return home safely as soon as they are fit to do so. The Plan should set out how services being commissioned will meet the requirement for more effective long-term condition management. The Plan should demonstrate how innovation in the delivery of services has been adopted, working with a range of providers to improve patient and client care, including through the use of innovative technologies to support people to manage their conditions at home.

(d) To promote social inclusion, choice, control, support and independence for people living in the community, especially older people, and those individuals and their families living with disabilities;

The Commissioning Plan must detail how the services to be commissioned will promote social inclusion and support people with health and care needs living in the community, particularly older people, and people with disabilities and their families. The Commissioning Plan should demonstrate an emphasis on home as the hub of care, including through the use of personal budgets, access to reablement services, age-appropriate day opportunities, enhanced provision of short breaks and the timely delivery of carers' assessments.

(e) *To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the community, voluntary and independent sector*;

The Commissioning Plan must detail how the Regional Board proposes to take forward the design and delivery of services developed around the local needs of patients, clients and carers through strengthened local commissioning and performance management systems, and working in partnership with other organisations as appropriate.

(f) *To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities*;

(a) S.I. 2003/431 (N.I. 9)

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations, and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act. It must also demonstrate how the Regional Board and Regional Agency will adopt and implement learning from relevant benchmarking studies; the experience of other organisations and how they intend to promulgate and share best practice.

(g) *To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services*;

The Commissioning Plan must demonstrate that the services being commissioned are sufficient to ensure that statutory responsibilities to assess needs, safeguard, protect and support vulnerable groups, including through the discharge of delegated statutory functions, will be met. There should be an emphasis on prevention and early intervention, in particular in connection with those families whose children are on the edge of care. The Plan will demonstrate how all HSC Trusts, as corporate parents, will be expected to meet the specific needs of looked-after children by providing high quality, enduring placements for them and supporting their transition out of care and into adult life.

Commissioning and the use of financial allocations

4.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1st April 2014 to 31st March 2015, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources. The Plan shall also provide details of indicative commitments for the financial year from 1st April 2015 to 31st March 2016.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

(3) This information shall be provided separately for each of the five LCGs, for provider organisations and for services commissioned regionally by the Regional Board in the manner specified by the Department in its budget allocation letters.

(4) This information shall include an analysis of how the Regional Board plans to shift the proportion of spend from hospital services to primary and community services in accordance with the planned transformation of health and social care services.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 13 November 2013.

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Standards and Targets for 2014/15

Priority	*Standard/ Target*
To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention	**Bowel cancer screening** 1. The HSC will extend the bowel cancer screening programme from April 2014 to invite, by March 2015, 50% of all eligible men and women aged 60-74, with an uptake of at least 55% of those invited. **Family Nurse Partnership** 2. By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust. **Substance misuse** 3. By March 2015, services should be commissioned and in place that provide seven day integrated and coordinated substance misuse liaison services within all appropriate HSC acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention programmes. **Tackling obesity** 4. By March 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.
To improve the quality of services and outcomes for patients, clients and carers, through the provision of timely, safe, resilient and sustainable services in the most appropriate setting.	**Hip fractures** 5. From April 2014, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. **Cancer care services** 6. From April 2014, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected

	cancer should begin their first definitive treatment within 62 days. **Unscheduled care** 7. From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours. 8. By March 2015, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area. **Hospital readmissions** 9. By March 2015, secure a 5% reduction in the number of emergency readmissions within 30 days (using 2012/13 data as the baseline). **Elective care – outpatients / diagnostics/ inpatients** 10. From April 2014, at least 80% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 15 weeks. 11. From April 2014, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken. 12. From April 2014, at least 80% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks **Healthcare acquired infections** 13. By March 2015, secure a further reduction of x% in MRSA and *Clostridium difficile* infections compared to 2013/14.**[x to be available in March 2014]** **Organ transplants** 14. By March 2015, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors. **Specialist drugs**

	15. From April 2014, no patient should wait longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis, ankylosing sponylitis or psoriasis. **Stroke patients** 16. From April 2014, ensure that at least 12% of patients with confirmed ischaemic stroke receive thrombolysis. **Pressure ulcers** 17. By March 2015, secure a 10% reduction in pressure ulcers in all adult inpatient wards. **Medicines Formulary** 18. From April 2014, ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area.
To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions	**Allied Health Professionals (AHP)** 19. From April 2014, no patient waits longer than nine weeks from referral to commencement of AHP treatment. **Telehealth** 20. By March 2015, deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract. **Unplanned admissions** 21. By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions (using 2012/13 data as the baseline).
To promote social inclusion, choice, control, support and independence for people living in the community, especially older people and those individuals and their families living with disabilities	**Carers' assessments** 22. By March 2015, secure a 10% increase in the number of carers' assessments offered. **Direct payments**

	23. By March 2015, secure a 5% increase in the number of direct payments across all programmes of care. **Telecare** 24. By March 2015, deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.
To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the community, voluntary and independent sector	**Patient experience** 25. The Regional Agency, in liaison with the Regional Board and HSC Trusts, to assist the Department to deliver a regional survey of inpatient and A&E patient experience during 2014/15, in order to baseline the position regarding patient experience and put in place a programme of work to secure improvements. **Integrated Care Partnerships** 26. By March 2015, 95% of patients within the four ICP priority areas [frail elderly, diabetes, stroke, respiratory] will have been identified and will be actively managed on the agreed Care Pathway.
To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities	**Delivering transformation** 27. By March 2015, transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. **Normative staffing** 28. The Regional Agency should continue to lead and monitor the programme of work to develop and implement Normative Nurse Staffing which should be used to commission and deliver services as follows: i. From April 2014, the Normative Nurse Staffing Tool should be applied to all inpatient general and specialist adult hospital medical and surgical care settings; ii. By March 2015 normative staffing

	ranges will be developed and introduced for Health Visiting within a range which secures the delivery of the service model detailed within the Departmental Strategy 'Healthy Futures'. **Unnecessary hospital stays** 29. By March 2015, reduce the number of excess bed days for the acute programme of care by 10% (using 2012/13 data as the baseline). **Cancelled clinics** 30. By March 2015, reduce the number of hospital cancelled consultant-led outpatient appointments by 17%. **Patient discharge** 31. From April 2014, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.
To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across all our services	**Learning disability and mental health** 32. By March 2015, resettle the remaining long-stay patients in learning disability and psychiatric hospitals to appropriate places in the community. **Mental health services** 33. From April 2014, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age). **Children in care** 34. From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%.

	35. By March 2015, ensure a three year time frame for 90% of children who are to be adopted from care. 36. From April 2014, ensure that all school-age children who have been in care for 12 months or longer have a Personal Educational Plan (PEP).

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2013

1. The Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister's vision and priorities during the year 1st April 2014 to 31st March 2015.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2014/15 financial year are resourced through the underpinning financial plan and will serve to deliver on the agreed planned transformation of services, including TYC. The Commissioning Plan shall provide details of indicative commissioning intentions and associated indicative commitments in 2015/16 to reflect the integrated nature of the Plan and the need to plan over the longer term timescale for effective implementation of agreed transformation.

4. The targets and standards included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year and are complemented by identified indicators of performance included in a separate Indicators of Performance Direction to the Regional Board.

5. Effective performance management of the health and social care system requires availability of a range of indicators to help track trends. An Indicators of Performance Direction will be produced alongside the Commissioning Plan Direction to ensure that the HSC has a core set of indicators in place, on common definitions across the sector. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

PROGRAMME FOR GOVERNMENT (PFG) COMMITMENTS AND MILESTONES

The Department leads on six PFG Commitments each of which has three annual milestones. The Commissioning intentions within the Commissioning Plan must support the continued delivery of milestones set for 2012/13and 2013/14, and the achievement of milestones for 2014/15.

PFG Commitment 22: Allocate an increasing percentage of the overall health budget to public health

2012//13 – Strengthen the cross-sectoral, cross-Departmental drive on improving health and mental wellbeing and reducing health inequalities by setting new policy direction and associated outcomes based on the most recent bodies of evidence available.

2013/14 – The HSC will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from 1st April 2014

2014/15 – Invest an additional £10m in public health (increase based on 2011/12 spend)

PFG Commitment 44: Enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic management programme

2012/13 – Identify and evaluate the current baseline of patient education and self management support programmes that are currently in place in each Trust area.

2013/14 – Health and Social Care Board and Public Health Agency should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long-term conditions effectively, alongside full application of the Remote Telemonitoring contract

2014/15 – People with a long-term condition will be offered access to appropriate education, information and support programmes relevant to their needs, including innovative application of connected health

PFG Commitment 45: Invest £7.2 million in programmes to tackle obesity

2012//13 – Invest £2 million in tackling obesity through support of Obesity Prevention Framework

2013/14 – Invest £2.4m in tackling obesity through support of Obesity Prevention Framework

2014/15 – Invest £2.8m in tackling obesity through support of Obesity Prevention Framework

PFG Commitment 61: Introduce a package of measures aimed at improving safeguarding outcomes for children and vulnerable adults across Northern Ireland

2012/13 - Develop a Strategic Plan for Adult Safeguarding in Northern Ireland and produce a joint Domestic and Sexual Violence and Abuse Strategy

2013/14 - Open new Sexual Assault Referral Centre at Antrim Area Hospital

2014/15 – Develop an updated inter-departmental Child Safeguarding Policy Framework

PFG Commitment 79: Improve Patient and Client outcomes and access to new treatments and services

2012/13 – Enhance access to life-enhancing drugs for conditions such as rheumatoid arthritis, cancer, inflammatory bowel disease and psoriasis and increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis

2013/14 – Improve long-term outcomes relating to health, well-being, education and employment for the children of teenage mothers from disadvantaged backgrounds by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site

2014/15 – Expand cardiac catheterisation capacity to improve access to diagnostic intervention and treatment and further develop the primary percutaneous coronary intervention (PPCI) service to reduce mortality and morbidity arising from myocardial infarction (heart attack)

PFG Commitment 80: Reconfigure, reform and modernise the delivery of Health and Social Care services to improve the quality of patient care

2012/13 – Development of a clear implementation and Population plan to ensure delivery of the new model of care as set out in the Transforming Your Care report

2013/14 – As part of a shift in the delivery of services to primary and community settings reduce by 2013/14, the number of days patients stay in acute hospitals unnecessarily (excess bed days) by 10% compared with 2011/12

2014/15 – Secure a shift from hospital-based services to community-based services together with an appropriate shift in the share of funding in line with the recommendations of Transforming Your Care

DIRECTION

2015 No. 4

The Health and Social Care Indicators of Performance Direction (Northern Ireland) 2015

The Department of Health, Social Services and Public Safety makes the following direction in exercise of the powers conferred by sections 6 and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009(**1**):

Citation, commencement and interpretation

1.—(1) This direction may be cited as the Indicators of Performance Direction (Northern Ireland) 2014 and shall come into operation on 15 May 2015.

(2) In this direction–

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act.

Performance indicators

2.In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the indicators of performance set out in the Schedule for the period 1st April 2015 to 31st March 2016.

3.The Regional Board shall record the information against the indicators of performance set out in the Schedule for the period 1st April 2015 to 31st March 2016.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 15 May 2015.

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

(**1**) 2009 c.1 (N.I.) as amended by 2014 c.5

SCHEDULE

Priority	*Indicators*
To improve and protect population health and wellbeing, and reduce health inequalities.	**Life expectancy** A1. Average life expectancy for women and men. A2. Life expectancy differential between Northern Ireland average and most disadvantaged areas for women and men. A3. Healthy life expectancy. A4. Potential years of life lost from causes considered amenable to healthcare. A5. Infant mortality. A6. Age standardised death rate for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas. **Suicide and self-harm** A7. Suicide rates across Northern Ireland and the differential in suicide rates between the 20% most deprived areas and the NI average. A8. Number of A&E presentations due to deliberate self-harm. **Diabetes** A9. Prevalence of diabetes. **Tackling obesity** A10. Level of overweight and obesity across the life course (2-10 year olds and 16+). A11. Proportion of adults meeting the Chief Medical Officer's recommended guidelines on physical activity. A12. Proportion of adults (aged 16+) consuming the recommended five

	portions of fruit and vegetables each day. **Alcohol and substance misuse** A13. Proportion of adults who report having reached or exceeded the recommended weekly alcohol limit. A14. Standardised rate of alcohol-related admissions to hospital within the acute programme of care. A15. Standardised rate of drug-related admissions to hospital within the acute programme of care. **Smoking** A16. Proportion of adults who smoke. A17. Number of pregnant women, children and young people, and adults from deprived areas (lower quintile) who set a quit date through cessation services. **Wellbeing** A18. Self-reported wellbeing. **Sexual health** A19. Number of new episodes of selected sexually transmitted infections diagnoses made by genito-urinary medicine clinics. A20. Number of new HIV diagnoses. **Pregnancy and young children** A21. Rate of births to mothers under 17 years of age (with breakdown against most deprived areas). A22. Breastfeeding rate at discharge from hospital. A23. Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.

To provide high quality, safe and effective care; to listen to and learn from patient and client experiences; and to ensure high levels of patient and client satisfaction.	**Care closer to home** B1. Number of pathways for each of the Integrated Care Partnership (ICP) initial priority areas being implemented by each ICP. B2. Percentage of risk stratified patients within the ICP initial priority areas, designated as high risk of hospital admission, who are actively managed on a care pathway. B3. Number of (i) patient education and self-management support programmes and (ii) participants in patient education and self-management support programmes. B4. (a) Number of patients benefiting from remote telemonitoring; (b) number of patients benefiting from the provision of telecare services; and (c) number of (i) telehealth and (ii) telecare monitored patient days. B5. (a) Number of client referrals passed to reablement and (b) number of clients who started on a reablement scheme. B6. Number of adults in receipt of day opportunities, by programme of care. B7. Number of older persons living in supported living facilities. B8. (a) Number of people with continuing care needs waiting longer than five weeks for an assessment of need to be completed and (b) number of people with continuing care needs waiting longer than eight weeks, from their assessment of need, for the main components of their care needs to be met. B9. Number of hearing aids fitted within 13 weeks as a percentage of completed waits. B10. Percentage of patients waiting over 13 weeks for any wheelchair (basic and specialised). B11. Percentage of patients who have lifts and ceiling track hoists installed within 16

	weeks of the OT assessment and options appraisal. **Mental health and learning disability** B12. Number of long-stay patients in learning disability and psychiatric hospitals resettled to appropriate places in the community. B13. Number of referrals for ASD (under 18). B14. Number diagnosed with ASD (under 18). **Safeguarding vulnerable adults** B15. Number of adult protection referrals received by HSC Trusts. **Looked after children** B16. Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type. B17. Proportion of school-aged children who have been in care for 12 months or longer, who have a personal education plan. B18. Number of new specialist/ professional foster care households and the number of children they are approved for, in line with TYC proposal 50. B19. Length of time for best interest decision to be reached in the adoption process. B20. Percentage of children with an adoption best-interests decision that are notified to the Adoption Regional Information Service within 4 weeks of the HSC Trust approving the adoption panel's decision that adoption is in the best interest of the child. B21. Percentage of care leavers in education, training and employment by placement type. B22. Percentage of care leavers at age 18, 19 and 20 years in education, training or employment.

	Patient safety B23. Summary hospital-level mortality indicator rates by LCG. B24. Percentage of all adult inpatient wards in which the Fall Safe bundle has been implemented. B25. Percentage compliance with the malnutrition universal screening tool in acute adult inpatient wards. B26. Number of incidents of hospital-acquired pressure-ulcers (grade 3 and 4) occurring in all adult inpatient wards, and the number of those which were unavoidable. **Flu vaccine** B27. Uptake of seasonal flu vaccine by front-line health and social care workers. **Maternity** B28. Activity in maternity and child health programme of care. B29. Percentage reduction in intervention rates (including caesarean sections) benchmarked against comparable units in UK and Ireland. B30. Percentage of babies born by caesarean section and number of babies born in midwife-led units either freestanding or alongside. **Unscheduled care** B31. (i) Total out of hours GP attendance and (ii) out of hours GP attendance by timeband 12am to 8.30am; 8.30am to 6pm; and 6pm to 12am. B32. Number of GP referrals to emergency departments. B33. Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to

	12 hours and 12 hours or more, before being treated and discharged or admitted.
	B34. (a) Number and percentage of attendances at emergency departments triaged within 15 minutes; (b) time from arrival to triage (initial assessment) for (i) ambulance arrivals and (ii) all arrivals; and (c) time from triage (initial assessment) to start of treatment in emergency departments.
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	B37. Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital.
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	outpatient services. B44. Number of outpatient appointments with procedures within the specialities of pain management, ophthalmology, gynaecology, general surgery, plastic surgery and dermatology. B45. Number of barium enema, computerised tomography, magnetic resonance imaging, non-obstetric ultra sound, positron emission tomography and plain film x-ray tests undertaken. B46. Percentage of routine diagnostic tests reported on within two weeks of the test being undertaken. B47. Percentage of routine diagnostic tests reported on within four weeks of the test being undertaken. B48. Total number of attendances at consultant-led outpatient services in the independent sector, by HSC Trust. B49. Total number of patients admitted for inpatient treatment in the independent sector, by HSC Trust. **Emergency admissions/ readmissions** B50. Number of 30 day emergency readmissions by days after discharge, by HSC Trust. B51. Percentage of emergency admissions returning within seven days and within 8-30 days, by HSC Trust. B52. Clinical causes of emergency readmissions (as a percentage of all readmissions) by Trust for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF). B53. Number of emergency readmissions with a diagnosis of venous thromboembolism. B54. Number and proportion of emergency admissions and readmissions for people aged 0-64 years and 65 years and over:

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	Organ transplants
	B55. Percentage change in overall transplants.
	B56. Total number of deceased organ donors by type.
	B57. Number of organs declined.
	Cardiac catheterisation
	B58. Percentage increase in access to cardiac catheterisation.
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	B60. Number of patients admitted with stroke.
	B61. Average length of stay for stroke patients.
	Specialist drug therapies
	B62. Number of patients waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.
	B63. Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for multiple sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.
	B64. Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye,

	and six weeks for the second eye. **Pharmacy, prescribing and medicines optimisation** B65. (a) Prescribing activity, and the level of compliance of GP practices, by LCG for each chapter of NI Medicines Formulary; (b) prescribing activity by LCG for generic prescribing and dispensing rates. B66. Level of prescribing compliance with the NI Formulary by HSC Trust. B67. Evidence of shared learning outcomes and communications issued arising from medication incidents reported in primary and secondary care. B68. The number and proportion of patients admitted to hospital receiving the integrated medicines management service, by HSC Trust. B69. The number of medicines management and public health pharmaceutical services delivered in the community reported by LCG area. B70. Proportion of people accessing the "Building the Community Pharmacy Partnership" programme residing in the bottom three quintiles of wards / Super Output Areas by deprivation.
To ensure that services are resilient and provide value for money in terms of outcomes achieved and costs incurred.	**Expenditure** C1. Balance of expenditure between community and hospital based services. C2. Percentage of funding spent on primary and community care. C3. Total investment in tackling obesity. **Hospital efficiency indicators** C4. Elective average pre-operative stay. C5. Elective average length of stay in acute programme of care.

	C6. Day surgery rate for each of a basket of 24 elective procedures. C7. Percentage of operations cancelled for non-clinical reasons. C8. Percentage of patients admitted electively who have their surgery on the same day as admission. C9. Ratio of new to review outpatient appointments attended, by HSC Trust. C10. Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust. C11. (a) Number of new and review outpatient appointments cancelled by the hospital, by HSC Trust and by specialty; (b) rate of new and review outpatient appointments cancelled by the hospital, by HSC Trust; and (c) ratio of new to review outpatient appointments cancelled by the hospital, by HSC Trust. C12. Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient, by HSC Trust and by (i) impact and (ii) reason of cancellation.

Martina	Scope	Roisin	Scope
Mental Health Services Framework Development	***Regional lead for design, development & implementation***	**Dementia Stepped Care Framework**	
Mental Health Informatics Reform	**Regional lead for design, development and implementation**	**Adult Safeguarding Reform**	
EHCR – Mental Health Documentation Reform	**Social Care Lead for Design Team of new NI one system, one time**	**NISAT**	
You In Mind Care Mental Health Pathways Lead	**Regional and strategic oversight role – generic and specialist care pathways**	**Carer Experience**	
Improvement Audits CAPA - You In Mind – WT LG Framework – Primary Care Hubs	**Strategic oversight for the Rolling Annual Mental Health Audit Programme**		
Unallocated Cases	**Regional SI lead working across 5 Trusts & with CSIB**		
Leadership of SIMs	**Provide strategic & regional oversight role to 5 Trust SIMs**		
Social Work SI and Innovation Lead	**Scoping, design, development & implementation of Social Work SI improvement strategy**		

Rodney	Scope	Joy	Scope
Establishing NI Trauma Network		***Re-organisation of School MDT Teams***	
Reform of Psychological Therapies		**Autism Services Remodelling**	
Population Management Modelling		**DOH –Cross Departmental Autism Strategy**	
Mental Health Service Strategic Framework		**CAMHS and Autism Experience**	
Mental Health Workforce Review and Modelling		**Integrated Developmental and CAMHs Services Model**	
DOH – CAMHS Managed Care Network		**Management of Autism Co-ordinators Network**	
Primary Care Hubs Development		**Adult Autism Improvement Network**	

Service Improvement Programme Updates

Older People & Adult Services

- Unscheduled Care Stepped Care Framework
- NISAT – Services User and Carer Experience
- Dementia Services Framework
- Adult Safeguarding Demand and Capacity Modelling

Children Services

- Autism Strategy and Autism Services Model Review
- Unallocated Case Services Reform
- Autism and CAMHS Sense Maker Project
- CAMHS Integrated Care Services Framework and Acute Services Review

Mental Health & Learning Disability

- Psychological Therapies – Trauma DSD Welfare Mitigation
- Mental Health Services Framework Development - Managed care Information System
- Primary Care Hub Development
- You in Mind Mental Health Care Pathways Project

MAHI - STM - 097 - 3913

Team	Job – Plans									
Name	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***
Martina	*Unallocated Social Care*	*Unallocated Social Care*	*MH Sense Maker*	*MH Care Pathway*	*IHI CPD*	*SIM Managers*	*MH Services Framework - Managed Care Data Systems*		*IHI CPD*	*Admin*
Joy	*ASD Co-ordination*	*ASD Strategy*	*CAMHS & ASD Sense Maker*	*MDT Review*	*NHSCT and BHSCT ASD*	*Trauma Mental Health*			*CPD – implementation Science*	*Admin*
Roisin	*Dementia Services Improvement*	*Dementia Services Improvement*	*NISAT Review*	*Adult Safeguarding*	*Carer Experience*				*CPD FISH Science*	*Admin*
Rodney	*CAMHS and ASD Systems Design*	*Psychological Therapies and Trauma Modelling*	*Unscheduled Care*	*Team Management*	*SI Development and Networking*	*Mental Health Improvement Systems Design*	*Dementia Services Systems Design*		*CPD*	*Admin*

Working together Excellence Openness & Honesty Compassion

We Matter

Learning Disability Service Model
For Northern Ireland

Final
Version 5.0 May 2021

Learning Disability Service Model
"We Matter"

EQUALITY STATEMENT

In line with Section 75 of the Northern Ireland Act 1998, Learning Disability Services will be provided and available to all irrespective of gender, ethnicity, political opinion, religious belief, disability, age, sexual orientation, dependant and marital status.

Learning Disability Services have a duty to each and every individual that they serve and must respect and protect their human rights. At the same time, Learning Disability Services also have a wide social duty to promote equality through the care it provides and in the way it provides care. This includes addressing the needs of those groups or sections of society who may be experiencing inequalities in health and wellbeing outcomes.

Alternative Formats

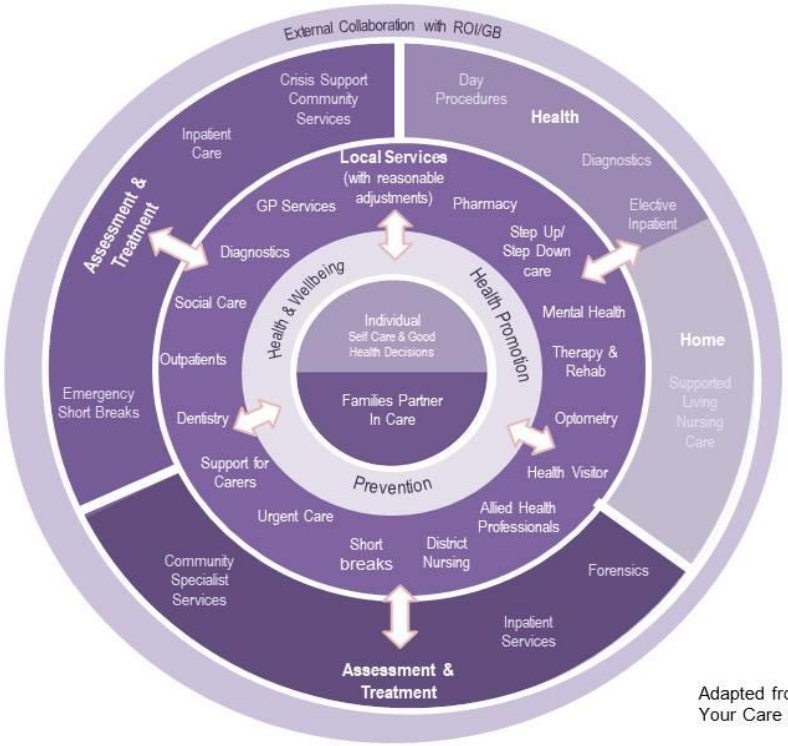
Any request for the document or communication from HSCB in another format will be considered. We will respond to requests for information in alternative formats in a timely manner, usually within 20 working days (unless third party timescales dictate otherwise, for example, Braille providers).

If you would like a document in an alternative format, contact us by email: Enquiry.hscb@hscni.net or telephone: 0300 555 0115

We Matter

"As an individual with a learning disability I will be respected and empowered to lead a full and healthy life in my community. I will be supported to make choices and decisions in my life that enable me to develop, live a safe, active and valued life."

An Integrated Model for Learning Disability Services



Adapted from Transforming Your Care (2011)

Meaningful Life and Citizenship

"I live in a society that respects my right to work, learn and enjoy my life."

(PFG 1, 2 , 4)

Health and Wellbeing

"I can live a healthy life."

(PFG 3, 4.& 8)

Home

"I am supported to live in my home."

(PFG 3, 4)

Life Changes

"I am prepared and supported through important changes in my life."

(PFG 11)

Carers and Families

"My carers are supported to help me live my best life."

(PFG 1, 2)

Specialist Assessment & Treatment

"I will have access to high quality, compassionate assessment and treatment services when required."

(PFG 4,& 8)

Contents

Foreword

[DN: to be completed on behalf of Minister Swann]

1. INTRODUCTION

1.1 Executive Summary

"This new service model has the potential to not just improve my life and how I access services, but will improve the lives of thousands of people with a learning disability, their families, friends ,carers and communities".

Peter Livingstone,
Mencap NI Inclusion Consultant
Member of the HSCB Project Steering Group

The NI Executive and leading organisations across Health and Social Care (HSC), community and voluntary sectors and individuals and carers are committed to transforming care for individuals with learning disabilities.

We have made progress under Bamford and Equal Lives, but much more needs to be done.

"We Matter" Adult Learning Disability Model for NI, thereafter known as 'the Model', is a strategic document which outlines a new outcomes based approach for Learning Disability services in Northern Ireland. The Model which has 6 Key Ambitions and 25 Outcome Measures builds on all the positive work to date whilst also describing what actions are required of services in order to provide quality, safe, compassionate and consistent support to individuals with a learning disability and their carers across the region.

Most importantly it outlines the following:

- what individuals with learning disabilities can properly expect of services – using an outcomes based approach;
- how this will be delivered – using an integrated approach supported by pathways of care depending on assessed needs;
- how it will be measured in order to ensure consistent, high-quality, cost-effective care.

The case for change for the Model is to address a number of on-going key challenges identified by those who use the system and who provide service, and include;

- reducing inequalities and improving health and social wellbeing for individuals with a learning disability;

- increasing levels of complexity of need;
- transitions between services including between children's and adult services and community to acute settings;
- the reduction of delayed discharges from hospital;
- lack of appropriate accommodation for people within the community;
- the provision of short breaks;
- support for older carers;
- data mapping and supporting resource mapping which can identify key health and social care needs of adults with learning disabilities to inform future commissioning and service planning;
- workforce development and training required to support the delivery of effective and efficient services; and
- clear strategic commissioning and procurement processes which are based on analysis of need and support a market of voluntary and independent sector organisations to provide the services.

A number of recent strategic developments, directives and more recent challenges, have highlighted a need to review Adult Learning Disability service provision. These include:

- The outcomes of the *Bamford Review of Mental Health and Learning Disability*, and the associated *Bamford Action Plan (2012-2015);*
- The *Review of Adult Learning Disability Community Services (Phase II)* (October 2016);
- The draft *Programme for Government (2016-2021);*
- The 10 year approach to transforming health and social care*: Health and Wellbeing 2026: Delivering Together* (2016);
- The *Mental Capacity Act (Northern Ireland) 2016*; and
- Recommendations for the Reform of Adult Social Care, outlined in *Power to People: Proposals to reboot adult care and support in Northern Ireland* (2017).

The model outlines a roadmap for transforming learning disability services in Northern Ireland within a projected timeframe of 3-5 years.

The Model has been co-produced after engaging with over 3,600 service providers, carers and service users. It is the result of an extensive programme of engagement, workshops, meetings and surveys (Feb. 2019–March 2020).

It will be led by a Learning Disability Transformation Taskforce (LDTT) bringing together senior responsible owners from all organisations working in Learning Disability.

The Model is informed by six Key Ambition Statements (with 25 key Actions) derived initially from Equal Lives, Former Department of Health and Social Services and Public Safety (DHSSPS 2005) and ratified through engagement with key stakeholders across the region. These statements are Life Changes, Health and Wellbeing, Carers and Families, Meaningful Life and Citizenship, Home and Specialist Assessment and Treatment.

It is grounded in the Programme for Government (PFG) Outcome Measures (2016–2020) as set out overleaf. It sits alongside a high level Delivery Plan and fully costed Implementation Plan for commissioners.

It is intended to provide greater autonomy, choice and independence for individuals with learning disability, their family and carers.

The Vision, Key Ambition Statements, Key Outcome Measures and Key Actions detailed in the Model represent a collective view on what is required of services to improve the lives of individuals with learning disabilities, their families and carers.

We will set up workstreams to adopt what is already good practice in the system at pace, test innovation and get the basics right. The workstreams will support a strong interconnected governance structure that holds the delivery programme to account, and ensures that a partnership and co-produced approach is transparent.

We are committed to provide a new Model built on the foundation of Bamford, but much more transformational, as we move into the future. We want individuals with a learning disability to be respected and empowered to lead a full and healthy life in their community. We want to support them make choices and decisions in their life that enable them to develop and to live a safe, active and valued life.

The Review of Adult Social Care noted “our vision is to place the person receiving care and support at the centre, building on their strengths and as far as possible, complementing family and community resources”. The call for partnering in care and support was evidenced very clearly during this engagement process and will continue as we move into the implementation phase.

A whole systems response is key to delivering the Model and will ensure a joined up approach to services which places quality of life outcomes at the heart of all we do, including all other ongoing work within Learning Disability Services.

Most importantly, the Model has been developed in recognition that citizens live within a whole system sector and needs to take a wider look at what is required from other public sector organisations including for example, Department for Education

(DE), Department for Communities (DfC), Department for Economy (DOE). The Programme of Government outcomes are critical to this transformation agenda. It is essential that DoH, other Government Departments, HSC organisations, voluntary and community sectors, private sector and carers work together providing support jointly to deliver the necessary change. These are described in Section 1.2 Background and Strategic Context (page 11).

Part of the work of the Learning Disability Transformation Taskforce (LDTT) will be to ensure that there will be joined up work with Children's Disability Services during the implementation phase, and this will be set out in the Delivery Plan.

The Model will also describe a number of transformational change ideas to help achieve the vision set out over the next 3-5 years and provide a road map to enable the dynamic change that will be required. These include a Learning Disability Systems Leader/Champion similar to the Mental Health Champion, a Learning Disability People's Parliament, a Learning Disability Network / Observatory, a regional website, a Regional Learning Disability Housing Lead, a Regional Informatics Framework and Register, a Learning and Development Framework, a Learning Disability Carer Consultancy model, and pathways of care for individuals based on their assessed needs.

Details of each of these transformational ideas can be found in Appendix 1 and further work will be required during the Delivery Plan phase.

The work of the Learning Disability Transformational Taskforce will include identifying innovation and opportunities to scale and spread pockets of good practice. It will ensure everyone will receive the same standard of good practice service no matter where they live in NI.

The Model will be supported by two additional documents which will be published separately.

- An Easy Read version of the Model which will be co-produced with individuals with lived experience and their families / carers.
- A Strategic Delivery Plan (SDP) which sets out the key actions and processes to achieve the Model is implemented and will measure it against key indicators developed across each of the 6 Key Outcomes. This is set out in Annex A.

The COVID-19 pandemic has, and will continue to, have an acute impact on individuals with learning disabilities and their carers and staff who support them. We in HSC and society in general, must learn and adapt from the first 'Covid-19 Wave' during 2020.

Partnership working is crucial to both maximise the use of community assets and to draw on the insight and expertise of partners to manage the Pandemic. Covid rebuild plans will be developed alongside individuals, families, carers, voluntary community sector (VCS) organisations as well as learning disability providers.

1.2 Background and Strategic Context

The Model is designed to improve the wellbeing of all individuals with a learning disability and support their carers to ensure individuals with a learning disability will be respected and empowered to lead a full and healthy life in the community, and will be supported to make choices and decisions in their life that enables them to develop and live a safe, active and valued life in Northern Ireland.

There are a number of relevant policy and strategic developments in Northern Ireland which underpin the Adult Learning Disability Service Model. A full summary can be found at Annex B.

As described in the Foreword, the Model needs to be set in the wider context of the 12 Programme for Government, which informs what we want public services in Northern Ireland to look like. These are:

1. We prosper through a strong, competitive, regionally balanced economy.
2. We live and work sustainably - protecting the environment.
3. We have a more equal society.
4. We enjoy long, healthy, active lives.
5. We are an innovative, creative society where people can fulfil their potential.
6. We have more people working in better jobs.
7. We have a safe community where we respect the law and each other.
8. We care for others and we help those in need.
9. We are a shared, welcoming and confident society that respects diversity.
10. We have created a place where people want to live and work, to visit and invest.
11. We connect people and opportunities through our infrastructure.
12. We give our children and young people the best start in life.

It is imperative that the LDTT sets out an infrastructure to ensure partnership working takes place for all key actions outside of the scope of HSC services.

Up to now Equal Lives represented the key strategic driver to shape delivery of services for individuals with learning disabilities and/or autism in Northern Ireland.

It has underpinned the development of the Model and states that individuals with a learning disability using public services should expect to be;

- be encouraged and supported to look after their own health and wellbeing, both mental and physical, and build up emotional resilience;
- be supported, as far as possible, in their own homes and communities, making best use of self-directed help;
- be supported, through effective collaboration between Government Departments and their agencies, in their life choices and in day to day activities of engaging in education, training, work and leisure;
- be consulted on and be able to influence the provision of services to meet their needs;
- be encouraged to access help at as early a stage as possible; and
- be supported towards personal fulfilment and full citizenship.

These overarching ambitions of Bamford remain relevant and lots of positive developments have taken place, but we want to move on. The Model will outline what a good service should look like for the future, using a human rights and person centred approach, an integrated model of care and sets out a number of Key Ambitions.

What is a Learning Disability?

A Learning Disability is a life-long condition which is known to affect three different areas of life:

- how I understand information;
- how I develop independent life skills;
- how I make social connections.

Learning disability criteria is described by British Psychological Society (2015). There are three core eligibility criteria for a diagnosis of learning disability:

- Significant impairment of intellectual functioning (defined as IQ quotient of below approximately 70, taking confidence intervals into consideration);
- Significant impairment of adaptive behaviour/social functioning (these terms are often used interchangeably);
- Onset before adulthood.

All three criteria must be met for a person to be considered to have a learning disability.

Mencap define a learning disability as having 'a reduced intellectual ability and difficulty with everyday activities – for example, household tasks, socialising or managing money – which affects someone for their whole life.'

People with a learning disability tend to take longer to learn and may need support to develop new skills, understand complicated information and interact with other people.

Every individual with a learning disability, like all citizens, is unique, and shares the same aspirations and needs. The needs of individuals who have a learning disability cover a wide spectrum with regards the support they may require. Like all citizens, this may change in increase with age, supports therefore will need to be tailored to the individual – some requiring minimal support and some with complex needs requiring on-going significant support. Some individuals who have a learning disability may also have other conditions too such as autism. Many will also have communication difficulties. Sometimes a learning disability will be apparent, but this is not always the case. The term Intellectual Disability is often used in other countries but Learning Disability is most widely used and accepted term in Northern Ireland, chosen as the preferred term set out in Equal Lives (2005).

HSC Trusts currently require a diagnosis of learning disability to access services and support. The scope of the Model will be broader to include those individuals who do need the formal criteria and may be best matched within this POC of care when considering issues of: safeguarding, mental health and /or autism. It will be necessary for Trusts to find the best match between mental health and learning disability.

The social model of disability is being proposed for use, an approach which proposes that what makes someone disabled is not their medical condition, but the attitudes and structures of society.

Adopting a human rights and person-centered approach is fundamental to the Model. This will promote a needs-led model and not one dependent upon clinical diagnostic criteria.

The Mental Capacity Act for People with a Learning Disability will also be important. This approach will help ensure that people who may lack capacity to make decisions on their own get the support they need to make those decisions. Where they are not

able to make their own decision, the Mental Capacity Act says a decision must be made that is in their 'best interests'.

The Model will also take cognisance of the new Adult Safeguarding/Protection Bill for Northern Ireland which will also help protect individuals with learning disability and other vulnerable members of society.

Legislative Context

The Model does not attempt to review or comment on legislation. Key developments in international, European, UK, and Northern Ireland law have been examined and discussed at length as part of the Bamford Review of Mental Health and Learning Disability (Northern Ireland) an independent review of mental health and learning disability law, policy, and service provision that was initiated in 2002 and reported in 2007. Its portfolio of publications includes, among others, reports titled: A Comprehensive Legislative Framework (DHSSPS, 2007a) and Human Rights and Equality of Opportunity (DHSSPS, 2007b). Further discussion can be found in Appendix 2.

Prevalence

When reviewing relevant literature there remains a gap in that no one data system is able to provide an overall population within Northern Ireland. It is hoped that the forthcoming system known as 'Encompass' may resolve this matter. A more detailed exploration of prevalence can be found at Appendix 3.

A review of the available data on learning disability across the UK shows that statistics vary widely across the region and by source. The numbers outlined in Appendix 3 are approximate, rely on data collated from a range of sources that categorise information differently, and typically do not include information on people who are not known to the health and social care system.

Mencap (2016-17), identify that there are approximately 1.4 million individuals with a learning disability in the UK, of which approximately 1,119,000 are adults, or 2.16% of the adult population. The prevalence of learning disability among children across the UK is believed to be slightly higher, at 2.5% of the child population as a whole: it may be anticipated therefore that a slight rise in learning disability prevalence among adults may be anticipated in the future.

The numbers outlined below are approximate, rely on data collated from a range of sources that categorise information differently, and typically do not include information on people who are not known to authorities

Table 1: Adults with a Learning Disability in the UK – Estimated Numbers

REGION	ESTIMATED NUMBERS
England	Estimations range from **930,400** (Public Health England, 2016) to **939,338** (Mencap, 2016-17)
Wales	Estimations range from **11,410** (Statistics for Wales, 2018) to **53,681** (Mencap, 2016-17) - **60,000** (Welsh Government, 2018)
Scotland	Estimations range from **23,446** (National Statistics Scotland, 2018) to **26,786** (ENABLE Scotland, n.d.)
Northern Ireland	Estimations range from **7,198** (McConkey, 2013) to **30,814** (Mencap, 2016-17) (All Party Group on Learning Disability, 2018)

The Northern Ireland Census (2011) also indicates that around 2% of the population or around 40,000 people (including children, young people, and adults) may have a learning disability. We await the 2021 Census, expected to be published in 2022 to note any changes in these figures.

Inequalities

Many individuals with a learning disability still face discrimination, marginalisation, and barriers to opportunities, which impact negatively on social integration, ability to work, and mental health. Please see a more detailed analysis of inequalities in Appendix 4.

Resources

The Northern Ireland Assembly Research and Information Service (2017) has noted that funding for learning disability services and support is lower in Northern Ireland than any other region of the UK, “with only 6% of the total Health and Social Care spending being allocated to learning disability in 2016..”, and “..although overall spending on learning disability in Northern Ireland increased by 15% between 2010 and 2015..”, the number of people here with learning disabilities also continues to rise.

Carers

The Northern Ireland Assembly Research and Information Service (2017) noted that "Informal carers provide much needed health and social care support to those with learning disabilities." Citing research conducted by Carers UK and the University of Sheffield in 2015, the service observes there are around "220,500 informal (unpaid) carers in Northern Ireland providing support worth an estimated £4.6 billion per year (around the same as the entire Northern Ireland health budget). Around 9% of these provide care for someone with a learning disability with many carers in poor health themselves."

The predominance care provision is in the home with 75% of individuals living with a member of their family noted by the Regulation Quality Improvement Authority Community Review of Services 2016.

Caring for Carers, Recognising, Valuing and Supporting the Caring Role, (2006) define carers as "people who, without payment, provide help and support to a family member or a friend who may not be able to manage without this help because of frailty, illness or disability. Carers can be adults caring for other adults, parents caring for ill or disabled children or young people who care for another family member."

Some of the key challenges noted by carers during the process included more involvement in decisions about care; better transition arrangements; the need for a Regional Scoring Tool for bed based breaks; improved communication; the frustration around having to fight for services; the lack of autism support; the need for more emergency short breaks; more domiciliary short breaks and emerging nursing beds; and challenges around Self Directed Support (SDS). Carers also noted that current domiciliary provision does not always meet the needs of those with behaviours that challenge.

Workforce

The learning disability workforce, like others, is facing significant challenges. We need to support our current workforce and bolster it through increasing the number of qualified, competent and confident Multi-Disciplinary Teams (MDT) staff and support networks, and a supportive infrastructure.

Some of the key workforces challenges noted during the engagement process included; appropriate workforce and skill mix to respond effectively to needs; additional staff training in day care; training to respond therapeutically to behaviours that may challenge supported by Specialist MDT workforce planning predictions to

meet the rising and increasing needs of individuals with complex presentations; recruiting staff to work in learning disability services, and in particular, staff who have specialist skills; recruitment shortage in rural areas; and challenges for independent and private sector organisations to source staff to support individuals with behaviours that challenge or forensic backgrounds.

A Training and Development Framework is recommended, which incorporates a coherent workforce model and tiered training for staff at all levels and includes shared training and development for all providing support and services to individuals with a learning disability. Both the Department of Health Workforce Review and the Social Work Strategy Workforce Review will be key drivers for this framework.

Part of this framework should consider a Regional Workload Management Framework. The Remain Open But Stable (ROBS) is currently being tested in the Western HSC Trust to inform job plans, and will aim to reduce levels of staff burnout, sickness and even moves out of services. Staff wellbeing is more important now than ever.

The 'Learning Together Working Together' framework which presently operates in mental health services is an exemplar model and could usefully be adapted for learning disability services for all organisations.

Current Services

Learning disability services across NI offer a range of services including; supported living accommodation; nursing home care; residential home care; inpatient services; buildings-based day care; day opportunities; domiciliary care; short breaks; shared care; adult placements and SDS. These services work to complement each other and it is the intention that the Model will develop even stronger partnerships in care with all of the organisations to support the integrated approach set out.

There are a number of key actions in the Model which call for further investment into both statutory and non-statutory services to ensure we realise the vision we have set out in the Model.

The intention is to ensure that care and support to individuals and their families is available consistently across Northern Ireland based on the assessed needs of both individuals themselves and support to carers, to ensure individuals live full and meaningful lives.

The Model sets the direction for a system which encourages personalised support. This means that individuals with learning disabilities, their families and carers should have more choice and control over the high quality services they use.

Further work in this area will be taken forward in the Work Streams.

Personalised Support

Personalised support, in the form of SDS, including Direct Payments, is promoted currently across all Trusts. Each Trust has an SDS Action Plan for all Programmes of Care which is reported monthly to the Health and Social Care Board (HSCB) in terms of activity, and reported annually under the delegated statutory functions process. This odel/approach remains a priority for HSC services.

SDS is a flexible way of providing social care support, which gives people more choice over the way their care and support needs are met. It aims to give people more control over how their support is arranged and managed. This includes deciding the kind of support they want, when they want to use it and who will provide it. SDS is available to those who have been assessed as being in need of social care support.

Following an assessment, a personal budget will be agreed to meet identified support needs. It is provided by the individual's local HSC Trust to organise and purchase care and support around the following package of care options:

- Direct payment
- Managed Budget
- Trust Arranged Service
- Cost Neutral

For those using and benefitting from SDS and Direct Payments, it is well received and spoken of warmly, however for others the process is lengthy and arduous.

During the engagement process carers and staff spoke of a process that was difficult to understand, daunting; taking charge of tax matters with an employee and recruiting a carer/personal assistant. Whilst the processing of weekly pay and tax for an employee can be dealt with by the Centre for Independent Living, that did not address concerns regarding recruiting someone in a rural location or for someone with behaviours that challenge. The rate of pay is regionally agreed with and reviewed annually by the HSCB, however, carers and staff remain concerned that this was not attractive to recruit and retain potential carers. Carers and staff indicated difficulty in accessing appropriate carers within a predominately rural area. It also

requires enough flexibility to extend its potential use for employment or education opportunities for individuals, and in relation to caregiving arrangements during any emergency situations

Generally carers thought the concept was good but difficult to navigate. Staff involved in the process asked if any future review of criteria could include provision for accessing health professional assessment e.g. occupational therapy or podiatry. As SDS includes Direct Payments, it would be recommended that the criteria are reviewed.

It is important that service providers in these sectors are seen as partners in the delivery of support and care, and that a diverse, vibrant and sustainable market is encouraged so there are different types of provider organisations for people to choose from. This will be further explored during the Implementation Phase of the Model.

Commissioners will need to work collaboratively with individuals, their families and carers people and providers to understand what is needed, and how to support the market so providers can offer the services people need and want, now and in the future. It also means encouraging collaboration and partnership to create a choice of appropriate, quality and affordable services.

The Impact of COVID-19

The COVID-19 pandemic has impacted on individuals with learning disabilities and their carers and staff who support them. It is recognised that the cessation of services, in March 2020, placed a further burden on individuals and carers due to limited alternatives being available.

Access to beds, short breaks, both planned and emergency, day opportunities and day care, etc. were stood down during the first lockdown in March 2020, with all services were impacted. Help and support were available but had to be limited compared with usual provision,

Front line staff responded to the pandemic by ensuring critical services such as inpatient/supported living and crisis response services were sustained, following Public Health Agency (PHA) guidance relating to infection protection and control. Services adapted using a blended care and support model through the use of IT for virtual ward rounds and community assessments. It is important to note that the HSC offices have remained open through COVID-19, with collapsed services via non face to face contacts, and use of IT.

Minister for Health Robin Swann has indicated how the HSC and society in general must learn and adapt from the 'Covid-19' during 2020. COVID-19 remains in general circulation at the time of writing this report and it is therefore important adherence to Public Health guidance continues to be implemented. Those providing support to an individual, should use their usual methods of communication to help them continue to understand the restrictions.

Important areas relating to COVID-19 management include helping individuals understand the virus; social distancing guidance and support; managing relationships; staying well; healthcare issues; advance planning; any legislative impacts; safeguarding and, most unfortunately, death and bereavement.

It has become so important to think about what family members enjoy normally what strategies and plans typically work when things are not going well, and to continue to provide calm and reassuring support. Much has been changed by COVID-19, but the personality, preferences and interests of the individual will likely not have done.

Individuals with learning disabilities are likely to be worried about their own health, and that of their loved ones, while also having routines interrupted, and access to friends or colleagues halted. Those providing support to them will be concerned about their own and their family's health too, and may be facing knock-on effects of the pandemic such as lost income or jobs.

It is important that individuals are supported to maintain their relationships with family, friends and partners.

Despite everyone's best efforts, individuals may experience loneliness as a result of the reduction in opportunities to socialise, connect with people, take part in physical activity and everyday cultural and faith experiences. They may experience anxiety about the virus outbreak. NI Direct, HSC websites and local organisations continue to offer useful resources to support them. There are also excellent resources in the PHA COVID 19 Library to support families and organisations working with individuals to support their needs.

Contingency planning is also hugely important as it is likely to be a difficult time for families and carers, as well as for the individual themselves. This is understandable and carers, where possible, should do what they can to take care of themselves as well as the person they support. It is also important that staff and non-staff make arrangements to reach out to carers during this difficult time. Local voluntary and community organisations continue to offer advice for carers on protecting their mental wellbeing.

Families noted that the use of Direct Payments and SDS (and stimulation of the market to generate more choice) will underpin some of the learning/changes arising from COVID-19 going forward, which we must embrace. The use of these payments needs to flex to support the needs of individuals and their families, should we incur further COVID-19 waves into the future.

In preparing for and responding to COVID-19, organisations working in learning disability services continue to make decisions in the context of reduced capacity and increasing demand. Partnership working is crucial to both maximise the use of community assets and to draw on the insight and expertise of partners. Response plans should be developed alongside individuals, families, carers, voluntary and community sector (VCS) organisations as well as learning disability providers.

Services that a VCS partner may be well placed to provide, which would help to maintain safety in the community, include: peer support, family/carer support, befriending, telephone or social media outreach. In addition, they may work as part of crisis teams to provide telephone support and listening support.

Providers will need to maximise the use of digital and virtual channels to manage the impact of self-isolation on staff and patients, for example, by enhancing single point of access (SPA) lines to make them available 24/7 and review information on their websites to ensure it is clear. Robust access assessment arrangements will also be important to ensure the most acutely unwell patients receive the care they require in a timely way.

Evidence of these new ways of working are cited in many publications written about the first wave of COVID-19, and important lessons have been learned for future responses.

1.3 Our Scope

The Model is for all who access, develop and deliver services for individuals with learning disabilities and their families/carers. Whilst it specifically focuses on responsibilities for HSC, Department of Health (DoH) and HSC providers, including the voluntary and community sector providers as well as private sector providers, it also considers key actions for other Government Departments including Department of Education (DE), Department of Communities (DfC) and Department of the Economy (DOE),. It will provide a platform to link partners together to identify key objectives and work effectively to provide services, share skills and knowledge and build on a shared value base in line with legislation and policy guidance.

The Model will focus on the following key groups:

- **Individuals Diagnosed with a learning disability:**
  - who live in Northern Ireland;
  - who may have mild, moderate or severe learning disability and need support.

- **Family and Carers**

- **Staff who provide care to individuals with a learning disability:**
  - HSC Trusts;
  - local communities;
  - Independent community, voluntary and private organisations.

Whilst the Model is not specifically relating to children and young people, it is required, as per legislation under the Children's Services Co-operation Act (2015) and the Special Educational Needs Disability Act (NI) 2016 that there will be joined up work with Children's Disability Services during the Implementation Phase, and will be set out in the Delivery Plan.

1.4 How the Model was Developed

The Model provides recommendations for future service delivery aimed at improving outcomes for individuals, carers and support to staff/organisations working across Northern Ireland.

It has been developed through engagement with individuals living with a learning disability families and carers and Health and Social Care practitioners, and supported by key policies and best available evidence.

The following engagement took place:

- Over 190 engagement events were hosted across Northern Ireland (March – December 2019), of which 2860 individuals attended and/or responded to.

- A regional online survey was rolled out, delivering 794 responses from those living with a learning disability, families and carers and staff working in disability services.

- A series of visits to service providers both statutory and independent sector providers were held as well as meetings with individuals who used learning

disability services, carers, staff and representatives from professional organisations to listen to what they felt were important now and in the future.

- Three regional workshops with local service provider organisations were also facilitated by Association for Real Change (ARC) NI.

- In summary, 3,654 responses were received to identify key priorities for the Model. This feedback has been instrumental in developing key priorities for action for the next 3-5 years.

- Details about ideas and recommendations are formulated in the Strategic Delivery Plan.

The engagement process repeatedly reinforced the requirement for a Model that is responsive to the unique environment and challenges in Northern Ireland. We therefore opted to create the Model from the ground up, rather than import one from another region.

In developing the Model, however, a detailed analysis of the service delivery policy and models in England, Wales and Scotland was carried out to explore key points of learning/reference arising from other models and strategic developments in the other UK nations. A summary is set out below and more detail can be found at Annex C.

Region	Analysis
England	Overall, the strategic documentation in relation to the English learning disability service model offers a systematically developed framework underpinned by a strong value base and commitment to standards and quality. In context, this model is designed for implementation through joint commissioning rather than integrated health and social care service delivery: as such the model reads as a high-level framework for action and accountability.
Wales	Overall, the Welsh learning disability service model offers a streamlined, value-oriented framework underpinned by clearly defined processes. Notably, the model and service improvement recommendations place particular emphasis on communication, effective working relationships at all levels across the system, and staff training, development, and support. The emphasis of these 'softer' skills/elements within the programme of change is distinctive.

Scotland	Overall, the Scottish learning disability service model offers an accessible framework for action that is readily understood by a lay person, and firmly grounded in the day-to-day life, challenges, and opportunities facing people with a learning disability. This grounded approach embodies the underlying value base and mission of the strategy i.e. to improve the *quality of life* for people with learning disabilities. The model is also notable for the synergy it highlights between national outcomes for the population as a whole, and the specific objectives and outcomes it projects for people with learning disabilities.

- A regional reporting structure was established to develop the Model (see Appendix 8 for details). Five key groups were as follows: Project Board
- Project Steering Group
- Regional Service User Reference Group
- Expert Panel for review of Assessment and Treatment
- Project Implementation Team comprising of Project Manager and 5 Trust Project Leads

The Project Board reported to the Transformation Implementation Group (TIG) via the Mental Health and Learning Disability Improvement Board, led by the Director of Social Care and Children's Service, HSCB.

The Project Steering Group was represented by the Department of Health and Professional Leads for Learning Disability. Social Care Leads for Learning Disability from the HSCB, Assistant Director of Nursing, PHA, HSC Trusts Assistant Directors, ARC NI, service user representation, carer representation and Regional Project Manager.

A regional Project Team, led by the regional Project Manager and five HSC Trust Project Leads developed a structured engagement with all stakeholders, seeking a strategic response to the key challenges as described on page 6.

It is important to note that Project Leads were recruited at different times during 2019, which resulted in a staggered commencement to the project across the region. The nature of temporary funding also had an impact on retention of staff as two Trusts saw the movement of Project Leads to permanent posts during the timeframe.

1.5 Our Service Model Vision

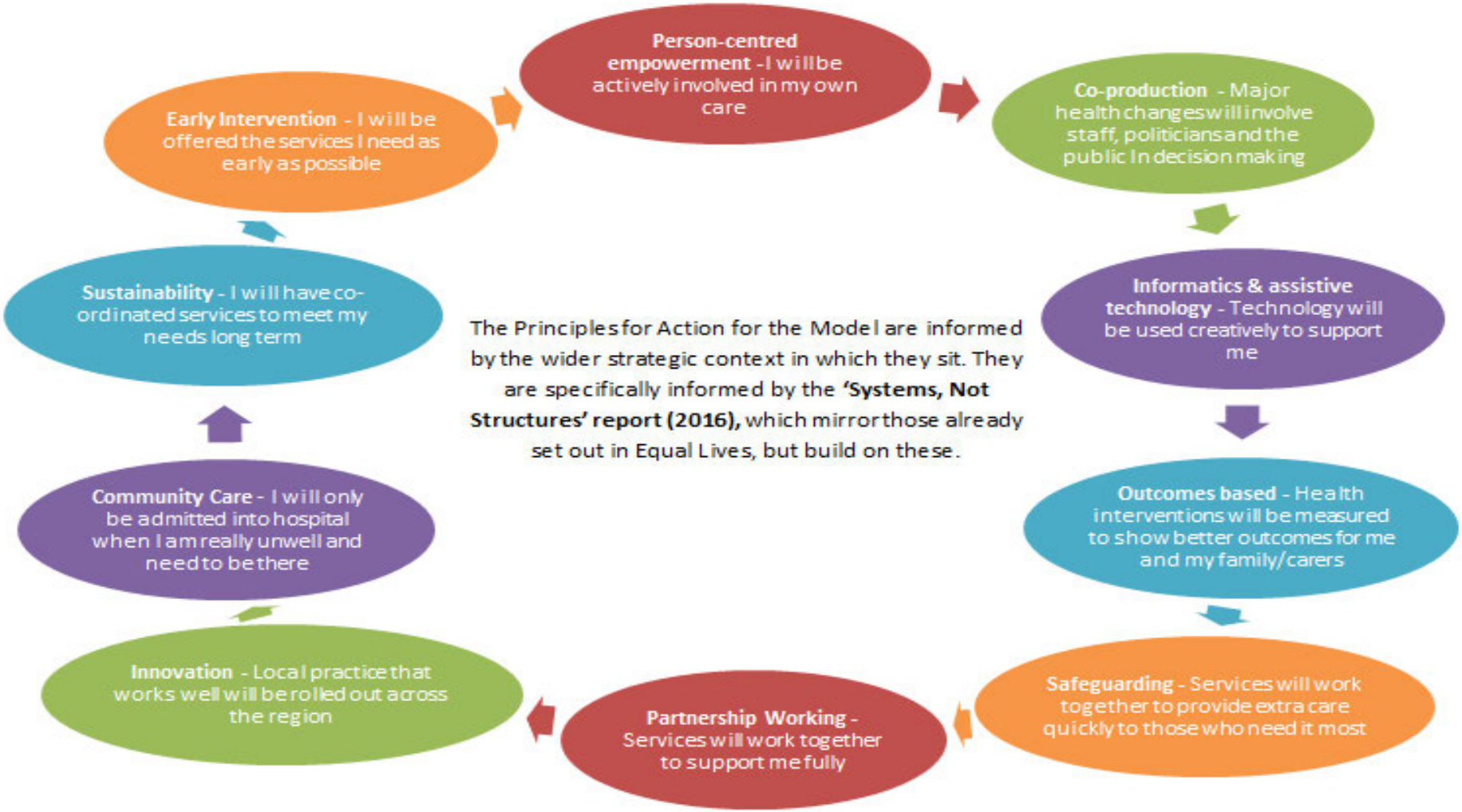
The vision for the Model is set out below:

"As an individual with a learning disability, I will be respected and empowered to lead a full and healthy life in my community. I will be supported to make choices and decisions in my life that enable me to develop, and live a safe, active and valued life."

Values

The Model is first and foremost grounded in our HSC values of working together, excellence, compassion and open and honesty. These also mirror the Equal Lives values, which "We Matter" has evolved from.

1.6 Our Values and Principles for Action



The Scottish Governments PANEL Principles (2015) are also important for our Model in Northern Ireland as they will also ensure that the needs and rights of individuals with learning disabilities are reflected as paramount throughout this model.

These outcomes are embedded within the context of the Scottish Public Sector Reform agenda and have validity in NI:

PANEL Principles	
Participation	Everyone has the right to participate in decisions which affect them. Participation must be active, free, and meaningful and give attention to issues of accessibility, including access to information in a form and a language which can be understood.
Accountability	Accountability requires effective monitoring of human rights standards. For accountability to be effective there must be appropriate laws, policies, administrative procedures and mechanisms of redress in order to secure human rights.
Non-discrimination and equality	Human Rights based approach means that all forms of discrimination must be prohibited, prevented and eliminated. It also requires the prioritisation of those in the most vulnerable situations who face the biggest barriers to realising their rights.
Empowerment	People should understand their rights, and be fully supported to participate in the development of policy and practices which affect their lives. People should be able to claim their rights where necessary.
Legality	The full range of legally protected human rights must be respected, protected and fulfilled. A human rights based approach requires the recognition of rights as legally enforceable entitlements, and is linked in to national and international human rights law.

1.7 Our Purpose

The purpose of the Model is to outline what individuals with learning disabilities expect of services, how services will achieve this and how they will be measured to ensure high quality, cost effective care.

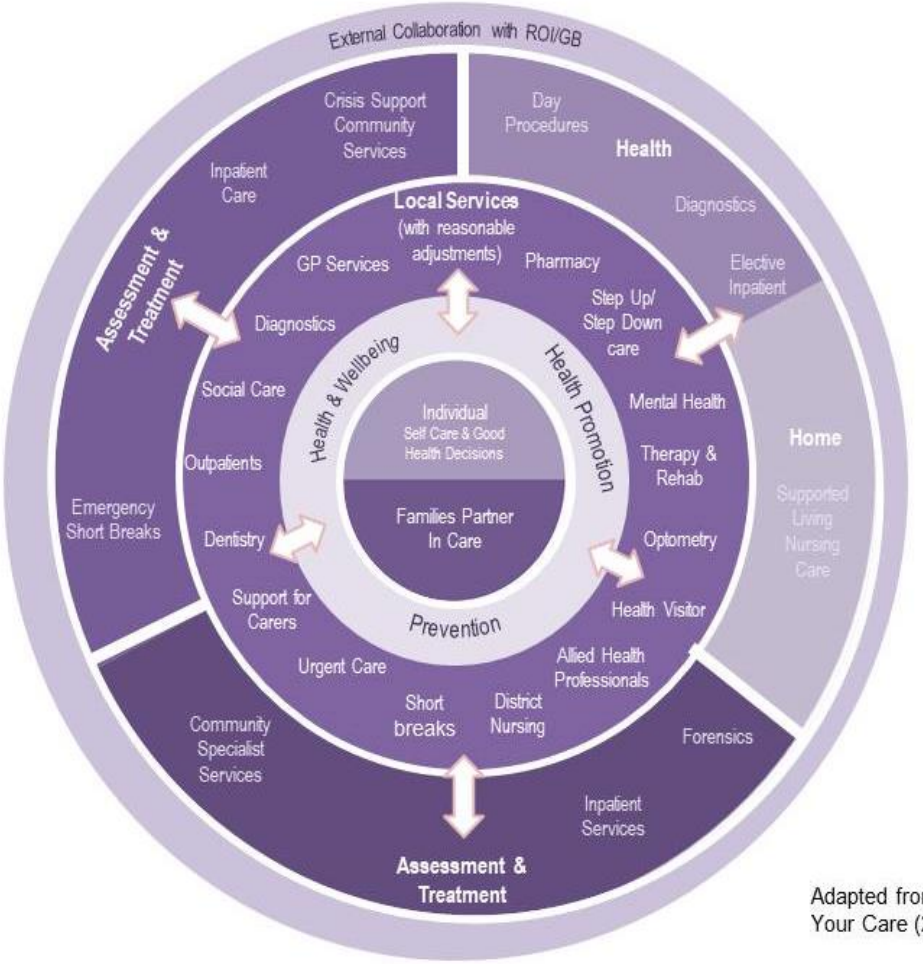
The Model will provide more autonomy, choice and independence for individuals and support to their families and carers.

The Model describes a range of services and supports that should be in place for individuals with learning disability. Depending upon their needs, individuals and their families will have access to services and support that is right for them and also be supported to navigate their way through the system, as their needs change.

2. THE INTEGRATED MODEL OF CARE

Set out in Transforming Your Care (2011) the integrated model of care is grounded in 12 principles for change, most importantly placing the individual at the centre of the model and providing the right care in the right place at the right time. The model will ensure that individuals with learning disabilities will have opportunities to make decisions that help maintain good health and wellbeing and all providers of services will provide the tools to do this.

Services will be provided locally and will regard home as the hub and be enabled to ensure individuals can be cared for, based on their assessed needs.



Adapted from Transforming Your Care (2011)

Where possible a mainstream service approach will be adopted, which entails facilitating access to generic/universal services for individuals with learning disability. Two important factors to ensure equitable access for individuals with learning disabilities are appropriately resourcing 'reasonable' adjustments and standardised pathways to care.

Reasonable adjustments ensure that care received by individuals with learning disabilities is appropriate and high quality. These are small but significant changes to the way a service or practitioner interacts with an individual in order to make the service suitable for them, e.g. changes to environment, length of appointment and communication styles. Reasonable adjustments must always be tailored to the individual's level of functioning and specific needs.

The Model offers a range of care based on the premise that individuals with learning disabilities will lead fulfilling lives in the community. The various elements of the Model recognise the range of levels of need for those with mild to moderate needs who manage and thrive with support of family, friends and mainstream HSC services, to those who require more intensive and specialist supports in community and inpatient environments. The Model aims to offer the most effective intervention which supports the individual to remain at home.

Access to services will be based on assessed needs of local populations and commissioned accordingly, to ensure equity and access of care.

In responding to changing need, crisis or circumstance, the Model will offer a speedy response with the flexibility to move between the range of support available at each element.

Individuals with learning disabilities may require access to services across a number of different elements simultaneously. Key workers will co-ordinate access to a range of services based on an individual's needs. This will require explicit links and interfaces between different pathways of care in order to provide an integrated approach. Organisations will work together in a more integrated way and be supported by pathways of care.

2.1 Pathways of Care/Support Pathways

Pathways of care/support pathways as they are usually referred to, describe the nature and anticipated care and support journey for an individual. Pathways of care/ support pathways will be developed during the Implementation Phase and set out in

the Delivery Plan. A thematic Work Stream will be engaged to do this work. A care pathway example, *"Sample Pathway of Care for Transitions"* is set out in Appendix 7.

Organisations working in learning disability services already use this care pathway/ support pathways approach but it is the intention of this Model to ensure consistency, standardisation of approach and equity across Northern Ireland for all our citizens.

The *You in Mind Mental Health* suite of Care Pathways offers an example in practice, and it is anticipated that a similar suite of regional standardised pathways of care will be developed for learning disability services.

The pathway(s) of care/ support pathways will explain how individuals with learning disabilities and their families can access services to ensure individuals themselves live a *"safe, active and valued life"* as described in the Vision Statement, across the 6 Key Ambition Statements using the Integrated Model of Care. Care and support will be delivered in a co-ordinated and integrated way, and have consensus and support from all key stakeholders. They will be co-produced with individuals and their families will put the individual themselves at the heart of all decision making and will be needs-led and rights based.

This approach ensures there is agreement on standardised referral and care and treatment, to define where and when particular individuals should be referred to services, and what services they will choose, want and need. They should link to each other across the range of services seamlessly described above and also identify and work with outside HSC services.

Each pathway of care/ support pathway will have an agreed referral flow diagram, as per the example set out in Appendix 7. They will be designed to be flexible and will have agreed protocols for referral, eligibility and joint working arrangements in order to deliver a seamless and co-ordinated programme of care. An example is also set out below. This approach was adopted from a similar model in existence in the Lambethand Southwark local care network.

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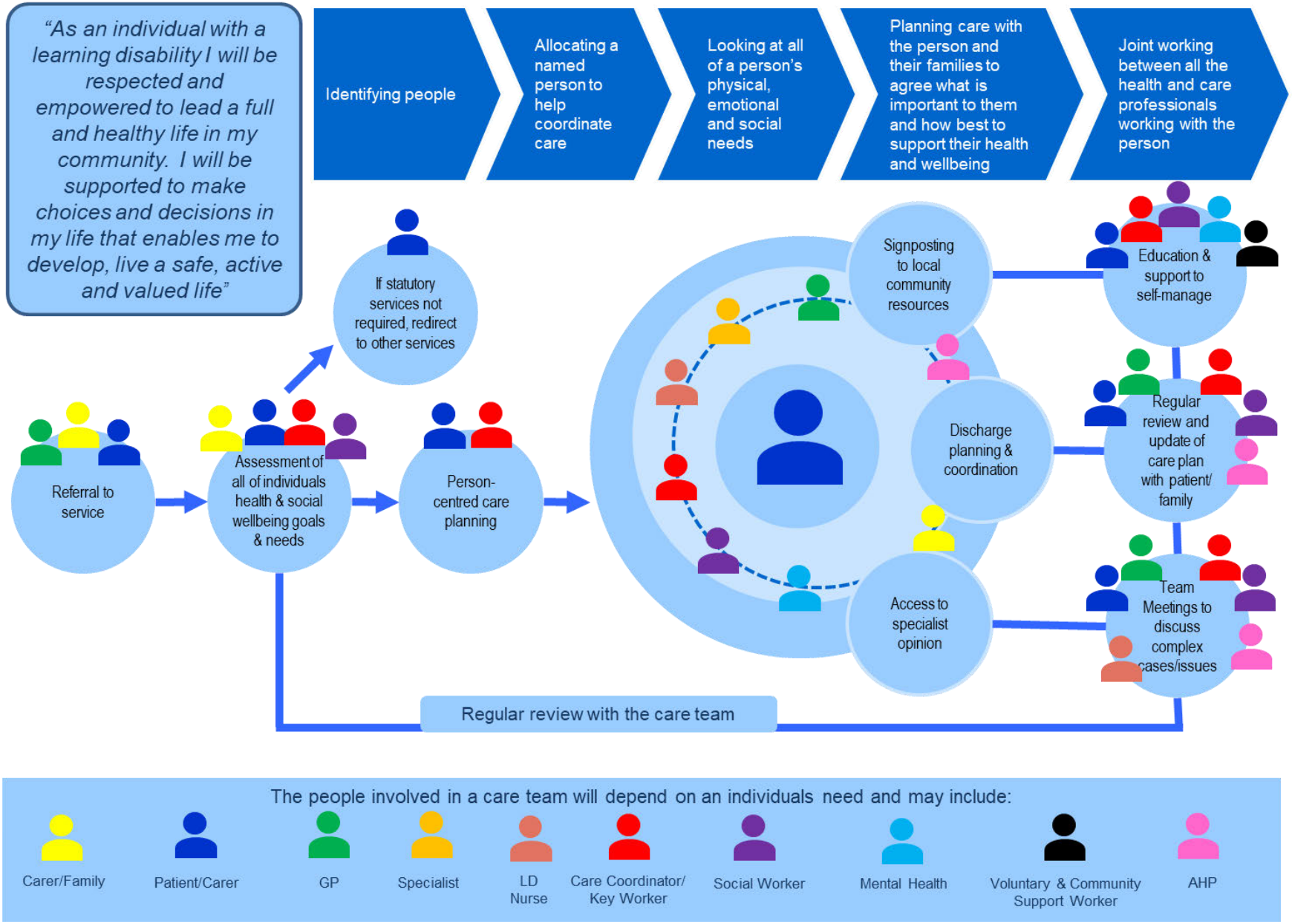
PATHWAY OF CARE APPROACH

"As an individual with a learning disability I will be respected and empowered to lead a full and healthy life in my community. I will be supported to make choices and decisions in my life that enables me to develop, live a safe, active and valued life"



3. OUR KEY AMBITIONS AND OUTCOME MEASURES

In order to achieve the vision set out in the Model, a number of Key Ambition Statements and associated Outcome Measures have been developed. These will guide the transformation of services, and be supported by the ideas for transforming the way we work noted on page 10 and further described in Appendix 1

The next section of the Model sets out each of the 6 Key Ambition Statements in full, including each Statement, Introduction, and Outcome Measures.

Appendix 6 sets out some of the Key Challenges associated with each of the 6 Key Ambition Statements expressed during the regional engagement process, and described in the extensive literature search carried out during the Project:

It is anticipated that the Key Actions set out in this Model will not be implemented immediately; a phased approach (3-5 years) will be required and will be set out in the Strategic Delivery Plan (SDP).

3.1 Key Ambition 1- Life Changes

Key Ambition Statement 1: *I am prepared and supported through important changes in my life.*

3.1.1 Introduction

Everyone will go through changes in their lives. A life change is a phrase used to reflect different stages of my life. This is sometimes called "Transitions" and is normally associated with moving from children's to adult services. This is only one of many life changes that occur. We also change throughout our lives, as we and our parents grow older.

I would like social workers to talk to me, not just my family.

As I go through life, I may try new things, make new friends, go to school, get a job, move house, get married. These are important changes in my life. Sometimes I can plan these on my own; for some I may need support from my family or other health and social care staff such as when a family member dies.

3.1.2 Outcome Measure - What Success Looks Like

- Individuals with a learning disability who require assessed health and social care services will receive these using a single, lifelong care model, which is flexible and responsive to their needs.

- Every individual who receives services will be involved in co-producing a comprehensive, holistic Life Plan/ Goals, or Service User Care Plan.

- Every individual will have their needs assessed using a rights based and person centred model. This will ensure that services are targeted according to the assessed needs of individuals and will be informed by a regionally agreed and standardised approach.
- Every individual in receipt of services will have a Key Contact Person/Link Worker to offer support if needed through all life changes. They will enable the person to support and signpost the individual to other agencies that can help them achieve their Life Plan goals.

- For children and young people with a long term accommodation need after aged 16, planning should commence early and in a timely manner with Department for Communities for a home suitable into adulthood.

3.2 Key Ambition 2 – Health and Wellbeing

Key Ambition Statement 2 : *I will live a happy, healthy and active life*

3.2.1 Introduction

Knowing how to stay healthy and take steps to care for myself is important to me. There are things I can do to keep myself healthy. I can eat healthy foods and make sure that I do activities, for example, if I can walk or do sports. I should do these regularly and make sure to get outdoors. Spending time with friends and family who make me laugh and who I like can help take care of my emotional health.

"If I'm in busy environment it can be helpful to be seen first or last so fewer people and there is less noise so that upset can be kept to a minimum" (Service User/Carer, WHSCT)

I know myself. My GP is there for me if I need medical help or my GP can ask other health care staff to help too. Health and social care staff will communicate with me directly in a way I understand. They will work with me and my family or someone I

choose to have with me to understand and consider my care and treatment needs. They can offer me help and guidance when I have to attend hospital appointments. My hospital passport is really helpful in helping me to do this too. My Hospital (Health) Passport will help to let hospital staff know all about my abilities and needs. It will help them give me better care when I am in hospital. I will make sure my information is up to date. My Hospital (Health) Passport is owned and kept by me.

3.2.2 Outcome Measures - What Success Looks Like

- Individuals will have the same access to health and social care services with consideration given to reasonable adjustments. They will have access to integrated, community-based health and well-being multi-disciplinary team support in their local areas.

    - Individuals will receive a comprehensive Annual Health Check by a GP.

    - Individuals will have a Health and Social Wellbeing Action/Support Plan which is focused on prevention and early intervention activities, will be person-centred and flexible and be supported by Multi-disciplinary Teams who are appropriately trained. This will include a dedicated Management Plan for any specialist treatment/support/health conditions.

    - Individuals will have access to a Healthcare Facilitator who will support them to identify health and social wellbeing goals and how these will be met. They will offer clear, accessible and practical information about keeping fit and healthy and will include suitable health and wellbeing programmes available through general HSC services and community partners. This will form a key part of the individual's overall Life Plan/Service User Care Plan.

    - Individuals will be supported to access acute general hospital appointments when required. They should have access to an acute Hospital Liaison Service. This is particularly important for those with communication difficulties or specific environmental challenges. Where appropriate an individual's Health Passport will be used to help general HSC services make reasonable adjustments for the individual.

3.3 Key Ambition 3 – Carers and Families

Key Ambition Statement 3: *My carer is supported to help me live my best life.*

3.3.1 Introduction

Family means the people who have known me since I was a child. This can be parents, grandparents, sisters, brothers, cousins, nieces, nephews, aunts and uncles. Sometimes friends or neighbours who we have known our whole lives also feel like family. Not everyone has a large family, but we all belong somewhere. A family often knows me best. They understand me. They know about things that have happened in my life, and they know what I like and what I don't like. Many family members are also carers.

"Family Carers are presently providing the bedrock of social care; they know their family member better than anyone and need recognition as partners." (Carer)

3.3.2 Outcome Measures - What Success Looks Like

- Family and carers will be offered flexible practical and emotional support to carry out their care giving role, including signposting and support networks.
- Family and carers will be offered a Carer's Support Assessment of their own needs using a standardised Regional Scoring Tool i.e. NISAT / Carer's Conversation Wheel and a Carer Support Plan will be developed.
- When a short break is needed carers will be offered a flexible choice based on assessed need with clear, transparent regional standardised criteria and a menu of options available.
- Family and carers will be offered support by HSC staff to plan for the future life changes of the individual they care for.
- Carers will have access to a local independent advocacy service, when required

3.4 Key Ambition 4 - Meaningful Lives and Citizenship

Key Ambition Statement 4 : *I live in a society that respects my rights and choices as a citizen - where I am enabled to have choices to learn, work, and enjoy my life.*

3.4.1 Introduction

Engaging in meaningful activities and have opportunities to learn, contribute to my neighbourhood, work and build friendships or relationships in my life are important for good health and well-being. As an equal citizen I am entitled to access a range of public and health and social care services that enable me to lead a fulfilling and purposeful life.

"I love my garden. I love my gardening job. I make things that people buy in my job."

I share my life with my family and friends. My friends can come from anywhere. Some people make friends easily and for others it's more difficult. Having places to meet with my friends and make new ones is important to me. Activities in my community can offer me these opportunities. I will have access to a range of opportunities to lead a full life. This will improve the quality of my life.

"I like going shopping, I get to talk to my neighbours and doing yoga with my friends."

3.4.2 Outcome Measures - What Success Looks Like

- An Individual's Life Plan/Service User Care Plan will be reviewed with them on an annual basis.
- Individuals will have access to a local independent advocacy service, when required.
- Individuals will have access to activities and services in the community that are meaningful and purposeful. They will have choice and control over the activities in which they participate in.
- Individuals will have training, education and employment opportunities in their local area. This will be developed in partnership with other relevant government departments and providers.
- SDS will be flexible to allow individuals to realise their wishes, goals and dreams for a meaningful life.

3.5 Key Ambition 5 - Home

Key Ambition Statement 5*: I am supported to live in my home.*

3.5.1 Introduction

Home is the place where I can relax and be me, it is important that my home meets my needs. Having the right home helps me do as much as I can for myself, and enable me to be independent should I wish to be. The right type of house in the right place is important to me.

"I like having my own front door key and living on my own. I like being able to go out on my own when I want."
(Individual who accesses services)

I want to have the opportunity to talk regularly about where I live and my housing needs. If I move to a different type of home, I want to be supported to make choices about where I live. I will have housing options made available to me in my preferred location. Organisations will explain clearly and involve me, my family carer and or advocate in the decisions that need to be made. Like everyone else in society, I want to live in an ordinary house.

3.5.2 Outcome Measures - What Success Looks Like

- Individuals will be supported to remain in their own home for as long as possible. This should include considering the assessed present and future needs of the individuals and their environment. These will be included as their Home Plan in the individual's overall Life Plan/Service User Care Plan.

- When a change of home is being considered, the individual, with their family/and or their advocate, will be included in the decision making process about where they live and with whom. They will be offered a regular needs assessment and personal choices relating to their Home Plan and will be reflected in their overall Life Plan.

- Individuals will have access to the same housing options as any other citizen. HSC staff will support the individual to anticipate their future housing needs and liaise with housing services to plan for these at an early stage, making best use of emerging assistive technology.

3.6 Key Ambition 6 - Specialist Assessment and Treatment

Key Ambition Statement 6: *I will enjoy the highest attainable standard of physical and mental health possible and have access to high quality, compassionate, assessment and treatment services, when required.*

3.6.1 Introduction

For me to live a happy, healthy and active life I will be supported by my GP and health care facilitator in primary care, and have access to a team of support professionals in the community close to where I live. However, there may be times when I might need more specialist assessment and treatment services to help me and my carers when I am going through difficulties. This might be because I have a mental health problem, or that I have some behaviours which are difficult for me to manage due to an Autistic Spectrum Disorder, for example. It might also be because I have committed a crime or at risk of committing a crime.

It is important for me to get the right specialist support at the right time. Mental and physical health and communication problems can be more frequent among individuals with a learning disability. If something is wrong or doesn't feel right there are people who can help solve the problem and help me manage my behaviour.

3.6.2 Outcome Measures - What Success Looks Like

- I can remain at home or in a homely setting wherever possible, and I will have access to community based assessment and treatment services so that I am not admitted to hospital if I can be supported to stay at home.

- If I need to be admitted to hospital I will be supported to leave in the shortest time possible. A plan will be put in place to make sure I leave hospital at the right time for me.

4. HOW THE MODEL WILL BE TAKEN FORWARD - STRATEGIC DELIVERY PLAN (SDP)

The Model sets out the vision for the future of learning disability services in Northern Ireland. Publication is only the beginning of the process. There are a number of key mechanisms that now need to be put in place to ensure it is implemented. We call this the Strategic Delivery Plan (SDP).

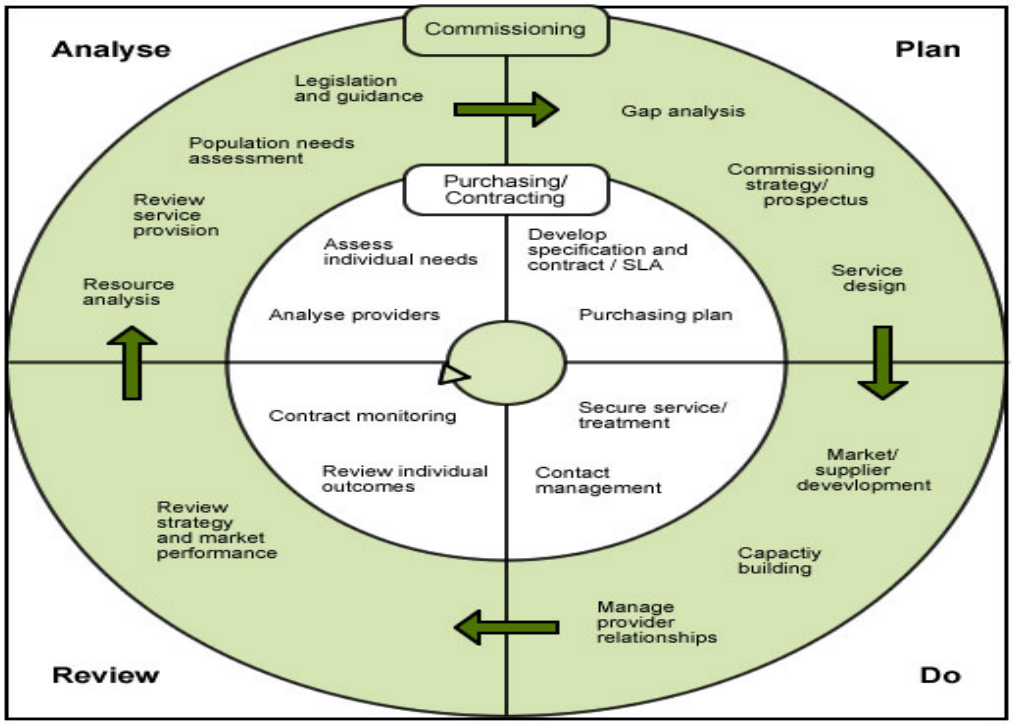
The SDP will be remain a live document and sets out key outcome measures and key actions as described in the Model, as well as how we report progress, defines lead responsibility, identifies resource implications and sets timeframes. A phased approach to delivery is described and will be closely monitored and reviewed to reflect strategic priorities and available resource.

The key outcomes in the SDP recognise the importance of 'Quality of Life' and 'Health and Wellbeing', and in particular, to enable individuals with learning disabilities to live safe, active and valued lives.

Detailed action plans will be developed by the project manager and members of thematic work streams and will be based on the key outcomes/ actions of the SDP. Key Performance Indicators (both qualitative and quantitative) will also be established to effectively monitor the success at delivering the key outcomes. The thematic work streams will be set up in discussion with the Learning Disability Transformation Taskforce (LDTT).

The SDP will also draw on the Institute of Public Care (IPC) Joint Commissioning Model, as also set out in the Scottish "Keys to Life" model, to describe strategic commissioning as "all the activities involved in assessing and forecasting needs, linking investments to agreed desired outcomes, considering options, planning the nature, range and quality of future services, and working in partnership to put these in place;" 'joint commissioning' is "where these actions are undertaken by two or more agencies working together, typically health and other Government Departments, and often from a pooled or aligned budget."

While health and social care are integrated in Northern Ireland, this model offers a structured framework for considering the process that applies to commissioning and monitoring services.



In order to progress the key action as described within the Model, local Action Plans will be developed within each HSC Trust area specifically for learning disability and led by Local Transformation Taskforce(s). The composition of the groups should be 'multi-agency multi-spread' and have individuals living with a learning disability, their families and their carers at the heart of the decision making process. This will be the output of what is more commonly referred to as the 'strategic commissioning' process. Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

4.1 Reporting Infrastructure

Whilst all Government Departments have a part to play in an individual's life, in terms of service provision, the Department of Health has a primary responsibility for the delivery of this Model. There must be, however, accountable co-operation, collaboration and partnership working across all Departments if the Model is to be implemented in full.

Whilst awaiting the formation of a cross-Departmental group for Learning Disability, the existing Mental Health and Learning Disability Improvement Board will oversee the implementation of the Model against the key Ambitions, Outcome Measures and Key Actions set out in the Strategic Delivery Plan (SDP).

The LDTT will be established to oversee all developments relating to both the Model itself, and other future developments relating to learning disability in general. A Terms of Reference for the group will be written. This group will include assistant directors, clinical leads, Department of Health policy and professional leads, voluntary sector representation, individuals with lived experience, carers, and will have HSC oversight and other key stakeholders.

A Learning Disability Champion and Care/ Service User Reference group will sit independently alongside the LDTT and provide an advisory role from service users and carers with lived experience.

The group will convene a number of Thematic Work streams based around the Key Ambition Statements and other associated priorities, to take forward the Strategic Delivery Plan. (See Appendix 8 for details of proposed reporting arrangements).

A Project Manager employed by the HSCB will oversee the implementation of the Model in partnership with all the key stakeholders, on behalf of the LDTT. The Project Manager will report directly to the Social Care Lead for Learning Disability.

4.2 Outcomes Based Reporting

Similar to the Programme for Government (PfG) and to other strategies and models being developed at present, the Outcomes Based Accountability (OBA) approach will be employed to implement and monitor the Model going forward, focusing our attention on the results we plan to achieve through the Implementation Phase.

For each Key Ambition set out in the Model we will ask the three key OBA questions:

- How much did we do?
- How well did we do it?
- Is anyone better off?

The “We Matter” Plan on A Page illustrates this, as shown in Annex D.

For our Key Ambition Statements, Outcome Measures and Key Actions we will report on progress ‘using OBA terminology’ or ‘turning the curve’ i.e. the actions we need to take to improve the lives of individuals with a learning disability.

To ensure consistency of approach, the LDTT will adopt the same reporting mechanisms and templates as currently used by Adult Mental Health Services, to report progress on the Model to the Mental Health and Learning Disability Improvement Board using the Outcomes Delivery Plan template, as per Annex A. This will ensure consistency of approach across Programmes of Care.

5. REFERENCES

To be completed in due course

6. ANNEXES

Annex A – "We Matter" Adult Learning Disability Service Model Strategic Delivery Plan

Annex B - Health and Social Care Policy: Summary Overview 2011 – 2019

Annex C – Key Elements of Regional Models – England

Annex D – Key Elements of Regional Models – Wales

Annex E – Key Elements of Regional Models - Scotland

Annex D – "We Matter" Plan on A Page

Annex A – "We Matter" Adult Learning Disability Service Model Strategic Delivery Plan

The following Strategic Delivery Plan sets out the key actions and processes to ensure the Model is implemented. We will measure it against Outcome Measures and Key Actions developed across each of the 6 Key Ambition Statements:

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
Life Changes ***I am prepared and supported through important changes in my life.***	**1.1**	Individuals with a learning disability who require assessed health and social care services will receive these using a single, lifelong care model, which is flexible and responsive to their needs.	• We will develop a rights based and person centred lifelong care pathway for learning disability services. A lifelong care plan will be created together with individuals and their respective carers and families and will include key transitions. • We will ensure services are adequately resourced with Transition Workers/Adult Link Workers to support ALL transition points and across all agencies. • We will continue to co-operate with the Education Authority and Department of Communities to provide health and social care services to individuals with a learning disability in Education and further education.	**LDTT** **LDTT** **DoH/DE**	**TBC** **Scoping Exercise required**	**Year 1** **Year 2** **Year 1**
	1.2	Every individual who receives services will be involved in co-producing a comprehensive, holistic Life Plan/ goals.	• We will design and develop a co-produced, standardised Life Plan Tool for regional use. • We will design and implement a Transition Pathway for all transition points.	**LDTT** **LDTT**		**Year 1** **Year 1**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
	1.3	Every individual will have their needs assessed using a rights based and person centred model. This will ensure that services are targeted according to the assessed needs of individuals and will be informed by a regionally agreed and standardised approach.	• We will ensure there is a regionally agreed rights based and person centred model using a thresholds of need approach. • We will ensure there are care pathways and associated supports for all individuals who are assessed under the rights based and person centred thresholds of need approach.	**LDTT** **LDTT**		**Year 1** **Year 1**
	1.4	Every individual in receipt of services will have a Key Contact Person/Link Worker to offer support if needed through all life changes. They will enable the person to support and signpost the individual to other agencies that can help them achieve their Life Plan goals.	• We will co-produce regionally consistent easily accessibly information and communications resources on services from diagnosis/birth of a child to support transition process from childhood to adulthood, and other life changes • We will consider the recommendations and roll out of the Future Planning Programme (Taggart et al.) for carers and HSC providers. • We will scope out community resources to ensure they are meeting older individuals needs and those requiring physical rehabilitation in hospital and the community. • We will ensure the Regional Dementia Care Pathway is implemented. • We will ensure the provision of palliative care services to all individuals with a learning disability	**LDTT** **LDTT** **LDTT** **PCOP** **HSCTs**	**£100k** **Scoping Exercise £20k** **Scoping Exercise**	**Year 1 & 2** **Year 1** **Year 1** **On-going** **On-going**
	1.5	Children and young people with a long term accommodation need	• We will **engage with other Government Departments** and agencies in relation to	**DoH/DE/ DfC/**		**Year 1**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
		after aged 16, planning should commence in partnership with Department for Communities in a timely manner, for a home suitable into adulthood.	education, leisure, employment, accommodation and training opportunities in support of goals to set out in an individual's Life Plan to ensure that they plan inclusively.	**DoE/ Voluntary Sector**		
Health and Wellbeing ***I will live a happy, healthy and active life***	**2.1**	Individuals will have the same access to health and social care services with consideration given to reasonable adjustments. They will have access to integrated, community-based health and well-being multi-disciplinary team support in their local areas.	• We will ensure that health and social wellbeing goals will be included in the Life Plan and programmes are inclusive and resourced at a local level. (possible expansion of DES) • We will explore and pilot a Health and Wellbeing Co-ordinator post in each locality to oversee and monitor Health and Social Wellbeing Action/Support Plans, including partnerships with other Government Departments. • We will ensure that there is regionally consistent and appropriately resourced staffing of Multi-disciplinary Teams. These staff should ensure that general HSC services provide equity of access and equality of outcomes for individuals with learning disabilities. • We will pilot specialist Learning Disability support in Integrated Care Multi-Disciplinary Teams.	**LDTT** **LDTT/ Voluntary Sector** **LDTT** **LDTT/IC**	**Pilot x 1 locality (2 x Band 6)** **Scoping Exercise** **Pilot (1 x Band 7 per Trust)**	**Year 1 & 2** **Year 1** **Year 2** **TBD**
	2.2	Individuals will receive a comprehensive Annual Health Check by a GP.	• We will fully implement recommendations from Hospital Passport Phase II Evaluation. • We will ensure that the Encompass Programme design for Learning Disability Services incorporates a mechanism to record and monitor health and social care data, as part of an	**LDTT** **LDTT**		**Y1 & 2** **TBD**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
			individual's Annual Health Check.			
	2.3	Individuals will have a Health and Social Wellbeing Action/Support Plan which is focused on prevention and early intervention activities, will be person-centred and flexible and be supported by Multi-disciplinary Teams who are appropriately trained. This will include a dedicated Management Plan for any specialist treatment/support/health conditions	• We will develop a Positive Behaviour Support framework for use in both Community Specialist Services (community and inpatient) and in Community Learning Disability Teams, where appropriate. • We will ensure each HSC Trust has an Epilepsy Nurse Specialist. • We will ensure there are healthcare pathways for both specialist learning disability and general specialist services. • We will consider the creation of a LeDeR project to review and monitor performance against premature deaths, as part of the Learning Disability Observatory/Network Transformational Change project.	**LDTT** **LDTT** **LDTT** **LDTT**	**Scoping Exercise to determine required budget** **Band 7 x 5 HSCTs** **TBC**	**Year 1 & 2** **Year 1** **Year 1** **Year 2**
	2.4	Individuals will have access to a Healthcare Facilitator who will support them to identify health and social wellbeing goals and how these will be met. They will offer clear, accessible and practical information about keeping fit and healthy and will include suitable health and wellbeing programmes	• We will evaluate and, based on findings, explore the role of multi-disciplinary Healthcare Facilitators, and include a pilot Healthcare Assistant role.	**LDTT**	**Band 4 x 5 HSCTs**	**Year 2**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
		available through general HSC services and community partners. This will form a key part of the individual's overall Life Plan.				
	2.5	Individuals will be supported to access acute general hospital appointments when required. They should have access to an acute Hospital Liaison Service. This is particularly important for those with communication difficulties or specific environmental challenges. Where appropriate an individual's Hospital Passport will be used to help general HSC services make reasonable adjustments for the individual	• We will ensure that a regional Acute Hospital Liaison Service is established. • We will ensure there is adequate investment in hospital estates to fully achieve reasonable adjustments and communication standards.	**LDTT** **LDTT**	**4 x Band 7's** **TBD**	**Year 1** **On-going**
Carers and Families ***My carer is supported to help me live my best life.***	**3.1**	Family and carers will be offered flexible practical and emotional support to carry out their care giving role, including signposting and support networks.	• We will develop a Regional Carer Support Plan for carers that will include physical, social, emotional and carer supports. • We will produce a communication and information resource, including a co-produced regional website. This will provide information about services regionally and locally. • We will co-produce a regional programme to share relevant health and social care training to support carers in their role.	**LDTT** **LDTT** **LDTT**	**TBC** **£50-100k** **£150k**	**Year 1** **Year 1 & 2** **On-going**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
	3.2	Family and carers will be offered a Carer's Support Assessment of their own needs using a standardised Regional Scoring Tool i.e. NISAT / Carer's Conversation Wheel and a Carer Support Plan will be developed for Carers.	• We will work with other agencies to offer access to local Carer Support Networks.	**LDTT/ Voluntary Sector**	**£200k**	**Year 1 & 2**
	3.3	When a short break is needed carers will be offered a flexible choice based on assessed need with clear, transparent regional standardised criteria and a menu of options available.	We will consider the findings of the Review of Short Breaks (2019), and agree and implement regionally consistent criteria for short break options. • We will review and deliver planned short breaks options for individuals and carers based on assessed need. • We will develop a regionally agreed pathway and criteria for emergency short breaks.	**LDTT** **LDTT** **LDTT**	**Scoping Exercise** **Scoping Exercise**	**Year 1** **Year 1** **Year 1**
	3.4	Family and carers will be offered support by HSC staff to plan for the future life changes of the individual they care for.	• Based on findings from the evaluation of the Carer Consultant Role in Belfat HSC Trust, HSC will consider and introduce any recommendations for scale and spread across Northern Ireland to ensure a Carer Consultancy Model is in place. • We will consider the recommendations and roll out of the Future Planning Programme (Taggart et al.) for carers and HSC providers • We will ensure that the Shared Lives NI framework is developed further and utilised as a	**LDTT** **LDTT** **Shared Lives**	**£200k** **As per 1.4** **Nil**	**Year 1 & 2** **As per 1.4** **On-going**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
			highly personalised alternative to residential and other forms of care.			
	3.5	Carers will have access to a local independent advocacy service, when required.	• We will ensure that there is regional consistency in contractual independent advocacy services and explore a range of different models/approaches.	**LDTT/ Voluntary Sector**	**TBC(Enhance existing contracts depending upon model of choice)**	**Year 1 & 2**
Meaningful Lives and Citizenship ***I live in a society that respects my rights and choices as a citizen - to learn, work, and enjoy my life*.**	**4.1**	An Individual's Life Plan will be reviewed with them on an annual basis.	• We will ensure that Royal College of Speech and Language Therapists Five Communication Standards (2013) are adopted by all organisations.	**LDTT**		**On-going**
	4.2	Individuals will have access to a local independent advocacy service, when required.	• We will ensure that there is regional consistency in contractual independent advocacy services and explore a range of different models/approaches.	**LDTT/ Voluntary Sector**	**Scoping Exercise**	**Year 1 & 2**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
	4.3	Individuals will have access to activities and services in the community that are meaningful and purposeful. They will have choice and control over the activities in which they participate in.	• We will ensure adherence to the regulations and guidance set out in the Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) (2019), and ensure there is education and support packages for carers and staff for implementation. • We will contract activities and services from local health and social care providers in line with assessed need. This will involve regional operational consistency and flexibility in approach. • We will ensure full implementation of the Regional Day Opportunities Review (2016). • We will undertake a Day Care scoping exercise to determine current and future needs. • We will develop peer support networks for individuals in their own communities. • We will commission research focusing on individual's sense of well-being with specific focus on loneliness and sense of connection. • We will implement the Regional Forensic Care Pathway.	**DoH** **LDTT/ Voluntary Sector** **HSCTs** **LDTT** **Voluntary Sector** **DoH** **FMCN**	**Nil** **TBC** **TBC** **Cost neutral** **£250k** **£30k** **TBD**	**On-going** **Years 1-3** **On-going** **Year 1** **Year 2** **Year 2** **TBD**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
	4.4	Individuals will have training, education and employment opportunities in their local area. This will be developed in partnership with other relevant Government Departments and providers.	• We will explore the role of a Day Opportunities Hub Co-ordinator or sometimes known as a Community Navigator, to work in partnership with other agencies/Government Departments to develop and sustain a range of flexible and appropriate programmes, in areas such as volunteering, education, training and employment. • Public, independent and voluntary sector organisations will develop mechanisms and agree targets for providing appropriate job opportunities for individuals with a learning disability. • Public, independent and voluntary Sector organisations will ensure that individuals with a learning disability have access to a range of transport options for social, leisure, health, training, day opportunities, volunteering and employment opportunities. This will require collaborative working and resources from across Government Departments.	**LDTT/ Voluntary Sector** **DoH/DfC** **DoHDfC/ DoE**	**2 x Band 6's per locality (10)**	**Year 1 & 2** **Year 1 & 2** **Year 1 & 2**
Home	**5.1**	Individuals will be supported to remain in their own home for as long as possible. This should include considering the assessed present and future needs of the individuals and their environment. These will be included as their	• We will develop a regional standardised Home Plan template for individuals. • We will offer early assessment of health and social care needs in relation to future housing demand. • We will explore the potential for pilot projects to test out new innovative models for example,	**LDTT** **LDTT** **DfC**		**Year 1** **Year 1** **Year 1 & 2**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
I am supported to live in my home		Home Plan in the individual's overall Life Plan	nursing/ MDT supports aligned to private tenancies. • We will continue to explore and scope out the use of technological solutions to support community living, with key partners. • We will work with Department for Communities to explore broadening the definition used in the Disabilities Facilities Grant to improve accessibility for an individual with a disability, to include physical needs of those individuals who have behaviours that challenge, dementia and those with autism.	**All** **DoH/DfC**		**Year 1 & 2** **Year 1**
	5.2	When a change of home is being considered, the individual, with their family/and or their advocate, will be included in the decision making process about where they live and with whom. They will be offered a regular needs assessment and personal choices relating to their Home Plan will be reflected in their overall Life Plan.	• We will continue to work in partnership with Department for Communities (DfC) to explore and offer flexible housing options for individuals with learning disability to support future planning based on specific projected housing need and demand.	**DoH/DfC**	**TBD**	**On-going**
	5.3	Individuals will have access to the same housing options as any other citizen. Health professionals, such as Occupational Therapists will support the individual to anticipate	• We will engage with Department of Communities to ensure that the Housing Adaptation Officer role continues to develop appropriate housing specifications for individuals. • Public Sector bodies will work in partnership to	**DfC** **DoH/DfC**	**50% funding per locality** **50% funding £50k**	**Year 2** **Year 2**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
		their future housing needs and liaise with housing services to plan for these at an early stage, making best use of emerging assistive technology.	develop a Regional Learning Disability Housing Lead role with funding control/influence of build and design to meet the accommodation needs of individuals with learning disability, whether general or bespoke housing.			
Specialist Assessment and Treatment ***I will enjoy the highest attainable standard of physical and mental health possible and have access to high quality, compassionate, assessment and treatment services, when required***	**6.1** **6.2**	If I need specialist services related to my learning disability this should be provided in the least restrictive setting possible and ideally in the community. I can remain at home or in a homely setting wherever possible, and I will have access to community based assessment and treatment services so that I am not admitted to hospital if I can be supported to stay at home.	Work is currently underway to develop Community based assessment and treatment services for people with a learning disability and/or complex needs, Autistic Spectrum Disorders and those within the criminal justice system. This work will link to the consideration of acute hospital provision for individuals who require specialist hospital admission due to mental health problems or behaviours that challenge. The key recommendations of this work will feature in the Model's Delivery Plan, and will be published later in the year as an Annex to the Model itself.	**CAT Task & Finish Group**	**TBC**	**In line with Model implementation timeframes**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
Ideas for Transforming Change						
Learning Disability Champion		Outcome measures to be determined by thematic work stream.	• DoH to explore role and function	**DoH**	**£150k**	**Year 1**
Learning Disability Innovation Fund		Outcome measures to be determined by thematic work stream.	• Design Application Process • Develop Application criteria • Design Evaluation process	**DoH**	**TBD Mental Health £500k**	**Commence in Y2**
Learning Disability Network/ Observatory		Outcome measures to be determined by thematic work stream.	• Communications Thematic Work Stream to scope and cost the model • Employ a Network Co-Ordinator	**HSCB**	**Band 7 + B3**	**Year 2**
Design Regional Register/ Database		Outcome measures to be determined by thematic work stream.	• Design Team in place • Engage with Encompass to develop specification	**HSCB/HSC Ts**	**Band 5 LD Informatics x 5 Trusts**	**Year 1**
Design a standard Minimum Data Set and Associated Informatics Framework to Support the Collection of Data to Deliver the Model		Outcome measures to be determined by thematic work stream.	• Informatics Thematic Work Stream to develop and pilot template • Engage with Encompass to develop specification	**HSCB/HSC Ts**	**As above**	**Year 1**
Develop Standardised Reporting Documentation and Systems		Outcome measures to be determined by thematic work stream.	• Informatics Thematic Work Stream to scope, design and test • Engage with Encompass to develop specification	HSCB/HSC Ts	As above	**Year 1** **On-going**
‘ We Matter’ Training		Outcome measures to be	• Task & Finish Group set up to design and			**Year 1 & 2**

Ambition Statement	No	Outcome Measures	Key Actions	Lead	Resource Requirements	Implementation Phase
and Development Framework and Regional Shared Knowledge Network		determined by thematic work stream.	cost framework	DoH/HSCB / PHA	TBC (check 'Working Together, Learning Together Framework in MH Services')	
Information Resources/Guide		**Outcome measures to be determined by thematic work stream.**	• Communications Thematic Work Stream to explore digital and hard copy resources	All	As per 3.1	**On-going**
Regional Website		**Outcome measures to be determined by thematic work stream.**	• Communications Thematic Work Stream to explore and cost options	All	As per 3.1	**On-going**
People's Parliament		**Outcome measures to be determined by thematic work stream.**	• Scoping exercise to explore options	HSCB Project Mgr	TBC	**Year 1 & 2**

Reporting Progress

For each Key Outcome set out in the Model we will ask the 3 key OBA questions:

- How much did we do?
- How well did we do it?
- Is anyone better off?

Example

Key Outcome 1 – Life Changes							
	KEY ACTIONS	**HOW MUCH WILL WE DO?**	**HOW WELL WILL WE AIM TO DO IT?**	**HOW WILL WE KNOW IF ANYONE IS BETTER OFF?**	**HOW WILL WE MEASURE IT**	**WHEN?**	**OWNERS**
1.1							
1.2							

The “We Matter” Plan on A Page at **Annex E** also sets out a High Level example of this type of OBA reporting.

Annex B - Health and Social Care Policy: Summary Overview 2011 – 2019

REF	POLICY / STRATEGY	RELEVANT INFORMATION
1	*Quality 2020: A 10-Year Strategy to Protect and Improve Quality in Health and Social Care in Northern Ireland* (DHSSPS, 2011b)	• Underpinned by **3 core themes**: ○ Safety ○ Effectiveness ○ Patient and Client Focus
2	*Transforming Your Care: A Review of Health and Social Care in Northern Ireland* (DHSSPS, 2011a)	• Proposes model for future service delivery (see Figure 3 below) and 99 recommendations for change across 16 themes, including the following with relevance to learning disability: ○ Quality and outcomes to be the determining factors in shaping services. ○ Confirming the closure of long-stay institutions in learning disability and mental health with more impetus into developing community services for these groups ('resettlement' - see section 3.14 above). • Identifies 12 principles for change: ○ Placing the individual at the centre of any model by promoting a better outcome for the service user, carer and their family ○ Using outcomes and quality evidence to shape services ○ Providing the right care in the right place at the right time ○ Population-based planning of services ○ A focus on prevention and tackling inequalities ○ Integrated care – working together

REF	POLICY / STRATEGY	RELEVANT INFORMATION
		○ Promoting independence and personalisation of care ○ Safeguarding the most vulnerable ○ Ensuring sustainability of service provision ○ Realising value for money ○ Maximising the use of technology ○ Incentivising innovation at a local level • Highlights the need for a new service framework setting out standards of care for those with learning disability. This was subsequently published in 2015 (see section 3.16 below).
3	*Making Life Better: A Whole System Strategic Framework for Public Health 2013-2023* (DHSSPS, 2014)	• Vision: A whole system approach to increasing personal control, improving health and wellbeing, reducing health inequalities across the population: "*All people are enabled and supported in achieving their full health and wellbeing potential. The aims are to achieve better health and wellbeing for everyone and reduce inequalities in health.*"
4	*Systems, Not Structures – Changing Health and Social Care (The Bengoa Report)* (DOH, 2016)	• Guided by 'The Triple Aim': ○ Improving the patient experience of care (including quality and satisfaction); ○ Improving the health of populations; and ○ Achieving better value by reducing the per capita cost of health care. • Key observation: (despite the commitments/vision outlined above) *"The present model of care in Northern Ireland is not delivered on a population agenda. It is struggling to provide continuity of care in an organised way and the organisations delivering it are still operating in silos. There is a need to move away from hospital centred care to a more integrated model."* • Provides a succinct transformation model that may be useful in the development of the new Adult Learning Disability Service Model (see Figure 4 below). • Makes 14 recommendations for transformation focused on three components for practical implementation which, though they have different life spans, are noted to be urgent and connected, and should be launched simultaneously:

REF	POLICY / STRATEGY	RELEVANT INFORMATION
		○ Driving the system towards Accountable Care Systems (integrating – by agreement, and without the need for structural reform – the 'provider sector', to take collective responsibility for all health and social care for a given population and with a joint capitated budget linked to population based outcomes under agreement with the commissioning system to be decided by the Minister) ○ Aggressively scale up good practice ○ Rationalisation and stabilisation
5	*NI Executive Children's Strategy 2019-2029*	• Key strategic driver which requires the NI Executive to promote co-operation across relevant bodies and to adopt a strategy to improve the wellbeing of all children and young people • *Will require all authorities to co-operate in the delivery of transition provision from Children's to Adult Services*
6	*Health and Wellbeing 2026 – Delivering Together* (DOH, 2017)	• Policy response to Bengoa Report and recommendations for transformation. • Identifies 18 actions to be taken forward over the first 12 months, including consultation on transformation of adult social care services (no specific reference to learning disability) • Aligns to Draft Programme for Government (see section 3.20 below).

Annex C - Key Elements of Regional Models – ENGLAND

The key documents and strategic developments outlined below have informed and driven the **Transforming Care** process, which has been undertaken following the Department of Health investigation in 2012 into staff abuse of patients with learning disabilities and autism at Winterbourne View Hospital. Collectively, the documents reviewed comprise the overarching strategic direction and priorities of NHS England and its partners in relation to the delivery of learning disability services in England.

These developments are presented in a logical order in terms of the sequence of information and ideas discussed, rather than chronological order by publication date.

1 *Transforming Care For People With Learning Disabilities – Next Steps* (Association Of Directors Of Adult Social Services Et Al, 2015)

1.1 This report is issued by the Transforming Care delivery board. It outlines key steps envisaged to establish the basis for long-term transformation. These steps are organised into five work streams, shown in Table 1 below.

Table 1: NHS England Transforming Care Work Streams

REF	WORK STREAM	DETAILS
1	**Empowering people and families**	Consulting on a range of measures to strengthen people's rights in the health and care system
2	**Getting the right care in the right place**	Developing a clearer model for health and care services, describing outcomes to be achieved with associated performance indicators, what kind of services should be in place (both inpatient capacity and community-based support), and service standards.
3	**Regulation and inspection**	Tightening of regulation and inspection of providers, and strengthening providers' corporate accountability, responsibility, and management to improve quality of care.
4	**Workforce**	Improving care quality and safety by raising workforce capability.
5	**Data and information**	Ensuring the right information is available at the right time to the people who need it – this focus underpins all the work stream activity described above.

1.2 The document also includes a summary overview of the report produced by Sir Stephen Bubb on behalf of NHS England (the Bubb report) in November 2014, which makes recommendations for organisations across the health and social care system for accelerating the transformation process. These recommendations cover four key areas, as follows:

- Strengthening the rights of people with learning disabilities and their families.
- Improving commissioning, with the introduction of a mandatory commissioning framework (as per the Ensuring quality services report discussed at 3.2 below).
- Closing inpatient institutions.
- Building capacity in community services.

2 *Ensuring Quality Services: Core Principles For The Commissioning Of Services For Children, Young People, Adults And Older People With Learning Disabilities And/Or Autism Who Display Or Are At Risk Of Displaying Behaviour That Challenges* (NHS England et al, 2014)

2.1 This 'Core Principles Commissioning Tool' reflects extensive engagement and consultation for service improvement conducted as part of the Transforming Care process.

2.2 The document describes 14 core principles that "should be present across all education, health, and social care services being accessed by children, young people, adults, and older people with learning disabilities and/or autism who either display or are at risk of displaying behaviour that challenges" (p.7).

2.3 The core principles are underpinned by a consistent emphasis on the value of involving service users, carers, and staff in the development of improved services. Table 2 below shows the 14 themes covered by these principles.

Table 2: NHS England Core Principles Commissioning Tool

REF	PRINCIPLE
1	Positive Behavioural Support
2	A whole systems life course approach
3	Prevention and early intervention
4	Family, carer and stakeholder partnerships
5	Function based holistic assessment
6	Behaviour that challenges is reduced by better meeting needs and increasing quality of life
7	Support for communication
8	Physical health support
9	Mental health support
10	Support for additional needs
11	Specialist local services
12	Safeguarding and advocacy
13	Workforce
14	Monitoring quality

2.4 The authors argue the application of these principles should result in:

- Improved quality of life for the service users and their families.
- Reduced prevalence and incidence of behaviour that challenges among these service users.
- Reduced numbers of individuals placed in restrictive settings inappropriate to their needs.
- Reduced incidence of inappropriate use of psychoactive medication, restraint, and seclusion to manage behaviour that challenges.

2.5 The document includes an extensive reference list of relevant background information, online resources, and further reading. In addition, a useful synopsis of the 'Detailed Pathway and Policy Specification' recommending specific actions for individuals and organisations is included in the Appendix. All of this information forms the basis for subsequent strategy and implementation developments, discussed below.

3 Building The Right Support: A National Plan To Develop Community Services And Close Inpatient Facilities For People With A Learning Disability And/Or Autism Who Display Behaviour That Challenges, Including Those With A Mental Health Condition (NHS England et al, 2015)

3.1 This document builds upon the developments outlined above to outline the NHS England agenda for achieving what it describes as a necessary "change in culture" and "shift in power to individuals" to deliver sustainable positive change in the delivery of improved, person-centred services for individuals with a learning disability and/or autism.

3.2 Key points that stand out in this document include:

- An emphasis on the "highly heterogeneous" or diverse characteristics of the population referred to as 'people with a learning disability and/or autism'. The authors argue that it is important to respect and reflect that diversity in the improved service model.
- A focus on reducing the need for inpatient services, which is quantified over time and sets a target for "closing, at minimum, between 35%-50% of inpatient provision nationally by March 2019" (p. 27).
- An overview of the proposed new service delivery model, underpinned by nine core principles – this is published in more detail alongside the document – see point 2.4 below.
- The description of new Transforming Care Partnerships – collaborations of Clinical Commissioning Groups, local authorities, and NHS England specialised commissioners – to drive forward the programme of change by implementing the new service delivery model.

3.3 The vision set out in this document is to deliver a service model that can better meet the complex and diverse needs of this heterogeneous population, both now and with increasingly positive impact in the future.

4 Supporting People With A Learning Disability And/Or Autism Who Display Behaviour That Challenges, Including Those With A Mental Health Condition: Service Model For Commissioners Of Health And Social Care Services (NHS England Et Al, 2015)

4.1 This document describes in detail the new service delivery model outlined at point 3 above.

4.2 This model builds on previous service commitments to focus on rights, independence, choice, and inclusion for people with a learning disability and/or autism. It promotes a vision of a whole-system response that enables effective multi-disciplinary and multi-agency working to deliver access to high quality services and support based on individual need.

4.3 In line with the provisions of the Children and Families Act 2014[1] and the Care Act 2014,[2] which focus on outcomes, personalisation, and wellbeing, this model focuses on strengthening support in the community and preventative support to avoid crises and enable people to be active members of their communities.

4.4 The model was developed by a reference group of stakeholder leads. Through a process of engagement, NHS England, the Local Government Association, and the Association of Directors of Adult Social Services consulted with clinicians, commissioners, providers, families, and people with a learning disability and/or autism. The document clarifies that NHS England anticipates the model should be implemented over a 3 year period following its publication. It is therefore currently due for review/evaluation.

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[1] See: http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted
[2] See: http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

4.5 The model is underpinned by a human rights-oriented value base of five 'golden threads' as outlined in Table 3 below.

Table 3: NHS England Service Model: Vision / Value Base

REF	VALUE	DETAILS
1	**Quality of life**	People should be treated with dignity and respect – there should be a focus on supporting people to live in their own homes, supported by local services
2	**Keeping people safe**	People should be supported to take positive risks whilst ensuring they are protected from potential harm – there should be a culture of transparent and open reporting, ensuring lessons are learned and acted upon
3	**Choice and control**	People should have choice and control over their own health and care services – people should be supported to make their own decisions and, for those who lack capacity, any decision must be made in their best interests involving them as much as possible and those who know them well
4	**Support and interventions**	These should always be provided in the least restrictive manner – where an individual needs to be restrained either for their own protection or the protection of others, restrictive interventions should be for the shortest time possible and using the least restrictive means possible
5	**Equitable outcomes**	Individual outcomes should be comparable with the general population, addressing the determinants of health inequalities, and delivered as far as possible by mainstream services adjusted where necessary in line with Equality Act legislation[3]

4.6 These values inform nine core principles around which the model is organised, and which set the direction for specific actions required by health and social care commissioners.

4.7 A distinguishing element of these core principles is that they acknowledge a small percentage of people with a learning disability and/or autism engage in behaviour that may lead to contact with the criminal justice system, and potentially diversion to a hospital setting, and that the specific needs of this

[3] See: https://www.legislation.gov.uk/ukpga/2010/15/contents

group have not always been recognised. Core Principle 8, "*If I need it, I get support to stay out of trouble*," addresses this point specifically.

4.8 The nine core principles are outlined in Table 4 below.

Table 4: NHS England Service Model: Core Principles

REF	PRINCIPLE	SUMMARY NOTES
1	**I have a good and meaningful everyday life**	Everyone should: • be included in activities and services that enable them to lead a good and meaningful everyday life; • have access to education, training, and employment (including supported internships) which they can access in their local area; and • have the opportunity to develop and maintain good relationships with other people.
2	**My care and support is person-centred, planned, proactive, and coordinated**	• Local health and care services should develop a dynamic register based on sophisticated risk stratification of their local populations. • Everyone should have a single person centred care and support plan. • Everyone should be offered a named local care and support navigator or keyworker.
3	**I have choice and control over how my health and care needs are met**	• Everyone should receive information about their care and support in formats that they can understand (see Accessible Information Standard[4]). • Individuals, and where appropriate families/carers, should be integral partners in care and planning discussions. • People should have access to different types of independent advocacy.
4	**My family and paid support and care staff get the help they need to support me to live in the community**	All families or carers who are providing care and support for people who display behaviour that challenges should be offered: • practical and emotional support and access to early intervention programmes; • carers' assessment and advocacy support; and

[4] See: https://www.england.nhs.uk/ourwork/accessibleinfo/

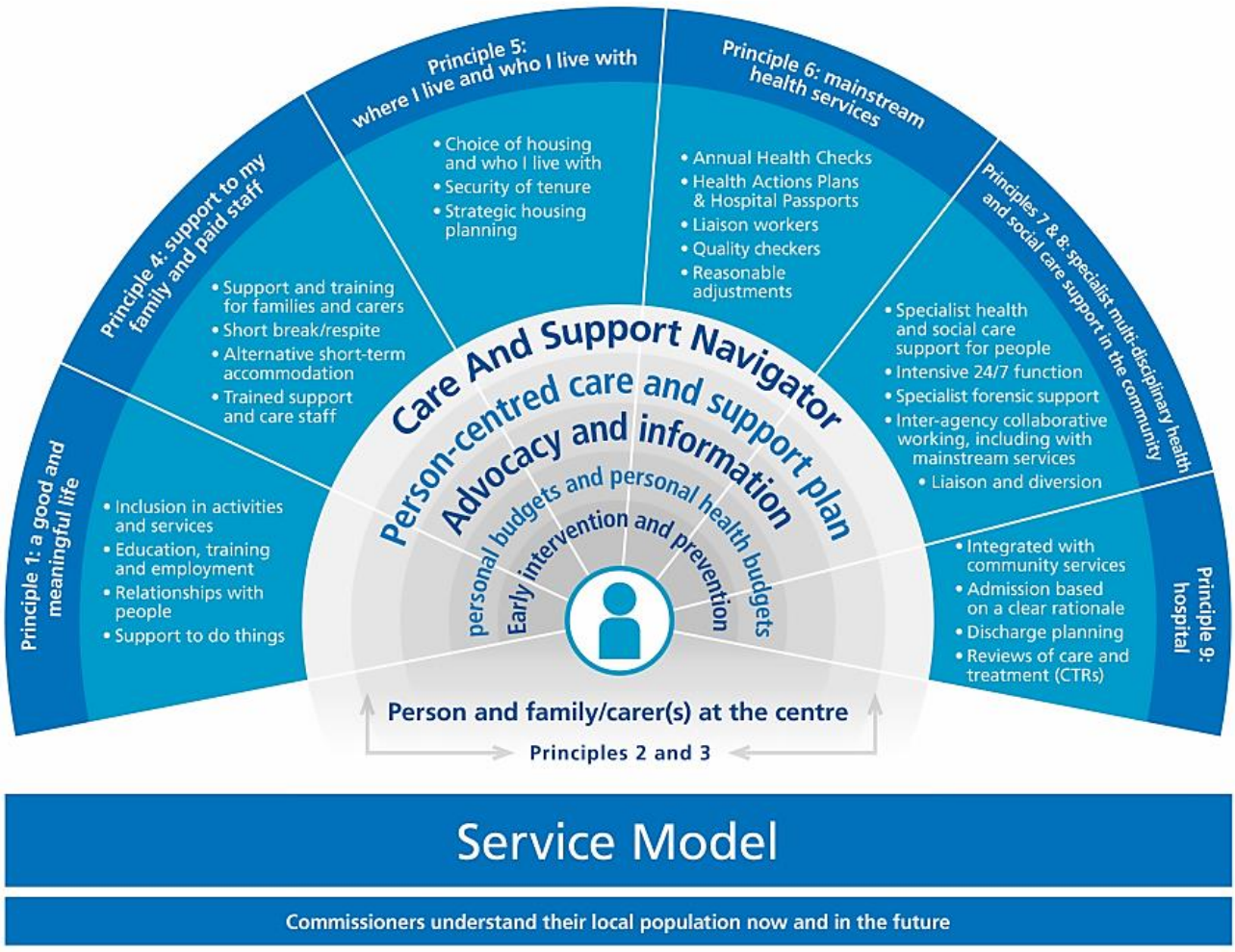
REF	PRINCIPLE	SUMMARY NOTES
		• access to suitable short breaks/respite. In addition: • Alternative short term accommodation should be available to people. • Everyone in receipt of a social care package should have access to paid, and suitably trained and experienced support and care staff. • Local authorities should use Market Position Statements with an explicit focus on people with a learning disability and/or autism, and preferred providers with minimum standards and competencies.
5	**I have choice about where I live and who I live with**	• People should be offered a choice of housing, including small-scale supported living. • Everyone should be offered settled accommodation. • Commissioners should work closely with housing colleagues to ensure future needs of this group are understood, considered, and planned for strategically as part of local housing strategies.
6	**I get good care and support from mainstream health services**	• Everyone with a learning disability over age 14 should be offered an Annual Health Check, have a Health Action Plan, and where appropriate, a Hospital Passport to help mainstream NHS services make reasonable adjustments to meet specific needs and ensure equitable health outcomes. • Everyone should expect NHS services to employ clearly identified and readily accessible healthcare liaison workers with specialist knowledge and skills in working with people with a learning disability and/or autism. • Everyone should expect quality checker schemes and annual audits to be implemented, ensuring mainstream health services serve them appropriately, evaluate delivery and outcomes, and deliver real improvements.
7	**I can access specialist health and social care support in the community**	• Everyone should have ready access to integrated, community-based, specialised multidisciplinary health and social care support for people with a learning disability and/or autism that is responsive to the needs of the individual. • Anyone who required additional support to prevent or manage a crisis should have access to hands-on intensive 24/7 multi-disciplinary health and social care support at home or in other appropriate community

REF	PRINCIPLE	SUMMARY NOTES
		settings. • Interface between specialist routine multi-disciplinary support services and intensive support should be seamless
8	**If I need it, I get support to stay out of trouble**	• People who have/may be at risk of coming into contact with the criminal justice system should have access to the same services aimed at preventing or reducing anti-social or offending behaviour as the rest of the population, and should expect those services to identify and make reasonable adjustments for people with a learning disability and/or autism. • Liaison and diversion schemes, ensuring clear pathways to health and social care services, should support people through the youth/criminal justice system. • People should have access to specialist multidisciplinary health and social care support when (at risk of) coming into contact with the criminal justice system.
9	**If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to**	• Everyone who is admitted to a hospital setting should expect this to be integrated into their broader care and support pathway, and to experience a focus on independence and recovery. • People admitted to hospital on the basis that they present an immediate risk to themselves or those around them should have access to high quality assessment and treatment in non-secure hospital services with the clear goal of returning them to live in their home. • Admission to secure inpatient services should only occur when a patient is assessed as posing a significant risk to others. • Admissions should always be with a clear stated purpose and set of expected outcomes. • For all inpatient provision, secure or not, children admitted to hospital should be placed in an environment suitable for their age and must have access to education. • For adults, provision of single-sex accommodation is essential.

4.9 The nine core principles are summarised in the Service Model diagram shown in Figure 1 below.

5	Overall, the strategic documentation in relation to the English Learning Disability Service Model offers a systematically developed framework underpinned by a strong value base and commitment to standards and quality. In context, this Model is designed for implementation through joint commissioning rather than integrated health and social care service delivery: as such the model reads as a high-level framework for action and accountability.

Figure 1: NHS England Service Model (2015)[5]



[5] Excerpted from: *Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: service model for commissioners of health and social care services* (NHS England et al, 2015) (p.12).

ANNEX D: Key Elements of Regional Models – WALES

The strategic approach of the Welsh government to addressing need in relation to learning disability is underpinned by the *Social Services and Well-being 2013 Bill.* This legislation places statutory responsibility on local government and its partners to develop **outcomes-based services** that **emphasise personal independence** and aim to **prevent or reduce the requirement for targeted services and long term or institutional care.**

The following documents provide the overarching framework for adult learning disability services in the region.

1 Sustainable Social Services for Wales: A Framework for Action (Welsh Government, 2011)

1.1 This overarching strategic framework is proposed as a response to the dual challenges of increasing demand and expectations from service users and carers, and ongoing austerity. It sets an agenda for transformation, change, and modernisation across social services, promoting renewal and innovation in response to these challenges, rather than retrenchment and minimisation. This framework informs and shapes the process and recommendations in the two documents discussed below.

2 Transforming Learning Disability Services in Wales (SSIA & Welsh Government, 2014)

2.1 This report provides information on the programme for transforming learning disability services in Wales, the analytical models used in the programme, and the implications for the future of Learning Disability services in Wales. The programme was developed to help councils and their partner agencies to assess current learning disability provision and practice across Wales and identify a sustainable service model for the future.

2.2 Values and principles: The programme is founded on the values and vision established in historic strategic planning and service development in relation to learning disability in Wales, summarised in Table 1 below.

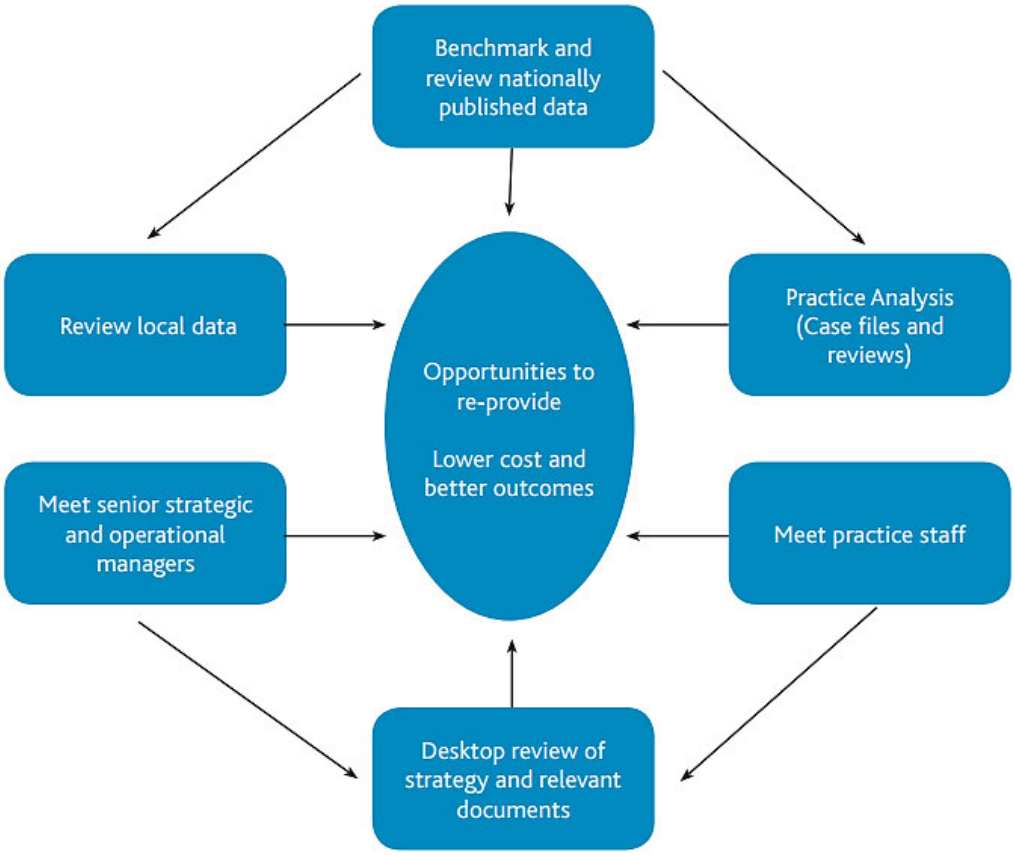
Table 1: Welsh Government: Learning Disability Strategy Values/Principles

REF	VALUE / PRNCIPLE
2001 policy document: 'Fulfilling the Promises' ***People with a learning disability have the same value and status as everyone else, and have equal rights to:***	
1	Good health
2	Good housing
3	Protection from harm
4	Safety and financial security
5	Opportunities to obtain meaningful work
6	Positive roles in their families and communities
7	Opportunities to learn and improve skills
8	Civic rights
2007: Welsh Government Statement on Policy and Practice for Adults with a Learning Disability ***All people with a learning disability are full citizens, equal in status and value to other citizens of the same age. They have the same rights to:***	
9	Live healthy, productive, and independent lives with appropriate and responsive treatment and support to develop their maximum potential
10	Be individuals and decide everyday issues and life-defining mattes for themselves, joining in all decision-making which affects their lives, with appropriate and responsive advice and support where necessary
11	Live their lives within their community, maintaining social and family ties and connections which are important to them
12	Have the support of the communities of which they are a part and access to general and specialist services that are responsive to their individual needs, circumstances, and preferences

2.3 Analytical models adopted in this new programme include:

a) The Opportunity Assessment model is a three-pronged approach to assessing provision based on: existing service data; commissioning and delivering strategies; and current practice using case files and engagement with practitioners. This approach underpins the whole programme, and is shown in Figure 1 below.

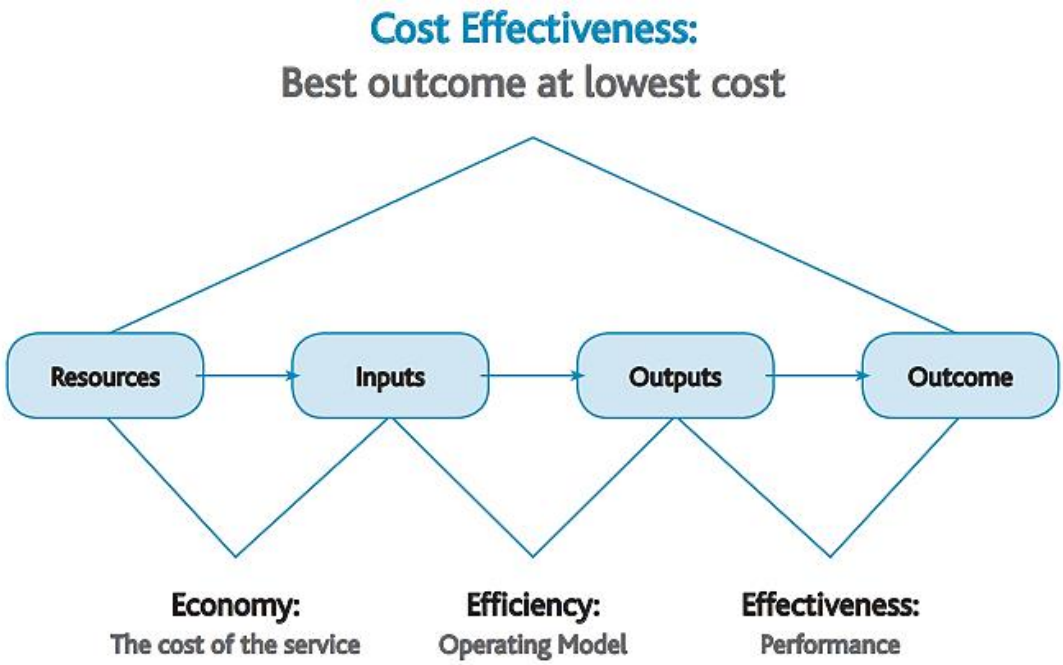
Figure 1: Alder's Opportunity Assessment Approach (SSIA Wales)[6]



[6] Excerpted from: *Transforming Learning Disability in Wales* (SSIA & Welsh Government, 2014) (p. 7)

a) A useful model for conceptualising Cost Effectiveness, shown in Figure 2 below.

Figure 2: Cost Effectiveness Model (SSIA Wales)[7]

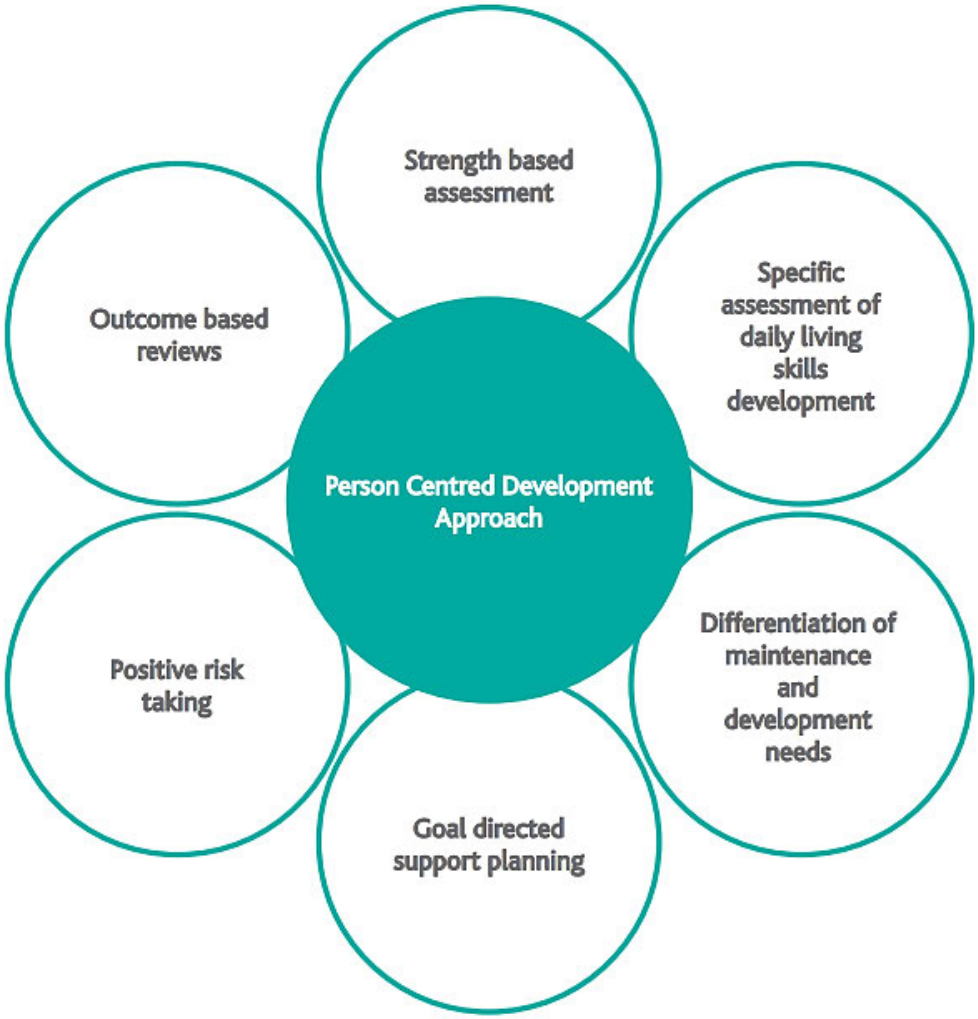


a) The framework proposes a Progression Model, which it describes as a person-centred developmental approach that takes a long-term view of the future accommodation and support needs of the individual, and seeks to help a person realise their aspirations for independence. Crucially, the model assumes that people prefer to be less, rather than mode, dependent, and that most people with a learning disability are able to learn at their own pace. The model also takes account of the fact that people can lose skills, for example through progressive conditions such as dementia

The aim of implementing this approach is to deliver a reduction in costs as independent living skills are gained and the need for/provision of support diminishes. The model is built on six principles, as shown in Figure 3 below.

[7] Excerpted from: *Transforming Learning Disability in Wales* (SSIA & Welsh Government, 2014) (p. 8)

Figure 3: Progression Model: Implications for Practice[8]



2.4 **Recommendations:** The programme recommends embedding the principles of the Progression Model into routine practice, and notes that that future work on the planning, commissioning, and delivery of learning disability services in Wales should take an integrated approach across the NHS and local government. The full list of seven recommendations is shown in Table 2 below.

[8] Excerpted from: *Transforming Learning Disability in Wales* (SSIA & Welsh Government, 2014) (p. 19)

Table 2: Recommendations: *Transforming Learning Disability Services in Wales*

REF	RECOMMENDATION
1	The Progression Model should be adopted as the future model for learning disability services throughout Wales and implementation should be undertaken on a regional basis.
2	Future work should develop on the basis of a genuinely integrated approach, across the NHS and Local Government, to the planning, commissioning, and delivery of learning disability services in Wales.
3	People with a learning disability, their families, carers, and communities, including the voluntary sector, should be engaged in this work at local levels.
4	Further work must be undertaken with Health Boards to ensure joint planning and joint commissioning at a regional level for learning disability services and to better understand the resources, particularly Continuing Health Care funding, that supports people with a learning disability.
5	A new and different conversation and relationship needs to be undertaken with providers of services to ensure they are delivering on new models of support.
6	Managers and staff within local authorities must engage in this change process from the onset and senior management support and commitment is also crucial. Assessment must focus on outcomes and must be reviewed and monitored regularly. This model requires a significant change in approach for staff and so may necessitate additional or different training.
7	Additional short-term capacity may be required to analyse case management information. Implementation of the whole programme may require specialist skills, as well as initial resources, which should be recouped in full implementation.

3 *Learning Disability: Improving Lives Programme* (Welsh Government, 2018)

3.1 This programme links to both the Transforming Learning Disability Services (2014) agenda, and the overarching health and social care strategy, A Healthier Wales (2018).

3.2 The programme aims to identify improvements in five key areas:[9]

- **Early Years:** reducing ACEs and improving the ability of parents with a learning disability to bring up their children.
- **Housing:** new models of supported housing will be developed, helping people to live closer to their friends and families.
- **Social Care:** making sure everyone who needs it has access to good quality care and support which is focused on their needs.
- **Health:** through reasonable adjustments to mainstream services and access to specialist services when needed.
- **Education, Skills and Employment:** supporting young people to make the most of their potential, and when they become adults ensuring they have the right support to allow them to live successful lives, providing targeted careers advice and making sure more people with a learning disability have paid jobs.

3.3 The programme makes detailed recommendations across each of these five areas. These can be summarised into three key priorities:

- **To reduce health inequalities** through adjustments to mainstream services and access to specialist services on need
- **To improve community integration** by increasing housing options closer to home, integrated social care, health and education, and increased employment and skills opportunities
- **To enable improved strategic and operational planning** and access to services through streamlined funding, better data collection, partnership working, more training and awareness

3.4 A Learning Disability Ministerial Advisory Group has been established by the Government to support the programme implementation, including people with a learning disability, families, carers, local authorities, the health sector, and charities.

[9] See: https://gov.wales/newsroom/health-and-social-services/2018/learning-disability/?lang=en

4	**Overall, the Welsh learning disability service model offers a streamlined, value-oriented framework underpinned by clearly defined processes.** **Notably, the model and service improvement recommendations place particular emphasis on communication, effective working relationships at all levels across the system, and staff training, development, and support. The emphasis of these 'softer' skills/elements within the programme of change is distinctive.**

ANNEX E: Key Elements of Regional Models – SCOTLAND

The overarching strategic statement and policy direction for learning disability services in Scotland is *The Keys to Life* (2013) document discussed below.

While an initial impression of the document may be that it is very detailed and lengthy, closer reading reveals a comprehensive and considered approach to every aspect of the lives of people with learning disabilities, centred on developing an improved understanding of maximising quality of life. The strategy is notable among all of the four nations' policy statements for both:

- The **depth and breadth of the consideration of issues relevant to people with a learning disability** across the lifespan; and
- The **resources made available to the public** to understand and access the document, in particular via the **dedicated website**: https://keystolife.info/

1 *The Keys to Life: Improving quality of life for people with learning disabilities* (Scottish Government, 2013)

1.1 The strategy focuses on tackling health inequalities for people with a learning disability, addressing the poor health and early mortality characteristic of this population. This focus is reflective of a broader focus on tackling the equality gap across other Scottish policy areas.

1.2 In keeping with the NHS England and Welsh Government core values, the Scottish strategy is underpinned by rights-based principles as shown in Table 1 below.

Table 1: Scottish Government: Learning Disability Strategy Values/Principles

REF	VALUE / PRINCIPLE
1	Everyone – including people with learning disabilities – should be able to contribute to a fairer Scotland where we tackle inequalities and people are supported to flourish and succeed.
2	People with learning disabilities should be treated with dignity, respect and understanding. They should be able to play a full part in their communities and live independent lives free from bullying, fear and harassment.

1.3 The delivery approach is founded on a well-defined landscape of relationships and functions which the strategy describes as a whole system, whole population, whole person approach. This is outlined in Table 2 below.

Table 2: Scottish Government: The 'whole system, whole population, whole person approach' [10]

REF	COMPONENT	DESCRIPTION
1	**Whole System**	Incorporating local and national government, the third and private sectors – and going beyond 'traditional' boundaries of learning disability activity and services (see (5) below).
2	**Whole Population**	Incorporating the whole life journey from childhood to older age.
3	**Whole Person**	Considering the whole person, recognising the capabilities and talents of people with learning disabilities as well as the challenges they face. Understanding how important relationships and communication are for the wellbeing of people with learning disabilities, both personal and professional.
4	**A Rights Based Approach**	Recognising the human rights of people with a learning disability, reflecting the UN Convention on the Rights of Persons with Disabilities and the Scottish National Action Plan on Human Rights (SNAP) commitment to Participation, Accountability, Non-discrimination, Empowerment and Legality (the PANEL approach).
5	**A Fairer Scotland**	Aligned to the Scottish Government's National Performance Framework, *A Fairer Scotland Action Plan* (2016),[11] which commits to building a society that treats all people with kindness, dignity, and compassion.

[10] Excerpted from https://keystolife.info/strategy/our-approach/
[11] See: https://www.gov.scot/publications/fairer-scotland-action-plan/

6	**Collaboration**	Working with key strategic and delivery partners across the third, public, and private sectors, including in particular: **a) The Scottish Commission for Learning Disability**, which "aims to be a knowledge hub offering support, information and new ideas about learning disability in Scotland" (https://www.scld.org.uk/). Its activities include: *promoting engagement and dialogue* (with people with learning disabilities and carers, and professionals, policy officials and service providers); *leading innovation and collaboration* (in service design and delivery, and practice, support, and advocacy); and *building and disseminating evidence* (about lived experiences of people with learning disabilities, and what works to drive better outcomes). **b) The Scottish Learning Disabilities Observatory**, based in the University of Glasgow (https://www.sldo.ac.uk/), which aims to provide better information about the health and health care of people with learning disabilities and autism in Scotland, and to inform actions, practice, and policy to benefit these populations.

1.4 Tables 3 and 4 below outline the key Strategic Outcomes and Ambitions of the strategy.

Table 3: Scottish Government: The Keys to Life – Strategic Outcomes

REF	OUTCOME	DETAIL
1	**A Healthy Life**	People with learning disabilities enjoy the highest attainable standard of living, health and family life.
2	**Choice and Control**	People with learning disabilities are treated with dignity and respect, and protected from neglect, exploitation and abuse.
3	**Independence**	People with learning disabilities are able to live independently in the community with equal access to all aspects of society.
4	**Active Citizenship**	People with learning disabilities are able to participate in all aspects of community and society.

Table 4: Scottish Government: *The Keys to Life* – Strategic Ambitions [aligned to *A Fairer Scotland Action Plan* (2016)[12]]

REF	AMBITION
	OVERARCHING AMBITION: ***Disabled people can participate as active citizens in all aspects of daily and public life***
1	Support services that promote independent living, meet needs and work together to enable a life of choices, opportunities and participation.
2	Health and social care support services are designed to meet - and do meet - the individual needs and outcomes of disabled people.
3	Decent incomes and fairer working lives.
4	Making sure disabled people can enjoy full participation with an adequate income to participate in learning, in education, voluntary work or paid employment and retirement.
5	Places that are accessible to everyone.
6	Housing and transport and the wider environment are fully accessible to enable disabled people to participate as full and equal citizens.
7	Protected rights.
8	The rights of disabled people are fully protected and they receive fair treatment from justice systems at all times.
9	Active participation.

1.5 The structure of the strategy document reflects its comprehensive scope.

Table 5 below provides a summary overview of its key sections: this information could function almost as a checklist of relevant issues and concerns to be taken into account by health and social care services across the individual's lifespan, in line with the strategic values, outcomes, and ambitions outlined above.

On the basis of the information considered in each section, the document includes 52 detailed recommendations that span the ten sections/themes.

[12] See: https://www.gov.scot/publications/fairer-scotland-action-plan/

Table 5: Scottish Government: The Keys to Life – Information Covered in the Strategy

REF	SECTION	KEY SUB SECTIONS
1	**Human Rights**	*"…whatever the individual circumstances of people's lives, including age, gender, ethnicity, disability, religion, sexual orientation, mental health, economic or other circumstances, they should have access to the right health services for their needs."*
2	**Definitions and Numbers**	• Review of current data – who are the people with learning disabilities?
3	**Commissioning of Public Services**	• Joint Commissioning, Integration of Adult Health and Social Care and Commissioning • Care for Older People • Self-Directed Support

4	**Health**	• Scottish Learning Disability Observatory (see Table 9)
		• Health Inequalities
		• Healthy Lifestyles – prevention and self help
		  ○ Diet, obesity, weight management, exercise, smoking, drinking
		• Good quality general health support in the community
		• Health in Hospital
		  ○ Avoidable hospital admissions
		  ○ Use of A&E
		  ○ Dementia, Palliative Care
		  ○ Bereavement and Loss

5	**Independent Living**	• Mitigating the effects of UK Welfare Reform • Day Opportunities • Housing, Supported Living, Adaptations, Travel/Transport • Advocacy

6	**Shift the Culture and Keeping Safe**	• Relationships
		  ○ Building resilience
		  ○ Friends and partners, Family carers, Paid carers
		  ○ Parents with learning disabilities
		• Protecting children, young people, adults
		  ○ Early intervention for improved outcomes
		  ○ Legislation
		  ○ Guardianship
		  ○ Abuse

7	**Break the Stereotypes**	• Education • Transitions • Further or Higher Education

REF	SECTION	KEY SUB SECTIONS
		• Employment and Volunteering

8	**People with Profound and Multiple Learning Disabilities (PMLD)**	• Healthcare issues for people with PMLD
		  ○ Invasive Procedures, Annual Health Checks, Oral Healthcare
		• Transitions for people with PMLD
		  ○ Child to adult services
		  ○ Family home to supported living
		• Meaningful activities for people with PMLD
		  ○ Further and continuing education
		  ○ Day opportunities
		  ○ Changing Places toilets
		• Bereavement and loss for people with PMLD

9	**Criminal Justice**	• Criminal Justice Services • Victims and Witnesses • Being Accused or Suspected of Committing a Crime • Legislation • Young People • Prison Health
10	**Complex Care**	• Autism Spectrum Disorder • Mental Health • Delayed Discharge • Out of area placements

1.6 Strategic Commissioning:

The strategy draws on the Institute of Public Care (IPC) Joint Commissioning Model[13] to describe strategic commissioning as "all the activities involves in assessing and forecasting needs, linking investments to agreed desired outcomes, considering options, planning the nature, range and quality of future services, and working in partnership to put these in place;" 'joint commissioning' is "where these actions are undertaken by two or more agencies working together, typically health and local government, and often from a pooled or aligned budget."

[13] This model has also been recommended to the Welsh Government as a good practice model for planning and commissioning care for people with a learning disability – see: https://ipc.brookes.ac.uk/publications/LD_Commissioning__Guidance.html

While health and social care are integrated in Northern Ireland, this model offers a structured framework for considering the process that applies to commissioning and monitoring services.

The model is shown in Figure 1 below.

Figure 1: Institute of Public Care Joint Commissioning Model[14]

1.7 The strategy recommends 10 strategic outcomes to guide joint commissioning in practice. These outcomes relate to statutory bodies' legal obligations and wider national policy priorities. They are summarised in the document as shown in Table 6 below.

[14] Excerpted from *The Keys to Life* (2013) and available here: https://services.salford.gov.uk/solar_documents/nsc2103114.2.doc

These strategic outcomes correlate broadly with the NHS England Service Model Core Principles outlined in Annex 1, Table 4 above.

Table 6: Scottish Government: Joint Commissioning Strategic Outcomes

REF	OUTCOME
1	People have choice and control in their daily lives and are supported to live as independently as they can
2	People enjoy the best possible emotional health and wellbeing
3	People have good things to do that help them achieve their full potential
4	Carers are supported
5	People are safe, respected, and included in their communities
6	People are involved in the planning, development, design and delivery of services that help them to achieve the outcomes they want
7	People are satisfied with their experience of health and social care services
8	Statutory bodies fulfil their statutory legal responsibilities, adhere to meeting quality standards, services are safe and continually improving
9	People working in services are positive about their role
10	Services are efficient and responsive to local people's needs

2 **Overall, the Scottish learning disability service model offers an accessible framework for action that is readily understood by a lay person, and firmly grounded in the day-to-day life, challenges, and opportunities facing people with a learning disability.**

This grounded approach embodies the underlying value base and mission of the strategy i.e. to improve the *quality of life* for people with learning disabilities.

The model is also notable for the synergy it highlights between national outcomes for the population as a whole, and the specific objectives and outcomes it projects for people with learning disabilities.

Draft "We Matter" Plan on a Page

What we'll do

Our Vision:
"As an adult with a learning disability I will be respected and empowered to lead a full and healthy life in my community. I will be supported to make choices and decisions in my life that enables me to develop, and live a safe, active and valued life"

Our Ambition Statements:
AS1- I am prepared and supported through important changes in my life
AS2 – I can live a happy and healthy life
AS3- My carers are supported to help me live my best life
AS4 – I live in a society that respects my right to work, learn and enjoy my life
AS5 – I am supported to live in my home
AS6 – I will have access to high quality. Compassionate, assessment and treatment services, when required

Preoccupations:
Address the growing demand for services and ensures individuals get access to services based on their assessed needs
Support recruitment and retention of staff
Integrating services and supporting joint working across Departments
Securing investment is critical to deliver the Model

Priorities:

To be determined by PSG and MHLDIB

How we'll do it

- We will establish a lifespan Learning Disability Group and associated infrastructure to ensure delivery of "We Matter"
- We will improve the knowledge, competence confidence and capacity of professionals responding to the needs of individuals through investment and support to undertake relevant and accredited training
- We will strengthen our information systems to consistently gather data in relation to demand, need, activity and outcomes which is published.
- We will improve the arrangements and experience for young people transitioning to Adult Learning Disability Services
- We will secure recurrent investment in Adult Learning Disability Services
- We will develop services which are co-produced with individuals with learning disabilities and their families and professionals across sectors and delivered as locally as possible
- We will explore and embed innovative ways to transform the way we work
- We will adopt an integrated service approach and establish links across health, social care, education and further education services, to improve access and service quality recognising that individuals will present with a range of difficulties and co-morbidities

How we'll know if we've made a difference

Agreed Outcomes as per "We Matter" to be included after PSG meeting on 21-10-20

Three behaviours that underpin everything – PSG to consider

A collaborative, partnership approach will be adopted in all aspects of service provision – development, design and delivery.	Service development and professional practice is evidenced based and informed.	A proactive approach is adopted towards prevention and early intervention.

7. APPENDICES

Appendix 1 – Ideas for Transforming the Way We Work - Implementation Phase

Appendix 2 – Legislation Background

Appendix 3 – Prevalence

Appendix 4 - Inequalities

Appendix 5 – Project Steering Group Reporting Structure

Appendix 6 – Key Challenges To Deliver 'We Matter' Ambitions

Appendix 7 – Pathway of Care Example, 'Transitions from Children's Disability Services to Adult Learning Disability Services'

Appendix 8 - Proposed Reporting Arrangements for "We Matter"

APPENDIX 1

Ideas for Transforming the Way We Work - Implementation Phase

Consideration to be given to a Learning Disability System's Leader/Champion for Adults and Children who would have oversight of all government departments with a specific brief in relation to Learning Disability. The role should be a non-political office endorsed with cross party support e.g. via the All Party Group on Learning Disability. The Systems Leader will provide oversight of all government departments and promote values within the model wider society, to ensure that the rights of individuals with a Learning disability are upheld, promoted and key performance targets are met per area of need. The Champion will seek to promote, encourage, and maintain high standards and good practices in the delivery of learning disability services and to protect the interests of individuals. This role is primarily to enable the cross linkages and achieve the aspirations of Programme for Government.

Consideration will be given to the setting up of a Learning Disability Network/Observatory to support information sharing, ongoing co-production of services, and research opportunities. Carers and individuals with learning disabilities have been clear and consistent during this engagement in their request to be involved in the decision making process, for their voices to be heard and for more information made available to help inform choices. Co-production recognises the importance of partnership working for service design. Other jurisdictions have responded to these requests by developing effective networks between carers, users, commissioners and community agencies, such as the Centre of Excellence, Scotland These partnerships play an essential role in:

- Contributing to government policies
- Involvement in high quality research both nationally and internationally
- Delivering local training
- Evaluating local implementation of key policy documents
- Promoting greater awareness of learning disability in society

Components of Centre for Excellence

- Inclusive, ongoing network linking research to service delivery.
- to support information sharing, ongoing coproduction of service, and research network

- A formal partnership approach adopted with experts drawn from all stakeholders to inform future planning of services from strategic and government level to local implementation as has already been established in other jurisdictions
- Centre of Excellence developed with key stakeholders to build on evidence base and increase accountability for govt policies and learning and development framework.
- Training, and Knowledge Exchange Partnership for staff (HSC / non HSC staff) and family carers See like dementia center in Scotland.
- Central register/database - Informatics linked with future planning / creation of minimum dataset

The key components of the Learning Disability Network/Observatory will be explored further in the Implementation phase.

Consideration will be given to the feasibility of a regional register/database. A national database of individuals is an essential means of informing future planning and targeting resources. Recent advances in technology and examples of how this is being used successfully in other countries such as Ireland and Scotland adds evidence to the debate. The development of a national database for N. Ireland would provide us with information on prevalence and forecast potential numbers of those requiring services in the future (McConkey and Craig, 2015). We can use this to predict local needs in terms of housing; specialist services to allocate can be equitable resources. The dataset would allow us to measure outcomes on new system initiatives such as suggested within this model and although not immediate, is a sustainable way to evidence outcomes longitudinally. The key components of the Learning Disability Database will be explored further in the Implementation phase.

Many of the indicators that will be set out in the Strategic Delivery Plan (SDP) will likely come from existing data sources. Where there are gaps we will design a standardised Minimum Data Set and associated Informatics Framework to support the collection of data to deliver the Model.

There is a need to develop a Training & Development Framework which incorporates the vision of Health & social care staff training and learning at all levels and includes shared training and development for all providing support and services for an individual with a learning disability including:

- Health & social care staff;
- Service providers;
- Public services;
- General public;
- Carers & families; and
- Individuals with a learning disability.

There is a need for a qualified, competent and confident workforce and support network to support people with learning disabilities and it is crucial to develop an infrastructure to support this. The use of information technology would enable wide reaching opportunities to explore and learn through digital resources alongside face to face and group training. The development and implementation of a Regional Shared Knowledge Network alongside traditional training opportunities could provide a learning platform (Learning zone) to facilitate this idea.

Development of standardised reporting documentation and systems similar to those embedded in mental health services through the You in Mind project, in readiness for one system for NI, delivered through Encompass.

Consideration to be given to the establishment of a Peoples Parliament as a forum to enable individuals with a learning disability to be meaningfully involved in decision making with regard to the planning, design and delivery of health and social care services (and beyond) ultimately to improve quality, safety and to reduce health and social inequalities. Active participation in decision making in all aspects of daily and public life concerns citizenship, enabling a person with a learning disability to play a full part in the community in which they live. It is a cornerstone of a human rights based approach to service planning, design and delivery and aligns completely with

the goal of person centred services where the individual with a learning disability has a voice and is heard.

There is a need for linked up consistent messaging and branding, both to support individuals as well as to raise awareness and the stature of individuals with a learning disability in society. A Regional website is the vehicle for more information on services, policies and legislation that impact on individuals with learning disabilities and their families/carers, and the opportunity to use technology in a different way to connect with others when leaving the home can be challenging due to caring commitments. An interactive website should be developed for N. Ireland that shares, receives information and provides a forum for open debate. The website should also contain updates during the implementation of the Service Model, minutes of public meetings as well as information relevant to adults with learning disabilities and carers. This could fall under the remit of centre of excellence.

Information Resources/Guide should be designed and set out clearly the menu of services available in a way that is inviting for individuals and their families to engage, enabling easier navigation and consent.

APPENDIX 2

Legislation Background

"We Matter" does not attempt to review or comment on legislation. Key developments in international, European, UK, and Northern Ireland law have been examined and discussed at length as part of the Bamford Review of Mental Health and Learning Disability (Northern Ireland) an independent review of mental health and learning disability law, policy, and service provision that was initiated in 2002 and reported in 2007. Its portfolio of publications includes, among others, reports titled *A Comprehensive Legislative Framework* (DHSSPS, 2007a) and *Human Rights and Equality of Opportunity* (DHSSPS, 2007b).

Current legislation requiring reasonable adjustments to be made to mainstream services are contained within section 75 of the Northern Ireland Act 1998, the Good Friday Agreement and other pieces of equality legislation but not one central piece of legislation. This differs from the approach taken in England which uses the Equality Act (2010) as a single framework which merges legislation on anti-discrimination and equalities. The Equality Act (2010) places a legal duty on all service providers to take steps and make further *"reasonable adjustments"* in addition to existing adjustments described within Disability Discrimination Act 1995.

A key action of the Bamford Review was the incorporation of mental health and mental capacity law into a single piece of legislation. This has been achieved under the Mental Capacity Act (Northern Ireland) 2016 and a Deprivation of Liberty Code of Practice (2019) for professionals.

A succinct overview of relevant legislation and official statements pre-dating the Mental Capacity Act (Northern Ireland) 2016 is included in the Bamford report: *Promoting the Social Inclusion of People with a Mental Health Problem or a Learning Disability* (DHSSPS, 2007c) (pp.6-9). This includes discussion of the following:

- Mental Health Declaration for Europe (2005)
- Human Rights Act (1998)
- The Madrid Declaration (2002)
- UN Convention on the Rights of Persons with Disabilities (2006)
- Disability Discrimination (Northern Ireland) Order 2006
- Northern Ireland Act 1998 – Section 75

With particular reference to transitions, or Life Changes as we describe it in the Model, statutory agencies have also specific duties to promote the welfare of children and young people with disabilities, through a number of different pieces of legislation. It is universally agreed that there is a great need for better coordination of supports and services for children and young people with disabilities and their families. Relevant legislation includes:

- UN Convention on the Rights of the Child (1989) – Article 4 requiring Governments to take all appropriate legal, administrative and other measures to implement children's rights
- UN Convention on the Rights of Persons with Disabilities (2006) – ensure that individuals with disabilities are treated equally
- Children Order (NI) 1995 – Article 17a child shall be taken to be in need if he/she is disabled
- Children's Services Co-operation Act (2015) – requires the NI Executive to promote co-operation across relevant bodies and to adopt a strategy to improve the wellbeing of all children and young people
- Special Educational Needs and Disability Act (NI) 2016 – provides for increased co-operation between Education Authority and HSC Services to provide services they have identified to be of benefit to address a child's special educational need (SEN).

Recommendations set out in the NI Executive's Children's Strategy 2019-29, led by the Department of Education (DE), will dovetail into the lifespan approach for children and young people with a learning disability. Outcome measures and key actions relating to Life Changes, transitions from Children's Services to Adult

Learning Disability Services will be monitored by the Learning Disability Transformation Taskforce (LDTT) and through the Children's Strategy reporting arrangements. Key stakeholders from Children's Services and other Government Departments will be represented on the Learning Disability Transformation Taskforce (LDTT).

Safeguarding

Safeguarding means protecting vulnerable adults from abuse or neglect and putting systems in place to prevent abuse or neglect from happening. As a society and those working in health and social care services, we are responsible for any individual who has needs for care and support, is experiencing or is at risk of abuse or neglect. HSC services have a duty of care to individuals with learning disabilities in this regard.

The essence of the Mental Capacity Act promotes individuals' rights; and challenges potential assumptions around choice and control. Principle Four considers that a person can make an unwise decision; this societal perspective which extends to most members of the public has not always been extended to individuals with a learning disability, the right or dignity of risk, challenging the parameters of choice and control. Whilst an outcome may be unwise that does not preclude the Trust or others from a duty to care and risk manage a person's safeguarding needs.

Building on the current models of advocacy already in operation, the development of other forms of advocacy should form part of the Model to ensure that advocacy permeates throughout all areas of planning, practice and approaches; locally and regionally, providing a preventative and protective impact, and support implementation of the Mental Capacity Act.

The role and development of advocacy, set out for example, in the Scottish model, Keys to Life (2016) indicates that numerous forms of advocacy exist and could be developed to improve representation, choice and control to individuals. Individuals engaged during the project were seeking to be included in decision making and being informed especially when seeking or receiving medical care and advice. A

future model should explore methods of providing advocacy and review current methods of investment and / funding source

APPENDIX 3

Prevalence

According to Mencap (2016-17), there are approximately 1.4 million individuals with a learning disability in the UK, of which approximately 1,119,000 are adults, or 2.16% of the adult population. The prevalence of learning disability among children across the UK is believed to be slightly higher, at 2.5% of the child population as a whole: it may be anticipated therefore that a slight rise in learning disability prevalence among adults may be anticipated in the future.

Taking into account the caveats highlighted at point 2.1 above, Table 1 shows the estimated numbers of adults with a Learning Disability across the UK.

Table 1: Adults with a Learning Disability in the UK – Estimated Numbers

REGION	ESTIMATED NUMBERS
England	Estimations range from **930,400** (Public Health England, 2016) to **939,338** (Mencap, 2016-17)
Wales	Estimations range from **11,410** (Statistics for Wales, 2018) to **53,681** (Mencap, 2016-17) - **60,000** (Welsh Government, 2018)
Scotland	Estimations range from **23,446** (National Statistics Scotland, 2018) to **26,786** (ENABLE Scotland, n.d.)
Northern Ireland	Estimations range from **7,198** (McConkey, 2013) to **30,814** (Mencap, 2016-17) (All Party Group on Learning Disability, 2018)

Learning Disability in Northern Ireland

As noted above, the estimated numbers of people, and specifically adults, with a learning disability in Northern Ireland vary according to the source and definitions employed. In 2009, the DHSSPS noted that up to 2% of the population may have a learning disability, with half of those falling into the 0-10 age group (DHSSPS, 2009: 15). This finding correlates with the most recent Northern Ireland Census (2011), which revealed that, at that time, around 2% of the population or around 40,000 people (including children, young people, and adults) may have a learning disability.

HSC Trust Health Care Facilitators (HCF) noted anecdotally there may be a number of individuals attending yearly Health Checks with a GP and Health Care Facilitators (HCF) that may have a diagnosis of learning disability but decline further services, and others that decline diagnostic assessment.

The Northern Ireland Assembly Research and Information Service (2017) has noted that funding for learning disability services and support is lower in Northern Ireland than any other region of the UK, “with only 6% of the total Health and Social Care spending being allocated to learning disability in 2016”, and “although overall spending on learning disability in Northern Ireland increased by 15% between 2010 and 2015, the number of people here with learning disabilities also continues to rise, and it has been highlighted that current one year commissioning is too short to plan long-term strategies for this group.”

Additional funding should be made available to offset the inherent inequalities and disadvantages (e.g. premature deaths and differential health outcomes compared to the general public), allowing services to be targeted and reasonable adjustments made to deliver health improvements; as described within the Marmot Review (2010). The author introduces the concept of “proportionate universalism”, which means that whilst the health service is free to all, it is not used or accessible in an equitable manner just because the door is open, hence the need increased funding for adults with a learning disability.

Care and Carers

The Northern Ireland Assembly Research and Information Service (2017) has also noted that “Informal carers provide much needed health and social care support to those with learning disabilities.” Citing research conducted by Carers UK and the University of Sheffield in 2015, the Service observes there are around “220,500 informal (unpaid) carers in Northern Ireland providing support worth an estimated £4.6 billion per year (around the same as the entire Northern Ireland health budget).

Around 9% of these provide care for 'someone with a learning disability' with many carers in poor health themselves."

Inequalities

Research has shown that individuals with a learning disability in Northern Ireland are a vulnerable group who experience particular health inequalities (Black, 2013). This finding is supported by wider current research and practice in relation to applying a social determinants approach to improving the lives and health outcomes of people with learning disabilities – i.e. understanding and improving the conditions in which people are born, live, and work (Rickard & Donkin, 2018).

This research reveals that, in both Northern Ireland (see: All Party Group on Learning Disability, 2018) and elsewhere (see: Rickard & Donkin, 2018), individuals with a learning disability are more likely than the general population to:

- Grow up in poverty and poor environments, which can limit the ability and freedom to pursue healthy options, be socially included, and/or afford decent housing.
- Can have difficulty forming close relationships in their early years, which can lead to behavioural and mental health problems.
- Have poor educational attainment.
- Experience social isolation and loneliness.
- Experience mental health difficulties.
- Have poor physical health.
- Have a shorter life expectancy: individuals with a learning disability die on average, 15 to 20 years sooner than their peers.

Additional issues pertinent to the lives of individuals with a learning disability in Northern Ireland include:

- **Accommodation:** Around 60% of adults with a learning disability in Northern Ireland live with family carers, while the remainder live in long stay hospitals, residential homes, or supported living schemes. A small

number live independently by themselves. . The RQIA Review of Adult Learning Disability Community Services Phase II (2016) noted a level of approximately 70 % living alone or with family, with numbers fluctuating from 65% to 76% depending on each Trust.

- **Access to employment***:* Only one in ten adults with a learning disability in Northern Ireland is in paid employment. . However there is an important qualification to add. By way of example, according to a report titled "Mapping the Employability Landscape for People with Learning Disabilities in Scotland" identifies employability of learning disability at 7% and 10% in England and Scotland. To qualify these statistics that employment is an umbrella term and does not relate solely to employment in open employment; many are employed within the context of supported employment and that does not mean fulltime either e.g for example: 65%-70% are working less than 16 hours per week. By type of employment 49% were in open employment, 29% were in non-open or sheltered employment and 21% were in employment but not known if open or non-open. This is significant because unemployment has been associated with increased premature mortality and poor mental and physical health as well as increased poverty and associated health impacts.

- **Exclusion and discrimination**: Many people with a learning disability still face discrimination, marginalisation, and barriers to opportunities, which impact negatively on social integration, ability to work, and mental health.

- **Legislation:** Current legislation protecting requiring reasonable adjustment are contained within section 75 of the Northern Ireland Act 1998, the Good Friday Agreement and other pieces of equality legislation but not one central piece of legislation. However within Great Britain stronger legislation has been passed i.e.: the Equality Act 2010, which is a single framework for that brings together all of the antidiscrimination and equality law which applies to both public and private sectors. The Model should consider at least to seek parity with Great Britain or explore

stronger legislation via our own legislative assembly. The Equality Act 2010 places a legal duty on all service providers to take steps and make further *"reasonable adjustments",* in addition to existing adjustments described within Disability Discrimination Act 1995.

- **Access to health and social care**: Research has found that individuals with a learning disability make far less use of their GP than the general population, due to a variety of reasons including, for example, communication difficulties and access issues. Since GPs act as the gatekeepers to the healthcare system and are usually the first point of contact, this trend of low uptake of GP services by individuals with a learning disability can lead to delays in diagnosis and treatment in relation to the full range of physical and mental health and wellbeing needs.
  (see: Black, 2013 – need full Ref)

UK Population Profile:

According to the Scottish Government, 2013 *People with Learning Disabilities in Scotland: 2017 Health Needs Assessment Update Report, w*hile life expectancy is increasing individuals with a learning disability innately it remains shorter by approximately **20 years** when compared to the general population and is shorter for individuals with severe learning disabilities.

The Learning Disability Mortality Review (LeDeR) Annual Report (2018) data suggests a disparity in the age at death for people with learning disabilities (aged 4 years and over) and the general population (all ages) to be 23 years for males and 27 years for females. A person with a learning disability's life expectancy is averaging 70 years of age, with a projected 164% increase in the number of people with learning disabilities aged 80 and over using social care services by 2030 (Emerson & Hatton, 2011). Due to the earlier onset of dementia often experienced by those who also have a learning disability, particularly with Down's Syndrome, the need for services can be required at an earlier age than the majority of the population.

This growing population of older people with learning disability and additional conditions related to ageing brings about new challenges for health professionals and care services.

Individuals with a learning disability have high rates of mental health comorbidity (Deb et al, 2001). Epidemiological studies have suggested a prevalence rate of 31–41% (Cooper et al, 2007; Morgan et al, 2008). For those who are treated within hospital settings, (RCPsych, 2013) mental health co-morbidity ranges from 50- 84%. This is in addition to other comorbid conditions such as autism spectrum disorders, attention-deficit hyperactivity disorder, personality disorders and substance misuse.

For individuals treated within or referred to forensic (i.e. Secure) hospital services for those with learning disability, similarly high figures are reported. Up to half have a personality disorder, up to a third have an autism spectrum disorder, about a third to half have a major mental illness, about a third to half have substance misuse/dependence and about a fifth have epilepsy (Alexander et al, 2002, 2006; Plant et al, 2011). For those people with a learning disability who come into contact with specialist learning disability services, their clinical presentations are often a complex mix of learning disability, mental illnesses, other developmental disorders, personality disorders, substance misuse, and physical disorders including epilepsy.

APPENDIX 4

Inequalities

Many individuals with a learning disability still face discrimination, marginalisation, and barriers to opportunities, which impact negatively on social integration, ability to work, and mental health.

Health Inequalities

According to the Scottish Government, *w*hile life expectancy is increasing individuals with a learning disability remains innately it remains shorter by approximately 20 years when compared to the general population and is shorter for individuals with severe learning disabilities.

The Learning Disability Mortality Review Annual Report (2018) data also suggests a disparity in the age at death for people with learning disabilities (aged 4 years and over) and the general population (all ages) to be 23 years for males and 27 years for females. A person with a learning disability's life expectancy is averaging 70 years of age, with a projected 164% increase in the number of people with learning disabilities aged 80 and over using social care services by 2030 (Emerson & Hatton, 2011).

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For individuals treated within or referred to forensic (i.e.Secure) hospital services for those with learning disability, similarly high figures are reported. Up to half have a personality disorder, up to a third have an autism spectrum disorder, about a third to half have a major mental illness, about a third to half have substance misuse/dependence and about a fifth have epilepsy (Alexander et al, 2002, 2006; Plant et al, 2011).

For individuals with a learning disability who come into contact with specialist learning disability services, their clinical presentations are often a complex mix of learning disability, mental illnesses, other developmental disorders, personality disorders, substance misuse, and physical disorders including epilepsy

The provision of services to meet the needs of people with mental disorder and/or learning disability who are, or are likely to be, in contact with the criminal justice system requires a co-ordinated multi agency approach. In 2018 the HSCB developed a Forensic Managed Care Network (FMCN) for mental health and intellectual developmental disability. Its infrastructure is made up of a high level Advisory Board and three specific sub groups to take forward the priority areas of work for forensic services. It is important that the FMCN and the six Ambitions set out in the Model provide an integrated approach for people with forensic learning disability across community and inpatient services to ensure that their needs and supports are met. Services will need to work, collaboratively on a multidisciplinary and interagency basis, across community and inpatient services.

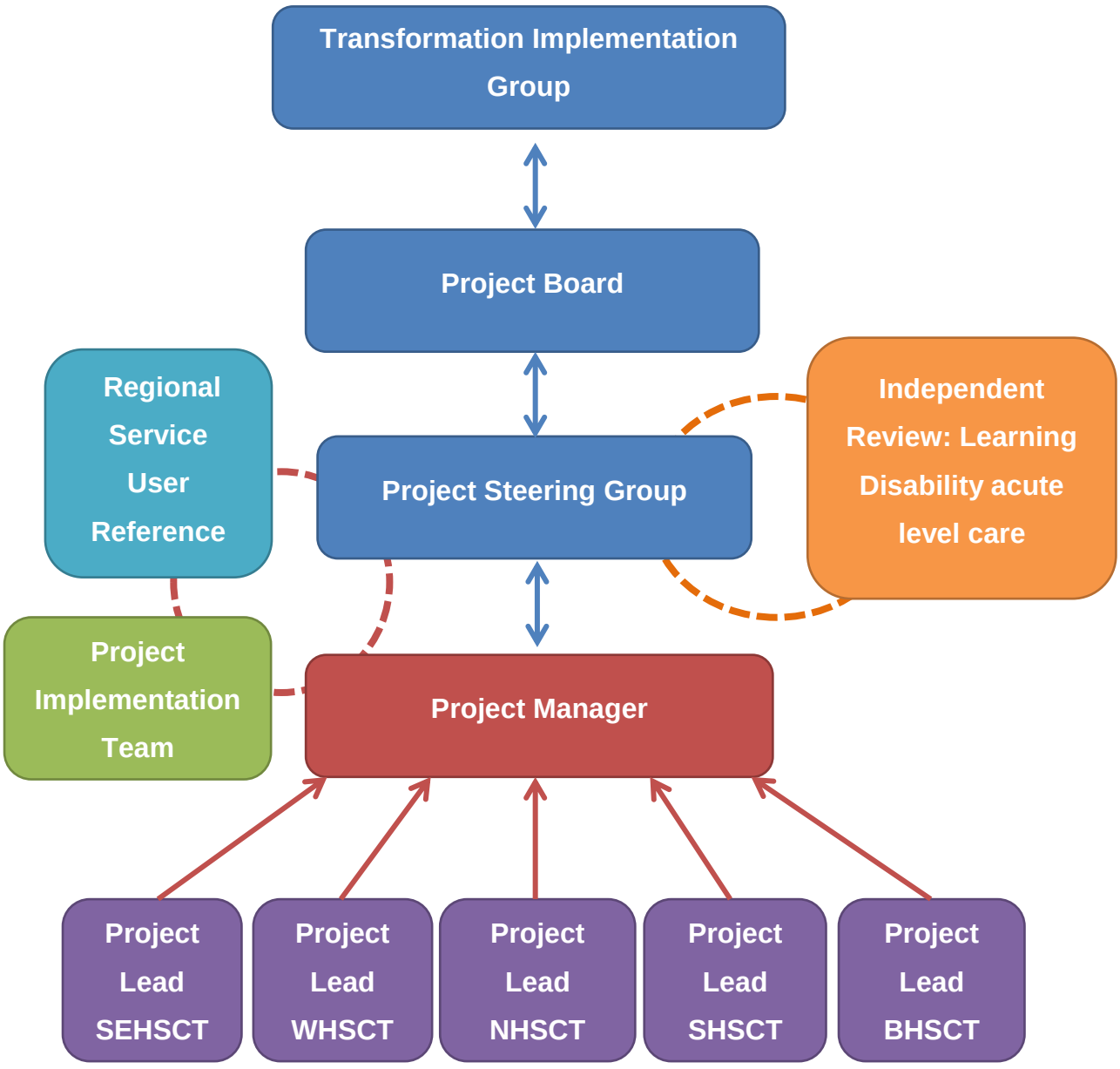
Other Inequalities

There are also a number of other social, emotional and financial factors which impact on the health of people with learning disabilities and research notes that individuals with a learning disability are more likely than the general population to:

- Grow up in poverty and poor environments, which can limit the ability and freedom to pursue healthy options, be socially included, and/or afford decent housing.
- Can have difficulty forming close relationships in their early years, which can lead to behavioural and mental health problems.
- Have poor educational attainment.
- Experience social isolation and loneliness.
- Experience mental health difficulties.
- Have poor physical health.

APPENDIX 5

Project Steering Group Reporting Structure



APPENDIX 6

Key Challenges To Deliver 'We Matter' Ambitions

Life Changes

Ambition Statement 1 - *I am prepared and supported through important changes in my life.*

Within Northern Ireland, Adult Services in each HSC Trust have different provision than Children's Services. Most Trusts have dedicated Transition Workers within Children's Services identifying needs and profile, an eligibility criteria, which is sometimes varied, is applied to determine whether the individual has a diagnosis of learning disability, at which point an adult assessment of need is completed. Keys to Life in Scotland noted a marked reduction in availability of services from Children's to Adult Services. Children's services in NI use a needs-led and whole child model approach, where services are wrapped around a child, based on their assessed needs. Services however, do not follow the child into Adult Services when they transition.

Under the new Special Educational Needs and Disability Act (NI) 2016 there is a call for provision for increased co-operation between Education Authority and HSC Services to provide services they have identified to be of benefit to address a child's special educational need (SEN). Under the Special Education Needs and Disability (NI) Order 2005 (SENCO) Code of Practice, transition planning in schools commences at the first annual review following the 14th birthday. A diagnostic assessment for Learning Disability may be best completed at the same age. Staff reported that they saw benefits in assessment of need commencing at an earlier age, from at least 14. In the development of the Model, individuals and carers acknowledged a need for earlier notification and contact with Adult Services, currently identification of need can occur from 16 and 17 years of age onwards.

Access to Adult Services is currently via an agreed eligibility criteria based on a diagnosis of Learning Disability, which has also not always been completed earlier enough in the transition process.

Currently a diagnostic/ eligibility process should identify those with and without a learning disability, providing an opportunity for an individual and carers to adjust to the outcome. Carers and staff however identified the need to support service users that do not have a learning disability, but still present with vulnerabilities e.g. educational, safeguarding, mental health issues and may also have a diagnosis of autism. Further work is required to explore the profile of need for these individuals and to apply a human rights and person centred approach rather than clinical diagnostic criteria.

Individuals and carers reported ongoing difficulties in navigating the process from Children's to Adults Services, and staff from with Children's Services did not understand Adult Services in the context of: legislation, service provision and issues facing children turning 18. To aid understanding service users, carers and staff all indicated the need for easier access to local information in respect of services available in cities, towns and villages, the creation of a single information platform, preferably online which includes information pertaining to: statutory, non-statutory, council, private and voluntary sector organisations.

As noted within the policy context; legislation and regulations continue to change within Adults Services, and a mechanism to cascade such changes should be provided to children's services to ensure all staff are kept up to date of changes and implications of same e.g. Mental Capacity Act and the provision of short and long term detentions and implications for service user and families. Statutory staff reported that Children's Services seemed not fully informed or up to date of legislative changes from childhood to adulthood; continued updates would assist awareness and work with respective young people during reviews and home visits when preparing for transition.

Whilst there is evidence of good working between Children's and Adults services, challenges remain within the service, it is hoped that earlier assessment of need will assist in identifying the numbers requiring Adult Learning Disability Services but only if subsequent assessment and care planning occurs in a timely fashion. Equal Lives indicted that *"much of planning occurs in the last year at school, which is too late to ensure that a range of options are sampled or explored."* Equal Lives also indicates other options being explored with college, day services and potential employers these will be discussed under supports which are relevant not just at transition to adult services.

Carers attending engagement events spoke of late notification of outcomes within Adult Services and need for earlier decision making, regarding what happens next in the individual's care pathway. Transition from Children's to Adults Services is unlike other transitions within a non-disabled world; this straddles issues of legislation, service provision, change and capacity. Independence, for many is not a progression after acceding the age of 18, the respective individual will continue to need varied supervision and/or 24/7 care and/or support but is treated like an adult.

If the care pathway is agreed by 17 this will allow the individual and families time to access the short breaks when turning 18.

Carers and families stressed the importance of a standardised approach to transitions, better partnership working, adopting a systems-led approach, seamless with a key worker supporting all transition paths.

As an individual gets older and their needs changes, services will respond to other transition points requiring support, these will be reflected elsewhere within this report. For individuals and carers changes in health and age are challenging times. Adjustment to these changes is not easy to manage or navigate. As the age of an individual rises, the ability for a carer to be involved will become harder as they may die before them. Many carers have indicated their desire that housing and future planning occur earlier allowing their involvement in future decision making.

The circumstances and expectations of people with a learning disability have evolved over more recent decades with a greater emphasis on inclusion and community living. While these are welcome developments which raise expectations for opportunities for positive ageing, there remain questions over how support for ageing generations is to be provided in the future. In their systematic review of caring for older people with a learning disability, Innes et al. (2012) have argued that the ageing experience of these individuals with a learning disability should not be seen as exactly the same as those of the general population.

In a small qualitative study of perceptions of active ageing, Buys et al. (2008) noted that with the move away from institutional care, many older service users with a learning disability have had different experiences in the latter part of their lives that have led to new hopes and expectations on their part.

For health and social care service providers, the expanded horizons which have come with the transition towards ageing and inclusion also brings a host of new challenges in terms of lifestyle support issues in order to assist new generations of older people with a learning disability move through this new 'unknown' phase of their lives. Today's generation of older persons with a learning disability are the first for whom transitions are required to support movement from services provided to adult persons, towards provision that is more suited to their changing demographic and health needs.

Many individuals with learning disabilities miss out on the usual milestones of growing older, having a career, getting married, bringing up a family, retiring. It can be challenging for them to recognise that they are getting older. Sometimes they can be so protected by family that they continue to feel like a child and may have no sense of feeling like an adult at all. It is important to help them to learn about older adulthood. It is a life change just like others, with its own challenges, and it is important that they understand and are supported to manage these.

According to Keys to Life (2013), "life limiting illness is more likely in Learning Disability population with an estimated 61% of people with learning disabilities living

with a specific long term illness or additional disability]". The increase in co-morbidity begins to rise from the age of 40 onwards which is significantly earlier than the general population which is similar to aged 65. Whilst the overall age will increase in learning disability it would be important to ensure that a future model enables each service user to enjoy maximum independence for as long as possible, shortening periods of ill health that accompanies ageing.

Whilst ageing can impact on physical and cognitive health, research shows that dementia occurs at an earlier stage and higher frequency within the learning disability population particularly those with Down's syndrome. The standards set out in the Regional Dementia Care Pathway will also apply to individuals with a learning disability.

Research by Tuffrey-Wijne (2017) noted that "all people with advanced progressive incurable conditions, in conjunction with their carers, should be supported to have their end of life care needs expressed and to die in their preferred place of care." By way of example, within the SHSCT palliative supportive ranges from district nursing, complex nursing, access to Macmillan/ Marie Curie nursing and the use of a local hospice care. It is expected that communication recommendations will improve an individual's experience during any hospice admissions. Research within Learning Disability is limited, but Tuffrey-Wijne (2017) identified certain key issues:

- Communication difficulties,
- Difficulties around insight and participation in decision making,
- Distress, multiple co-morbidities,
- Complex family and social circumstances and
- Higher levels of behavioural and psychiatric problems.

Tuffrey-Wijne considers that someone with a learning disability has difficulty with equal access, challenges in accessing palliative care and that health professional can misinterpret symptoms of ill-health as matters pertaining to their learning disability. This can result in misdiagnosis, described as "diagnostic

overshadowing." Secondly training, it is important that care staff delivering such services have completed adjustment training.

Health and Wellbeing

Ambition Statement 2 - I will live a happy, healthy and active life

Research has shown that individuals with a learning disability face many health inequalities compared to the general population in terms of health conditions and life expectancy. The 2018 Learning Disabilities Mortality Review (LeDeR) found the average age at death was 60 for men and 59 for women, compared to age of death of 83 for men and 86 for women in the general population. The typical life expectancy overall for general population is lower in NI, however there are no published figures to suggest the same principle applies to the average life expectancy for individuals with learning disability in N.I Individuals with learning disabilities are more likely to experience a range of health conditions. Coronary heart disease is the main cause of death amongst this population, with respiratory disease higher than the general population. There are also increased incidences of psychiatric disorder, dementia and epilepsy. There is also low uptake of health screening including breast, cervical, bowel, and AAA.

Research indicates that individuals with a learning disability are less likely to eat healthy foods and do regular exercise without help and support and therefore are at an increased risk of obesity and diabetes. Individuals with a learning disability face many challenges in maintaining good health and wellbeing because of:

- Not being able to take part or access local exercise classes/programmes in their community;
- Poor communication which impacts on ability to understand;
- Lack of support to help maintain a healthy lifestyle;
- Services unable to make reasonable adjustments;

- Conditions go undetected or are masked with other conditions.

Central to ensuring the health and wellbeing of an individual with a learning disability not only is being healthy, which is a key goal, but having access to services to enable a happier healthier and more active life. It is vital that individuals have access to all health and social care services which are required to improve their health and wellbeing outcomes, including access to the full range of AHP services. Survey responses in relation to health and wellbeing during the consultation phase found signfiicant numbers of carers unhappy with services in this area.

We know that the needs of individuals with a learning disability have changed since the Bamford review in 2005. The range and breadth of health and wellbeing services have evolved in response to need to provide a menu of options available to the individual, carers and families to consider. Day Care Services are moving towards supporting individuals with complex needs whilst Day Opportunities are for individuals assessed as being more independent.

It is important that we consider extending and developing our links with community initiatives and health improvement programmes to ensure that individuals with a learning disability have access to a range of social, physical and emotional health and wellbeing activities which may also help address isolation and loneliness. The DOH "Making Life Better", a whole system framework for public health, is a key driver to take this forward, including Active Inclusion programmes, and the Take 5 campaign.

Health Care Facilitation was a service commissioned in 2008 to provide Annual Health Checks in GP practices in order to reduce inequality and access to appropriate screening. A 2013 Review identifed the need to record the impact of Annual Health Checks during the course of the year and at the next Review. This aspect of the service remains outstanding at this stage. A co-ordinated informatics response would assist in enabling and measuring the added value of this service.

Throughout the engagement process Case Managers also indicated a desire to be more involved in health improvement and health promotion. Case Managers could be involved in the implementation and monitoring of Health Actions Plans.

To ensure that health improvement is part of not just community teams, Health Action Plans should be linked to the use of commissioned services – either statutory or the independent sector. Examples of Health improvement initiatives specific to learning disability include: fit 4 U, I Can Cook It, Heart Health Toolkit, Understanding Relationships, Walk Leader Training, and Home Accident Prevention. These are all initiatives which have been adopted and offered in Day Services and could be delivered within Community Teams. The Review of Adult Learning Disability services by RQIA (2016) recommended "a plan that can demonstrate measurable evidence of health improvements for adults with learning disability".

One Trust is currently piloting a Health and Wellbeing Coordinator post within Day Services to embed the health and wellbeing agenda across day services and in particular tackle obesity and other long term conditions. The post holder works closely with the Health Care Facilitators. This could be identified as a potential pilot across all Trusts.

Consultation responses also noted greater adjustments required to facilitate attendance at HSC seminars, including longer GP appointment times, countinuity of care by the same GP and a GP flag on Case Notes. Adjustments should not relate solely to GPs but include other providers, e.g., Dentists, Opticians and Acute Services and any other health and social care services attended by individuals with a learning disability. These adjustments should ensure that information is available in a timely fashion.

The consultation process also noted challenges when visiting hospital services, accessing wards, waiting times, for example, Hospital Passports not being read or understood by staff. The recently published 'Regional HSC Passport For People with Learning Disabilities – Phase Two Evaluation' (2020), to review the Hospital Passport introduced by the Public Health Agency in 2017, noted that whilst many

healthcare professsionals across NI welcomed the Hospital Passport and saw real benefits in terms of ensuring reasonable adjustments for individuals receiving healthcare, some challenges remain. Key recommendations have been set out in the Phase II Evaluation and will be set out in the Strategic Delivery Plan.

Carers also reported that when their son or daughter requires admission they would want to stay with them to ensure their needs were supported within a hospital setting. Health care professionals with expertise in Learning Disability e.g., a Learning Disabled Nurse, AHPs with skills and expertise in Learning Disability,are essential to ensure that a individual's needs are communicated, discussed and reasonable adjustments are made.

The Confidential Inquiry Into Premature Deaths of People with Learning Disabilities (2014) noted that whilst ageing can impact on physical and cognitive health, research shows that dementia occurs at an earlier stage and higher frequency within the learning disability population particularly those with Down's syndrome. It is intended that the Regional Dementia Care Pathway will support individuals with a learning disability who develop dementia.

The links between dementia and development of epilepsy and increased occurrence of cognitive decline amongst those with Down's Syndrome is also well recognised.

Future planning and decision making also require consideration as cognitive and physical needs will change as dementia progresses. Appropriate support mechanisms should be available to the individual and their carers.

There is a higher occurrence of epilepsy in learning disability compared to the general population. Frequency changes significantly with age. According to the People with Learning Disabilities in Scotland report (2017), there is an average occurrence of 22% but this rises with age to 31% with those aged 40-49 within learning disability. A specialist epilepsy service is currently operating in one HSC Trust in NI since 2007, which provides assessment, seizure care plans, nurse-led

review clinics, monitors medication, staff support and ongoing range of training packages for staff.

The ESPENTE, Epilepsy Specialist Nurses the Evidence: A systematic mapping review study (2019) carried out by Epilepsy UK concluded that epilepsy specialist nurse is highly valued by patients, their families and other health care professionals. It is important that this service need is reflected in the new Model.

Research within learning disability is limited relating to palliative care, but Tuffrey-Wijne (2017) noted someone with a learning disability can have challenges in accessing palliative care and that health professionals can misinterpret symptoms of ill-health as matters pertaining to their learning disability. This can result in misdiagnosis. It is important that care staff delivering such services have completed adjustment training.

The Confidential Inquiry into Premature Deaths of People with Learning Disabilities (2014) identified a range of factors that led to premature deaths which occurred and can be attributed to issues arising within the community and hospital. Key factors included: advanced health and care planning, recognising needs and adjusting care, coordination of care, information sharing and record keeping.

The Confidential Inquiry also highlighted the need for appropriate coding and recording of learning disability. In order to measure a reduction in premature deaths it would be necessary that hospitals and coroners service ensure that learning disability is recorded following admission and/ or death. A LeDeR Learning Disability Death Review which ensures that individuals with a learning disability are clearly recorded within respective systems, hospital, community and coroners service to allow learning and research to improve services, should be considered in the new Model and commissioned in the ‘once for NI’ Encompass system.

Carers & Families

Ambition Statement 3 – *My carer is supported to help me live my best life.*

The NI Research & Information Service noted that informal carers provide much needed health and social care support to people with learning disability. There are 220,500 informal carers in Northern Ireland providing support worth an estimated £4.6b per year. Around 9% of these informal carers provide care to someone with a learning disability, with many carers in poor health themselves.

It is recognised that within a person-centred approach family caregivers are partners in provision. Professionals need to support caregivers in this role by working in partnership with them and by providing them with the support they need. Carers work very hard to support each other and work in partnership with HSC organisations to ensure their loved ones have a good quality of life.

According to the Human Rights Commission (2014), carers are not a homogenous group. Carers can be all ages. Each carer is an individual who has his or her own story to tell and has particular needs. Delivering Together (2016) stated we need to ensure carers can access up to date information and crucially consider how we can support carers to live their own lives, need to encourage greater take up of Carer's Support Assessments and expand the options for short breaks, as well as enabling the greater use of personalisation and personal budgets where appropriate.

Although helping others may bring personal satisfaction, carers can face substantial health and financial challenges. According to Taggart et al (2011), there is a plethora of research evidence that documents the stresses and strains that carers experience and the consequential ill-health that often results. In their study, 'Supporting People with Intellectual Disabilities who challenge or who are ageing: A Rapid Review of Evidence', they make reference to the key principles set out in the DHSSPS (NI) Valuing Carers Strategy (2006) which remain fundamental:

- Carers are real and equal partners in the provision of care**.**

- Carers need flexible and responsive support**.**
- Carers have a right to a life outside caring.
- Caring should be freely chosen
- Government should invest in carers.

The Foundation for People with Learning Disability (2015) also noted that parents have often said their hope for the future is that they will outlive their adult son or daughter, but as individuals with learning disabilities are living longer, this is frequently not the case. But in any event, living with fear and worry for the future should not be the way for a family to live.

NICE NG 150 'Supporting Adult Carers' (2020) sets out the standards for support for adults (aged 18 and over) who provide unpaid care for anyone aged 16 or over with health or social care needs. It aims to improve the lives of carers by helping health and social care practitioners identify people who are caring for someone and give them the right information and support. It covers carers' assessments, practical, emotional and social support and training, and support for carers providing end of life care.

NICE NG96 "Care and Support of People Growing Older with Learning Disabilities" (2018) also recommends that we review the needs and circumstances of carers at least once a year and give help and information to families and carers, including siblings, as part of planning and providing support for individuals growing older with learning disabilities

Given the increased life expectancy of individuals with a learning disability, many older individuals are now living with family carers and indeed may outlive their parents. The Department of Health in England (2010), through their Valuing People Strategy, placed particular emphasis on policy initiatives in relation to older carers of persons with learning disabilities. Based on the evidence of this review it is recommended that:

- Family caregivers who seem dissatisfied with services they receive should be listened to and their views incorporated into service delivery
- Future planning involving parents and clients in a true person-centred way needs to take place to prepare for transitions and the future
- Attention needs to focus on siblings and their views on being potential future main caregivers (this is an area that would benefit from future research).
- Services should be provided in the home to support families as far as possible and family caregivers should be provided with education, training and support for their caring role.
- Short term respite breaks should be more available and meet the complex needs of people who challenge
- If out of home placements are required these should be available at local level and be for short duration.

Carers NI 'State of Caring- A Snapshot of Unpaid Caring in NI' (2019) represents the most up to date study into unpaid carers. 694 respondents participated in this research and a number of key recommendations were made. These included ensuring that carers did not suffer financial hardship as a result of caring, recognition of the value of carers, funding for older individuals and those with disabilities to access quality affordable care, funding and choice of breaks for carers and to ensure that carers are able to juggle work and care if they wish to.

One such approach is the Shared Lives approach. This matches dedicated host carers who provide support in their own homes to individuals who require day services, short breaks or long term placements. Shared Lives is a regulated approach that provides choice, control and flexible person centred care, enabling individuals to remain living in their communities. It creates and maintains long term sustainable relationships and provides a direct response to managing social isolation. The approach has proved to be a cost effective and highly personalised alternative to residential and other forms of care. It enables health and social care

partnerships to offer better outcomes for the individuals involved and has been reported that individuals feel settled, valued and have improved self-esteem.

The 'Shared Lives' model is currently in 4 of the HSCTs and plans are under way to develop a region wide service. Transformational funding was made available to develop a regional framework which includes a standardised approach for any organisation adopting a shared lives NI model. By adopting this approach it is envisaged the Share Lives Model can grow more substantially across Northern Ireland.

Carers noted a number of other key issues during the consultation phase, including the need for a Regional Scoring Tool for bed based breaks, improved communication, services provide by family, the need to have to fight for services and the lack of autism support.

The RQIA Review (2016) also noted the need to increase the uptake and completion of Carers Assessments. Staff indicated that carers found conversations regarding the future challenging, a subject that can be delayed until a crisis.

The Southern Trust Physical Disability Service piloted a new approach called the 'Carers Conversation Wheel' and at each Annual Review a conversation should occur regarding future planning.

Other key challenges noted by carers included need for emergency short breaks, domiciliary short breaks and emerging nursing beds.

Carers noted that current domiciliary provision does not always meet the needs of those with behaviours that challenge. The provision of home support via a domiciliary provider could offer another support or alternative support to some carers with sons or daughters that demonstrate behaviours that challenge. For example, a short break of 3 hours in an evening, up to at least 7 days per week. For an individual who presents with behaviours that challenge and / or autism, could be

more settled within their home environment as opposed to moving to a short breaks location.

Carers also noted that Self-Directed Support also proved difficult to achieve in a rural setting. Recruitment and retention within this area of need can be difficult and therefore consideration should be given to the need to consider a specialist provider targeting this need

Carers spoke of the need for a Regional Scoring Tool that would assist staff and carer agreeing the quantity of short breaks needed, based on a regionally agreed schedule to provide a fairer, equitable and standardised approach. This would generate regional data when considering future need.

Current provision in Trusts includes: nursing, residential, shared care and activity based short breaks normally over a weekend. The most recent data from the Health and Social Care Board's Performance Management Service Improvement Directorate shows that regionally, 9,286 adult carers received a short break at Quarter Ending December 2019, a 12% increase from Quarter Ending December 2018. Of these, 1841 were carers of an individual with a learning disability.

Meaningful Lives and Citizenship

Ambition Statement 4 - I live in a society that respects my rights and choices as a citizen - to learn, work, and enjoy my life.

The Regional Learning Disabiity Day Opportunities Model Consultation report (2014) stated that providing opportunities for individuals with learning disabilites to become true citizens in their own communities is the responsibility of us all. Citizenship and Social Inclusion also represent two of the core Equal Lives values drawn from Bamford, which continue to be critical to developing the vision for the Model.

Significant progress has been made over the last ten years to promote a meaningful life for individuals with learning disabilities but challenges still remain, as noted by those who engaged in the consultation process. These include accessible information, advocacy services, day opportunities, education, training and employment, self-directed support, transport and social isolation and lonlieness.Accordng to the report 'Five Communication Standards' by the The Royal College of Speech and Language Therapists (2013), 90% of individuals with learning disabilites have communication problems of differing degrees. The Care Standards for Nursing Homes (2015) Standard 20 also referenced the need for the use of effective communication , which is also reflected in legislation and regulations as set out in the Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland) 2019. 5.7 of the Regulations note, "….every effort must be made to provide information in a way that is most appropriate to help the person to understand (e.g. via use of visual aids, or simple language)."

With the creation of the Patient Client Council and requirement of Personal and Public Involvement (PPI) and the RQIA Review (2016) there is also a need to introduce standards regarding advocacy. According to the Scottish Model, Keys to life, advocacy "supports people to understand information and choices and to make their voice heard." Different advocacy models should form part of any future Model to ensure that advocacy permeates throughout all areas of planning, practice and approaches; locally and regionally, providing a preventative and protective impact. The essence of the agreed Mental Capacity Act (Northern Ireland) 2016 provides this regulation in that it will promote service users rights; and challenge potential assumptions around choice and control.

The Mental Capacity Act (2016) means that everyone has the right to make choices about their own life and what they want. You can even make choices about your future now, so that everyone will know what you want later on in life. The government has made sure that there are certain safety measures in place under this new law. These are called Deprivations of Liberty Safeguards. A deprivation of Liberty is when all of the following occur:

- A person is in a place where care or treatment is being provided
- A person is not free to leave
- A person is under continuous supervision and control

Where an individual has the capacity to consent to family/carer involvement in any part of their contact with Learning Disability Services, they must give that consent prior to the service engaging with families and carers. With consent in place, Learning Disability Services should seek to fully involve families and carers in decision-making. Where an individual does not have the capacity to consent to family/carer involvement, Learning Disability Services will seek to fully involve families and carers in decision making as appropriate, and in the best interests of the individual." It would be reasonable to assume that the need for advocacy is likely to be effected by the implementation of the Mental Capacity (Deprivation of Liberty) Regulations (Northern Ireland).The Learning Disability Service Framework (2015) Standard 9 also called for independent advocacy, "independence means structurally independent from statutory department or agency providing the service

Carers have also called for standardised and universal day opportunities provision. During the engagement process they had mixed views on provision across HSC Trusts, and raised issues relating to access and cost differential. The Regional Learning Disabiity Day Opportunities Model Consultation Report (2014) recommended a new model for Day Opportunities to ensure a modern, sustainable and quality service for individuals, which should be delivered on a joint basis, requiring cross Departmental working, to put in place a network of services operating for individuals with learning disabilities. The Scottish Model, Keys to Life (2013) proposed that no individuals should go to a Day Centre full-time, and instead should use it as a base to identify and participate in activities in the wider community. It promoted that Day Centres or support services should become more community focused by helping individuals with learning disabilities to access continuing education and development, real jobs, achieve their desired outcomes and become more involved in their communities.

Many HSC Trusts since Bamford have been developing structured day activities, excluding work and volunteering, which provide a mix of day opportunities and day care based activities, this has afforded many service users a different experience in community based settings, whilst physical numbers have fallen slightly in daycare need has increased in terms of complexity, cost per head with service users with high dependency needs requiring higher staffing ratios, nursing interventions, service users with behaviours that challenge with bespoke arrangements and/or individual rooms and a range of high cost equipment. This has been a challenge to respond to within the constraints of existing: budgets, building stock and room sizes often not designed for these new needs.

It is recognised however that for individuals with more complex needs and those with profound and multiple learning disabilities, Day Centres will continue to be an important part of their overall support arrangements.

An excellent example of good practice can be found in South Lanarkshire and Renfrewshire Council Council areas in Scotland where they have invested in new Day Centres based entirely within their Council Leisure Centres. Not only has this resulted in more individuals with learning disabilities becoming part of the wider community, but has also achieved the positive outcome of easy access to healthy activities such as swimming and sports. In both Councils, there is the added benefit of encouraging the wider public to make use of the day services resources including sensory room, dance studio and music room, thus breaking down barriers traditionally associated with learning disabilities.

There are similar challenges around support in navigating and locating potential employment, volunteering and other meaningful activity. There are a range of projects run across Trusts provided by different organisations, offering educational or vocational training with supported employment, however programmes are time limited and there are no further supports or monitoring of work placements when the programme ends or resources to extend the programmes. A possible solution is to call Public Sector organisations to facilitate employment opportunities via positive

discrimination, and to consider reasonable adjustments like apprenticeships or job trialling as alternatives to minimum qualifications or job interviews.

As with employment opportunities, there are similar concerns expressed by individuals and carers that commencing volunteering can have a detrimental effect on respective social security benefits. There is obviously a role for the Department for communities (DfC) and/ or Department for Works and Pension (DWP) to ensure that the benefit system does not unfairly penalise service users or discourage individuals that access or seek to access employment or college.

The Norfolk County Council "My Life, My Ambition, My Future" strategy is an example of best practice in this area. The strategy was co-written by individuals with learning difficulties, their families and service providers. It says people with a learning disability want to "have the ambition, choice and opportunity to be equal members of the Norfolk community". The new Life Opportunities model has three levels, known as pathways:

- Wellbeing – providing meaningful activity, social support and care for those with the most complex needs
- Promoting Independence – supporting individuals to develop life skills and access community provision and services
- Skills and Employment – supporting individuals to obtain paid work.

Self–directed support (SDS) also offers an opportunity for individuals and carers to make choices about how they receive domiciliary services. For those using and benefitting from direct payments, it is well received and spoken of warmly, however for others the process is lengthy and arduous. There are challenges around recruitment in rural locations or for someone with behaviours that challenge, as well as the system being described as difficult to navigate. Staff involved in Direct Payments asked if any future review of criteria could include provision for accessing health professional assessment e.g. occupational therapy or podiatry.

To enjoy a meaningful life individuals also need to be able to get out an about. Throughout the engagement process all stakeholders were unanimous that transport options and availability needs to improve, particularly outside of towns, allowing individuals access to educational, social, work, and volunteering opportunities. This area of work will require agreement across Government Departments to improve breadth of coverage, but it is outside the scope of this Model.

Individuals with learning disability and their carers also noted difficulties in accessing friends, connecting and even seeing old school friends. According to 'Preventing Loneliness and social isolation: interventions and outcomes', Windle et al (2014) noted that within the general population this is described as a risk factor in relation to premature deaths. Research has found that the impact of loneliness can cause earlier than planned admission to nursing or residential care. Potential remedies to loneliness include: befriending, navigating, mentoring, group services and wider community involvement.

Home

Ambition Statement 5*: I am supported to live in my home*

A good quality home and community life is at the centre of positive living and promoting independence for individuals with learning disability.

The DoH Systems, Not Structures Bengoa Report (2013) noted, "*when support becomes available and what should it look like, is the service able to support service users at home and their carers*." During the engagement process individuals expressed a desire to live as independently as possible. Home can mean different things to different people, however. The Office of the First Minister and Deputy First Minister (OFMDFM) (2013) stated that *"people with disabilities and their families have appropriate accommodation and adequate support to live independently."* It has already been noted that the vast majority, approximately 75% live with a carer as their home.

The Department for Communities (DfC) Facing the Future: Northern Ireland Housing Strategy Action Plan 2012-2017 recommended the introduction of “a new strategic, intelligence-led approach to needs assessment across all client groups to identify current future patterns of need”.

Led by the HSC NIHE Regional Housing Interface Group, the Health and Social Care Board Learning Disability Services carried out a pilot of the Strategic Needs Assessment (SNA) Template. 706 individuals with learning disabilty in Northern Ireland informed the SNA, 60% were male, 40% were female. 622 of 706 (88%) were assessed as requiring a move to specialist housing.

The preferred housing options was overwhelmingly for a move to supported housing (646 – 92%). The remaining 8% were assessed as either being able to remain in their current accommodation with or without support/adaptation. 361 (51%) were assessed as requiring a change in their accommodation needs between 2 years and 10 years and 141 (20%) were assessed as requirng a change in their accommodation needs in the next 6 months. 113 (16%) were predicted to require a change in accommodation within 6 months – 2 years.

More recently, Delegated Statutory Functions reports from HSC Trusts noted individuals were living with a family member, some lived alone with or without support, supported living, residential and nursing care, and a small minority reside temporarily in hospital for care and treatment. The vast majority of supported living, residential and nursing is group type or shared accommodation. Group living arrangements vary from a small shared accommodation from two to at least 20.

Whilst peripatetic support is not widespread in Trusts, it is an effective mechanism in some areas of one of our HSC Trusts, for allowing or maximising independence and should be considered throughout the Region. Additional housing options and levels of support could be extended from existing supported living priorities if floating support extended beyond core buildings to support individuals. When Equal Lives

was written in 2005 approximately 10% of service users lived alone in the community, a target which should be increased for the future.

Individuals with learning disability and carers requested better access and choice in their local areas, reducing dependence or reliance on others or services. They called for greater flexibility in terms of renting private accommodation with nursing support instead of nursing home provision. They also called for bespoke housing models. Carers have also called for a shift in the accommodation response, from reactive to preventative. Black and McKendrick's report entitled "Careful Plans' Report in (2010) in Northern Ireland identified that only a third of carers had a plan in place.

Due consideration should also be given to commission new technologies or assistive technologies. Research should be commissioned to identify the best products and approaches available or being used within learning disability or related fields.

Planning and/or anticipating future need can be challenging, however. The majority of carers supporting someone with severe cognitive and physical disability preferred to care for that person in their home in the long term. However those with lower levels of need were seeking independence and carers were supportive of this option. Carers noted during the consultation that preferred group accommodation should be focused and bespoke to the needs of individuals with learning disability and not mainstream residential or nursing care Funding of capital projects however, continues to be challenging. Cross Departmental partnerships and collaboration is key to meeting learning disability needs when planning, locating and expanding public housing stocks.

Commissioned services need to be responsive and flexible and this would suggest that the need for domiciliary support, SDS, short breaks and home adaptions will be necessary, to ensure homes are responsive to changes in health. An excellent example of this is the provision of a Disabled Facilities Grant which can improve accessibility for an individual with a disability and is used widely within Learning Disability Services. This provision is overseen by occupational therapist (OT) and paid from the Northern Ireland Housing Executive. This grant provision is applicable

to anyone with a learning disability, but staff and carers reported that eligibility and guidance are limiting accessibility. A broader definition which considers the physical needs of behaviours that challenge, dementia and those with autism would be beneficial.

Learning Disability Services continue to have a lack of control over development, funding and design of housing, which is compounded by the smaller population size comparative to other programmes of care or general housing needs. This could be changed by the creation of a Learning Disability Housing Project/ Lead that has funding control and design rights to anticipate future need and respond accordingly within general and bespoke learning disability housing throughout Northern Ireland.

More effective joint commissioning based on assessed need and timely transition across DoH and DfC is critical if transformational change is to be achieved.

Specialist Assessment and Treatment

Ambition Statement 6: *I will enjoy the highest attainable standard of physical and mental health possible and have access to high quality, compassionate, assessment and treatment services, when required*

Delayed discharges or delayed complex discharges occur within most health care systems and reflect as an issue in recent strategic and literary reviews within the UK.

An expedited regional Work Stream was convened in 2019 by the Department of Health to undertake an Independent Review of Learning Disability Acute (intensive community and inpatient) level care for adults. The key drivers for this expedited Review were:

- Findings from Draft Level 3 SAI Review report relating to Muckamore Abbey Hospital;
- Evaluation of the Bamford Action Plan 2015-2017 (report pending);
- Systems, Not Structures, DoH (2016)
- Service provision for people with learning disabilities and psychiatric disorders in Northern Ireland. Advances in Mental Health and Learning Disabilities, 1 (1), 18 – 21. Taggart, L. (2016);
- Transforming Care: A national response to Winterbourne View Hospital, DoH 2012;
- RQIA Review of Restraint and Seclusion 2018 (report pending);
- Delivering Together (2016);
- Learning Disability and Behaviour that Challenges: service design and delivery, NICE Guideline, March 2018.

The purpose of this workstream was to undertake a review of the current service model/provision and clinical pathways in order to recommend a future best practice model for Acute (inpatient and intensive community) care and support for adults with a learning disability, which is regionally consistent and focused on relevant clinical and patient related outcomes, and which would form part of this Model.
The key challenges set out in this Review will be explored by the new Regional Task and Finish Group, called the Community Based Assessment and Treatment for Adults with a Learning Disability and Complex Needs. It is represented by all key stakeholders, to co-produce specialist services for community and inpatient care, in line with legislative and policy direction, NICE guidance and best practice. The focus of this work will be for individuals with complex needs, including ASD, behaviours that challenge and forensic. The key recommendations of this work will feature in the Model's Strategic Delivery Plan, and will be published later in the year as an Annex to the Model itself.

A key recommendation which can be progressed in Year 1 of the SDP is Positive Behaviour Support (PBS). PBS is a person centred framework for providing long term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing behaviours that

challenge. PBS approaches are based on a set of overarching values. These values include the commitment to providing support that promotes inclusion, choice, participation and equality of opportunity.

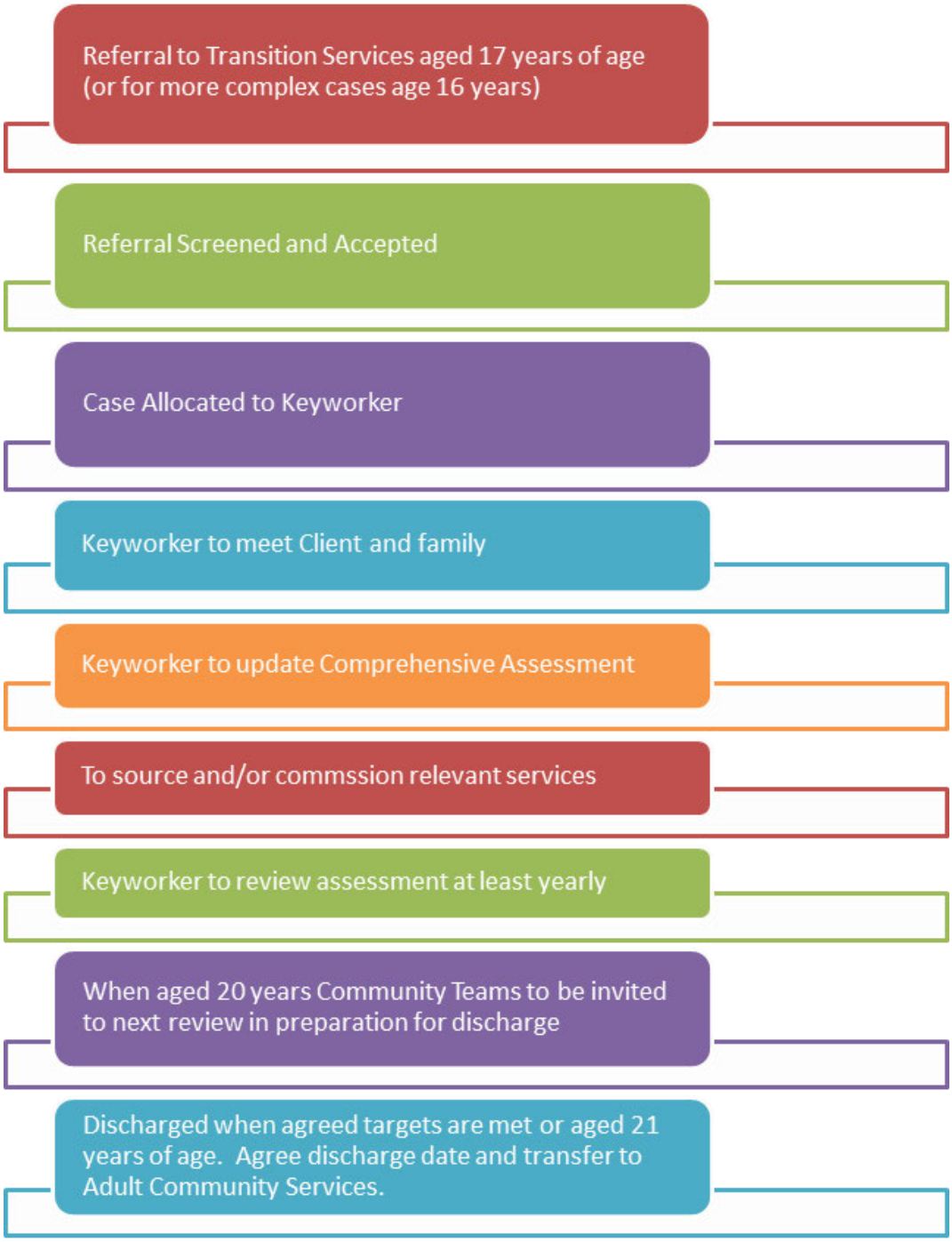
The overall aim of PBS is to improve the quality of a person's life and that of the people around them.

Over the past three decades, PBS has increasingly become the model of choice for supporting people whose behaviour poses a challenge to services. In order to ensure a regional PBS model for Northern Ireland, an Organisational and Workforce Development Framework should be developed as part of the overall LDSM Learning Development Framework. This will help support actions within all 6 Key Ambition Statements.

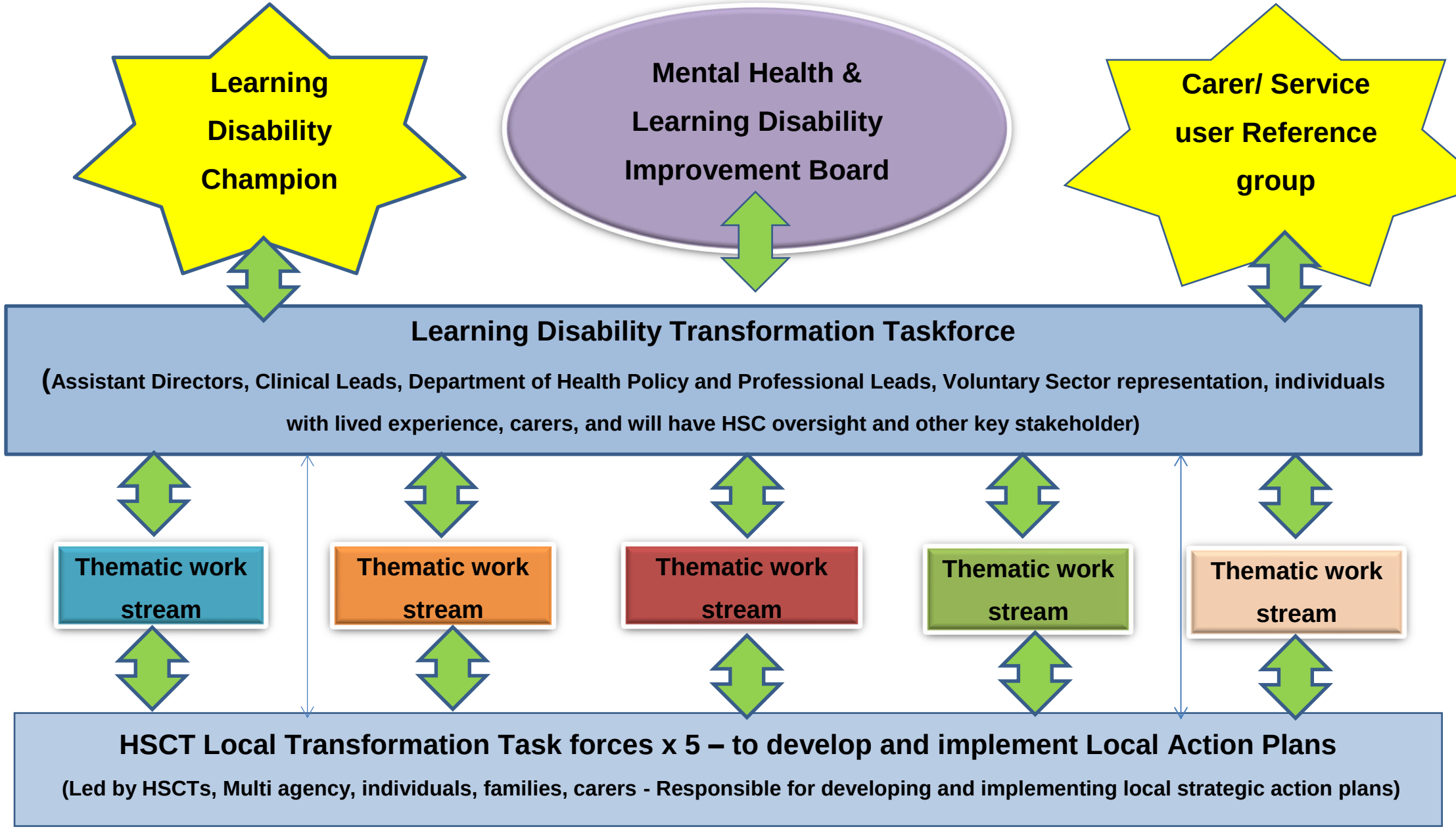
APPENDIX 7

Pathway of Care Example

Transitions from Children's Disability Services to Adult Learning Disability Services



APPENDIX 8 -Proposed Reporting Arrangements for "We Matter"



CIRCULAR (OSS) 02 / 2022:

SOCIAL CARE AND CHILDREN'S FUNCTIONS (STATUTORY FUNCTIONS): MANAGEMENT AND PROFESSIONAL OVERSIGHT

DEPARTMENT OF HEALTH (DOH) CIRCULAR

ROLES AND RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH, CHIEF SOCIAL WORK OFFICER AND OFFICE OF SOCIAL SERVICES; SOCIAL CARE AND CHILDREN'S DIRECTORATE IN THE STRATEGIC PLANNING AND PERFORMANCE GROUP, DEPARTMENT OF HEALTH AND THE HEALTH AND SOCIAL CARE TRUSTS (HSCTs), FOR THE MANAGEMENT AND PROFESSIONAL OVERSIGHT OF THE EXERCISE OF STATUTORY FUNCTIONS

1 INTRODUCTION

1.1 The Health and Social Care Act (NI) 2022 dissolved the Health and Social Care Board (HSCB) and placed responsibility for the management and professional oversight of the exercise of statutory functions directly with the Department.

1.2 Under the 1994 HPSS Order, provision was incorporated for the discharge of functions to be delegated to and exercised by Health and Social Care Trusts (HSCTs) on behalf of the HSCB by way of an instrument in writing under seal ("an authorisation").

Authorisations required the approval of the Department.

The 1994 HPSS Order required that each HSCT submit to the HSCB for approval a scheme for the exercise by the HSCT of specified relevant functions. The HSCB was then obliged to submit the scheme for the approval of the Department.

1.3 Schemes, known as "Schemes for the Delegation of Statutory Functions" were developed by HSCTs in co-operation with the HSCB, which subsequently approved each scheme and submitted it to the Department for approval.
As part of the approval process, the Department's role was to ensure that proper provision has been made for the exercise of the relevant functions to be delegated to HSCTs and that the HSCB had appropriate arrangements in place to assure themselves that HSCTs were exercising relevant functions effectively.

A review of the arrangement for the delegation of statutory functions undertaken in 2011/12 recommended that HSCB agree one single uniform

template Scheme with each of the five HSCTs to ensure that there was regional consistency in the Schemes approved.

1.4 The HSCB could, with the approval of the Department, revoke an authorisation to a HSCT to exercise relevant functions, should circumstances warrant such action.

1.5 The requirement for an unbroken line of assurance and professional oversight of the discharge of Delegated Statutory Functions from HSCTs to the HSCB and ultimately to the Department of Health (DoH) came into place in 1994 following concerns raised by the judiciary with the introduction of legislation[1] which enabled the delegation of relevant statutory functions from the legacy Health and Social Services Boards to HSCTs

Arrangements for professional oversight were designed to ensure that DSFs were discharged in accordance with the law and to relevant professional standards within a system of delegation.

1.5 The Chief Social Work Officer (CSWO) in the Department, the Director of Social Care and Children's Directorate in the HSCB (the HSCB Director) and the Executive Director for Social Work (EDSW) in each of the HSCTs' were individually and collectively responsible for the effective operation of an unbroken line of professional oversight of Delegated Statutory Functions.

1.6 Professional oversight arrangements were an integral part of the overall system of checks and balances that held the HSCB and HSCTs' to account for their performance. Professional oversight involved:

- Approval of Schemes for the Delegation of Statutory Functions
- The appropriate discharge of functions of statute
- Performance management
- Strategic oversight
- Quality Assurance
- Continuous improvement
- Reporting

1.7 The Health and Social Act (NI) 2022 dissolved the HSCB.

To ensure the continued effective performance of functions of statute relevant to social care and children's functions the Social Care and Children's Directorate (SCCD) has been included into the Department's Strategic Planning and Performance Group (SPPG).

[1] Health and Personal Social Services (Northern Ireland) Order, 1994

1.8 The Director of SCCD of the SPPG is responsible for the performance management of the SCCD and is accountable to the Deputy Secretary of the SPPG who in turn is responsible to the Department's Permanent Secretary, and on to the Minister.

The Director of SCCD of the SPPG will work in partnership with the Department's Social Services Group (SSG) and the Office of Social Services (OSS) and will be accountable to the Deputy Secretary/Chief Social Work Officer (CSWO) regarding matters of professional advice, guidance and insights in relation to the provision of the full range of social care and services to children and families.

1.9 The Health and Social Care Act (NI) 2022, revised the HPSS Orders 1991 and 1994:

Articles 3 and 4 of the HPSS order 1994, which provided for relevant functions of the HSCB, as specified, to be exercisable on their behalf by HSCTs, with the approval of the Department, by instrument in writing signed under seal (an authorisation), and requiring HSCTs to submit a scheme for the exercise by HSCTs of functions on behalf of the HSCB were removed.

The addition of Article 10B to the HPSS Order 1991 under the Health and Social Care (NI) Act 2022 provided that the Department could direct, by way of a Delegation Direction, that specified functions would be exercisable by HSCTs on behalf of the Department; and, the addition of Article 6B (Schedule 3) provided that the HSCTs must submit to the Department a scheme for the exercise of its social care and children's functions. The requirement for approval by instrument in writing under seal (an authorisation) was removed.

2. PURPOSE OF THIS CIRCULAR

2.1. This circular outlines the roles and responsibilities of the Chief Social Work Officer (CSWO)/Deputy Secretary of the Social Services Policy Group (SSPG), the Deputy Secretary of the Department of Health (DoH) Strategic Planning and Performance Group (SPPG) the Director of the DoH Social Care and Children's Directorate (SCCD)in the SPPG, the Deputy Chief Social Work Officer (DCSWO) and Director of the Office of Social Services (OSS) in the DoH SSPG, and the Health and Social Care Trust (HSCT) Executive Directors of Social Work (EDsSW) for the management and professional oversight of social care and children's functions exercised by HSCTs by virtue of a Delegation Direction in line with the role, function and responsibility of each body.

2.2 This circular should be read in conjunction with Circular (OSS) 01 / 2022: Social Care and Children's Functions (Statutory Functions) which sets out the legislative and structural arrangements in respect of the authority of the

Department and HSCTs in the exercise of statute related to social care and children's functions.

3. STATEMENT OF PRINCIPLES

3.1 Arrangements for the management of and professional oversight of functions exercised by HSCTs on behalf of the Department by virtue of a delegation direction within and between the Department and the HSCTs should be based on a commitment to:

(i) co-operation in the interests of improving and safeguarding the social wellbeing of children, families and adults;

(ii) evidence-informed decision-making;

(iii) the provision of quality services and securing improved outcomes for service users;

(iv) regional consistency and fairness in availability, quality and effectiveness of services;

(v) continuous improvement based on learning from the professional oversight processes;

(vi) timely reporting, prompt responses and early resolution of issues;

(vii) efficiency, proportionality and effectiveness.

4. ACCOUNTABILITY

4.1 Accountability is a key element in the exercise of functions of statute.

The Department, as the parent sponsor body, carries ultimate responsibility for the performance of HSCTs, including the exercise of functions on behalf of the Department by way of a Delegation Direction

This responsibility is not transferable to any other body.

4.2 The Director of the SCCD in the DoH is responsible for the professional oversight, governance, performance management and strategic oversight of HSCTs in relation to the exercise of social care and children's functions (statutory functions).

4.3 The Deputy Secretary of the SSPG/CSWO, the Director of SCCD of the DOH SPPG, the DCSWO/Director of OSS, and the EDSW of each HSCT are individually and collectively responsible for:

- providing management and professional leadership on all social work and social care matters, including the exercise of social care and children's functions within their respective organisations, and, where relevant, to other organisations;

- ensuring appropriate internal organisational, managerial and professional arrangements are in place for the management and professional oversight of social care and children's functions in line with the requirements set out in this and other relevant guidance;

- providing authoritative managerial and professional advice and analysis in respect to the exercise of social care and children's functions to their Accounting Officer and board of directors;

- maintaining open and constructive working relationships and sharing information with each other as appropriate; and

- adopting a collaborative and supportive approach to clarifying and resolving issues as they arise thereby minimizing the need for escalation and/or formal intervention.

4.4 The CSWO, the Director of the SCCD of the SPPG, the DCSWO/Director of OSS, and EDsSW of HSCTs are required to be professionally qualified social workers in accordance with Article 8 (1) of the Health and Personal Social Services Act (Northern Ireland) 2001 (the 2001 Act) and registered with the Northern Ireland Social Care Council (NISCC). They are responsible for ensuring the availability of high quality professional advice within their respective organisations on the complex issues involved in the exercise of duties, powers and responsibilities particularly, but not exclusively, with regard to protecting individuals from risk of harm of neglect, abuse or exploitation.

5. Delegation Directions

5.1 The Health and Social Care Act (NI) 2022 empowers the Department of Health to make **Delegation Directions** to HSCTs to enable HSCTs to deliver social care and children's functions on behalf of the Department.

5.2 The Deputy Secretary of the SSPG/ Chief Social Work Officer will issue an instruction by way of a delegation direction to the HSCTs for specified functions of the Department to be exercisable by the HSCTs and requesting the HSCTs to submit a scheme confirming that they have proper provision in place for the effective exercise of these functions. The SCCD will provide a template to the HSCTs to be used in submitting a Scheme to the Department.

5.3 The SCCD will consider the submitted schemes in consultation with OSS in the DoH.

5.4 The SCCD will agree with the HSCTs any necessary modifications or amendments and will then recommend the Schemes to the CSWO for approval and issue.

5.5 The SCCD are responsible for the design and issue to the HSCTs of a single regional performance management and reporting template in relation to the exercise of social care and children's functions.

6. The DoH's Responsibilities for Delegation Directions

6.1 The CSWO may approve a scheme recommended by the Director of SCCD either without modifications or with such modifications as are agreed with the SCCD and the HSCT concerned.

6.8.2

6.2 The Department will inform the HSCTs of all relevant changes in legislation which require an amendment or update to the Schemes in a timely way.

6.3 The Department may, by direction, provide for specified social care and children's functions to cease to be exercisable by a HSCT and to be exercised instead by; the Department, another HSCT by Delegation Direction, or by another specified person or body by Delegation Direction.[2]

6.4 The SCCD in the DoH will agree the HSCTs' internal monitoring arrangements, as well as direct the HSCTs regarding the information they must record in respect of the exercise of these functions, in what form it is to be recorded, at what intervals it should be provided and for how long it should be retained.

6.5 The SCCD should ensure that HSCT Schemes have been agreed by the HSCT Accounting Officer prior to submission to the Department for approval.

[2] HPSS (NI) Order 1991, Schedule 3, PART 3A DIRECTIONS THAT CERTAIN FUNCTIONS BE EXERCISED BY OTHERS 22A (1) as amended by the HSC (NI) Act 2022.

6.6 The SCCD is responsible for considering the submitted Schemes in collaboration with OSS and recommending approval and issue of the Scheme to the CSWO.

6.7 The SCCD, in consultation with OSS, are required to keep the Schemes and Delegation Directions under regular review to ensure their adequacy and fitness-for-purpose and should formally review Schemes along with HSCTs at a minimum of three yearly intervals

6.8 The SCCD is required to retain a copy of the approved Schemes of Directed Delegation.

7.0 Health and Social Care Trusts (HSCTs) Responsibilities Under Delegation Directions

7.1 Under the provisions of the Health and Social Care Act (NI) 2022, HSCTs have a responsibility to submit a Scheme for their arrangements for the exercise of social care and children's functions under a delegation direction from the Department.

7.2 HSCTs must complete the single regional performance management reporting template, as provided by the SCCD, at intervals prescribed by the SCCD and retained as prescribed by the SCCD on the exercise of their social care and children's functions.

7.3 The SCCD will work with HSCTs at least every 3 years, to keep their Schemes under review. New, amended or updated Schemes require approval and issue by the CSWO in the Department,

7.4 The Chief Accounting Officers of the HSCTs are required to agree their Schemes for the exercise of social care and children's Functions under a Delegation Direction and prior to submission to the SCCD in the Department.

7.5 HSCTs are required to retain a copy of the Scheme agreed and approved by the CSWO in the DoH.

7.6 HSCTs are required to record and report such information with respect to the exercise of its functions as the SCCD in the DoH may direct.

7.8 An HSCT must give effect to any scheme approved by the Department.

7.9 An HSCT must, if so requested by the SCCD in the Department, submit a new scheme to the DoH for approval

7.10 HSCTS, as separate legal entities, are responsible in law for the discharge of relevant statutory functions delegated to them by the Department under a Delegation Direction.

7.11 HSCT EDSWs are responsible for ensuring approved Schemes for Delegation Directions are properly implemented and managed within all programmes of care. This includes ensuring:

- legal and professional responsibilities are assigned and necessary systems and procedures are in place;

- compliance with all statutory, regulatory or professional requirements;

- all staff responsible for the discharge of social care and children's functions have access to relevant training, professional support and supervision;

- the maintenance and operation of an efficient data collection system and provision of data and reports to SCCD in the Department as required;

- implementation of actions, including improvement plans agreed with the SCCD in the Department, to improve the safety, quality and effectiveness of services;

- the Accounting Officer, HSCT board and the SCCD and OSS in the Department are informed, at agreed intervals, on the HSCT's performance in respect of social care and children's functions, including early notification of risks, resource pressures and legal challenges and proposed actions to address;

- timely action to address and/or prevent the escalation of any identified issues;

- the SCCD and, where appropriate, OSS are notified in a timely way of any relevant issues through established mechanisms[3] and proposed actions to address.

7.12 HSCT EDSWs will be supported in their responsibilities by a Social Care Governance Officer (HSCT Governance lead) who will report directly to the

[3] Established mechanisms include the Early Alert, Serious Adverse Incident, Adverse Incident, Untoward Incident and Complaints reporting systems.

EDSW in relation to the HSCT's compliance with social care and children's functions and related governance issues.

7.13 The HSCT Governance lead will be supported by an identified social work lead in each programme of care who is responsible for reporting to and informing the HSCT Governance lead in relation to their respective area's compliance with social care and children's functions and related governance issues.

7.14 HSCT Governance leads and identified social work leads are required to be suitably qualified professional social workers in accordance with Article 8(1) of the Health and Personal Social Services Act (Northern Ireland) 2001 (the 2001 Act).

7.15 Responsibility for the performance of HSCTs in respect of the exercise of functions rests fully with the organisation's Chief Executive Officer (CEO) who acts as the organisation's Accounting Officer. The CEO is required to account for the HSCT's performance as part of the formal Assurance and Accountability processes between the Department and the HSCTs.

7.16 Professional oversight arrangements ensure the Accounting Officer and the board of directors of each HSCT receive authoritative professional advice and analysis regarding their organisation's exercise of functions.

This enables each Accounting Officer to account to the Department as appropriate. The Department's Accounting Officer is advised by the CSWO and the Deputy Secretary of the DOH SPPG on all relevant performance and professional matters, including the exercise of relevant functions of statute.

7.17 As such, arrangements for the professional oversight of functions exercisable by HSCTs on behalf of the Department are an integral part of each HSCT's internal corporate governance and accountability arrangements and should not duplicate reporting processes in place for these purposes.

7.18 Due regard will be given by the Department and HSCTs as to the views of individuals and/or agencies in terms of the performance of the HSC system in improving and safeguarding the social wellbeing of people in Northern Ireland.

8.0 PERFORMANCE MANAGEMENT RE Social Care and Children's Functions Under Delegation Directions.

8.1 HSCTS are responsible for ensuring the approved Schemes for Delegation Directions are implemented by the HSCTs through agreed performance management and quality assurance mechanisms.

8.2 The Director of the SCCD is responsible for ensuring approved Schemes for Delegation Directions are properly implemented by the HSCTs to agreed standards. This includes:

- ensuring effective arrangements within the SCCD for monitoring and quality assurance of each HSCT's management and discharge of social care and children's functions in compliance with approved schemes and all statutory, regulatory and professional requirements;

- maintaining oversight of individual HSCT compliance with social care and children's functions through regular liaison with HSCTs and receipt and analysis of relevant information, data and reports;

- maintaining regional oversight of consistency of HSCTs' compliance with social care and children's functions and related governance issues and ensuring the best use of resources;

- taking prompt action to address and/or prevent escalation of any issues, including under performance or non-compliance;

- overseeing the implementation of HSCT improvement/action plans approved by the SCCD;

- advising the Deputy Secretary of SPPG and the CSWO/Deputy Secretary, at agreed intervals, on the HSCTs' performance in respect of social care and children's functions , including timely notification of risks, resource pressures and legal challenges and proposed actions to address;

- alerting the Deputy Secretary of SPPG, and the CSWO/Deputy Secretary in a timely way of any unresolved disputes, substantive issues or concerns regarding a HSCT's discharge of social care and children's functions and proposed actions to address.

8.3 The Director of SCCD will be supported by a Social Care Governance Officer. The Social Care Governance Officer will report directly to the Director of SCCD in relation to the HSCTs' compliance with social care and children's functions and related governance issues.

The Social Care Governance Officer will be supported by the professional social care commissioning leads for each programme of care in the SCCD of the SPPG and the HSCT Governance leads. The HSCT Governance leads will inform and/or report to the SCCD Governance lead on social care and children's functions and related governance issues to ensure a comprehensive overview of performance at programme of care level, individual HSCT level and regionally is available.

The Social Care Governance Officer and professional social care commissioning leads and HSCT Governance leads are required to be a suitably qualified professional social worker in accordance with Article 8(1) of the 2001 Act.

8.4 The Deputy Secretary of the DOH SPPG is ultimately responsible for ensuring approved schemes for Delegation Directions are implemented by the HSCTs through agreed performance management and quality assurance mechanisms.

9. STRATEGIC OVERSIGHT of Social Care and Children's Functions under Delegation Directions

9.1 OSS/the CSWO is responsible for maintaining a strategic professional oversight of the effectiveness of the SCCD arrangements for professional oversight of each HSCT's exercise of their social care and children's functions.

9.2 The Deputy Secretary of the SPPG and the CSWO/Deputy Secretary are responsible for ensuring that each HSCT discharges their responsibilities as the named 'authority' for the discharge of relevant social care and children's functions in accordance with the law, approved Schemes for Delegation Directions and relevant policies, guidance, standards and directions. This includes:

- ensuring effective arrangements within the Department to maintain ongoing oversight of all relevant information including the receipt and analysis of data and reports in respect of social care and children's functions submitted by HSCTs;

- ongoing engagement with the HSCT EDSWs through established mechanisms and as and when required;

- providing authoritative professional advice and/or direction from OSS/CSWO/Deputy Secretary, and Director of SCCD to the HSCTs to address identified issues of concern, non-compliance or under-performance;

- advising the Permanent Secretary and Departmental board at agreed intervals on social care and children's functions, including timely notification of risks, resources pressures or legal challenges and proposed actions to address.

9.3 In the event of significant concerns arising from any HSCTs performance in relation to the discharge of social care and children's functions, the Department may use its powers under Articles 10B of the Health and

Personal Social Services (Northern Ireland) Order 1991 to direct the HSCTs to take specific actions that the Department deems necessary to improve a HSCT's performance.

9.4 The CSWO will be supported in his/her responsibilities by the Deputy CSWO who will report directly to the CSWO on the HSCTs' discharge of social care and children's functions.

The Deputy CSWO will be supported by professional and policy officers with responsibility for professional and/or policy lead for children's and adult social care services.

The Deputy CSWO and professional officers are required to be suitably qualified social workers, registered with NISCC in accordance with Article 8(1) of the Health and Personal Social Services Act (Northern Ireland) 2001.

10. CONTINUOUS IMPROVEMENT Re Social Care and Children's Functions Under Delegation Directions

10.1 Arrangements for the professional oversight of social care and children's functions should support a systems-wide culture of learning and continuous improvement and contribute to HSCTs compliance with the statutory duty to monitor and improve the quality of services[4].

10.2 Continuous improvement will continue to be supported by:

- evidence-informed improvement initiatives;
- programmes of audit; and
- Identification and promulgation of good practice.

Evidence informed improvement initiatives

10.3 Proposals for improvement initiatives should be: designed and planned to improve outcomes for service users; informed by research, evidence and people's experiences of services; and measured for impact and outcomes.

Programmes of audit

[4] Article 34, HPSS Quality, Improvement and Regulation (Northern Ireland) Order, 2003

10.4 Each HSCT is required to plan and undertake an annual programme of audit as part of the internal monitoring and quality assurance of the discharge of social care and children's functions. The learning and outcomes of audit activity will be used to inform improvements in each HSCT's arrangements for the discharge of social care and children's functions.

10.5 Each HSCT will report on its audit and improvement activity in its end year report to the SCCD.

10.6 The HSCTs will carry out and/or commission a programme of audit to be undertaken each year as part of its performance management and monitoring arrangements. The learning and outcomes of this audit activity will be used to inform improvements in individual HSCT and/or regional arrangements for social care and children's functions.

10.7 The HSCTs will report on its audit and improvement activity in its end of year overview report to the Department.

10.8 The Department ensures an internal audit of the SCCD's arrangements for the professional oversight of HSCTs' discharge of social care and children's functions is carried out at agreed intervals, but no longer than 5 yearly intervals. The learning and outcomes of this audit activity will inform improvements in the management and professional oversight arrangements.

10.9 It is imperative that the Department and HSC audit activity does not duplicate their efforts. The outcomes of other relevant audit activity should be used by the Department, and HSCTs as part of their compliance with the requirements of:-

- Circular (OSS) 01 / 2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care And Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions); and

- Circular (OSS) 02 / 2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight.

10.10 All audits of Direction Delegations and performance management in respect of social care and children's functions should be led by suitably qualified staff in accordance with Article 8 (1) of the Health and Personal Social Services Act (Northern Ireland) 2001 who have relevant experience and/or expertise in audit and/or social care governance.

11. REPORTING ARRANGEMENTS

In-year reporting

11.1 Effective performance management and professional oversight is a dynamic process and involves ongoing monitoring and reporting throughout each reporting year. This is done through established Departmental mechanisms.

11.2 Timely reporting in respect of the exercise of social care and children's functions is important and early reporting of emerging concerns or significant issues is crucial in order to facilitate appropriate decision making and, where necessary, timely responses.

11.3 Any substantive issues regarding the exercise of social care and children's functions should be reported promptly to the SCCD in the Department to facilitate timely action.

End year reporting

11.4 End year reports provide an opportunity for both the HSCTs and the Department to take stock of performance throughout the year and plan for the future. End year reports should facilitate strategic decision making about actions required to further improve services and outcomes for service users.

11.5 Each HSCT is required to submit an annual end year report, approved by its HSCT board, on how it has exercised its social care and children's functions to the SCCD no later than end of May each year.

11.6 The HSCT end year report should include an analysis of data and performance to assist the HSCT board and the Department in their respective governance, accountability and strategic planning roles to identify the HSCT's:

- compliance with the law and agreed standards and targets;
- performance gaps and/or areas of concerns, including non-compliance with social care and children's functions;
- effectiveness of HSCT's monitoring and reporting arrangements;
- outcomes of in-year audit and improvement activity;
- outcomes for service users;

- new or emerging trends or pressures.

11.7 The SCCD will produce an annual end year overview report to the Office of Social Services (OSS), approved by the Deputy Secretary of the DOH SPPG, by the end of June each year based on its analysis of HSCTs' end year reports and any other relevant data and information gathered as part of its professional oversight throughout the year.

11.8 The end year overview report should reflect both operational performance and strategic issues and assist the OSS, the CSWO/Deputy Secretary and the Permanent Secretary in their governance, accountability and strategic planning roles including:

- overview and analysis of HSCTs' performance in respect of social care and children's functions , including good practice and performance gaps;

- level of compliance with the law, policy, procedures, guidance, professional standards and targets;

- outcomes of in-year audit and improvement activity;

- emerging pressures and/or concerns;

- regional comparison and trends.

11.9 The SCCD will agree an action/improvement plan with agreed timelines for implementation with each HSCT by end of June each year.

11.10 The SCCD will also submit within the same timeframe, either separately or as an integral part of its end year overview report: data on the configuration of the Social Work workforce in all Programmes of Care across HSCTs; an update on the qualification profile of the social work workforce in HSCTs including numbers of relevant qualifications achieved in-year against Departmental targets; the volume and range of learning and development activity including spend against Departmental commissioning priorities.

11.11 The CSWO/Deputy Secretary will advise the Permanent Secretary and Departmental board of the key findings of the approved end year overview report from the SCCD within 6 weeks' of receipt and/or confirmation of approval.

11.12 Where a significant issue is identified in the process of compiling end year reports which has not been previously reported during the year, the OSS should be alerted immediately by the SCCD in advance of submission of the end year report.

12. Chief Social Work Officer – Role and Responsibilities

Introduction

12.1 Chief Professional Officers, including a CSWO, are employed by the Department at a senior level to provide the Minister, Permanent Secretary and Department board with authoritative professional advice and insights in respect of the provision of the full range of health and social care.

12.2 The CSWO (who is also Deputy Secretary for the Social Services Policy Group)is the lead professional officer for social work and social care in Northern Ireland and sets the strategic direction for relevant service areas. S/he provides strategic professional advice and expertise to policy colleagues, government Departments, HSC agencies and other organizations as required.

The CSWO/Deputy Secretary of the SSPGsits as an executive member on the Departmental board.

12.3 The CSWO/Deputy Secretary of the SSPGD has a wide range of professional responsibilities including responsibility for the professional oversight of the exercise of statutory functions within an integrated HSC system. This oversight is part of the overall system within the Department for monitoring the delivery of the Department's policies by HSCTs and holding them to account.

12.4 The CSWO/Deputy Secretary is responsible for issuing and keeping under review all relevant Circulars, professional standards, guidance or directions in respect of arrangements for the exercise of social care and children's functions.

Accountability

12.5 The CSWO is directly accountable to the Permanent Secretary (PS) and to the Minister for the provision of authoritative professional advice and insights in respect of all social work and social care matters and for reporting on relevant social care and children's functions across a range of children's and adult services.

Professional Leadership

12.6 The CSWO is responsible for providing professional leadership for the social work and the social care workforces in Northern Ireland, including:

- Setting the strategic direction for social work and social care within an integrated HSC system;

- Promoting a strong voice for all adults, families, children and carers using social care services and for frontline workers delivering services in the development of policies, strategies and standards;
- Working collaboratively with others, including other Government Departments, the Executive Directors of Social Work (EDsSW) within the HSC system and other key stakeholders in the public, voluntary and private sectors to improve and safeguard the social wellbeing of people in Northern Ireland;
- Promoting and supporting evidence-informed approaches to decision making at practice, service and policy levels.
- Promoting and supporting a culture of innovation, continuous learning and improvement and implementation in social work and social care practice and service provision;
- Building and maintaining East/West, North/South and international professional relationships and networks to share best practice and learning;
- Communicating the positive contribution of social workers and social care workers in improving and safeguarding social wellbeing based on evidence and outcomes.

Professional Advice

12.7 The CSWO is responsible for providing authoritative professional advice and insights to the Minister of Health, and other Executive Ministers in respect of social work and social care matters including social care and children's functions, including:

- Providing authoritative professional advice and insights to the PS, senior policy colleagues, other Departments and their ALBs, the NI Assembly and its Committees, HSC agencies, community, voluntary and the independent sector, the Further and Higher Education Sector and the media.
- Working in collaboration with the Director of the DOH Strategic Planning and Performance Group, Social Care and Children's Directorate and HSCT EDsSW with regard to seeking and giving professional advice on social work and social care matters including social care and children's functions.
- Ensuring appropriate professional advice in the development and implementation of policies, strategies and standards and in Departmental responses to Regulatory reports, Judicial Reviews, Tribunals, Inquiries and Assembly Questions.

Senior Professional Practice Lead

12.8 The CSWO is responsible for making authoritative and final decisions on complex/controversial professional practice matters, including intervention action through the SCCD, including;

- Providing professional advice on the most complex cases, where individual cases may be the subject of public and/or media interests and in which the Minister may be asked/be required to become personally engaged;
- Ensuring appropriate professional input for discharging Departmental responsibilities in respect of Intercountry Adoptions in accordance with the Adoption (NI Aspects) Bill 2002 and obligations under the Hague Conventions;
- Professional endorsement of HSCT applications for admission of under 13s to secure accommodation in line with Volume 4 of the Children (NI) Order 1995 Regulations and Guidance;
- Discharging the responsibility of the Department's Child Protection Officer;

Professional Governance

12.9 The CSWO is responsible for ensuring effective arrangements within the Department for the approval of schemes for the exercise of Delegation Directions and professional oversight of social care and children's functions , including fulfilment of Corporate Parent duties, within an integrated HSC system in line with:-

- Circular (OSS) 01 / 2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care And Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions): and
- Circular (OSS) 02 / 2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight.

12.10 S/he is also responsible for:

- ensuring effective arrangements within the Department for professional advice and responses to professional issues raised by MLAs, members of the public or through established reporting mechanisms[5] that relate to social care and children's functions;
- Contributing as a senior professional lead to the Department's formal assurance and accountability arrangements with HSCTs;
- Accounting directly to the Permanent Secretary and the Departmental Board on the discharge of the Department's social care and children's functions;
- Promoting (alongside those responsible in the Department for advice on the commissioning system) a robust framework for commissioning and delivery in

[5] Established mechanisms include Early Alert, Serious Adverse Incident, Adverse Incident, Untoward Incident and Complaints reporting systems.

social care and children's services, including the continuing development of standards for social care and children's services;

- Escalating any issues of concern and/or risks, including issues regarding performance or resource or service pressures on social care provision, to the Permanent Secretary and relevant policy leads;
- Sponsorship of the Northern Ireland Social Care Council (NISCC), the Northern Ireland Guardian ad Litem Agency (NIGALA) and the Safeguarding Board for Northern Ireland (SBNI).

Professional Capacity and Capability

12.11 The CSWO is responsible for the promotion of professional standards, education, training and workforce regulation to ensure safe and effective practice and service provision, including social care and children's functions , and compliance with all relevant standards;

- Commissioning sufficient social work student places to ensure an adequate supply of qualified social workers to meet social acre and children's service needs;
- Contributing to workforce planning to identify the numbers and skills requirements of social workers and social care workers in specific practice/service areas for the future linked to service need;
- Setting the strategic direction and annual commissioning priorities and targets for the education and training of social workers and social care workers;
- Promoting a robust infrastructure for the professional development, supervision and support of social workers and social care staff
- Working collaboratively within the HSC system to agree strategic priorities in respect of building the capacity and capability of the social work and social care workforces;
- ensuring that social workers and all relevant social care workers are registered with the NISCC, comply with their Codes of Practice and associated regulatory requirements and take appropriate action for non- compliance;
- make recommendations, as necessary, to the Department in relation to professional and disciplinary matters regarding social services issues;

13.0 Deputy Chief Social Worker/Office of Social Services – Roles and Responsibilities

Introduction

13.1 The Office of Social Services (OSS) is a Professional Social Work Group[6] within the Department of Health led by the DCSWO.

Accountability

13.2 The DCWO reports directly to the CSWO/Deputy Secretary of the SSPG. Role

13.3 The DCSWO and OSS support the professional social work role of the CSWO.

13.4 The DCSWO/OSS provides professional social work advice and expertise to the Minister, the DoH, other government departments, social care and criminal justice agencies, education, and the voluntary and community sector in the arena of social work and social care and children's functions.

13.5 The DCSWO/OSS works with others to ensure that social work and social care services are responsive to the needs of people living and working in Northern Ireland and are of the highest possible standard in keeping with the resources available.

The DCSWO/OSS is responsible for:

- promoting the quality of social work and social care services, improving their efficiency and effectiveness and ensuring the safety and well-being of service users and carers;

- providing professional advice and expertise to Ministers, government departments, agencies, statutory, voluntary, private and community sector organisations, where appropriate, on the formulation of policy and procedures;

- the implementation and review of social care and children's services and related health policies, and the efficient and effective delivery of social work and social care services;

- developing and promoting policy on training, qualifications and staff development for the social services workforce and ensuring effective policy implementation;

[6] In accordance with Article 8 (1), Health and Personal Social Services Act (Northern Ireland) 2001, anyone taking or using the title social worker, or any title or description implying same, is required to be a qualified social worker and registered on the Northern Ireland Social Care Council (NISCC) Social Work Register.

- Leading on social work and social care workforce policy and strategy in conjunction with DoH Workforce Policy Unit;

- The development of social work and social care professional and quality standards;

- sponsoring and holding to account the Northern Ireland Social Care Council (NISCC), which is the regulator of the social care workforce and professional social work training in Northern Ireland;

- facilitating the conduct of business between DoH, commissioners and providers of social work and social care services and other agencies;

- Ensuring appropriate professional input for discharging Departmental responsibilities in respect of Intercountry Adoptions in accordance with the Adoption (NI Aspects) Bill 2002 and obligations under the Hague Conventions;

- Professional endorsement of HSCT applications for admission of under 13s to secure accommodation in line with Volume 4 of the Children's (NI) Order 1995 Regulations and Guidance.

14.0 Deputy Secretary of the DOH Strategic Planning and Performance Group Role and Responsibilities

Introduction

14.1 The Deputy Secretary of the DOH SPPG is responsible for the performance management of the SCCD within the SPPG.

14.2 The Deputy Secretary of the DoH SPPG sits as an executive member of the DoH Board.

Accountability

14.3 The Deputy Secretary of the SPPG is directly responsible to the Permanent Secretary of the DoH.

Role

14.4 S/he is required to work collaboratively with the CSWO/Deputy Secretary of the SSPG who is responsible for providing professional leadership and strategic direction for social work and social care within an integrated HSC system.

14.5 The Deputy Secretary of the SPPG is also responsible for the performance management of the exercise of social care and children's functions by HSCTs and for providing strategic advice at board level on future developments and direction.

14.6 The CSWO/Deputy Secretary of the SSPG and the Deputy Secretary of the SPPG Group are together responsible for ensuring coherent regional arrangements for the delivery of relevant services.

14.7 The Deputy Secretary of the SPPG is responsible for the oversight, performance management and direction of the SCCD in relation to Social Care and Children's Functions and reports on same to the Department's Permanent Secretary, who in turn reports to the Minister

14.8 The SPPG is also responsible for providing strategic oversight and ensuring that each HSCT discharges their responsibilities as the named 'authority' for the discharge of relevant social care and children's functions in accordance with the law, approved Schemes for Delegation Directions and relevant policies, guidance, standards and directions; and for providing strategic advice at board level on future developments and direction.

14.9 The SPPG, working collaboratively with OSS, is responsible for reviewing Schemes of Delegation Directions received from HSCTs; and ensuring approved Schemes are implemented by HSCTs through agreed performance management and quality assurance mechanisms.

14.10 The SPPG consider and make determinations on recommendations and advice from the Director of SCCD, after consultation with the CSWO, for the revocation of Delegation Directions to HSCTs and recommend and advise Permanent Secretary on same.

14.11 The SPPG consider notifications of risk, resource pressure and legal challenges and proposed actions to address; escalating to the Deputy Secretary/CSWO, Permanent Secretary and the Departmental Board as necessary.

14.12 The SPPG approve annual end year overview report received from SCCD for submission to OSS.

14.13 SPPG, provide the approved end year overview report and any proposed actions to OSS, who provide the CSWO/Deputy Secretary with a professional overview of issues, who in turn, advises the Permanent Secretary and Departmental Board.

15.0 Director of the SCCD in the SPPG – Role and Responsibilities

Introduction

15.1 The Director of the Social Care and Children's Directorate is responsible for the professional oversight, governance, performance management and accountability and strategic oversight of HSCTs in relation to the exercise of social care and children's functions.

15.2 The Director of the SCCD is, in accordance with Article 8 of the Health and Personal Social Services Act (Northern Ireland) 2001, required to be a social worker and a registrant with the Northern Ireland Social Care Council (NISCC). S/he works collaboratively with the Deputy CSWO/OSS and the CSWO/Deputy Secretary of the SSPG who are responsible for providing strong professional leadership and strategic direction for social work and social care within an integrated HSC system.

15.3 The Director of the SCCD is also responsible for the review of the Schemes of Delegation Direction submitted by HSCTs, in collaboration with OSS, and recommending the approved schemes to the CSWO.

Accountability

15.4 The Director of the SCCD reports directly to the Deputy Secretary of the SPPG, in respect of compliance and performance management issues related to the delivery of social care and children's functions and, through (OSS), to the Deputy Secretary of SSPG/Chief Social Work Officer, in respect of professional social work issues related to same.

Performance Management Accountability

15.5 The Director of SCCD is responsible for providing managerial accountability for the performance of the social work and the social care workforces in Northern Ireland, including:

- Contributing to the strategic direction for social work and social care within an integrated HSC system;
- Promoting a strong voice for all adults, families, children and carers using social work and social care services;
- Working collaboratively with the HSCTs' EDsSW and other professional leads, agencies and key stakeholders in the public, voluntary and private sectors to improve and safeguard the social wellbeing of people in Northern Ireland;
- Promoting and supporting evidence-informed approaches to decision making at practice, service and policy levels.
- Promoting and supporting a culture of innovation, continuous learning and improvement and implementation in social work and social care practice and service provision;
- Building and maintaining internal and cross-Departmental regional relationships and networks to share best practice and promote continuous learning;
- Communicating the positive contribution of social work and social care services to improving and the social wellbeing of adults, families, children and carers;

- Providing strong managerial leadership across different staff groups, professions and Government Departments to plan, commission, secure and sustain social care and children's social care services based on assessed need, including child and adult safeguarding and protection services, to improve and safeguard social wellbeing of people in Northern Ireland;
- Building and sustaining effective partnerships with and between all relevant bodies in the statutory, voluntary, community and private sectors, to improve the health and social wellbeing of adults, children and young people and their families.
- Working in collaboration with the DCSWO/OSS, the CSWO/Deputy Secretary of SSPG and HSCT EDsSW to support their professional advice on social work and social care matters and in relation to social care and children's functions.
- Providing senior managerial advice in the development and implementation of policies, strategies, standards and guidance and in Departmental responses to Regulatory reports, Judicial Reviews, Tribunals, Inquiries and Assembly Questions;
- Responsibility for ensuring that the SCCD:-

    - discharges its duties in relation to social care and children's functions and in respect of children's services planning as required by the Children (Northern Ireland) Order 1995 as amended by the Children (1995 Order) (Amendment) (Children Services Planning Order) (Northern Ireland) 1998;

    - fulfils its obligations as set out in departmental circulars and guidance;
    - provides authoritative managerial and oversight advice and guidance and recommendations to Departmental Board in relation to the numbers of children in need[7] within the HSCT's area, the nature and extent of those needs and the services requires to meet those needs;

    - contributes professional social work advice to the CSWO on guidance and recommendations to Departmental Board on the most complex cases, where individual cases may be the subject of public and/or media interests.

- Taking a lead managerial role for the development of SCCD's strategic and operational policies for meeting the social care needs of adults, children and young people, families and carers;

[7] A definition of 'child in need' is provided in Article 17 of the Children (Northern Ireland) Order 1995

- Involving and listening to children, adults who use services , families and carers to ensure their views inform the SCCD's planning and commissioning of services for them;
- Ensuring compliance with professional and other quality standards through appropriately informed commissioning of social services at both regional and local levels and through audit and review of services;

Professional Governance

15.6 The Director of SCCD is responsible for establishing and operating an efficient system to ensure effective social care governance arrangements within the SCCD and overseeing social care governance arrangements within SCCD;

- Ensuring, in collaboration with the CSWO/Deputy Secretary and OSS, that there are effective arrangements within the SCCD for the managerial and professional oversight of the discharge of social care and children's functions, including fulfilment of Corporate Parent duties within an integrated HSC system in line with:-
    - Circular (OSS) 01 / 2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care And Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions): and;
    - Circular (OSS) 02 / 2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight;

- assuring the SCCD is discharging relevant functions effectively and in accordance with statutory requirements, departmental circulars and guidance and, where appropriate, take remedial action;
- Managerial responsibility and accountability for the effectiveness, availability, quality and value for money for social care and children's services commissioned by, and delivered on behalf of, the SCCD;
- Providing managerial leadership and ensuring regional consistency of high standards of social work and social care services provided to adults, families, children and carers by HSCTs;
- ensuring the appropriate collection, maintenance and analysis of data to monitor the discharge of social care and children's functions and sharing such information with the Department;
- ensuring that resources allocated to and by the HSCTs are efficiently and effectively used to ensure the safe and effective discharge of social care and children's functions;
- Providing feedback to HSCTs regarding their performance in respect of social care and children's functions and the agreement of action plans to address non-

compliance and/or areas of concern, ensuring the resolution of any performance issues in respect of a HSCT's discharge of social care and children's functions;

- Oversight of the production of an Annual Action Plan for each HSCT identifying improvements required in relation to a HSCT's performance in respect of social care and children's functions and Corporate Parenting responsibilities, a prescribed timescale for actions required and arrangements for review and assurance that improvements have been achieved and maintained;
- Ensuring, in collaboration with CSWO/Deputy Secretary, that the permanent Secretary and Departmental Board are appropriately briefed in relation to HSCTs' discharge of social care and children's functions, the Action Plans agreed with each HSCT in respect of social care and children's functions and Corporate Parenting responsibilities, and any instances of non-compliance
- the production and submission to the Department of an annual regional Overview Report in respect of the HSCTs' discharge of social care and children's functions, including the SCCD's critical analysis of the HSCTs' performance;
- escalating
    - issues that the SCCD has been unable to resolve with a HSCT
    - issues of concern and/or risks, including resource issues and/or service pressures in relation to social care and children's functions,

  to the CSWO/Deputy Secretary and SPPG Deputy Secretary and in turn to the Permanent Secretary and the Departmental Board as appropriate.

Capacity and Capability

15.7 The Director of SCCD is responsible for working, collaboratively within DoH and HSCTs, to ensure strategic priorities in respect of building the capacity and capability of the social work and social care workforces are met, including;

- Promoting and monitoring compliance with professional and regulatory standards/requirements for the workforce and commissioning relevant education and training to ensure safe and effective practice and service provision, including discharge of social care and children's functions ;
- Specifying, in agreement with the OSS, DCSWO and CSWO, through the commissioning process, the workforce skills and qualifications required for high quality, safe and effective service provision;
- Advising, in agreement with the OSS, DCSWO and CSWO the Permanent Secretary and Minister on staffing levels which are sufficient to ensure the safe discharge of social care and children's functions and delivery of commissioned social work and social care services by HSCTs for which the SCCD is responsible;
- Promotion of professional standards, education, training and workforce regulation to ensure safe and effective practice and service provision, including the discharge of social care and children's functions , and compliance with all relevant standards;
- Contributing to workforce planning to identify the numbers and skills requirements of social workers and social care workers in specific practice/service areas for the future linked to service need;

- Ensuring that each HSCT has adequate numbers of professionally qualified social work staff and social care staff to ensure effective management and delivery of effective services to fulfil social care and children's functions;

    - Ensuring in agreement with the OSS, DCSWO and CSWO, that adequate, high quality education and training is provided for social work students and social workers and social care workers employed in HSCTs to ensure the safe and effective discharge of social care and children's functions ;

    - Promoting a robust oversight infrastructure to ensure that all social workers receive professional supervision in compliance with professional standards and regional guidance and that social care workers receive appropriate and adequate training, supervision and support;

    - Ensuring that systems are in place to ensure that social workers and all relevant social care workers are registered with the NISCC, comply with their Codes of Practice and associated regulatory requirements and take appropriate action to remedy non-compliance.

16.0 HSCT Executive Director of Social Work (EDSW) – role and responsibilities

Introduction

16.1 The role of a HSCT EDSW is to provide strong professional leadership for social work and social care across the full range of social care services provided by or commissioned within his/her HSCT for children and adults in the statutory, voluntary and private sectors; and providing assurance that satisfactory arrangements are in place for the exercise of social care and children's functions by the HSCT.

This includes professional responsibility for ensuring the exercise of social care and children's functions in accordance with the law, the approved Scheme for the exercise of Delegation Directions to agreed professional standards and for providing strategic advice at board level on future developments and direction.

The EDsSW have key responsibilities within the HSCT to provide professional advice and support to the CEO and HSCT Board to ensure that all legislative requirements and social care and children's functions are fulfilled in compliance with regulations, guidance and procedures and to a high quality standard, including high professional standards.

The EDSW is responsible for seeking assurances from any other Operational Directors who have responsibility and accountability for the relevant service area that all social care and children's functions are being fulfilled to the required standard.

HSCT EDSWs are prescribed members[8] on HSCT Boards and are required to participate in and share corporate responsibility for the work of the HSCT.

Accountability

The EDsSW are responsible for the managerial and professional oversight of the social care and children's functions exercised by the HSCTs as directed by the Department and are directly accountable to their HSCT's CEO who reports to the HSCT Board in relation to the HSCT's performance in respect of social care and children's functions.

EDsSW are directly accountable to the HSCT CEO and HSCT Board for the provision of authoritative professional advice and insights in respect of all social work and social care matters, social care and children's functions and for reporting on relevant statutory functions across a range of children's and adult services.

Role

A summary of the professional responsibilities of the EDsSW are provided below:

Professional Leadership

- Providing strong professional leadership for the social work and the social care workforces in the HSCT , ensuring high standards of social work and social care provision and full compliance with legislative, policy and procedural requirements and compliance with standards established by the Department;
- Providing professional advice and support to the CEO and HSCT Board to assist setting the strategic direction for social work and social care within the HSCT;
- Promoting a strong voice for all adults, families, children and carers who use or need social work and social care services;
- Supporting HSCT managers, frontline social workers and social care workers delivering social care and children's functions and services on behalf of the HSCT;
- Working collaboratively with other EDsSW, the Director of the DOH SPPG and the CSWO/Deputy Secretary to deliver social care and children's functions and to improve and safeguard the social wellbeing of people in Northern Ireland;
- Working collaboratively within the HSC system and with other key stakeholders in the public, voluntary, community and private sectors to improve and safeguard the social wellbeing of people in Northern Ireland;

[8] Section 4(1)(d) The Health and Social Services HSCTs (Membership and Procedure) Regulations (Northern Ireland) 1994

- Promoting and supporting evidence-informed approaches to decision making at managerial and operational practice levels.
- Promoting and supporting a culture of innovation, continuous learning and improvement and implementation in social work and social care practice and service provision;
- Communicating, at local and regional levels, the positive contribution of social workers and social care workers in improving and safeguarding social wellbeing based on evidence and outcomes.

Professional Advice

- Responsibility for giving advice and assistance to the HSCT in determining its policies and strategies for personal social services and for executing those policies and strategies to deliver social care and children's functions;
- Advising the HSCT on professional social services issues and ensure robust professional governance arrangements for the exercise of social care and children's functions within Children's and Adult Social Care Services;
- Giving advice and assistance to the HSCT Board and CEO in determining its policies and strategies for social care services and for executing those policies and strategies ;
- Advising and assisting the HSCT Board and CEO in determining its expenditure on personal social services and securing the resources required to deliver social care services, including exercise of social care and children's functions , and in tracking expenditure on service delivery;
- Providing authoritative professional advice and insights to the CEO and HSCT Board in respect of social work and social care matters and social care and children's functions;
- Proving authoritative professional advice and insights to other professional leads, partner and key stakeholder organisations, the independent sector and the media.
- Working in collaboration with the Director of the DOH Director of SCCD, other EDsSW and the CSWO/Deputy Secretary with regard to seeking and giving professional advice on social work and social care matters and social care and children's functions.
- Ensuring appropriate professional advice in the development and implementation of HSCTs policies, strategies and standards and in responses to Regulatory reports, Judicial Reviews, Tribunals, Inquiries and Assembly Questions.

Senior Professional Practice Lead

- Providing authoritative professional advice to the CEO and, when necessary, making authoritative and final decisions on complex/controversial professional social work and social care practice matters and social care and children's functions on behalf of the HSCT;
- Providing authoritative professional advice and, as necessary, making decisions/recommendations on the most complex social work and social care cases

and social care and children's functions, where individual cases may be the subject of public and/or media interests;

- Encouraging the development and maintenance of relationships with the voluntary and private sectors to foster constructive and collaborative relationships.

Professional Governance

- Ensuring compliance with the general guidance issued by the Department of Health and within the terms of contracts with purchasers;
- Ensuring effective arrangements within the HScTs for the professional oversight of the exercise of social care and children's functions, including fulfilment of Corporate Parent duties, within an integrated HSC system in line with:-

    - Circular (OSS) 01 / 2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care And Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions): and

    - Circular (OSS) 02 / 2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight.

- Ensuring effective arrangements within the HSCT for professional advice and responses to social work and social care issues and social care and children's functions raised through established reporting mechanisms;
- Accounting directly to the HSCT's CEO and HSCT Board on the exercise of social care and children's functions and ensuring they are briefed about the HSCT's performance in respect of social care and children's functions and Corporate Parenting responsibilities and any instances of non-compliance
- Implementing any actions or directions agreed within the HSCT to address any issues of under-performance and/or non-compliance;
- Promoting a robust framework for commissioning and delivery in social care services, including the development of standards for social care services to deliver services.
- Escalating any issues of concern and/or risks, including issues regarding performance or resource or service pressures on social work/social care provision, to the HSCT's CEO and HSCT Board;
- Submitting to the Department for approval the Schemes for the exercise of social care and children's functions ;

- Ensuring that the HSCT's legal responsibilities in relation to social care and children's functions are assigned and the necessary systems and procedures developed within the context of the scheme devised by the HSCT and agreed by SCCD and the Department;
- Monitoring the operation of those systems and procedures and reporting to the HSCT Board;
- Ensuring that an appropriate system of professional audit exists for assessing and reviewing the quality of social work and social care practice and services and the delivery of social care and children's functions;
- Monitoring, evaluating and quality assuring the provision of social care services commissioned by the Regional Group and in particular the exercise of social care and children's functions through audit and review;
- Establishing appropriate monitoring arrangements to assure the SCCD and Department that the HSCT is exercising social care and children's functions effectively and in accordance with statutory requirements, departmental circulars and guidance and, where appropriate, taking immediate remedial action;
- Ensuring the appropriate collection, maintenance and analysis of data to monitor service provision, including the exercise of social care and children's functions, and sharing such information with the SCCD and Department;
- Establishing and operating an efficient system to ensure effective social care governance arrangements within the HSCT and to oversee social care and children's functions and the social care governance arrangements associated with them within the HSCT;
- Submitting an annual report, including a self-assessment and critical analysis of performance, to the SCCD, OSS and Department on the exercise of social care and children's functions;
- Escalating any issues of concern and/or risks, including resource issues and/or service pressures, to the HSCT Board and, where appropriate, to the SCCD and Department.

Professional Capacity and Capability

- Contributing to workforce planning within the HSCT to identify the numbers and skills requirements of social workers and social care workers in specific practice/service areas for the future linked to service need;
- Advising the HSCT Board and CEO on staffing levels which are sufficient to ensure the safe exercise of social care and children's functions and social work and social care services for which the HSCT is responsible;
- Ensure all social work staff have a working knowledge of and comply with all relevant legislation, regulations, Departmental Circulars, policies, procedures, protocols and guidance in their practice, exercise of social care and children's functions and delivery of social care and children's social care services;

- Promoting high standards of professional practice by identifying training needs and ensuring social workers and social care staff receive appropriate learning, training and development opportunities and professional supervision to support effective practice and the safe exercise of social care and children's functions;
- Working collaboratively within the HSC system to agree strategic priorities in respect of building the capacity and capability of the social work and social care workforces;
- Ensuring that social workers and all relevant social care workers are registered with the NISCC, comply with their Codes of Practice and associated regulatory requirements and take appropriate action for non-compliance;
- Make recommendations, as necessary, to the HSCT in relation to professional and disciplinary matters affecting social services staff.