Health and Social Care Board

Public Health Agency

Draft Commissioning Plan 2019/20

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FINAL

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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

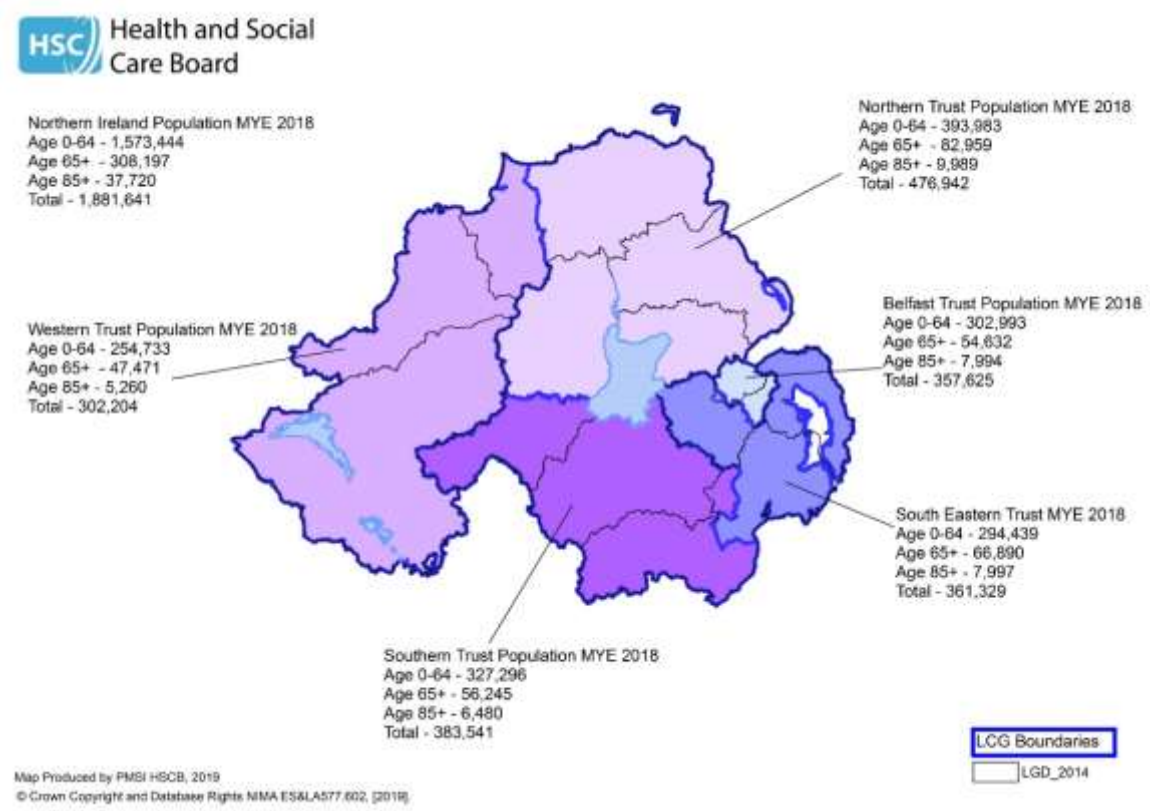
According to the recently published Mid-Year Estimates for 2017, Northern Ireland has the fastest growing population in the UK. Some of the key demographic changes are noted below:

- 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

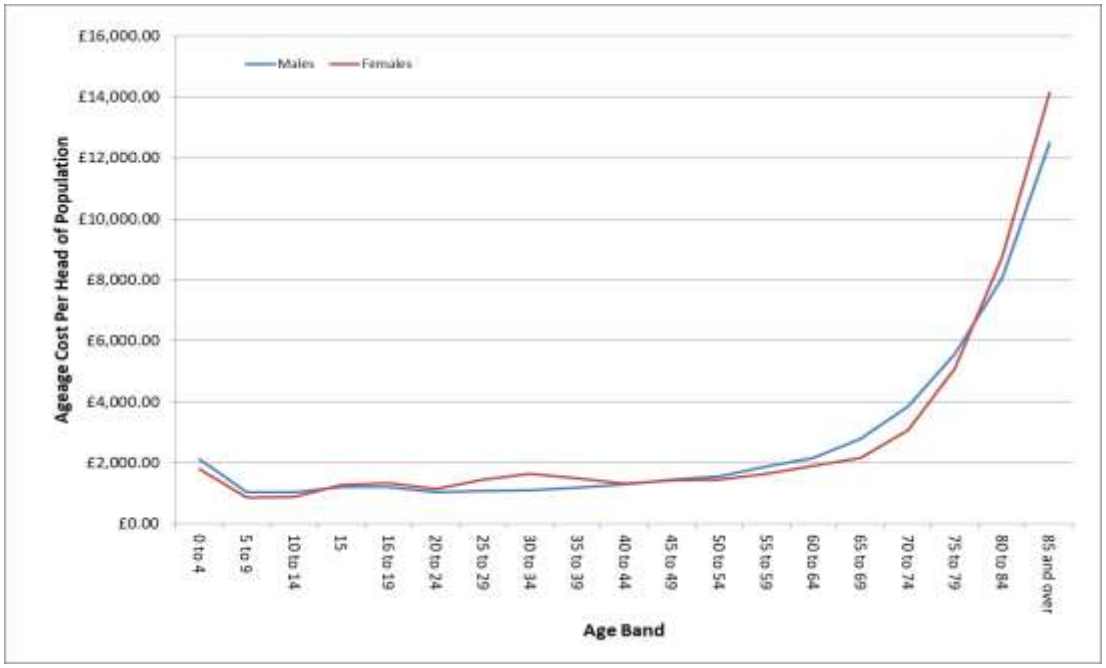
Northern Ireland resident population split by LCG / Trust area



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.

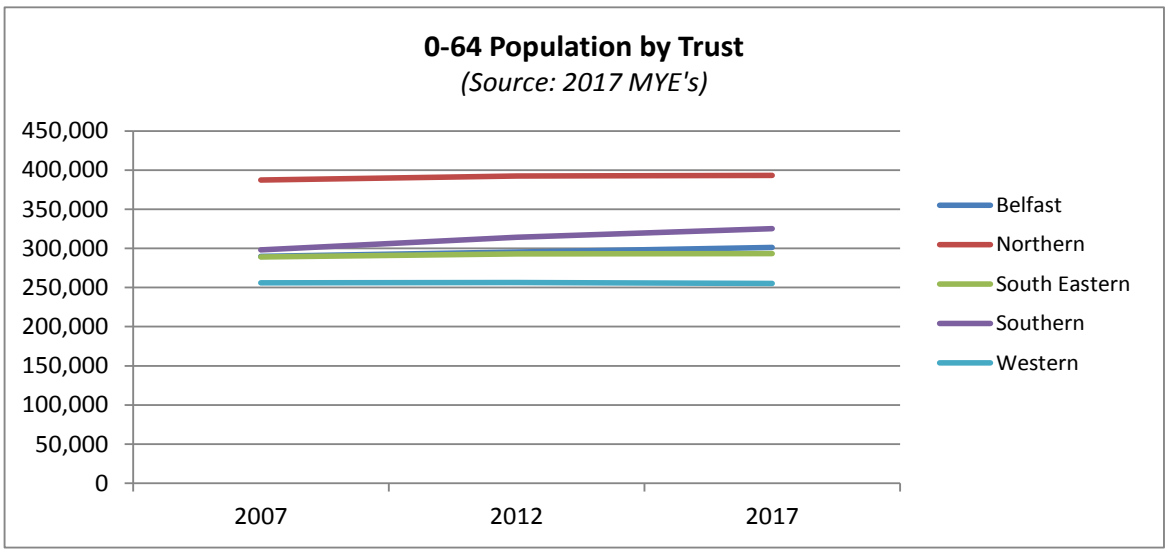
Total population percentage across age bands by area

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%

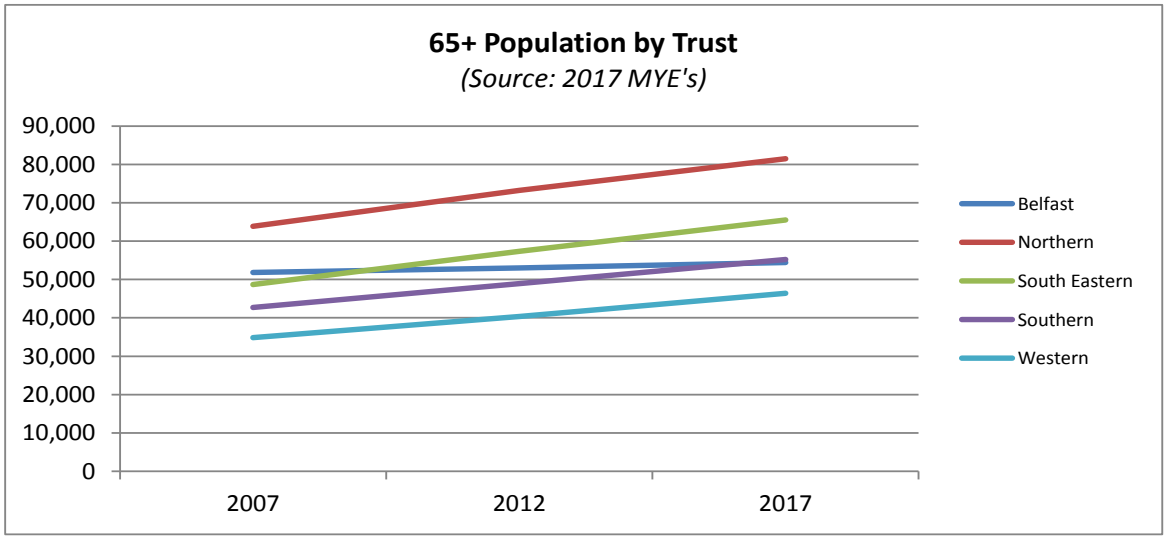
Figures 3 and 4 shows the estimated population numbers for each of the age bands and how these numbers have changed in the decade between 2007 and 2017.

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%.

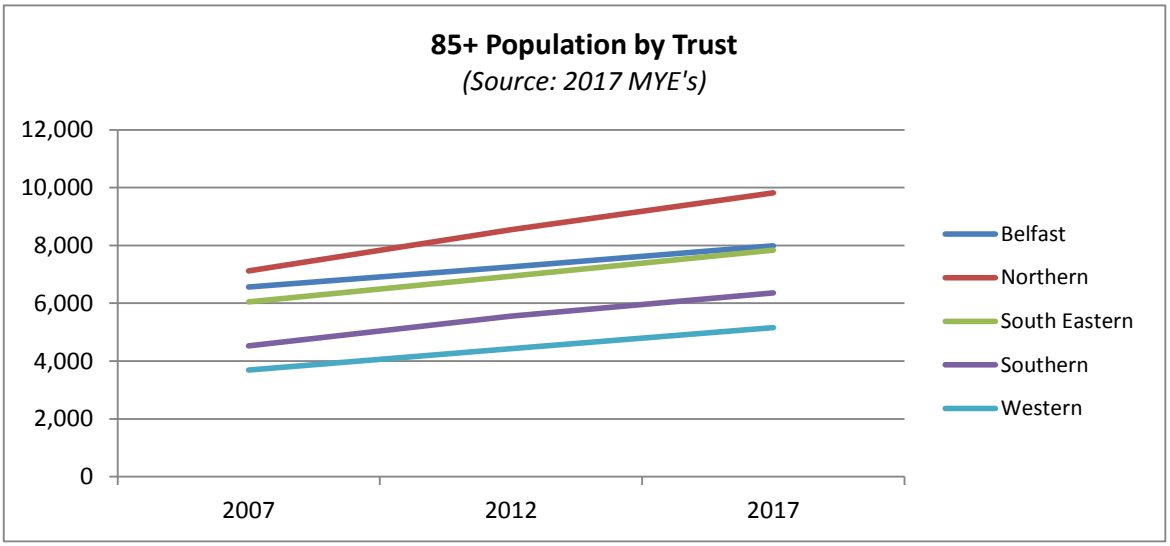
Figure 4
Over 65 population



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

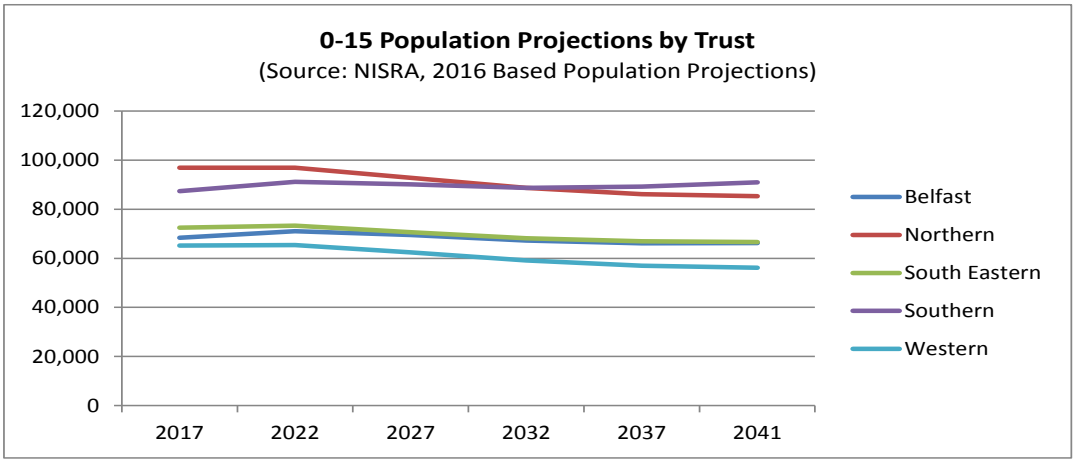
Over the 10 year period from 2017-2027, the population of Northern Ireland is projected to increase by 4 per cent to reach 1.946 million; rising again to 1.971 million by mid-2032 (an increase of 5.3 per cent).

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

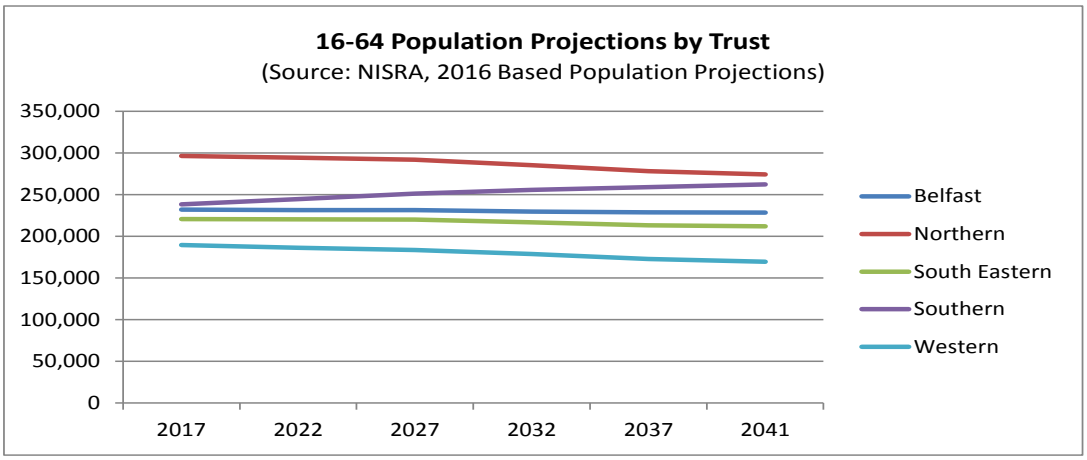
The tables and charts below illustrate the anticipated demographic changes over the next 24 years in each of the LCG/Trust areas (0-15, 16-64, 65+ and 85+ population).

Figure 6
Age 0-15 Population Projections by Trust



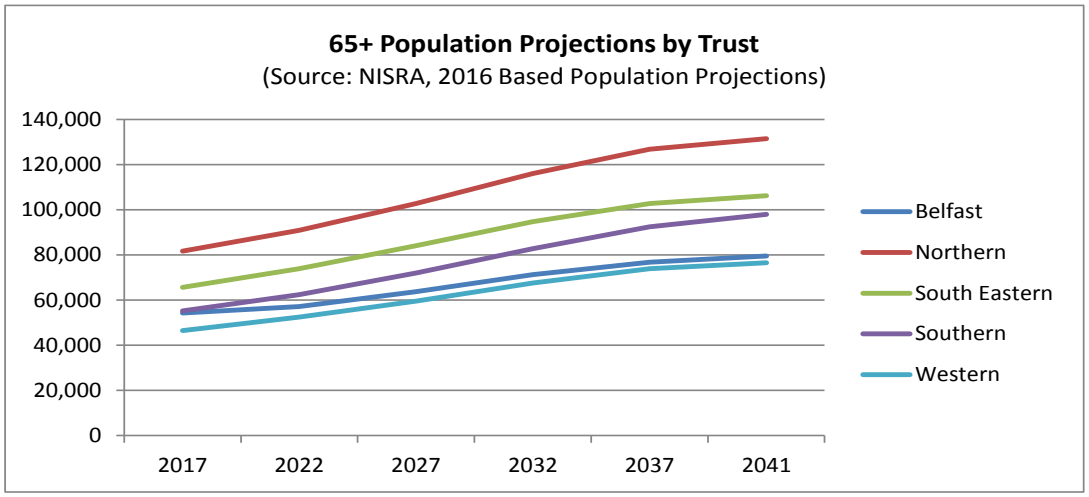
By 2041, it is projected that the 0-15 population in Northern Ireland will be approximately 365,000, an estimated decrease of 6% from 2017. The Southern Trust/LCG area is projected to have a 4% growth and the Western Trust/LCG area a projected decrease of 14%.

Figure 7
Age 16-64 Population Projections by Trust



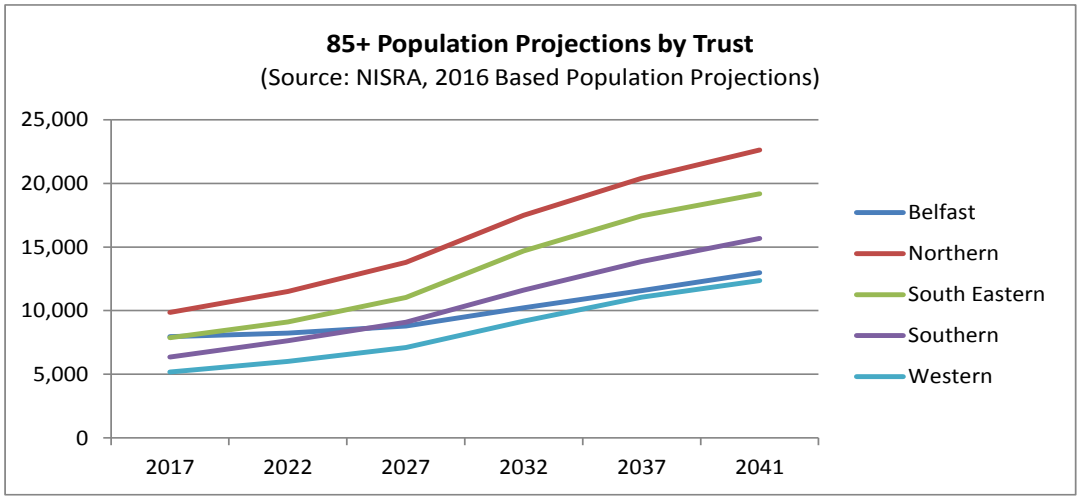
By 2041, it is projected that the 16-64 population in Northern Ireland will be approximately 1.15 million, an estimated decrease of 3% from 2017. The Southern Trust/LCG area is projected to have a 10% growth and the Western Trust/LCG area a projected decrease of 11%.

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



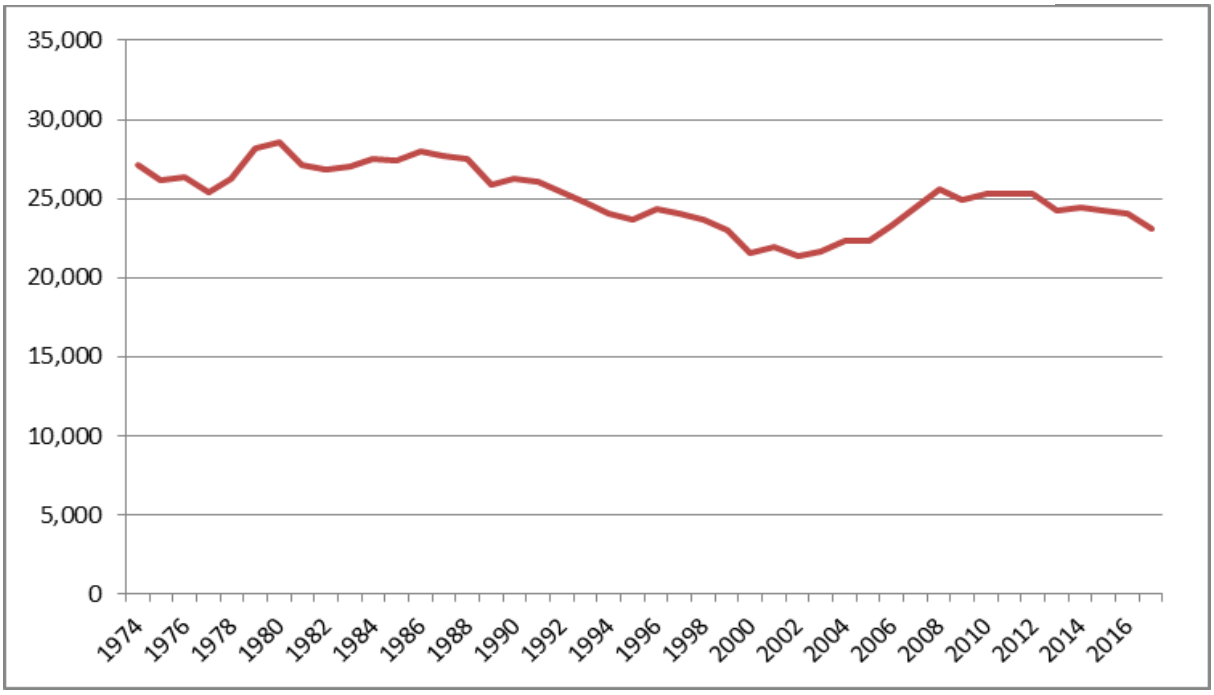
As widely expected, by 2041, it is projected that the 85+ population in Northern Ireland will be approximately 83,000, an estimated increase of 122% from 2017. By 2041, 4.1% of the population will be in this age bracket. All Trust/LCG areas will experience significant increases in this population with 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

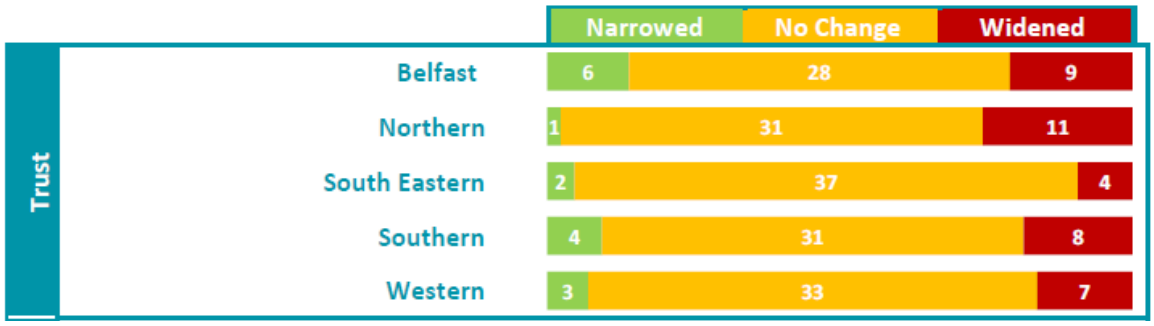
Factors outside the direct responsibility of the HSC system can also have significant implications for the health and well-being of our population. Health status can be influenced by socio economic factors such as deprivation which impact on disease prevalence and rates of mortality in local populations. 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



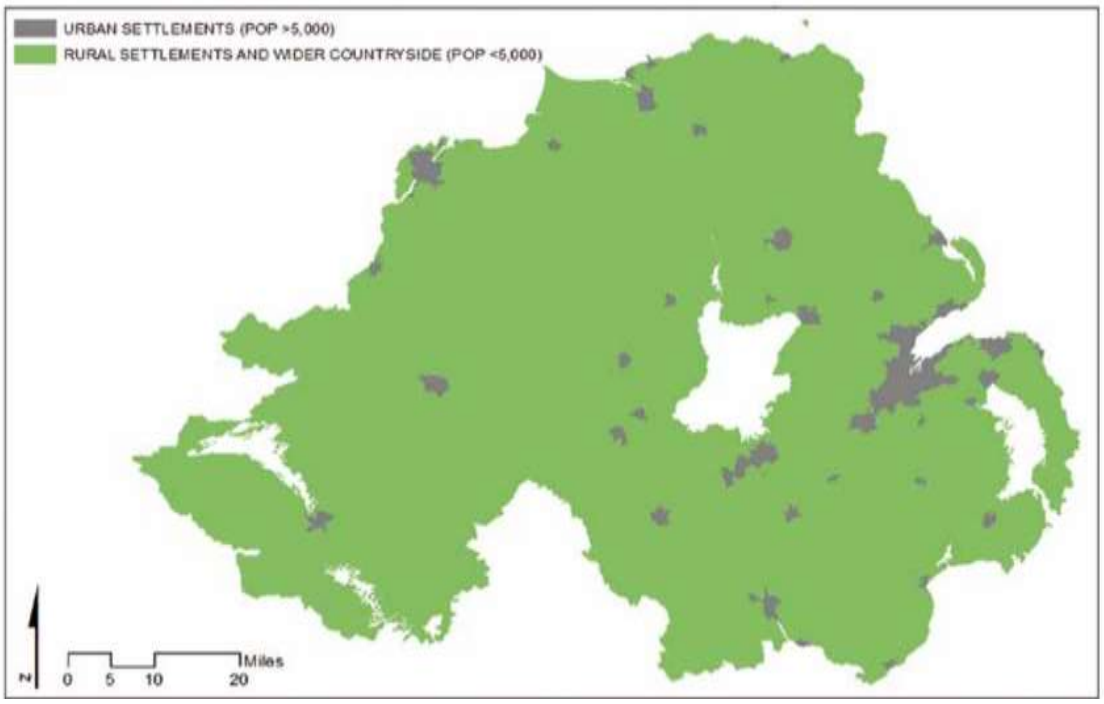
Source: Health Inequalities Annual Report 2019, Public Health Information & Research Branch, DoH

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

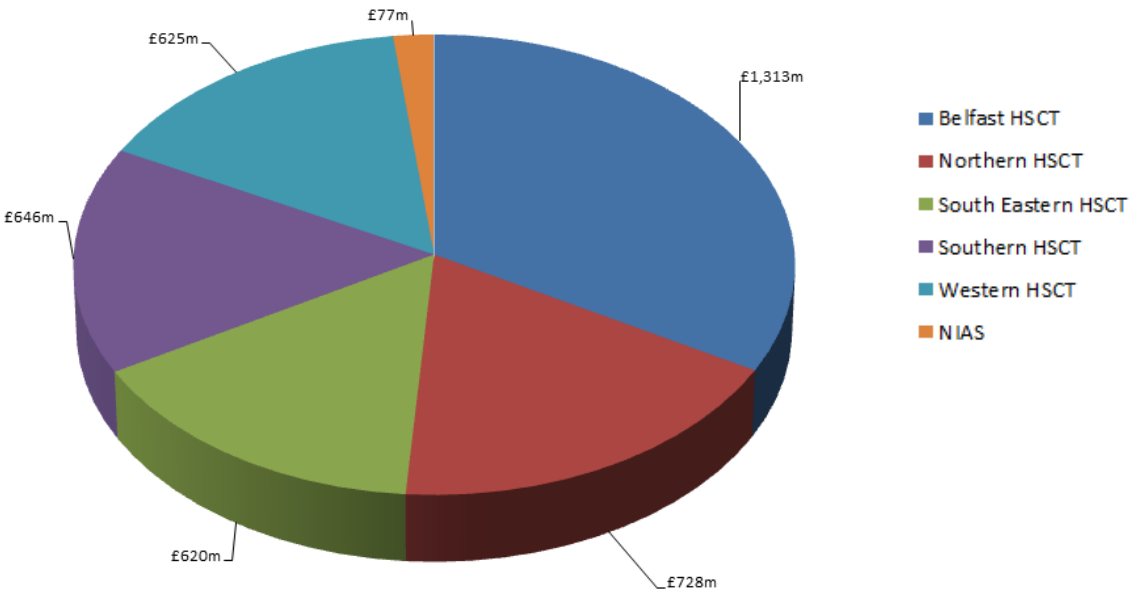
Table 9

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.

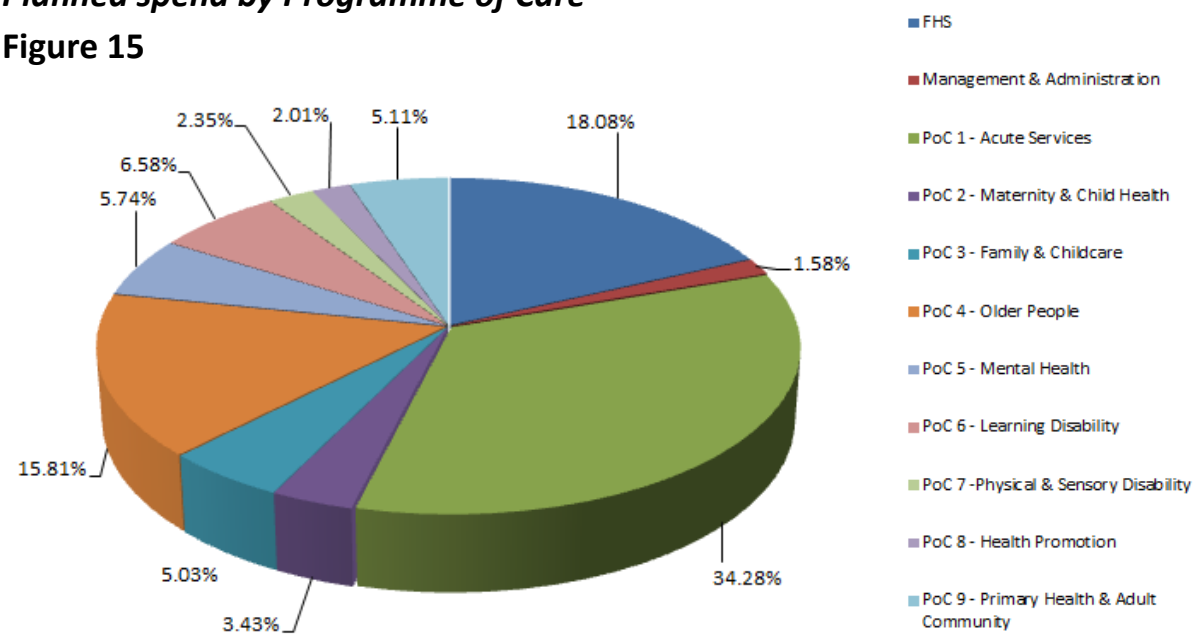
The HSCB will review these plans including any efficiency and savings proposals to ensure their deliverability and acceptability in the context of the need for financial breakeven, safety and quality considerations.

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

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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.