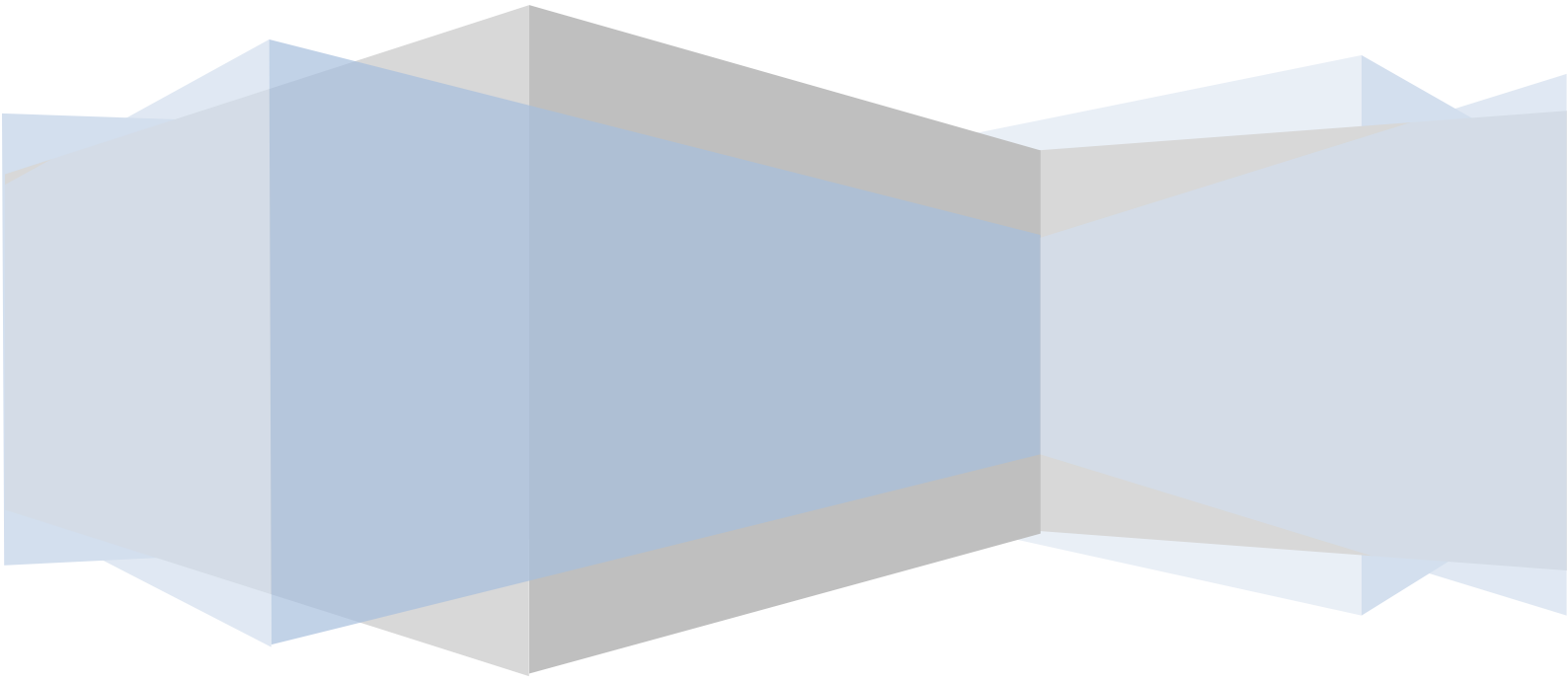
Health and Social Care Board

Public Health Agency

Commissioning Plan 2016/17



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Foreword

The 2016/17 Commissioning Plan describes the actions that will be taken across health and social care during 2016/17 to ensure continued improvement in the health and wellbeing of the people of Northern Ireland within the available resources. The Plan has been developed in partnership by the Health and Social Care Board and the Public Health Agency, and responds to the Commissioning Plan Direction as approved by the Minister for Health, Social Services and Public Safety, and formally issued on the 11 April 2016.

The Commissioning Plan describes the actions to be taken across Health and Social Care to ensure continued improvement in health and wellbeing of the people of Northern Ireland within the available resources.

The Plan also 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 and reform and transformation opportunities.

However, it should be noted that the Plan does not seek to highlight all of the work being taken forward by HSCB/PHA in 2016/17. 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 more direct oversight by the Department. The Plan outlines a number of key investments to be made in 2016/17 consistent with prior discussion with the Department. Trusts have already been provided with indicative allocations – from these allocations Trusts will be required to respond appropriately to the changing patient and client needs and to the specific service pressures identified within the Plan.

The Ministerial Themes and Outcomes highlight the need to redesign and transform services in order to:

- Ensuring that people are able to look after and improve their own health and wellbeing and live in good health for longer
- Ensure people using health and social care services are safe from avoidable harm
- Ensure people who use health and social care services have positive experiences of those services
- Provide health and social care services are centred on helping to maintain or improve the quality of life
- People are supported to recover from periods of ill health and are able to live independently and at home or in a homely setting in the community
- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
- Resources are used effectively and efficiently in the provision of health and social care services.
- People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide.

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

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

1.0 Introduction and Context

1.1 The Purpose of the Plan

The Commissioning Plan sets out the priorities to be taken forward by HSC and providers. The Plan has been developed in partnership by the Health and Social Care Board and the Public Health Agency, and responds to the Commissioning Plan Direction as approved by the Minister for Health, Social Services and Public Safety, and formally issued on the 11 April 2016. The priorities outlined within the Commissioning Plan also take account of the 2016/17 investments announced by the Minister for Health, including the new Transformation Fund.

The Commissioning Plan aims to respond to the three strategic themes and statutory obligations identified by the Minister in the Commissioning Plan Direction:

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

The Plan specifically responds to each of these strategic aims within Section 4. In line with established commissioning arrangements, the plan provides an overview of Regional Commissioning priorities for 2016/17 (Section 5) together with information on the priorities at local level (Section 6). Within these sections, the Plan makes explicit reference to areas of service development, service delivery and service reform and modernisation required from providers, who will be expected to respond, in their delivery plans for 2016/17. These sections will also highlight known unfunded areas where applicable. The HSCB/PHA will, through existing mechanisms, monitor the performance of providers against these plans.

In addition to the strategic themes within the Commissioning Plan Direction there are a number of outcomes and objectives for the wider HSC service to deliver. A summary of the objectives can be found in Appendix 1.

The Plan also incorporates funding from the most recent June monitoring round. These investments are reflected across both the regional and local Commissioning sections. Trusts are expected to respond to respond to the Commissioning Plan via the submission of Trust Delivery Plans. The financial allocation for 2016/17 includes a block sum to Trusts and as such the Commissioning Plan outlines the 2015/16 commissioned values and volumes as a baseline and it is expected that values and volumes will be amended following the submission of the Trust Delivery Plans.

The plan provides a view of the strategic transformation, reform and modernisation aims across all programmes of care both regionally and locally. The Plan does not seek to highlight all of the work being taken forward by HSC in 2016/17.

In compiling the Commissioning Plan, input from service users, carers and the public was drawn from a variety of sources, ensuring that HSC commitment to the principles, practice & duty of Personal & Public Involvement was respected. Information, input and guidance was drawn from a very diverse and wide range of reference groups, advisory groups, advocacy organisations and patient and service users themselves.

1.2 Delivering on Key Policies and Strategies

This section provides an overview of a range of key policies and strategies which inform the key regional and local priorities set out in sections 5 and 6 of this Plan. While the majority of these strategies are specifically referenced within the Plan, the HSCB and PHA remain committed to the delivery of all policies, frameworks, guidance and strategies highlighted below. It should be noted that it not an exhaustive list.

- Programme for Government (following NI Executive approval)
- Quality 2020

- Institute of Healthcare Improvement Liaison
- Service Frameworks
- Workforce Planning & Development
- Transforming Your Care
- Donaldson report
- Sexual Health Strategy
- Domestic Violence and Sexual Violence Strategy
- Making Life Better
- Maternity Strategy
- Physical and Sensory Disability Strategy
- Delivering Care: Nurse Staffing in NI
- Primary & Community Care Infrastructure
- eHealth & Care strategy
- Living Matters Dying Matters
- RQIA Reports
- NI Rare Disease Implementation Plan
- NICE guidance

1.3 Maximising Opportunities for Innovation

There are a number of enablers within the HSC which have and will continue to be utilised in order to deliver reform including Managed Clinical Networks, Integrated Care Partnerships, Project Echo, the Regional Unscheduled Care Network, and IHI Triple Aim Framework and the NI Genomes Medicine Centre. In addition GP Federations will be an invaluable tool working alongside secondary care to deliver outpatient reform during 2016/17.

1.3.1 ICT and eHealth

ICT and eHealth continue to be key enablers to maximising opportunities for innovation. An eHealth & Care strategy has been developed by the HSCB, supported by the PHA and by other HSC organisations. The strategy was formally launched by Minister Hamilton in March 2016. By September 2016, the current regional implementation plan will be developed to form an NI wide implementation plan to deliver the objectives in the published HSC eHealth & Care Strategy.

Key priorities to be taken forward in 2016/17 include:

- The development of a business case for the establishment of an integrated record for citizens and patients to build on the success of the NI Electronic Care Record, to be complete by March 2017.
- Working with NI Direct to further develop web portal access to support citizens for self-care; and rolling out the capacity to support online booking and repeat prescribing on line for 90% of all practice patients by June 2016.
- Roll out the electronic triage of GP to consultant referrals to all Trusts during 2016/17, and agree plans for the development of electronic referrals for non-consultant services.
- The development of a Directory of Services to support care professional staff to rapidly access and safely refer to appropriate HSC services to avoid unnecessary interventions.

1.3.2 Transforming Your Care

Transforming Your Care is built upon four main themes:

- The individual at the centre – building and designing our health and social care services with the individual at the centre, and providing care closer to home, where that is safe and appropriate.
- Independence – supporting people to live independently if possible, and giving people greater choice and control, and access to services when and where they need them.
- Sustainability & Resilience – building services to be sustainable and resilient into the future. This requires us to work differently, and across traditional boundaries of professions and settings and focus on delivering care in the right place at the right time.
- Having the right enablers in place and making the best use of what we have to meet our population's needs.

2016/17 will see a continued focus to embed the delivery of these themes across core services. Examples of the transformation, reform and modernisation agenda are reflected throughout the Commissioning Plan.

1.4 Achievement of Ministerial Targets

The Commissioning Plan Direction sets out the Minister's key themes, outcomes and objectives for the HSC for 2016/17, in many cases building on the targets and standards in 2015/16.

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

In 2016/17, the HSCB's performance management function will continue to enable and support a formal, regular, rigorous process to measure, evaluate, compare and improve performance across the HSC. Providers must have in place their own systems for identifying and responding early to performance issues but the HSCB will continue to identify trends and key performance issues, assess risk and where necessary work with providers to agree corrective actions and set goals. Where Trusts fail to improve in line with those goals appropriate escalation measures will be used.

The HSCB and PHA will work with Trusts during 2016/17 to maximise performance against all of the standards and targets set out in the Commissioning Plan Direction. Further detail on specific Ministerial Targets can be found in Section 5 under the relevant service area.

2.0 Summary of Key HSC Demographic challenges

This section provides an overview of key demographic changes of the NI population and outlines information relating to lifestyle and health inequalities. Consideration has been given to these within the needs assessments outlined within sections 5 and 6 in order to inform the commissioning of services at both regional and local level.

N Ireland Resident Populations by Local Commissioning Group

Table 1

Age Band (Yrs)	Belfast	Northern	South Eastern	Southern	Western	NI
0-15	67,143	96,179	71,396	84,234	64,831	383,783
16-39	124,457	142,451	102,921	118,711	94,075	582,615
40-64	106,226	153,576	117,007	114,890	96,485	588,184
65+	53,728	76,845	60,977	51,556	42,810	285,916
All ages	351,554	469,051	352,301	369,391	298,201	1,840,498
%	19.1%	25.5%	19.1%	20.1%	16.2%	100%

Source: NISRA, 2014 MYEs

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

- Mid-Year Estimates for 2014 indicate that there are approximately 1.84m people living in N Ireland (NI). Current population projections anticipate the population will rise to 1.935m by 2024.
- Western Trust has the lowest proportion of younger people aged 0-15 years, in comparison to other Trusts (17% or 65,000) and the Northern Trust has the highest percentage at (25% or 96,000).
- Persons aged 16-64 account for the highest proportions across all Trusts, ranging from 65.6% of the population in Belfast to 62.4% in the South Eastern Trust.
- There are a total of 286,000 older people (65+ years) in N Ireland, equating to 15.5% of the NI population.

- 19% of these or 54,000 persons are in Belfast Trust, 27% or 77,000 are in Northern Trust; 21% or 61,000 reside in South Eastern; 18% or 52,000 are in Southern Trust, and the remaining 15% or 43,000 live in Western Trust.
- The anticipated population increase is characterised by a marked rise in the proportion of older people. From 2016-2024 the number of people aged 65+ is estimated to increase by 62,500 to 362,000 – a rise of 21%. The number of older people will represent 19% of the total population compared with 15.5% currently.
- At sub-regional levels, the areas with the highest projected growth overall is the Southern Trust (+8%), for the aged 65+ and 75+ cohorts of the population is in the Western Trust at +24% and South Eastern Trust at +42%. For aged 85+ years, the highest projected growth is in the Southern Trust (+46%).
- Births in N Ireland have increased slightly from 24,300 in 2013 to 24,400 in 2014 – an increase of 0.5%
- 14,678 deaths were registered in N Ireland during 2014, which is a slight decrease of 290 or 1.9% since 2013.
- The main cause of death was cancer accounting for 29% of deaths in N Ireland (4,323).
- In 2011, males could expect to live to the age of 78 years and females to the age of 82 years. Males living in the 10% least deprived areas in NI could expect to live on average approximately 9 years longer and females, approximately 6 years longer than their counterparts living in the 10% most deprived areas.
- The prevalence of long term conditions such as COPD, diabetes, stroke, asthma and hypertension is increasing. In conjunction the number of people coping with co-morbidities is increasing.
- Deprivation has an impact on health and wellbeing in many ways resulting in the lack of social support, low self-esteem unhealthy life-style choices, risk taking behaviour and poor access to health information and quality services.

3.0 Commissioning and the use of Financial Allocations

The Commissioning Plan Direction requires the Commissioning Plan to explain how services will be commissioned within the available budget. This includes providing details of how the total available resources, as specified by the Department in its respective budget allocation letters to the HSCB and PHA for the financial year 2016/17 have been committed to the HSC Trusts and other organisations.

This chapter sets out:

- A summary of income sources for the HSCB and PHA in line with DHSSPS 2016-17 Budget Allocation letters
- A summary of HSCB spend areas for the planned additional investments in 2016-17
- An analysis of HSCB and PHA allocations by Provider including HSC Trusts
- An analysis of HSCB and PHA allocations by Programme of Care
- An analysis of HSCB and PHA allocations by LCG area
- An analysis of the in-year June Monitoring monies

In response to the Commissioning Plan, Trusts are required to provide Trust Delivery Plans which will incorporate individual financial plans for each Trust. These plans will provide further information for the HSC on additional financial pressures such as those resulting from population and price increases and how each Trust plans to address these. These plans can then be incorporated into an overall Strategic Resource Framework for the whole HSC which will be available later in the financial year.

Summary of Income Sources - Budget Allocations HSCB and PHA

The DoH issued separate allocation letters to the HSCB and PHA in April and May 2016. These allocation letters show the budgeted income, along with administrative savings reductions of 10%, for each respective organisation. These are set out in Table 2 below.

Income 2016/17

Table 2

Income 2016/17	HSCB £m		PHA £m		TOTAL £m
Opening Allocation	4,309	*	85	**	4,394
DHSSPS Additional funding	127		1		128
10% Admin Reduction	(3)		(2)		(4)
TOTAL	**4,433**		**85**		**4,518**
* adjusted to take account of Early Years Funding					
** adjusted to take account of R&D reclassification to capital					

In addition a further £72m of non-recurrent monies was secured through the June Monitoring round, of which £67m is to address a range pressures across health and social care and the remaining £5m is for capital spend. Of the £67m, £60m has been reflected in the Commissioning Plan.

HSCB/PHA spend areas and funding sources

The DoH allocation letters set out how the additional resources available for each organisation are to be applied in the financial year beginning April 2016. In addition a further £72m of non-recurrent monies was secured through the June Monitoring round, of which £67m is to address a range pressures across health and social care and the remaining £5m is for capital spend.

Additional resources are planned to be used to address the recurrent cost of 2015-16 service pressures, new HSCB/PHA pay and inflation related costs and Family Health Service pressures. In addition the DoH have ring fenced new resources for a detailed list of inescapable pressure areas such as elective and funding for NICE approved drugs and Transformation Fund resources which have been prioritised to meet the transformation of services vision. Table 3 summarises the areas of planned additional investment. A total of £36m has also been allocated to HSC Trusts. This allocation should form part of individual Trusts financial plans.

The table below shows how the total planned spend areas (pressures) will be addressed. In addition to the DoH additional allocation source (£128m), the

HSCB has been tasked with delivering £20m of productivity efficiency savings from the Family Health Services.

2016/17 Summary of spend areas and funding sources

Table 3

2016/17		£m	£m
PRESSURES	FYE of 15/16 pressures	(20)	
	HSCB/PHA Pay related pressures	(5)	
	Family Health Services	(20)	
	Inescapable Pressures	(38)	
	Transformation Fund	(29)	
	Contribution to Trust Pressures	(36)	
			(148)
SOURCES			
	Additional allocation from DHSSPS	128	
	Family Health Services Savings	20	
			148

HSCB Allocations to Providers

The following table shows how the total of the HSCB/PHA allocations of £4,518m are planned to be allocated across providers. Figure 1 provides a sub analysis of the allocations to HSC Trusts.

Allocations to Providers

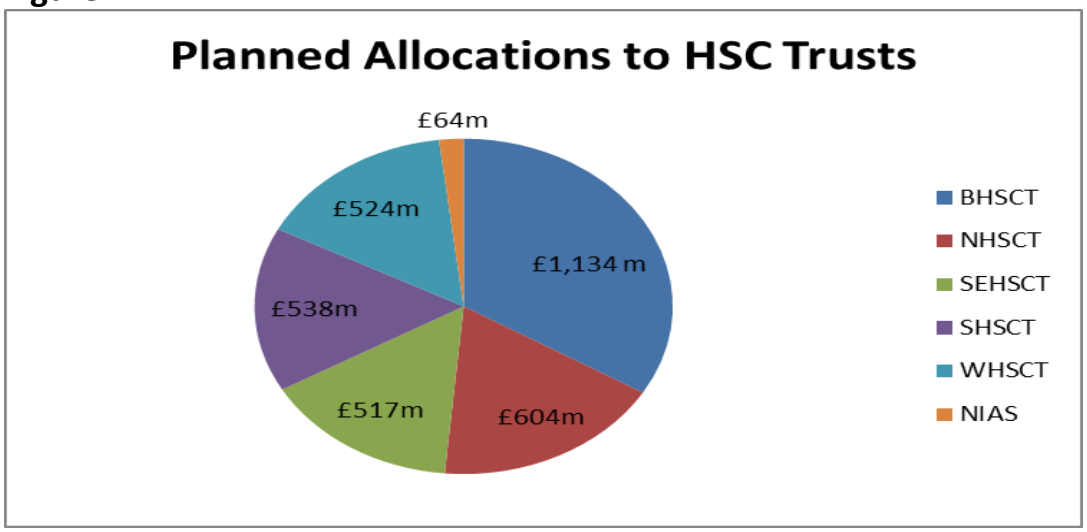
Table 4

Allocations to Providers	£m
HSC Trusts	3,382
FHS	865
Other*	271
TOTAL	**4,518**

* Managed at HSCB/PHA incl Elective and non Trust contracts

Planned Allocations to HSC Trusts

Figure 1



Trusts have been asked to develop individual savings plans which reflect the HSCB/PHA allocations and ensure pay, non-pay, additional national insurance contributions, national living wage and demography pressures are addressed. 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.

HSCB planned spend by Programme of Care

The following table categorises inescapable and Transformation Fund pressures set out by Programme of Care.

Programme of Care Analysis

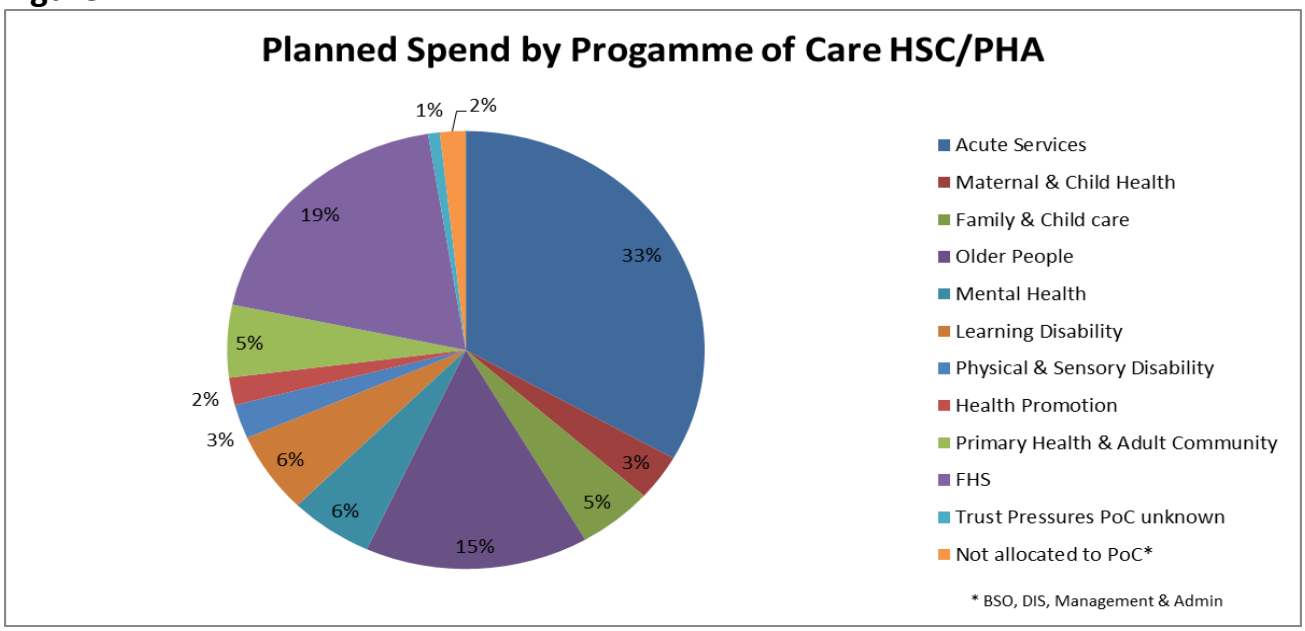
Table 5

Planned Spend by Programme of Care	Inescapable Pressures £k	Transformation Fund £k
Acute Services	25,805	4,765
Maternity & Child Health	319	-
Family & Child Care	1,462	355
Elderly Care	-	311
Mental Health	175	700
Learning Disability	9,100	-
Physical & Sensory Disability	220	-
Health Promotion	-	-
Primary Health & Adult Community	625	14,219
All POCS	-	6,030
Not allocated to POC	-	2,300
TOTAL	**37,707**	**28,680**

Figure 2 below shows how the total of the HSCB/PHA allocations of £4,518m are planned to be allocated across Programmes of Care. A more complete picture of planned investment across the HSC by Programme of Care will be available when Trusts have completed their Trust Delivery Plans. In particular the HSCB will seek to ensure that demographic needs in the elderly and other Programmes of Care such as mental health and learning disability are addressed.

Planned spend by Programme of Care

Figure 2



HSCB planned spend by Local Commissioning Group

The following table shows how the total of the HSCB/PHA allocations of £4,518m are planned to be allocated across Local Commissioning Group.

Planned spend by Local Commissioning Group

Table 6

	LCG								
Trust	**A&E**	**Belfast**	**Northern**	**South Eastern**	**Southern**	**Western**	**Regional**	**FHS**	**Grand Total**
BHSCT	45	574	124	108	48	27	209	0	**1,134**
NHSCT	21	1	550	1	0	1	30	0	**604**
NIAS	64	0	0	0	0	0	0	0	**64**
SEHSCT	20	46	3	397	6	0	45	0	**517**
SHSCT	22	1	8	6	477	2	22	0	**538**
WHSCT	16	0	10	0	4	466	28	0	**524**
Non-trust **	1	39	46	34	33	34	6	865	**1,057**
Total	**188**	**660**	**741**	**546**	**568**	**531**	**340**	**865**	**4,439**
Not Assigned to LCG *									**79**
Grand Total									**4,518**
* Includes Mgmt & Admin, BSO, DIS									
** Non Trust includes voluntaries and Extra Contractual Referrals									

The HSCB carries out an annual equity review to assess whether its total resources have been fairly deployed across local commissioning group populations. This will be carried out later in the year, following the submission of Trusts' TDPs.

Tables 7 and 8 detail the Inescapable Pressures and the Transformation Fund. In arriving at these prioritised funding areas the DoH sought submissions from the HSCB and PHA.

Inescapable Pressures

Table 7

Service Development Pressures identified as inescapable	£k
Maintaining existing approved drug regimes	10,750
Elective Care	9,821
Community Learning Disability Cost pressure	4,500
GMC Recognition of Trainers	2,412
Young people transitioning to adult services	2,000
Autism Investment	2,000
Recruitment requirements for Altnagelvin Radiotherapy Centre	1,500
High Cost Cases - Family & Childcare	1,200
Complex discharges from Learning Disability	600
Paediatric Asthma and Anaphylaxis	425
Insulin pumps	465
Diabetes Strategy	319
Palliative Care Modernisation – Final implementation DHSSPS LMDM	284
Community Dentists	280
Major Trauma Network	242
Regional communication support services for deaf people	220
Implementation Plan for Rare Disease – UK Genetics Testing Network (UKGTN)	190
Mental Trauma Service	175
Jointly Commissioned Supported Accommodation Projects	212
RCCE Banbridge Community Care and Treatment Centre (CCTC)	61
Remaining with Former Foster carers (GEM Scheme)	50
TOTAL	**37,707**

Transformation Fund

Table 8

Transformation Fund	£k
	£k
Practice Based Pharmacists	1,700
GP Federations -innovation in managing elective care	800
Delivering Social Change – Dementia Project	311
Family Support Hubs	295
ICT reform	1,000
ICPs	7,463
Stroke Services (Coordinator & NHSCT & SHSCT)	574
Trust Backfill	1,631
Day Opportunities	390
Self Directed Support	327
ICP Business & Clinical Support/Committees	1,500
HSCB Programme Team	597
HSCB Project Support costs	107
Ambulance Alternative Care Pathways	495
RAID (NHSCT)	700
MOIC (NHSCT)	300
Outpatient Reform (Regional)	600
Care Pathways Reform (Regional) HF & Asthma	250
Project ECHO	474
DNAV (net of Primary Care prescribing savings) - SEHSCT	1,227
Specialist Foster Carers	60
Direct Access Physio (4 Trusts - excludes SEHSCT)	100
NI Participation in UK Genomes project	1,270
Medicines Optimisation	2,000
Innovation in diabetes	1,000
Primary Care quality improvement	1,920
District Nursing and Health Visiting	850
HEMS	250
Community Resuscitation	250
Paediatric and obstetrics services at Causeway hospital	190
SABR	50
Total Transformation Fund	**28,680**

June Monitoring Monies

In recognition of the significant financial challenge and pressures set out in this chapter, in particular facing local Trusts, the Executive has allocated a further £72m (£5m of which is for capital) to the Department in the June Monitoring Round. The £67m revenue funding will help address a range of front line pressures, including unscheduled care, improving patient flow through our hospitals, childrens' services, mental health/learning disability services and additional social care provision to help meet increasing demands. Trusts should incorporate these additional resources as they continue to develop their TDPs.

Unfunded Pressures

The additional funding received in the June Monitoring round does not cover all of the pressures facing health and social care in 2016/17. The HSCB will therefore continue to work with the Department to explore all available measures that can be taken to maximise the resources available for investment in health and social care.

4.0 Overarching Strategic Themes

This section demonstrates how services will be commissioned in line with the key themes/aims set out within the Commissioning Plan Direction 2016, namely:

- Improving and Protecting Population Health & Reducing Inequalities
- Providing High Quality, Safe and Effective Care
- Listening to Patient and Client experience and learning from Personal and Public Involvement
- Ensuring services are efficient and provide value for money

4.1 Improving and Protecting Population Health and Reducing Inequalities

4.1.1 Improving health and reducing health inequalities

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

In NI between 2002 and 2012 more than 41,000 people died prematurely of disease which was potentially avoidable through public health interventions or potentially treatable through high quality healthcare. Nearly 700,000 life years were lost. In 2012, 3,756 people died of illness which could either have been prevented in the first place (84%) or if detected early enough could have been treated successfully.

Those most likely to die prematurely included men (61% for 2012), reflecting the four and a half year gap in life expectancy between men and women, and those living in our most deprived areas. Residents of most deprived areas are two and a half times as likely to die prematurely of preventable causes as those in least

deprived areas. This increases to a factor of four for drug and alcohol related deaths and three times for suicide, respiratory problems and lung cancer[1] .

The DOH disaggregation of life expectancy differentials in NI[2] highlighted the reducing impact of circulatory disease on premature mortality with the increased contribution of cancers and accidental injuries and suicide amongst the younger age groups, particularly in more deprived areas. Known inequalities in health have been identified across a range of groups including:

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

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

The PHA aims to improve the health and wellbeing of the population of NI and to reduce health inequalities. This work is founded on partnership with many different sectors and disciplines in order to maximise the benefits that can be gained through these collective efforts.

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

Health and Social Wellbeing Improvement activity is underpinned by six themes set out in Making Life Better, which include:

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

During 2016/17 the PHA will advance these objectives by building strong connections across society to improve health and wellbeing and reduce inequalities.

Joint working with the 11 councils will be strengthened to ensure close alignment with community planning processes to improve health and wellbeing.

The PHA will continue to progress the early years intervention agenda, in particular through the work-streams of the Early Intervention Transformation Programme, sponsored by a consortium including Government Departments. Work with communities and organisations will continue to focus on reducing some of the structural barriers to health and seek the active engagement of communities wherever possible.

In response to Commissioning Plan Direction, the PHA will advance the following specific objectives:

Giving Every Child the Best Start
The PHA will continue to prioritise investment in early years' interventions. Specific commissioning intentions during 2016/17 will include:

- Expansion of the Family Nurse Partnership Programme, within all five Trusts to cover the whole population of NI, and ensuring an increased level of availability to eligible mothers, thereby providing NI wide

coverage, and developments in health visiting, early intervention services and family support hubs.

- Expansion of evidence based parenting support programmes which will support the development of the infant mental health action plan; the implementation of the Early Intervention Transformation Programme.
- Implementation of the breast feeding strategy across all trust areas with specific attention to the training of staff, peer support and accreditation of facilities to meet the World Health Organisation UNICEF Baby Friendly standards.
- Contribution to the health improvement and safeguarding focus of LAC as a key target group and continue to contribute to the achievement of the goals for adoption and placement of LAC through support for the HSCB Residential Care, Fostering and Adoption Commissioning Leads.
- Continuing to work with DOH, HSCB and Trusts to ensure that the complete range of universal contacts as outlined in the Healthy Child, Health Future Child Promotion Programme is delivered to every child entitled to receive them.
- Three-monthly performance monitoring, using regionally agreed measures will continue until March 2018. Efforts relating to workforce planning, and securing sufficient education and training places for student health visitors, will continue.

Equipped Throughout Life

Specific commissioning intentions for 2016/17 will include:

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

Empowering Healthy Living

The PHA will continue to implement a range of public health strategies to empower healthy living. Specific commissioning intentions for 2016/17 include:

- Addressing rates of obesity in children and adults through the rolling action plan of the multi-agency Regional Obesity Prevention Implementation Group.
- Focusing on providing individuals with the knowledge, skills and opportunities to make healthier choices in relation to nutrition and physical activity.
- Implementation of the tobacco control strategy including smoking cessation services. First results published from the Health Survey, NI (2014/15) reveal that 22% of respondents were current smokers, a reduction from 26% in 2004/05. Data from the Young Persons Behaviour and Attitude survey (2013) shows the proportion of 11-16 year old children who smoke is 5%, a reduction from 8.4% in 2010. Data from NIMATS (2014/15) shows the proportion of pregnant women who smoke is 14.7%.
- Continuing to work with DOH on the development of a new strategy for the prevention of suicide and self harm, and the promotion of positive mental health. In 2016/17, this will include:
  - Public information campaigns to promote mental and emotional wellbeing and to promote help-seeking;
  - Offering training courses on suicide prevention and mental health awareness;
  - Community-led prevention support programmes and bereavement support services;
  - Support to address alcohol/substance misuse;
  - Local research into suicide;
  - Development of cluster response plans, to continue to ensure Health and Social Care Trusts are involved in any activation of community response plans and the reporting of 'SD1s'.
- Continue to improve access to public information and sexual health services – to include the development of a service specification which will enable closer integration of sexual and reproduction health services.
- Implementation of the New Strategic Direction for Alcohol and Drugs and the procurement of new services including a priority to work toward a seven day integrated and coordinated substance misuse liaison service in

acute hospital settings using agreed Structured Brief Advice or Intervention programmes.

Creating the Conditions

Specific commissioning intentions for 2016/17 will include:

- Build capacity of local people to support vulnerable adults to live independently in caring and responsive communities, such as Creative Local Action Response & Engagement (C.L.A.R.E.).
- Lead and implement 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.
- Develop and implement a consistent approach to health and social wellbeing programmes, working with local government and other partners.

Empowering Communities

The PHA will continue work with a range of partners to use sports, arts and other leisure opportunities to improve the health and wellbeing of local populations. Specific commissioning intentions for 2016/17 include:

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

Developing Collaboration

PHA will continue to support and extend strategic multi-agency partnerships in 2016/17, in particular supporting community planning with local government, to improve health and social wellbeing and reduce health inequalities. A key focus of developing collaboration should include strengthening and embedding Making Life Better across all HSC organisations.

4.1.2 Screening

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

During 2016/2017 the key deliverables will include:

- The bowel cancer screening programme has been fully rolled out to include the population aged 60-74. As the service has attained in excess of the 55% uptake. Investment will be made to ensure that standards are maintained. Preliminary work on introducing a new testing regime will be undertaken.
- Consolidate the business case for an IT system to support the new-born hearing screening programme (NHSP) in N Ireland in order to reduce the risk of adverse incidents, improve quality assurance and eliminate many manual processes within the programme
- Introduce surveillance clinics to the diabetic eye screening service and improve quality assurance of retinal photographs through the introduction of test and training sets for graders. Consider new models for the delivery of the diabetic eye screening programme and undertake preliminary work on the introduction of revised screening intervals
- Improve the infrastructure support to breast screening units to ensure that standards are maintained.
- Plan for the introduction of a QA management system for images taken as part of the AAA Screening Programme.
- Establish a planning group for the introduction of HPV testing as the primary screening tool in the cervical screening programme
- Input to the development of a specification and business case for the NHAIS transformation project, ensuring that this meets the future

needs of the adult screening programmes and that appropriate call recall functions are maintained in the transition period.

4.1.3 Health Protection

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

During 2016/17 will support the ability of commissioners will take forward the introduction of a surveillance system for antimicrobial resistant organisms and a region wide programme on antimicrobial stewardship.

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

Commissioning priorities for 2016/17 include:

- *Healthcare Associated Infections (HCAIs)*
  - Trusts, supported by PHA will develop and deliver improvement plans to reduce infection rates. This will be monitored via PHA

surveillance programmes for HCAIs. (In accordance with Ministerial Target for 2016/17.)

- *Flu immunisation*
  - Trusts urgently need to increase uptake of flu immunisation among healthcare workers.

- *Antimicrobial Resistance and Stewardship*
  - Trusts and Primary Care, supported by PHA, will work to monitor antimicrobial resistance and develop improvement programmes for antimicrobial stewardship.

4.2 Providing High Quality, Safe and Effective Care

A key priority for the Minster, Department and HSC is to ensure that people across NI are able to access high quality services in an appropriate setting.

Consistent with the strategic vision set out within Transforming Your Care, the HSC will continue to seek to provide care at home, or as close to home as possible supporting people to live independent, fulfilling lives.
Central to the delivery of high quality care will be the availability of appropriately resourced and trained clinical staff (doctors, nurses, allied health professionals, etc.) and social care staff.

The contribution of informal carers is also key to the delivery of this objective, and it is important that they are supported in this role.

The HSCB and PHA continue to place the quality of patient care, in particular patient safety, above all other issues, and are working on an ongoing basis to monitor and review services. In the context of continuing significant resource challenges, this focus on safety is more important than ever.

The HSCB and PHA will continue to work with Trusts and the HSC Safety Forum to better manage patients with sepsis and sever sepsis in acute care and improve the management of these patients across the interface between

secondary and primary care. This work will build upon existing work in EDs in the early management of sepsis. Current work will develop and embed the use of the sepsis 6 approach in pilot wards in pilot wards in all Trusts, with the intention to incorporate into general wards.

Specific commissioning intentions for 2016/17 in relation to the safety and quality agenda are set out below and in subsequent sections of this Commissioning Plan.

4.2.1 Providing care closer to home

A key priority for the HSC is to allow people to be cared for in their own home or as close to their home as possible potentially avoiding the need for visits to hospital.

During 2016/17 the HSCB and PHA will continue to work with providers (individually and through Integrated Care Partnerships (ICPs) and wider network arrangements) within available resources to enhance both the range of community services available to support people to remain at home, and to ensure the better integration of services, including linkages between:

- Primary and secondary care services, both in-hours and out of hours, including acute/enhanced care at home
- Statutory services and services provided by the independent sector, and by community and voluntary organisations
- The range of services provided in the community and those provided by the NI Ambulance Service.

Through the enhancement and better integration of community services – organised around the needs of patients and the maximisation of opportunities presented by technology, the expectation is that significantly more patients can be cared for at or near their homes, allowing them to retain their independence for as long as possible.

4.2.2 Delivering Care Same Day/Next Day

While the over-riding aim is to provide care for people at home or as close to home as possible, there will nonetheless be occasions where access to more specialist assessment, diagnosis and treatment services are required, typically in a hospital setting. Access to these services should not however require patients to be admitted to hospital, rather they should be available on an ambulatory basis, allowing the patient to return home as soon as possible without a lengthy hospital stay which, for elderly patients in particular, can significantly impact on their ability to return home and live independently.

Ambulatory care is used as an umbrella term to describe a range of pathways and models of care aimed at avoiding admission or reducing length of stay for both acute and chronic disease. Clinical staff in hospital Emergency Departments and the main acute specialties already aim to avoid unplanned admission where possible, with ambulatory services being delivered on a same day/next day basis, as appropriate. However the potential to which ambulatory care services have been maximised varies by individual Trust, site, time of day, day of week, special interest and availability of clinical staff, community service options and the configuration of the HSC estate.

During 2016/17 the HSCB and PHA will continue to work with providers (individually and through ICP and wider network arrangements) to secure greater consistency of service provision in relation to ambulatory care. Within available resources we shall seek to improve ambulatory services for unscheduled care patients and to explore opportunities to use such same day/next day models as an alternative to existing outpatient clinics for planned patients.

4.2.3 Improving the patients journey through hospital

Even with more effective services in the community (to allow patients to remain at home) and at the "front door" of hospitals (to allow them to receive specialist ambulatory care, avoiding the need for admission), there will continue to be some patient for whom admission to hospital is appropriate. The expectation is that such patients will be admitted to an appropriate hospital bed in a timely fashion, typically less than four hours and always less than 12 hours. Once

admitted, patients should be pro-actively managed throughout their hospital stay to ensure their period in hospital is as short as possible and allowing them to return to their home with appropriate support as required – living as independently as possible.

During 2016/17 the HSCB and PHA will work with providers (individual and through ICP and wider local network group arrangements) to improve the patient journey through hospital, both in the period of admission to the patient being declared medically fit to being discharged.

Key to improving patient flows and reducing the length of time patients spend in hospital will be the continued move towards seven day working. Good progress has already been made in this regard in 2015/16 including the establishments of seven-day radiology. ED minor injury streams, and increased specialist clinical and social care support into larger EDs seven days a week.

During 2016/17 the HSCB and PHA will continue to work with providers (individually and through ICP and wider network group arrangement) to secure improved patient flow through hospitals with a particular focus on ensuring timely, multi-disciplinary decision making onwards, and to ensuring that, once declared medically fit, patients are discharged from hospital in a timely fashion, ensuring hospital beds are available for those patients with truly acute needs.

4.2.4 Supporting recovery from ill health

It is important that, following a period of ill health, patients are supported to recover and return to independence. Reablement services are now in place across NI to provide short term support to help people perform the necessary daily living skills such as personal care, walking and preparing meals so that they can regain their confidence within their own home. Reablement helps people to do things for themselves rather than having to rely on others.

During 2016/17 the HSCB will seek to further embed reablement services across NI, specifically:

- Each local health economy should work with ICPS to support the implementation of the New Stepped Care Model for Older People and for People who have a Long Term Conditions.
- Develop a comprehensive understanding of population need by systemically adopting and implementing anticipatory care approaches and through needs/risk stratification target preventative intervention in response to identified population needs.
- Require a stronger focus on evidence based preventative health and social care interventions particularly in addressing frailty, falls prevention, incontinence, poly-pharmacy dementia and social Isolation.
- Enhance and integrate community nursing, AHP and Social Care professionals into single care teams.
- Make more effective use of enabling technologies.
- Develop a social enterprising approach in partnership with Local Councils and Third Sector organisations.
- Consolidate and integrate intermediate care services including Acute/Enhance care at home into a single system.
- Consolidate discharge function into a single integrated team. This team, working in partnership with acute specialities and community services should 'pull' through all discharges. This work should be organised around three key re-enabling pathways:

  - **Pathway 1:- Low Intensity:** -The individual has made a good recovery and their personal and social circumstances means they require minimum short-term support with activities of daily living (1-2 weeks). Usually the person's needs are met by core Health and Social Care Services (Nursing, Allied Health Professional and Home Care Services).

  - **Pathway 2:- Medium Intensity:** The person requires post-acute care and continuing rehabilitation. The person usually requires intensive support for up to six weeks with activities of daily living. Care at this level will usually entail the provision of enhanced home care or step down in a sub-acute/intermediate care facility. This

pathway also supports the proactive discharge and in-reach support from community services for those people who have been admitted to hospital from supported living and nursing home care services.

- **Pathway 3:- High Intensity:** The person has complex health and social care needs and requires long-term home care package at home or in supported living or indeed in care home setting. In this context every effort should be made to support the person at home before decisions are taken for a long-term care home placement. Should a person not be able to return home an interim placement supported by intensive rehabilitation for support for up to twelve weeks should be considered before a commitment is made for a long term placement.

4.2.5 Enhancing the availability of nursing care

Delivering Care: Nurse Staffing in NI is a key quality initiative in terms of identifying minimum nurse staffing requirements in a range of hospital and community settings, and ensuring these requirements are met.

To date the HSCB and PHA working with the Department, Trusts and RCN, has focussed on nurse staffing levels in medical and surgical hospital wards. During 2015/16, the required nurse staffing levels for each medical and surgical ward were developed and agreed with Trusts across NI. In total, some £12m has been invested for additional permanent nursing staff during 2016/17. The HSCB and PHA will continue to work closely with Trusts to ensure timely and effective implementation and ongoing monitoring against agreed targets.

During 2016/17 the HSCB and PHA will continue to support the regional work being taken forward in relation to the development of the staffing principles and recommendations for the other areas of the nursing workforce that have been identified as part of the Delivering Care strategy. £1.25m has been secured in year for district nursing and health visiting.

4.2.6 Allied Health Professionals (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.

In NI on average 30,000 referrals a month are made to 'elective AHP services' equating to around 360,000 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.

Access to AHP services

Over the last year, the HSCB and PHA have worked with Trusts to complete a demand and capacity exercise to ensure there is sufficient capacity in each of the AHP services to meet patient demand. During 2016/17, the HSCB and PHA will work with Trusts to agree the steps to be taken to implement the outcomes from this exercise and to address the waiting time position as far as possible within available resources.

Specific issues and opportunities for 2016/17 are as follows:

- To provide enhanced access to timely, effective and evidenced based AHP intervention for patients.
- Ensure dysphagia awareness training is available for relevant staff and that people with swallowing difficulties are assessed.
- Maximise AHP services capacity to provide interventions and services that aim to reduce ED admissions and facilitate safe timely and appropriate discharge from secondary care to appropriate primary care facilities.

- Evidence that the safety and quality of home enteral feeding regimens meets International Standard (ISO 80369)and ensure that the required standards for home enteral feeding is available across primary care particularly in nursing homes

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

Personal and Public Involvement (PPI) is core to the effective and efficient design, delivery and evaluation of HSC services. PPI is about the active and meaningful involvement of service users, carers and the public in those processes. The legislative requirements for HSC organisations in regard to PPI are outlined within the HSC (Reform) NI Act 2009. The need to embed the Involvement concept more effectively into HSC culture and practice has been shown through the Francis and Donaldson Reports and was also highlighted in the recent Human Rights Inquiry into Emergency Departments.

Recent Developments

The PHA launched a training and support programme for PPI, ranging from a short e-learning programme, to team briefings, coaching and direct taught materials.

A set of Standards and Key Performance Indicators for PPI which were developed under the leadership of the PHA, have been in the system for just over a year now and compliance against these standards and the legislative Duty of Involvement is assessed using a monitoring and performance management mechanism co-designed by the PHA & Service Users and Carers. This has again brought forth evidence of some excellent practice across the HSC. However, it has also revealed the depth and range of challenge facing such large and diverse organisations in truly embedding PPI.

The PHA working with HSC partners and service users and carers will take forward the following during 2016/17:

- Plan and oversee the roll out of Engage & Involve, the PPI training programme for HSC
- Lead and oversee the redevelopment of the Engage Website and associated outreach programme
- Organise a high profile, international PPI Conference, showcasing best practice and sharing learning for the benefit of service users and carers
- Work with the DoH and Trusts to identify ways to ensure adequate resources are aligned to deliver the Statutory Duty of Involvement
- Develop the implementation of building a vision for Nursing in older peoples services within the MLB strategy steering group

As part of the HSCB work with the PCC, the HSCB is currently working with Trusts to develop a regional approach to managing Myalgic Encephalomyelitis/Chronic Fatigue Syndrome which is estimated to affect 5-7,000 people in Northern Ireland, 10% of whom have a moderate-severe condition.

Those 10% of patients who have a moderate condition may be referred to Trusts for a short programme of condition management. This is being implemented on a pilot basis in the Northern HSC Trust to address the needs of those with moderate Myalgic Enc/CFS and to support GPs and primary care to manage these patients. The HSCB and PHA will also develop secondary care capability for this patient group. The pilot is the first step in the development of a regional network of expertise in ME/CFS.

The Patient Client Council will also support the progression of the following key service developments across 2016/17 alongside HSC partners:

- Endometriosis – Stage IV
- Recurrent Miscarriage
- Chronic Pain
- ME/CFS
- Continuation of work on elderly carers and planning for the future

Patient Client Experience and 10,000 Voices

The HSCB alongside the Public Health Agency are responsible for monitoring and reporting to the DOH on the Patient Client Experience (PCE) Standards. During 2015/16 the Patient Client Experience work programme was integrated with the 10,000 Voices Initiative to provide a robust and systematic process to listen to, learn from and act upon patient/client and staff experience. This approach is based on partnership working to ensure that the voices of patients/clients and staff are central to and can inform local and regional quality improvements.

Based on the outcomes from the Patient Client Experience /10,000 Voices work streams, the HSCB/PHA is committed to the following priorities in 2016/17:

- Monitoring Trust requirements to ensure a policies are in place for the provision of safe and effective care and treatment in mixed gender accommodation and compliance with same gender accommodation
- Monitoring the availability of meals and drinks in EDs
- Continuing to raise the profile of “Hello my Name is…” across all Health & Social care settings.
- Identifying and sharing processes to reduce ‘Noise at Night’ in hospital wards.

In addition, the HSCB/PHA are committed to:

- Undertaking a comprehensive Patient Client Experience work programme using various methodologies to capture the experiences of patients/clients and staff in a range of settings.
- Ensuring analysis of Patient Client Experience information is communicated to all staff involved in the commissioning and delivery of services.
- Engaging with education providers to ensure that findings inform training for pre and post registration medical, nursing and Allied Health Professional staff.

4.4 Ensuring services are efficient and provide value for money

The N.Ireland Health and Social Care System faces the same basic challenges moving forward as those experienced by other health and care systems in developed countries. Major drivers for change include a continuing increase in the average age of our population, the rising cost of new technologies in healthcare and the need to address the balance between care in the community and that delivered within a hospital setting. Of more immediate consequence are the financial challenges facing the health and social care system in 2016/17 and beyond. For these reasons it is essential that all appropriate opportunities to improve productivity and cost effectiveness are identified and taken.

At the highest level the HSCB seeks to ensure that the allocation of the additional funds available to it in any given year:

- Is in line with the strategic intentions of the Minister and the Department; and
- Contributes to the change agendas identified in the 2016/17 Commissioning Direction.

At an operational level, it is important to ensure that Trusts and other health and care providers funded by the HSCB deliver high quality services at the minimum possible cost. The HSCB has in place Service and Budget Agreements (SBAs) with Trusts which identify (amongst other things) the funding made available for services and the volume of activity which Trusts are expected to deliver for that funding. The Trust should ensure the most effective use of staffing resources by reducing sickness levels. This would include promoting uptake of the flu vaccination among staff.

Each year the HSCB engages in regular meetings with Trusts on the extent to which the levels and volumes of care specified in SBAs are being delivered. At the same time, Trusts are asked to re-examine how services are delivered with a view to:

- Improved management of demand in acute, community and social care, leading to a shift in how services are delivered in line with Departmental strategic intentions.
- Improved performance within a Trust's existing funded capacity.
- The transfer or reconfiguration of resources; both within programmes of care but also across programmes where this can be demonstrated to improve models of care delivery in line with our population's needs.

For several years the HSCB has produced a range of comparative measures to support Trusts in identifying the partial areas to target further efficiency and productivity gains. This work has included benchmarking Trust to Trust performance locally, and comparing Trust performance against equivalent healthcare providers in GB. During 2016/17, the methodology used to benchmark Trust performance will continue to be reviewed and refined, taking account of input from Trusts and the Department and changes to service models. In addition, the scope of the benchmarking indicators is being revised to include a wider range of performance measures for community-based services.

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

4.4.1 Procurement from Alternative Providers

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

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

- Another Trust in NI
- The community/voluntary sector
- Partnerships of providers e.g.GP Federations
- Providers from Independent Sector or the Statutory Sector in GB or RoI.

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

4.4.2 Delivery of Contracted Volumes

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

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

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

4.4.3 Workforce

Health and Social Care need in Northern Ireland has continued to change over the last 10 years, due to an aging population with increasing levels of complex and chronic conditions. Changing demographics in Northern Ireland continue to drive the need to change service provision to meet this demand. More recently, Transforming Your Care has informed service transformation between Secondary and Primary Care, with greater provision of services in Primary Care. The HSCB/PHA will continue to develop the appropriate workforce requirement to meet existing demand and planned future service provision and appropriate skill mix, in partnership with Trusts and DOH.

Additionally, to extend the GMC requirements to hospital based training in Northern Ireland, £2.4m has been secured to provide hospital based trainers with the additional time in their job plans to adequately and safety supervise trainees that are placed in hospital training units. For postgraduate medical training in NI to be confirmed to be recognised by the GMC, it is essential that the GMC standards for recognising and approving trainers are met.

This increased level of weekly training provision will ensure that Northern Ireland delivers medical postgraduate training on a par with the rest of the United Kingdom.

The regional HSC Workforce Planning Framework (March 2015) provides a joined up approach in managing workforce challenges across Health and Social Care. The HSCB, PHA and Trust will continue to support this framework. Trusts will ensure ongoing assessment of current and future staffing requirements to ensure that services are safe and sustainable to continue to meet the needs of the population of Northern Ireland.

5.0 Regional Commissioning

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

- Unscheduled Care
- Elective Care
- Maternity and Child Health
- Family & Childcare services
- Care of the Elderly
- Mental Health Services
- Learning Disability
- Physical Disability
- Family Practitioner Services
- Specialist services
- Cancer Services
- Long Term Condition
- Palliative and End of Life Care
- Prisoner health
- NI Ambulance Service

Commissioning priorities for 2016/17 for these areas are outlined below. Regional commissioning priorities complement the local commissioning priorities. To avoid duplication, priorities are reflected once in the Commissioning Plan, either locally or regionally.

5.1 Unscheduled Care Services

Service Context

The delivery of safe and effective unscheduled care remains a challenge for commissioners and providers. In September 2015 the DOH approved revised structures and governance arrangements to take forward implementation of the unscheduled care agenda with the establishment of new regional and local network arrangements. Improving performance as well as the patient experience remains a priority for the HSCB and it will continue to work with Trusts under the new regional unscheduled care arrangements, jointly led by the HSCB and PHA, to take this work forward during 2016/17.

Achievement of Ministerial Targets

Unscheduled Care (4 hour and 12 hour)

The HSCB and PHA will continue to work with Trusts and other partners under the new regional unscheduled care arrangements, to take forward implementation of the unscheduled care agenda during 2016/17. It is important to note that the reforms of unscheduled care, older people's services, long term conditions and ambulatory services are inextricably linked. All service improvement actions should recognise this interdependency. The primary objective of these reforms is to enable people to safely live more days independently at home.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the new regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to Unscheduled Care services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	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	Trust responses should demonstrate how core primary and community care teams will be effectively resources and organised around the needs of individual patients.

	attendance/admission.	Trust responses should demonstrate how, working with appropriate partners, Acute Care at Home services and equivalent (offering demonstrably more specialist services than those that should routinely be delivered by core primary and community care teams) will be made available for patients throughout the Trust area, 24/7; and how these services will be integrated with other services delivered in the community, including linkages to core primary/community care teams and NIAS Alternative Pathways.
2.	Effective arrangements should be in place at the front door of hospitals to provide ambulatory, rapid-response services for patients on a same-day or next-day basis, avoiding the need for patients to be admitted to hospital.	Trust responses should demonstrate how, working with appropriate partners, comprehensive ambulatory care services will be made available for patients, initially at the larger hospital sites, on a seven-day basis and where appropriate linked to planned (elective) services.
3.	Effective arrangements should be in place to optimise patient flow through hospital, both before and after the patient being declared medically fit.	Trust responses should demonstrate the particular actions to be taken in 2016/17, working with appropriate partners, to further improve LOS through timely, multi-disciplinary decision making and effective discharge arrangements on a seven-day basis, to include participation in the Unscheduled Care Champion Wards pilot arrangements.
4.	Effective arrangements should be in place to manage ambulance demand across hospital sites, consistent with regional planning assumptions.	The NIAS response should demonstrate how the Trust will ensure effective arrangements for ensuring equitable demand across sites on a rolling, seven-day basis.
5.	Effective arrangement should be in place to manage major Trauma. Each year around 370 people in NI suffer from major trauma, this is often life threatening and requires a prompt and coordinated approach.	All Trusts should participate in the establishment of a regional Trauma Network which seeks to reduce mortality and morbidity due to major trauma through coordinated care pathways, clinical leadership and participation in TARN (Trauma Audit and Research Network)
6.	Effective arrangements should be in place to manage Winter Pressures demand across the Trusts.	Trust responses should demonstrate the actions to be taken in 2016/17, working with appropriate partners to ensure effective arrangements to manage unscheduled care pressures to include the preparation of seasonally-adjusted, evidence-based resilience plans.

In the context of available resources in 2016/17, it is not expected that workforce levels within Emergency Departments can be brought fully in line with expected levels to be prescribed within Delivering Care. More generally, in the context of available financial and staffing resources and the current configuration of acute services, there will be challenges in ensuring appropriate levels of medical and other staffing in EDs and on wards.

5.2 Elective Care

Service Context

Demand for Elective Care services continues to exceed current Trust capacity, resulting in increasing waiting times to access elective services across NI.

In recent years a programme of planned recurrent and non-recurrent investments had the effect of reducing Outpatient, Diagnostic, Inpatient and Day case waits, however waiting times across NI remain extremely challenging. The HSCB plans to further invest, where possible, in both core service and waiting list initiatives to manage demand. Long term service redesign and modernisation will be expected to continue across 2016/17 and future budget years to deliver improved patient journeys within and between primary and secondary care.

It is important to note that the planned Transformation, Reform and Modernisation agenda will take several years to deliver across all specialties. An example of such reform is the Heart Failure Pathway associated with initial investigation and diagnosis, will be rolled out across the region. The pathway implementation is supported by a range of measures (a regionally standardised cardiac rehabilitation programme, locality based one-stop-shops and better utilisation of the valuable resources of Heart Failure Nurses) designed to improve patient outcomes and experience, at the same time as seeking to manage the increasing demand for heart failure services.

Preparations are under way for a consultation on modernising HSC Pathology Services and, subject to approvals, the consultation should be undertaken this Autumn.

The HSCB has developed a long-term plan to deliver sustainable short waiting times for patients. This plan will require substantial additional annual resources and is with the Department for consideration.

Achievement of Ministerial Targets

Elective Care waiting times

Progress was made in the last quarter of 2015/2016 in securing reductions in the length of time people are waiting to be assessed and treated. However it is clear that it will take time and significant non recurrent and recurrent investment to bring waiting lists back to an acceptable level while simultaneously increasing capacity to meet demand for a first outpatient appointment, and for inpatient or daycase treatment.

The HSCB plans to further invest, subject to the availability of funding, in both core service and waiting list initiatives to manage demand. In addition, to minimise the increase in waiting times, the HSCB will continue to work with Trusts to maximise the delivery of funded capacity and ensure the application of good waiting list management.

Issues and Opportunities

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place in primary and community care settings to minimise the need for patients to be referred by GPs 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: • General Surgery • Gastroenterology • ENT • Gynaecology • Dermatology • Rheumatology • MSK/Pain • T&O • Cardiology • Neurology • Urology • Ophthalmology

2.	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 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.
3.	Opportunities exist to improve further the efficiency and effectiveness of elective care services (outpatients, diagnostics and inpatients/daycase treatment) delivered by Trusts.	Trust responses should describe the specific actions being taken in 2016/17, 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 • 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 • Phased introduction of seven-day working for elective specialities • Plans to ensure maximum wait of 9 weeks for scopes by 31 March 2017. • Plans to address AHP staffing requirements in line with the recent AHP demand and capacity exercise. • More generally, actions to improve the efficiency and effectiveness of outpatients, diagnostics and treatment services.

Within Elective Care, the following are unable to be fully progressed at this time:

- Vascular Services Review
  Framework to improve the outcomes of Abdominal Aortic Aneurysm Surgery, with the aim of reducing the overall mortality rates.

- Pathology – Pre Referral Testing H-Pylori
  Investment in community based patient testing which evidences a reduction in unnecessary patient journeys into secondary care.

- Neurological Nursing – to include Huntingdon's
  Investment across neurology to enhance nursing capability and skill mix to meet demand. This includes sub specialisation including Huntingdon's disease.

More generally, substantial additional resources are required to reform waiting times for elective care services to acceptable levels.

5.3 Maternity and Child Health

Service Context

The Maternity Strategy 2012-2018 sets the context for the delivery of maternity services across NI, promoting improvements in care and outcomes for women and babies from pre conception through to the postnatal period.

The HSCB and PHA have commissioned a review of neonatal services. Now being finalised, it will be used to inform the future planning of safe, high quality, sustainable neonatal services for the population. The Department has consulted on a Paediatric Strategy and once issued it will inform the planning and delivery of paediatric services across 2016/17.

Issues and Opportunities

During 2016/17 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 maternity and child health services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that maternity services are arranged to meet the needs of all pregnant women. Effective arrangements should be in place to ensure that the agreed regional antenatal care pathway is delivered. Effective arrangements should be in place to ensure that women with more complex pregnancies are offered the best possible care in line with national evidence based guidelines.	Trust responses should demonstrate how they will implement the agreed care pathway for antenatal care for women with low risk pregnancies. They should evidence that they implement UNICEF Baby Friendly Initiative Standards. Trusts should also demonstrate how they will deliver services to meet the needs of more complex pregnancies. Plans should evidence; • How recent investment in ante-natal diabetic services is being used to improve care. • The implementation of the 'Weigh to a Healthy Pregnancy' programme targeting women with a BMI of >40. • How multiple pregnancies will be managed in line with NICE guidelines, including the delivery of dedicated 'twin clinics'.

		Trusts should continue to work with PHA/HSCB on the development and implementation of early pregnancy assessment and epilepsy care pathways both of which are based on NICE guidelines. Trusts should also work with PHA/HSCB to clarify and standardise the referral and clinical pathways for women who have recurrent miscarriages.
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 improvement work.	Trust responses should demonstrate commitment to collecting data to evidence best practice and identify opportunities for further service improvement. Plans should include evidence of full utilisation of NIMATS and Badgernet.
3.	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 evidence how recent investment in AHP services for neonatal units is resulting in the integration of AHP services into neonatal services with a focus on neurodevelopment and nutritional support.
4.	Effective arrangements should be in place to ensure that paediatric services respond to patient need, are accessible and provided in a timely way. This should include arrangements for same day and next day assessment, short stay assessment and ambulatory models of care.	Trust responses should demonstrate how they: • Offer short stay assessment models of care with agreed access to for primary care professionals and opening hours agreed with HSCB and PHA to maximise their impact. • Continue to work with the HSCB/PHA to develop and test models of care which reduce the reliance on in-patient and secondary care paediatric services.
5.	Effective arrangements should be in place to ensure children and young people receive age appropriate care and that the regional upper age limit for paediatric services of 16th birthday is implemented.	Trust responses should demonstrate how their paediatric services operate a minimum upper age limit of 16th birthday. 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 with input from paediatricians where necessary.

6.	Effective arrangements are in place to support multidisciplinary learning and service improvement through regular multidisciplinary morbidity and mortality review.	Trust responses should evidence how they are taking forward Departmental direction to implement a child death review pilot which is based on multidisciplinary mortality review.

Within Maternity & Child Health, the following are unable to be fully progressed at this time:

- Implementation of current draft DOH Paediatric and Palliative Paediatric Strategies:
  Will be used to inform the future development of services and additional funding will be required to meet all of the requirements in the Strategies.

- Improving pre-conceptual and pregnancy care of women with epilepsy:
  There are safety risks for women with epilepsy who become pregnant. National recommendations are that women with epilepsy should receive accurate pre-conception advice before pregnancy and that antenatal care is shared between an epilepsy specialist and obstetrician. A regional care pathway for women with epilepsy has been developed and funding is required to implement this.

- Implementation of Neonatal Review:
  The PHA/HSCB is finalising a review of neonatal care. The review is based on the principles of ensuring that babies who need neonatal support are cared for in the right setting by the right staff with the right skills and that mothers and babies are not separated unless there is a clinical need to do so through admission to a neonatal unit. Additional funding will be required to ensure optimum configuration of safe, high quality and sustainable neonatal services.

- Improving maternity services to meet the needs of vulnerable women:
  There is an increase in the numbers of migrant women giving birth in NI. A proposal for a specialist midwifery service for minority ethnic and migrant

women has been developed to meet the specific needs of this cohort of women.

- AHP support for children with statements of special education needs: A *service review has been completed and funding to ensure implementation is required.*

5.4 Family and Childcare Services

Service Context

The Child and Family Care Programme is a heavily legislated service which all aspects should be adhered to 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.

Achievement of Ministerial Targets

Children's services

In working to ensure, as far as possible, that children grow up in a stable environment, the HSCB will build on the work carried out with Trusts during 2015/16 in actively reviewing and promoting residential care structures.

The increasing demand for CAMHS remains a challenge and the HSCB 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.

Issues and Opportunities

During 2016/17 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 family and childcare services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to appropriately manage the increasing number of children with complex health care needs and challenging behaviour.	Trusts responses should demonstrate how service provision will meet the needs of children with complex health care needs and challenging behaviour.
2.	Effective arrangements should be in place to appropriately manage the increasing number of Looked After Children (LAC) entering the system.	Trusts 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; • initiatives will be put in place to increase the number of placements and specify how these will be provided; • support will be provided to young (16/17 year olds), homeless individuals who are seeking to achieve a safe, stable return to a family; • Specialist Therapeutic Foster Carer placements in keeping with the needs of children and in line with regional criteria will be provided which will be monitored as part of the DSF process; • 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 2016/17 will be delivered.
3.	Effective arrangements should be in place to meet the ever 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.	Trusts responses should demonstrate plans to address autism waiting lists in line with Autism Access Standard and support the development of an integrated service model to include assessment, early intervention, diagnostic and transitional services.
4.	Effective arrangements should be in place to establish a 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.	Trusts responses should demonstrate plans to establish 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.

5.	Effective arrangements should be in place to prevent the increasing threat of Child Sexual Exploitation (CSE) as identified by the Marshall Inquiry.	Trusts responses should outline their reporting arrangements to the HSCB in relation to the regional action plan.
6.	Effective arrangements should be in place to safeguard children and promote their welfare in line with Co-operating to Safeguard Children (2016).	Trusts 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. • to ensure access to an effective range of therapeutic supports based on assessed needs.
7.	Effective arrangements should be in place to appropriately manage the increasing number of unplanned/emergency placements where children are known to a Trust.	Trusts responses should demonstrate plans to ensure that admissions to care are planned and children are provided with placements matched to their assessed need to provide stability and continuity.
8.	Effective arrangements should be in place to appropriately manage the increasing demand for CAMHs and to improve the interface between acute and community CAMHs teams including working arrangements with secure care and the regional Youth Justice Centre.	Trusts responses should demonstrate how placements will be provided and ensure the implementation of the regionally agreed CAMHS Integrated Care Pathway by April 2017.
9.	Effective arrangements should be in place to ensure a seamless care pathway for LAC which promotes stability and permanency for children.	Trusts responses should demonstrate how the number of placement moves will be minimised as per the Placement Services – Strategic Direction Paper.
10.	Effective arrangements should be in place to ensure that children's care plans explicitly state what is to be achieved by the admission to care, what is expected from parents in order for the child to return home and the anticipated duration of the placement.	Trusts responses should demonstrate how robust assessments (in keeping with policy and 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.

11.	Effective arrangements should be in place to improve data collection in CAMHS services to capture need, demand activity, outcomes and service user experience.	Trusts 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. Trusts should demonstrate how the findings from the Sensemaker Audit on service user experience of CAMHS (expected October 2016), will drive any required service improvements.
12.	Effective arrangements should be in place to manage an increasing number of children who are looked after, those who are placed in kinship and non kinship foster carers, in keeping with the provisions and entitlements of GEM	Trust responses should demonstrate how recent investments will ensure equitable access by all young people in foster care to avail of GEM.

5.5 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. Whilst many have healthy and active lives older people place significant demands on acute and community services. 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. Additional funding has been made available through the Transformation fund to support the ongoing Dementia project during 2016/17.

Issues and Opportunities

During 2016/17 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 for older people.

Specific issues and opportunities in 2016/17 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	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 demography in investment to meet the needs of the aging population.
2.	Effective arrangements should be in place to optimise capacity to meet the numbers of people aged over 65 and over 85 which are projected to increase by 12% and 22% by 2022 respectively.	Trust responses should demonstrate plans to actively promote a range of health ageing initiatives in areas such as promoting good nutrition, social inclusion and falls prevention.
3.	Effective arrangements should be in place to optimise capacity to meet the number of people with dementia which is projected to increase by 35% by 2025.	Trust responses should demonstrate plans to work within the regional strategic implementation arrangements to develop early intervention models and timely access to memory services.

4.	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.
5.	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 examine the potential for progressing the tendering of services based on a more outcomes based approach to domiciliary care provision.
6.	Effective arrangements should be in place to support services for carers that can be developed to maintain individuals to live as independently as possible in their own home.	Trust responses should demonstrate plans to expand and promote the availability of short breaks.
7.	Effective arrangements should be in place to ensure the promotion of personalisation through Self Directed Support to increase individual choice and facilitate responsive remodelling of service models.	Trust responses should demonstrate plans to actively engage with the regional project implementation arrangements to optimise opportunities for services tailored to user needs and include the training and development needs of staff.
8.	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.
9.	Effective arrangements should be in place to further develop ICP initiatives targeted at frail older people.	Trust responses should demonstrate plans that engage with the range of integrated care initiatives/projects designed to maintain older people in the community.
10.	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.
11.	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.	Trusts should remain engaged with the current reform of statutory residential care and review the most appropriate balance and focus of statutory/independent sector domiciliary care provision.

12.	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 review options for remodelling existing provision or negotiating options with the independent sector to increase availability of these services.
13.	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 implement the New Stepped Care Model for Older People and for people with Dementia.

Within Care of the Elderly services, the full implementation of the Domiciliary Care Review cannot be progressed at scale and pace in light of available resources.

5.6 Mental Health

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. Other areas impacting on future service provision include the outcome of the Bamford evaluation (Autumn 2016).

Achievement of Ministerial Targets

Mental health services

The HSCB has previously identified the funding gap between need and provision in respect of mental health services and the level of funding available to invest in psychological therapies is likely to result in significant numbers continuing to wait longer than 13 weeks, particularly in adult heath psychology services. The HSCB will continue to work with Trusts to identify opportunities address this position, including plans to strengthen the range and scope of psychological therapies, arrangements for ensuring safe and effective case management and the promotion of Primary Care Talking Therapy Hubs to help manage demand in to Community Mental Health services in the longer term.

Issues and Opportunities

During 2016/17 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 mental health services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to manage the increased demand for psychological therapies.	Trust responses should demonstrate the particular actions to be taken in 2016/17 to further develop and implement Primary Care Talking Therapy Hubs in partnership with ICP leads.
2.	Effective arrangements should be in place to enhance clinical and personal outcomes by improving access to evidence based NICE approved psychological therapies including increasing the range and scope of Talking Therapies in primary care.	Trust responses should demonstrate how the range and scope of psychological therapies will be strengthened, including arrangements to ensure safe and effective case management.
3.	Effective arrangements should be in place to ensure that people with mental health needs and their families receive the right services, at the right time by the right combination of professionals.	Trust responses should demonstrate what specific measures will be taken in 2016/17 to further embed the Regional Mental Health Care Pathway and to strengthen the provision of psychological care within the role and function of Community Mental Health Services.
4.	Effective arrangements should be in place to improve the effectiveness of Crisis and Acute mental health interventions through the integration of Crisis Resolution, Home Treatment and Acute Inpatient Services and through the provision of modern therapeutically focused inpatient care to safeguard those people who are experiencing acute mental health needs	Trust responses should demonstrate plans to align and integrate their respective Crisis Home Treatment and Acute Inpatient Service into a single care service consistent with the development of a new regional High Intensity Care Pathway. Furthermore, Trust responses should outline plans to strengthen Acute Hospital Liaison Services in line with the principles of the RAID model.
5.	Effective arrangements should be in place to support the new Regional Mental Health Trauma Network arrangements to enhance services and integrate all existing mental health trauma care into a new single managed care network.	Trust responses should demonstrate plans to support and participate in the development and implementation of the Network in line with NICE guidance and to nominate two staff to undertake advanced Trauma Care training to facilitate the development of a dedicated psychological trauma clinical team.
6.	Effective arrangements should be in place to strengthen approaches to support people on their recovery journey in line with the principles and objectives of the Regional ImROC Programme.	Trust responses should demonstrate how, building on the findings of the Sense Maker Audit, co-production across their mental health services will be strengthened, including the appointment of Lived Experience Consultant, Peer Support Workers and Peer Educators and Peer Advocates. Trust responses should also provide details of the next phase of recovery

		college development and demonstrate the actions to be taken to promote the role and influence of carers across mental health services.
7.	Effective arrangements should be in place to develop condition / service specific care pathways in order to safeguard the physical wellbeing of people with mental health needs.	Trust responses should demonstrate how the recommendation of the RQIA Review into Eating Disorders will be implemented.
8.	Effective arrangements should be in place to ensure full implementation of the Choice and Partnership Framework in order to ensure the effective delivery of mental health and psychological care to patients.	Trust responses should demonstrate that the Choice and Partnership Framework has been fully implemented across all mental health services. Trust responses should also demonstrate that a full demand and capacity analysis has been completed in line with regional guidance and that each community mental health professional has an agreed job plan.
9.	Effective arrangements should be in place to ensure that the workforce delivering mental health care is appropriately skilled.	Trust responses should demonstrate the actions to be taken to implement the Mental Health Learning Together Framework. Details of Trusts' mental health workforce plans should also be provided.
10.	Effective arrangements should be in place to provide evidence of the impact of all mental health services.	Trust responses should demonstrate what measures are in place to ensure that an annual comprehensive analysis will be provided in line with the indicators set out in the new Mental Health Services Framework and that this will include an overview of presenting need, the volume of interventions provided, the outcomes achieved and the quality of people's experience of using the services.

Within Mental Health services, it is not possible to fully progress the implementation of the Alcohol/Substance Misuse Service within available resources. Phase 2 implementation would include the expansion of the alcohol/substance misuse service to encompass the wider range of admission wards, including enhanced ED cover.

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 NI. A lifelong 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 in NI continue to provide the bulk of care and support which people need.

Issues and Opportunities

During 2016/17 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 learning disability services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	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 2016/17 to further develop partnership working with community / voluntary / independent sector organisations to meet the needs of individuals already in services or coming through transition.
2.	Effective arrangements should be in place to manage the increased demand on Day Centres for those individuals with complex physical and health care needs or behavior support needs.	Trust responses should demonstrate what measures are in place to ensure facilities are appropriately designed and meet the needs of individuals with complex needs.
3.	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.	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.

4.	Effective arrangements should be in place to complete the resettlement of people from learning disability hospitals to appropriate places in the community.	Trust responses should demonstrate what processes are in place to complete the person centred resettlement of individuals from learning disability hospitals into the community, with appropriate long term support, in line with recent investments.
5.	Effective arrangements should be in place to manage the demand from individuals living with carers, specifically older carers, for future housing and support needs.	Trust responses should demonstrate what plans are in place to address future housing and support needs of those in the community through community integration.
6.	Effective arrangements should be in place for discharge once the patient has been declared medically fit for discharge.	Trust responses should outline clear protocols, processes and procedures to ensure timely discharge from hospital with appropriate support, where required.
7.	Effective arrangements should be in place to manage the increased demand for specialist services to respond to specific additional needs such as forensic services, behaviour support services etc.	Trust responses should demonstrate that specialist services are in place to meet the increased demand from individuals with complex needs in the community.
8.	Effective arrangements should be in place to further enhance the current Learning Disability Service Framework including arrangements to provide an appropriate range and type of day opportunities for people with a learning disability transitioning from school.	Trusts should demonstrate plans to ensure that standards outlined within the LDSF Framework including the extension of the Transitions Planning Scheme.

5.8 Physical Disability and Sensory Impairment

Service Context

Recent developments for people with a disability have been shaped by the implementation of the regional Physical and Sensory Disability Strategy (2012-15). This work has been led by the HSCB in conjunction with statutory and voluntary sector partners. Limited funding has been made available to support this process but the expectations of service users and their carers remain high as the current phase of implementation is reviewed. The principles of independence and autonomy have underpinned all of the work to date and will shape any future decision making.

Issues and Opportunities

During 2016/17 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 physical disability and sensory impairment Services.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to further develop services for the increasing number of people who are deaf-blind as a result of an ageing population.	Trust responses should demonstrate how existing services will be developed, awareness of the condition will be improved and appropriate staff training provided.
2.	Effective arrangements should be in place to manage the increased number of high cost packages due to increased life expectancy and an increased focus on supporting people at home.	Trust responses should demonstrate how domiciliary, equipment and staffing budgets will be targeted to provide appropriate service responses for individuals with increased support needs.
3.	Effective arrangements should be in place to ensure individuals are transitioned from childrens to adult services in a timely manner.	Trust responses should outline clear protocols, processes and procedures to facilitate transition planning which includes inter programme coordination.

4.	Effective arrangements should be in place to further enhance the current PDSI Strategy arrangements.	Trusts should demonstrate plans to support, participate and lead in maintaining coordinated strategic planning arrangements outlined within the PDSI Strategy.
5.	Effective arrangements should be in place to ensure there are appropriate accommodation options for people with severe disabilities in the community.	Trust responses should demonstrate how it will work within the existing Supporting People arrangements to examine the potential for further accommodation options.
6.	Effective arrangements should be in place to ensure service information and advice is accessible to all service users and that Trusts have a skilled and informed workforce.	Trust responses should demonstrate plans to ensure that all health and social care staff have access to disability, equality and human rights training and are trained to communicate appropriately with people who are blind or partially sighted.
7.	Effective arrangements should be in place to ensure that people with a disability receive a personalised package of care.	Trust responses should outline plans to change the pattern of service allocation including the promotion of Self Directed Support.
8.	Effective arrangements should be in place to ensure the appropriate provision of Day Opportunities.	Trust responses should demonstrate how it will partner with the Community and Voluntary Sector to develop alternatives to existing service provision.
9.	Effective arrangements should be in place to ensure that wheelchairs and equipment, and the maintenance and repair of the same continue to made available in line with demand.	Trust responses should consider the introduction of an access and eligibility criteria in order to ensure equitable allocation of equipment.
10.	Effective arrangements should be in place to ensure that people with Neurological conditions are supported to live as independently as possible.	Trusts should demonstrate plans to review the needs of people with neurological conditions, particularly those with life limiting circumstances, ensuring equitable access to support.
11.	Effective arrangements should be in place to ensure to provide appropriate communication support for people who are deaf.	Trusts should demonstrate plans to use transformation funds to provide appropriate services and support.

5.9 Family Practitioner Services

Family practitioner Services comprise the following key areas:

- General Medical Practitioners Services
- General Ophthalmic Services
- General Dental Services
- Community pharmacy provision
- Primary Care Infrastructure Development

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

5.9.1 General Medical Practitioner Services

Service Context

General Medical Practitioners (GPs) play a key role in ensuring that health service provision in NI is effective and efficient. GPs provide:

- The main point of entry to the health care system
- Person focused, on-going care covering whole episodes of ill health
- Delivery of the majority of care for all but the most uncommon conditions
- Coordination of care provided by others

Issues and Opportunities

During 2016/17 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 General Medical Practitioner Services.

Specific priorities for 2016/17 are as follows:

REGIONAL PRIORITY		GMS REQUIREMENT
1.	Effective integrated arrangements should be in place to; • Support patients with Long Term Conditions, • Manage Elective Care services and • Deliver Out of Hours pathways	As part of the HSCB's wider reform priorities, GMS will: • promote enhanced services for the management of patients with chronic conditions • develop common pathways across unscheduled care • evidence integrated working across GP Federations to provide innovative alternatives to hospital based elective services.
2.	Effective arrangements should be in place to improve access to GP services, both in and out of hours.	FPS will develop pathways to improve access for unscheduled services at the interface between in hours and out of hours GP services and include options to develop a baseline of GP appointments across NI to support practices in managing demand.
3.	Effective arrangements should be in place to optimise recruitment and retention challenges and ensure safe and accessible GP services.	FPS will develop plans to: • Support 20 additional GP training places • Implement and monitor the impact of the revised GP Retainer Scheme • Improve current working arrangements to attract more OOH GPs and implement skill mix, including both in hours and out of hours services
4.	Effective arrangements should be in place to develop Practice Based Pharmacists within GMS to help improve capacity for GPs.	FPS will develop plans to release GP time spent on prescribing to increase overall GP capacity and assist collaborative working through GP Federations. This will further improve quality and safety of prescribing whilst achieving prescribing efficiency and cost effectiveness

5.9.2 General Ophthalmic Services (GOS)

Service Context

Ophthalmology accounts for around 10% of all outpatient demand and first outpatient demand of 36,976 appointments in 15/16. "Developing Eyecare Partnerships; improving the commissioning and provision of eyecare in NI" (DEP) (DHSSPSNI, 2012) is a five year strategy aimed at taking a partnership, clinical networks and pathway approach to transforming how and where services are to be provided, enhancing skills mix and improving interfaces, and treating people closer to home where safe and appropriate.

Issues and Opportunities

During 2016/17 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 General Ophthalmic Services.

Specific issues and opportunities in 2016/17 are as follows:

REGIONAL PRIORITY		GOS REQUIREMENT
1.	Effective integrated demand management arrangements should be in place to address the increasing levels of age related long term conditions such as glaucoma, macular degeneration, Diabetes mellitus and complications such as sight threatening retinopathy.	FPS will develop plans to: • Meet the needs of this demographic increase in dealing with increasing attendances for long term review patients • Manage diabetic retinopathy screening and surveillance clinics to deliver timely access • Evidence full utilisation of skill mix opportunities • Promote robust data quality and participate in the development of regional performance indicators
2.	Effective arrangements should be in place to support improvement science and quality improvement initiatives that have the potential to improve patient flows, experience and outcomes.	FPS will advance plans to improve the examination, application and implementation of Improvement Science in healthcare to the following areas of Ophthalmology; • Eye Casualty • Cataract Pathway Plans will also indicate a method of capturing and reporting patient centred outcome and experience measures.

3.	Effective arrangements should be in place to ensure the transformation of eyecare services. Demand-management initiatives (Local Enhanced Services) such as glaucoma referral refinement, minor eye conditions, and primary care based post-operative cataract assessment schemes have the potential to positively impact on treating more people closer to home, away from secondary care.	FPS will ensure the provision of placements for primary care optometrists undertaking independent prescribing training. (DEP Objective10) HSCB will engage with GOS providers in the development of training to support this transformative care and facilitate participation in innovative governance and training models such as Project ECHO, building knowledge networks to expand capacity and capability in primary care and improve the interface between primary and secondary care.

5.9.3 Dental Services

Service Context

There are 1,100 General Dental Practitioners (GDPs) in NI 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 NI population had poor oral health, however, in recent years significant improvements have been observed in both children's and adult's dental health.

Issues and Opportunities

During 2016/17 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 Dental Services.

Specific issues and opportunities in 2016/17 are as follows:

REGIONAL PRIORITY		GDS REQUIREMENT
1.	Effective arrangements should be in place to understand the distribution of oral disease in the NI population. This includes dental decay prevalence and severity in hard to reach groups such as the elderly/infirm and very young children.	HSCB and PHA will develop plans to reconfigure local salaried dental services to support dental service capacity requirements.
2.	Effective arrangements should identify the number of patients being referred from	A regional three-part plan will be established to

	primary care to Trust Oral Surgery/OMFS departments, which significantly exceeds capacity in most Trusts.	enable : • Transfer 80 patients per month from SET OMFS department to BHSCT Oral Surgery department where there is more capacity • Provide training to GDPs in basic Oral Surgery treatments to reduce referrals from dental practices to Trusts • Establish a pilot PDS in Oral Surgery to increase the amount of treatment provided by High Street Oral Surgery Specialists and therefore reduce Trust referrals
3.	Effective arrangements should be in place that evidences a new GDS contract, that focuses on prevention, provides a sustainable business model for GDPs and allows cost control	FPS will review the 11 pilot practices that have completed the 1 year pilot period and engaged in the evaluation process. University of Manchester to produce evaluation report by 31 March 2017
4.	Effective arrangements should be in place to improve the 8 week turnaround times for GDS	FPS will develop a new prior approval process will be piloted in 2016/17 with the aim of reducing turnaround time and the current resources required to deliver the service.

Within Dental services, the following are unable to be fully progressed at this time:

- Pilot PDS for Primary Care Oral Surgery:
  An innovative form of dental contract for high street oral surgeons that increases the amount of work that they provide for HSC. The pilot evidences a reduction in referrals from GDPs to Trust oral surgery services and Trust oral surgery waiting times

- Regional Consultant Special Care Dentistry (SCD) service:
  All Trusts have specialist care dentistry teams offering specialist dental care to patients with complex medical co-morbidities. A small number of cases are so complex that they need to be managed in a regional service which is suitably staffed and equipped to manage the most challenging patients.

5.9.4 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. Pharmaceutical services are commissioned from a range of providers in primary and secondary care and with the volume and complexity of medicines being used, there is a requirement for on-going medicines management and optimisation. Indeed the DOH has set out a range of quality standards associated with its Medicines Optimisation Quality Framework and it is expected that services will be commissioned to take this forward in 2016/17.

In primary care, demand for GPs impacts on their ability to manage prescribing processes. There are increasing expectations around community pharmacy provision in line with DOH policy while at the same time there has been an on-going financial dispute that will require resolution in 2016/17. There is recognition of the need to develop pharmaceutical care models within both primary and secondary in order to maximise the quality and safety of service provision while at the same time deliver substantial efficiencies. In 2016/17, the Commissioning Direction has identified £20m to be delivered in primary care with further efficiencies of £10m required in secondary care.

Issues and Opportunities

During 2016/17 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 Pharmaceutical Services and Medicines Management Services.

Specific issues and opportunities in 2016/17 are as follows:

REGIONAL PRIORITY		PSMMS REQUIREMENT
1.	Effective arrangements should be in place to Commission Practice based Pharmacists services within General Medical Services to	The Pharmaceutical Services and Medicines Management Services Team will develop plans to re-orientate existing service provision, to

	improve capacity within GMS to meet additional demand and improve the safety and effectiveness of service	support the development of Practice Based Pharmacists.
2.	Effective plans should be in place to develop a service model for Medicines Optimisation for Older people and for Home Treatment Mental Health Services	The Pharmaceutical Services and Medicines Management Services Team will develop plans to ensure they will recruit additional pharmacy capacity in line with agreed spending.
3.	Effective plans should be in place to deliver £20m efficiencies in primary care through the Pharmaceutical Clinical Effectiveness programme (requiring support from secondary care) and deliver further additional efficiencies of £10m in secondary care	The Pharmaceutical Services and Medicines Management Services Team will develop plans to deliver the £20m target for primary care and further efficiencies of £10m to be delivered in secondary care.

5.9.4.1 Primary Care Infrastructure Development

Service Context

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

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

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

Issues and Opportunities

During 2016/17 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 Primary Care Infrastructure Development.

Specific issues and opportunities in 2016/17 are as follows:

REGIONAL PRIORITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to improve the quality of primary care facilities to meet all statutory standards	For Trust owned facilities, responses should demonstrate that facilities meet the minimum standards and provide adequate accommodation for services to be provided

5.10 Specialist Services

Service Context

Specialist acute hospital services include tertiary or quaternary level services delivered through a single provider in NI or designated centres in Great Britain/ROI. High cost specialist drugs are supported through this branch of commissioning. A process is underway to revise the process for consideration Individual Funding Requests (IFRs). The implications of any changes to the current arrangements will need to be taken account of by the HSCB.

Specialist Acute Hospital services have and will continue to develop strong clinical alliances with specialist peers in GB, ROI and with local clinicians across the region making best use of available information and communication technologies to facilitate delivery of care.

Issues and Opportunities

During 2016/17 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 specialist services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to address the growth in the number of patients accessing approved specialist drug therapies for a range of conditions. Each year there is growth in the number of patients receiving specialist drug therapies previously approved by NICE.	Trusts responses should demonstrate how they will engage with the HSCB to inform the projected requirements associated with the increase in the number of patients on existing treatment regimes across a range of conditions including rheumatoid arthritis, psoriasis, IBD, Hep-C, MS, HIV, specialist ophthalmology and cancer conditions.
2.	Effective arrangements should be in place to develop the model for specialist neuromuscular services.	Belfast Trust response should demonstrate the agreed service model /pathways for adults and children (including transitional care) with specialist neuromuscular conditions incorporating baseline resources as well as more recent investment. The proposed model and implementation plan to be submitted by end of June 2016.

3.	Effective arrangements should be in place to continue to support the implementation of the NI Rare Disease Implementation Plan through a programme of in-reach and networked services through formal alliances with tertiary and quaternary providers outside NI.	Belfast Trust response should demonstrate an implementation plan, by 30 September 2016, to deliver the NI Rare Disease Implementation Plan.
4.	Effective arrangements should be in place to ensure access to genetic tests in line with UKGTN recommendations.	Belfast Trust should submit an IPT by 30 September 2016 to ensure timely access to UKGTN tests approved for 2016/17 net of baseline costs.
5.	Effective arrangements should be in place to ensure access to new NICE TAs and other NICE recommended therapies approved during 2016/17.	Trust responses should demonstrate how they will deliver on the requirements of new NICE TAs in line with recent investment.
6.	Effective arrangements should be in place for the provision of Paediatric Congenital Cardiac Services in line with Ministerial decision on the establishment of an All-Island Network including: • SLAs, with specialist centres to provide a safe and robust service for children from NI during the implementation period for patients with paediatric cardiac conditions. • Improved antenatal detection rates of structural cardiac anomalies by issuing a standardising regional protocol for the cardiac scan and putting in place a training and audit programme for staff in this area.	Belfast Trust should demonstrate how they will work with the HSCB to develop an IPT related to the elements of the Full Business Case for an All-Island Congenital Heart Disease Service specific to local developments in NI e.g. Paediatrician with Specialist Interest in Cardiology role, additional specialist nursing liaison support etc. Timelines for submission will be consistent with the requirements of the Departmentally Chaired, NI CHD Implementation Group. Trusts should ensure implementation of the regional scanning protocol, participate in the training and audit programme.
7.	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 service to be fully operational in 2017.	Belfast Trust response should (with input from the NI Critical Care Network) demonstrate that it will finalise the IPT for this development and submit a detailed project plan for staff recruitment/training by end of August 2016, with a view to opening in 2017.
8.	Effective arrangements should be in place to ensure the development of weekend access to neuroradiology intervention for patients with subarachnoid haemorrhage, arising as a result of recommendations from the NCEPOD report 'Managing the Flow'.	Belfast Trust response should demonstrate that it will submit an IPT to achieve the NCEPOD recommendations with a project plan for establishment of the weekend access. Services expected to be in place by September 2016.

9.	Effective arrangements should be in place to ensure the further expansion of the NISTAR (NI Specialist Transport and Retrieval Service) for neonates, children and adults across NI and ROI. The service will ensure critical and supported clinical transports undertaken are managed consistently and to best effect. NISTAR will also work closely with the fixed wing Air Ambulance / Air Transfer provider.	Belfast Trust working with the NI Critical Care Network and the regionally established NISTAR group should bring forward proposals to identify phases of development for this service. This will include consultation with DGH and NIAS colleagues. The Belfast Trust should submit a final IPT by end of September 2016 with a view to services expanding on a phased basis from 1 December 2016.
10.	Effective arrangements should be in place to improve access to specialist immunology services for adults and children through establishment of a tertiary referral arrangement.	Belfast Trust should submit proposals incorporating the operational arrangements to move this service to a tertiary referral service for adults and children and effect this change by 1 November 2016.
11.	Effective arrangements should be in place to improve access to specialist paediatric services through the establishment of regional networks.	Belfast Trust should submit by 31 July 2016, an IPT and associated action plan to provide centralised waiting lists and outreach services in respect of paed orthopaedics, paed gastroenterology, paediatric cardiology and paed surgery.
12.	Effective arrangements should be in place to ensure the introduction of cranial stereotactic radiotherapy in NI to reduce the need to send some patients for treatment in GB and provide more accessible service and plans to expand stereotactic ablative radiotherapy (SABR) to include the treatment of oligometastatic and oligo-progressive advanced cancer disease.	Belfast Cancer Centre should deliver a cranial stereotactic service to treat 50 patients with Cerebral Metastases in 2016/17 increasing to 65 patients in 2017/18. Belfast Trust will bring forward plans to extend SABR in the treatment of oligometastatic and oligo-progressive advanced cancer disease.
13.	Effective arrangements should be in place to optimise drug efficiency savings.	Trust responses should demonstrate a co-ordinated approach to bringing forward proposals to maximise drug efficiency savings in line with key principles shared with Trusts during 2015/16.
14.	Effective arrangements should be in place to optimise the use of specialist capacity through development of protocols to support timely discharge of patients in specialist acute beds.	Trust responses should demonstrate a schedule of specialist acute areas, with timelines, for review by 1 October 2016. Protocols will follow and will be available on a phased basis from 1 December 2016.
15.	Effective arrangements should be in place to appropriately manage the service demands associated with an increasing number of patients requiring specialist services.	The Trust response should demonstrate how the Trust will deliver the required volumes of service activity in light of the changing population need and demand for specialist services in 2016/17.

Within Specialist services, the following are unable to be fully progressed at this time:

- Specialist drugs and infrastructure to deliver new drug regimes including NICE and HSTAs. Subject to policy clarification, there are also issues in relation to the funding of emerging NICE guidance in respect of previous CDF therapies.

- The provision of new technology and therapies within neurosurgery and neuro-radiology including Deep Brain Stimulation and to ensure availability and resilience of small highly specialist services.

5.11 Cancer Services

Service Context

In NI around 24 people are diagnosed with cancer each day, around 9,000 per year. With the increasing age of the population, this number is expected to rise by 25% for men and by 24% for women by 2020. Current estimates suggest that there are around 69,000 people living with cancer in NI today. With more new diagnoses and improvements in care and survival, this figure is increasing every year. As the population grows, ensuring they have the right care and support across their care pathway is becoming increasingly important.

Achievement of Ministerial Targets

The main challenges relate to the 14 day breast performance and 62 day waiting times in urology, skin, upper GI and lower GI cancer pathways. The HSCB and PHA 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 HSCB will continue to meet with all Trusts on a monthly basis via the cancer service improvement and AD forum to share best practice across the region and identify opportunities for delivering improved performance.

Issues and Opportunities

During 2016/17 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 cancer services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to deliver cancer access times.	Trust responses should demonstrate plans to deliver all cancer access standards across all relevant services.
2.	Effective arrangements should be in place to provide enhanced access to radiotherapy services for patients through	Trust responses should demonstrate that plans are in place to ensure that the new radiotherapy service in Altnagelvin will be operational by

	the delivery of a new radiotherapy centre at Altnagelvin.	November 2016 to provide high quality, sustainable services consistent with national standards.
3.	Effective arrangements should be in place to deliver the recently introduced Acute Oncology Service across NI in line with the agreed service model and to consider further development of the service to provide a more sustainable acute care service for patients across all Trusts.	Trust responses should demonstrate how acute oncology services will be provided in line with the agreed service model. Trust responses should also indicate how the acute oncology service will be developed to meet patient needs.
4.	Effective arrangements should be in place to improve the patient experience of cancer care services.	Trust responses should demonstrate how the key findings from the recent Cancer Patient Experience Survey will be addressed, in particular, the specific actions to be taken to: work more closely with primary care to improve early detection; improve access to patient information across the pathway; improve access to clinical nurse specialists; and, increase recruitment to clinical trials.
5.	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce in NI in line with national benchmarks, using a five-year phased approach.	Trust responses should demonstrate the particular actions to be taken in 2016/17 to expand the CNS workforce and, in doing so, how this will increase opportunities to modernise cancer care pathways and improve the patient experience of care.
6.	Effective arrangements should be in place to implement a regional Teenagers and Young Adults (TYA) Cancer Service in NI.	Trust responses should demonstrate what measures will be put in place to offer age appropriate care to TYA patients with cancer consistent with the regional service model.
7.	Effective arrangements should be in place to address any issues arising from the peer review of cancer multidisciplinary teams to ensure the quality of cancer services can be sustained or, as needed, improved.	Trust responses should demonstrate that arrangements will be in place to take action to address matters highlighted by the peer review team, and that priority will be given to immediate and serious risks where these have been identified.
8.	Effective arrangements should be in place to ensure timely access to chemotherapy.	Trust responses should demonstrate how chemotherapy services will be modernised in order to maximise current capacity and improve patient experience, with a particular focus on expanding non-medical prescribing.
9.	Effective arrangements should be in place to continue delivery of the Cancer Awareness Campaign in order to encourage people to seek medical advice at the earliest opportunity.	Trust responses should demonstrate plans to expand capacity to respond to potential increases in primary care referrals for patients with signs and symptoms suggestive of cancer.

5.12 Managing Long Term Conditions

5.12.1Stroke

Service Context

In NI around 1,000 people die each year and between 2,600 and 2,800 people are admitted to hospital every year with a diagnosis of stroke. There is a significant long term care cost associated with stroke.

Approximately a quarter of all nursing home residents have had a stroke, and around 300 stroke patients are newly admitted to residential care each year in NI. 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. National audits and the 2014 RQIA report into stroke services have made several recommendations for improving stroke care in NI many of which are included in this commissioning plan. It will also be the intention of the HSCB to consult on a regional modernisation plan for stroke services in 2016/2017.

Issues and Opportunities

During 2016/17 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 stroke services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		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 directly to a stroke unit in line with NICE guidance	Trust responses should outline plans to review their operational protocols for admission and develop processes that ensure that more than 90% of acute stroke patients are admitted to a

		stroke unit as the ward of first admission.
3.	Effective arrangements should be in place to provide appropriate specialist spasticity services for stroke survivors.	Trust responses should outline plans to work with the regional stroke network to develop a regional pathway for the management of spasticity after stroke.
4.	Effective arrangements should be in place to provide thrombolysis with alteplase as a possible treatment of acute ischaemic stroke.	Trust responses should demonstrate initiatives to ensure at least 15% of acute ischemic stroke patients, attending each of its hospitals, receive thrombolysis and that 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	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 weekend outpatient assessment for TIA patients with high risk TIA patients assessed within 24 hours of an event and commence appropriate treatments to prevent stroke.	Trust responses should demonstrate plans to provide ambulatory services for suspected high risk TIA patients seven days a week, in line with NICE guidance.
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 over seven days a week, able to respond within 24 hours of discharge, and provide required levels of therapy in line with transformation fund or demography investments.

Within Stroke Services, the extension of the interventional radiology service to provide a 24/7 thrombectomy service and the development of a regional post stroke spasticity service cannot be fully progressed at this time.

5.12.2Diabetes Care

Service Context

There are 85,000 adults (aged 17+) in NI living with Type 1 and Type 2 diabetes at the end of March 2015. This represents a 65% increase in prevalence of

diabetes in N Ireland since 2004/05. 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 1,092 children and young people Type 1 diabetes attending paediatric clinics. 5.2% of all pregnancies are complicated by diabetes, a 12-fold increase in numbers since 2001. 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 consideration of new models of care delivery.

Additional funding has been made available through the Transformation fund to support a number of priorities during 2016/17. There has been regional agreement to develop a network to focus on the planning, provision and improvement of services and proposals regarding its structure will be developed in the Autumn with an expectation for Trust/HSCB/PHA Board level involvement moving forward. All Trusts will be expected to be active participants in the evolving network structure over 2016/17 and going forward.

Issues and Opportunities

During 2016/17 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 diabetes care. This should be consistent with the aspirations and actions in the draft Diabetes Strategic Framework and implementations plan published in March 2016.

Specific issues and opportunities for 2016/17 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to expand • the use of insulin pumps and consumables for adults and children with Type 1 diabetes	Trust responses should demonstrate plans to continue to work with commissioners to review uptake in line with NICE guidance. Additional resources will be made available in

	• Consistent regional transition arrangements for children into adult services • consistent regional approach to the self-management and structured education programme	16/17 from the Transformation fund.
2	Effective arrangements should be in place to reflect that current transition arrangements from paediatric to adult services can be associated with sub optimal care	Trust responses should demonstrate plans to ensure effective transition arrangements are in place including increasing the upper age limit for in-patients to 16 years
3	Effective arrangements should be in place for antenatal management and post-natal assessment of gestational diabetes.	Trust responses should demonstrate new models of care to be implemented in 2016/17 to manage the increase in numbers attending antenatal clinics/develop capacity in the post natal pathway.
4	Effective arrangements should be in place to implement the Diabetic Foot Care Pathway	Trust responses should demonstrate plans to implement the regional pathway work in 2016/17 in partnership with the commissioner.
5	Effective arrangements should be in place to ensure the implementation of the recommendations of current reviews, e.g. inpatient audits, Thematic Review of Insulin	Trust responses should demonstrate plans to complete the baseline assessment of the NICE Clinical Guideline and plans for improvement, implement amended areas of practice, e.g. recommendations around Continuous Glucose Monitoring for Type 1 patients, use information from Near Patient Testing Trust responses should demonstrate plans to review their management of hypoglycaemia and hyperglycaemia in hospital in patient settings, including theatre. This should be linked in with Unscheduled Care Locality Network Groups in each Trust area.
6	Effective arrangements should ensure a consistent regional integrated pathway between primary and secondary care	Trust responses should demonstrate a commitment to participate in a workshop over the Autumn of 2016, to design new models of care for diabetes that clearly describes the delivery of Trust services in the overall care pathway.

7	Effective arrangements should be in place to enhance education of non-specialist health staff in diabetes through the use of competency frameworks, DNAV, WebEx or equivalent and Project ECHO.	Trust responses should demonstrate plans to ensure that educational resources are in place for all staff in hospitals to ensure: • Safe use of insulin • Effective management of hypoglycaemia • Effective management of hyperglycaemia • Early detection of foot problems when they arise in hospital

5.12.3Respiratory

Service Context

Respiratory services cover a wide ranging area of medicine that provide care for a number of illnesses affecting both the upper and lower respiratory tracts, either acutely or chronically. Patients with respiratory disease often require the expertise of a range of health and social care professionals who have specialised skills in the field of respiratory care. This includes prevention, assessment, diagnosis, treatment, care and rehabilitation.

Respiratory disease is the most commonly reported long term illness in children and young people and the third most commonly reported in adults, after musculoskeletal disorders and circulatory disorders. Respiratory disease continues to be one of the biggest causes of death and disability in NI.

Care for people with respiratory disease is a major contributor to the overall work and expenditure of health and social services. A report on the burden of respiratory disease by the British Thoracic Society reported that respiratory disease cost the United Kingdom (UK) £6.6 billion in 2004. This equated to £3billion in NHS care costs, £1.9billion in mortality costs and £1.7billion in morbidity costs.

Issues and Opportunities

During 2016/17 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 respiratory services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure local health economies deliver appropriate integrated pathways for both Adults and Children across primary, community and secondary care.	Trust responses should demonstrate plans to use transformational funding to deliver: • Pathways for children with asthma, allergies and anaphylaxis • Adult asthma pathways • Timely access to diagnostics for patients with suspected asthma • The implementation of Home Oxygen Service.
2.	Effective arrangements should be in place to deliver findings from the Respiratory baseline assessment.	Trust and NIAS responses should demonstrate that plans are in place to deliver: • Development of Trust area Respiratory Forum, including ICPs and primary care • Ambulatory oxygen therapy for patients continuing therapy outside the home • Access to discharge bundle for patients with COPD • Access to pulmonary rehabilitation courses and maintenance classes • Patients with a history of RF given alert cards in the event of conveyance • Patients should receive appropriately controlled oxygen when transported in ambulances to prevent acute hypercacnic failure • Maintenance of current service standards and where applicable, meeting minimum standards as outlined in the baseline review
3.	Effective arrangements should be in place to support the development of networked services across NI for the following diseases: • Interstitial Lung Disease (ILD) • Non-Invasive Ventilation (NIV) • Obstructive Sleep Apnoea (OSA) • Bronchiectasis Services • Home Oxygen Services (HOSAR)	Trust responses should demonstrate a commitment to: • nominate a clinical lead for ILD patients who will work closely with the regional specialist ILD regional centre • Belfast Trust to proceed with plans for one stop shop between neurology and respiratory services • Belfast Trust to reduce waiting list for sleep

		studies • work with ICPs to develop community based services for bronchiectasis • provide an end-to-end HOSAR service with an annual assessment service for every patient (i.e. existing not just new) in a local area – this is an invest-to-save scheme
4.	Effective arrangements should be in place to: • promote self-management, self-directed care and suitable training programmes for patients. • Provide access to psychological therapy and palliative care for all age groups.	Trust responses should demonstrate plans to deliver: • COPD Self-management programmes/pulmonary rehabilitation • Spirometry training programme • In-house or onward referral care pathways
5.	Effective arrangements should be in place to support 7 day delivery of COPD community support.	Trust responses should demonstrate plans to deliver this model in full across 2016/17

The Regional Interstitial Lung disease service (ILD) and regional specialist Non-invasive Ventilation (NIV) services for complex respiratory conditions are unable to be fully progressed at this time.

5.12.4Pain Management

Service Context

More than 400,000 people in NI suffer from pain persisting beyond the expected period of recovery; it is often the most important and disabling symptom of many long term conditions like diabetes, other cardiovascular diseases and arthritis, as well as being a long term condition in its own right. Persistent pain can be prevented and sufferers treated successfully in community, primary and secondary care.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the existing regional structures including the NI Pain Forum, will continue to seek to improve Pain Management Service availability, accessibility and patient experience.

Specific issues and opportunities for 2016/17 are as follows:

REGIONAL PRIORITY		TRUST REQUIREMENT
1.	Effective arrangements should be in place to enhance the skills and capacity and their capacity for integrated working.	Trust responses should demonstrate plans to; • Contribute to and participate in staff education and training for improved and integrated bio psychosocial management of persistent pain patients. • Contribute to the development and delivery of pain related public awareness campaigns and public awareness campaigns and other forms of information and education through the NI Pain Forum
2.	Effective arrangements should be in place to ensure patients have timely access to supported self-management options alongside a stepped care model.	Trust responses should demonstrate plans for a range of self-management options in line with the NI Pain Forum's service specification and in collaboration with LCGs. Depending on local priorities, this may include: • reworking of existing contracts with voluntary providers of self-management programmes and local support groups, • reconfiguration of community and primary care services • collaboration with other government agencies to booster condition management programmes
3.	Effective arrangements should be in place to ensure regional and local prescribing guidelines are followed and supported through pharmacy led regular medication reviews.	Trust responses should demonstrate plans to optimise prescribing practice, reduce the risk of side effects, misuse and addiction, as well as reducing prescribing costs by supporting services in secondary, primary and community care.
4.	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 in developing integrated patient pathways for painful conditions including MSK conditions, fibromyalgia, chronic fatigue syndrome, endometriosis and other long term surgical and medical conditions.
5.	Effective arrangements should be in place to ensure patients with persistent pain have equitable access to services.	Trust responses should demonstrate plans to develop referral pathways for pain management across inter-speciality based triage.

5.13 Palliative and End of Life Care

Service Context

Palliative care, as it relates to adults, focuses on the provision of care to those in the population who have an advanced progressive illness.

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 ensuing 12 months. It is estimated that at any one time 1% of the NI population are in the end of life phase (approximately 19,000 people). Of the actual deaths in NI each year (about 15,000) it is estimated that 11,250 of these individuals will have palliative care needs.

Given the choice most people would prefer to be cared for in their own home (or nursing home) at the end of life. In 2014, 48% of all deaths occurred in hospital. The provision of good palliative and end of life care is complex as it covers a range of condition areas and relies on excellent partnership working between primary and secondary care, the voluntary sector and urgent care services.

Arrangements are in place to progress the former Living Matters:Dying Matters strategy and the wider palliative care agenda through a new regional work plan called 'Palliative Care in Partnership' to take forward further improvements in palliative and end of life care.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the new regional structures will continue to seek to improve the availability, accessibility and experience of patients, their families and carers in relation to palliative care services.

Specific issues and opportunities for 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Improved arrangements for identifying patients in their last year of life will support timely needs assessment and lead to more effective advanced care planning for these patients.	Trusts in collaboration with the palliative care locality board, including ICPs, should set out the specific arrangements to be put in place during 2016/17 to increase the number of patients identified as being in their last year of life and to ensure that this information is communicated across the HSC system.
2.	The keyworker function needs to be embedded within Trust arrangements to support care planning processes, improve communication with patients and their carers and ensure continuity of care for patients and families in hospital, community and other care settings.	Trusts in collaboration with the palliative care locality boards, including ICPs, should set out the specific actions to be taken during 2016/17 to further embed the keyworker function across all aspects of patient care.
3.	Support arrangements for patients and families should be in place out of hours (in conjunction with the voluntary sector as appropriate).	Trusts in collaboration with the palliative care locality boards, including ICPs, should ensure that out of hours arrangements are in place for generalist palliative care 24 hours per days 7 days per week.
4.	Effective arrangements should be in place to provide a range of specialist palliative care services.	Trusts in collaboration with the palliative care locality boards, including ICPs, should ensure that there is access to specialist palliative care services.

5.14 Prisoner Health Services

Service Context

Within N Ireland there are over 5,000 prison committals annually and approximately 1,800 – 1,900 prisoners throughout the prison estate at any time. Prisoner Health Services are delivered within the three prison establishments of Maghaberry, Hydebank Wood College and Magilligan and are managed by the South Eastern Health and Social Care Trust. The HSCB supports the principle of ensuring that people in prison are entitled to the same level of healthcare as those in the community. However, security considerations may modify exactly how healthcare is structured and delivered. In this regard, there is a need to strengthen co-operation between the Criminal Justice System and Health and Social Care.

There is a particular need to address the healthcare needs of vulnerable groups such as young persons, women, older people and ethnic minorities. Rates of mental ill health for those in prison are higher than the general population, with the prison population having a much greater risk of depression, psychosis, suicide, self-harm or a plurality of such illnesses. Work continues on developing better integration with community and secondary care services on committal and discharge. There is also a need to ensure that, following the identification of prisoners' healthcare needs at committal, these are followed up with appropriate action. There remain issues associated with the misuse of prescribed medicines and the supply of illicit drugs.

Issues and Opportunities

During 2016/17 and beyond, the HSCB and PHA working through the South Eastern Trust will continue to seek to improve the existing level of healthcare in relation to prisoner health services. There are a number of factors arising from the prison environment and the nature of prison populations which need to be taken into account in taking forward service development and change agendas.

Specific issues and opportunities in 2016/17 are as follows:

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	There is a particular need to address the healthcare requirements of vulnerable groups within the prison population.	SEHSCT should demonstrate plans to progress the development of healthcare services and chronic disease management in line with the principle of equivalence and produce a Health Needs Assessment in 2016/17 to help inform commissioning priorities moving forward
2.	Effective arrangements should be in place to develop Mental Health services in line with the Bamford Action Plan 2012 – 2015 for people with Mental Health and Learning Disability	SEHSCT should demonstrate how mental health services will be provided in line with the recovery ethos and develop registers for individuals with alcohol addiction, drug addiction, personality disorder and learning disability
3.	Effective arrangements should be in place to provide Learning Disability services in line with "Equal Lives"	SEHSCT should demonstrate how individuals with a learning disability are identified during the committal process and that senior nurses assess their needs in cooperation with other departments such as Education, Probation and NIPS Discipline Team.
4.	The social care needs of the prison population should be reviewed in the context of current provision with a view to identifying unmet need.	SEHSCT should demonstrate how the Trust will co-operate with DOH, NIPS and the Probation Board to 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.
5.	Effective arrangements should be in place to develop care pathways for prisoners with complex needs, both in and out of prison.	All Trusts should outline plans to develop care pathways for individuals with complex needs in Primary Care.
6.	Effective arrangements should be in place to develop Trust based information systems to help facilitate a whole systems approach to prisoner healthcare.	SEHSCT should develop recommendations for service development / improvement linked to Mental Health systems, the monitoring of chronic medical conditions, improved discharge arrangements and medicines management. SEHSCT should develop improved healthcare information systems to increase inter-agency working.
7.	Effective arrangements should be in place to implement a Health & Social Well-being Strategy for Prisoners throughout 2016/17	SEHSCT should produce an action plan to support health improvement initiatives, including mental health promotion, smoking, healthy eating & nutrition, healthy lifestyles, sexual health and relationships, drugs and other substance misuse.

8.	Effective arrangements should be in place to develop alternatives to prison transfers for specialist and/or emergency assessments and reviews including tele-health options.	SEHSCT should demonstrate plans to reduce the number of prisoner transfers outside of prison to access health and care services by exploring alternative proposals for in-reach and remote viewing (tele-monitoring) SEHSCT should provide an analysis of activity (i.e. emergency attendance, outpatient new/review, diagnostic, daycase or inpatient) and volume
9.	Effective arrangements should be in place to engage stakeholders in any service area undergoing development	SEHSCT should demonstrate how the Trust will engage with stakeholders and provide an Annual Report on findings from the analysis of the Committal User Survey.
10.	Effective arrangements should be in place to appropriately manage the service demands associated with an increasing prison population.	SEHSCT response should demonstrate how the Trust will deliver the required volumes of service activity in light of the changing population need and demand for prisoner health services in 2016/17.

5.15 Northern Ireland Ambulance Service (NIAS)

Service Context

Increasing demand for emergency ambulance services is placing considerable pressure on the NI Ambulance Service to deliver against 8-minute response targets despite additional investment in recent years. Ambulance plays an essential role in supporting effective community pathways, maximising patient flow through hospitals and assisting patients to access elective care. Continued increase in demand for ambulance services makes it necessary during 2016/17 to reform through aligned staff rostering and appropriate care pathways and to prioritise based on greatest need.

Also during 2016/17, the HSCB and PHA working with NIAS and with the designated charity, will establish a dedicated Helicopter Emergency Medical Service (HEMS) for NI.

Issues and Opportunities

During 2016/17 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 Ambulance Services.

Specific issues and opportunities in 2016/17 are as follows:

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 demands for services.	The Trust's response should: • demonstrate plans to improve response times to CAT A calls across NI • outline how a robust capacity-demand analysis will be commissioned by the Trust in 2016/17, ensuring the full alignment of NIAS resources with predicted demand.
2.	While there have been some improvements in recent years, ambulance turnaround times in hospitals are too long, with more than half of ambulances spending more than 30 minutes at EDs	The Trust's response should describe how NIAS will improve significantly the handover time for patients, with at least 70% of handovers being completed in less than 30 minutes from March 2017.

3.	A new approach is required to the training of paramedics in the context of accreditation difficulties with existing programmes	The Trust's response should outline how NIAS will work with HSCB and DOH to develop proposals to support the training of new paramedics which may include a university degree route.
4.	Demand for non-emergency transport continues to grow and is delivered on a 'first come' basis which fails to ensure the most in need gain access to transport support.	The Trust's response should outline how NIAS will work with the HSCB to introduce in 2016/17 eligibility criteria for non-emergency transport which prioritise patients with mobility difficulties.
5.	There is a need to further expand NISTAR (NI Specialist Transport and Retrieval Services) for neonates, children and adults within NI, and to/from Dublin as appropriate.	The Trust's response should confirm arrangements for the introduction of a second retrieval ambulance during 2016/17.
6.	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 admission.	The Trust's response should demonstrate how NIAS will fully embed the range of alternative care pathways across all localities in NI during 2016/17 including the establishment of a paramedic-led clinical decision desk.
7.	A Helicopter Emergency Medical Service (HEMS) is to be established in NI to support the existing road-based emergency service.	The Trust's response should demonstrate how NIAS will work with HSCB/PHA and the designated charity to ensure the introduction in 2016/17 of a HEMS for NI.
8.	Effective arrangements should be in place to facilitate and promote collaboration, coordination, coordination, communication, learning, sharing of information between different agencies providing resuscitation training.	The Trust's response should demonstrate how NIAS 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 NI Community Resuscitation Strategy
9.	Effective arrangements should be in place to deliver appropriate CPR and BLS training programmes.	NIAS should provide plans to increase access to CPR training across NI and Basic Life Support (BLS) 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

10.	Effective arrangements include the development of public information / guidance about Automatic External Defibrillators covering purchasing, maintenance, location, access and signage	NIAS should provide plans to develop website literature and guidance information materials on AEDs.
11.	Effective arrangements should be in place to appropriately manage the increasing demand on ambulance services in the winter period.	The Trust should bring forward a winter plan which outlines how it will manage increased demand in Winter 2016/17.

6.0 Local Commissioning

6.1 Belfast Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the Belfast LCG area was 348,253 persons accounting for 19% of the Northern Ireland total. Population projections indicate an increase in population to 358,904 by 2020, with the highest increases forecast in the 0-14 and 75+ age groups. The increase in people aged 75 and over is also significant as this group tends to have the greatest need for Health and Social Care services. The extent of deprivation in the Belfast Trust area is greater than other local government districts in NI with 46% of the population estimated to be living in multiple deprivations (NINS 2010).

The population of the Belfast LCG has poorer life expectancy, higher mortality rates for Cancer, circulatory and respiratory diseases and higher incidence of suicide than other LCG areas. QOF data show higher prevalence of stroke, learning disability, diabetes and mental health conditions such as depression, than any other LCG area and has an over reliance on hospital care.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population, an 8% increase in the population aged over 75 years, and an 8%	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements:

	increase in the population of children aged less than 16. These population changes will impact on the demand for unscheduled care services.	1. To address each of the regional unscheduled care priorities as set out section 5.1. 2. To deliver the required volumes of service activity for 2016/17. In responding account should be taken of recent investments in Acute Care at Home, COPD/HOSAR, Stroke Early Supported Discharge, Diabetes, the Clinical Assessment Unit, Ambulatory Phase 1, RBHSC ED and the Short Stay PAU.
BL2	Effective arrangements should be in place to ensure unscheduled care services in the Belfast LCG/Trust area are safe, sustainable and accessible.	The Trust's response should demonstrate how it will seek to maintain safe, sustainable, accessible unscheduled care services at the Mater Hospital.
BL3	Effective arrangements should be in place to ensure patients in the Southern LCG/Trust area have access to high quality ophthalmology services, to be delivered in 2016/17 by Belfast and Western Trusts.	The Trust's response should demonstrate how it will work with the Southern LCG and Southern Trust to ensure from 2016/17 the provision of appropriate ophthalmology outreach services to the Southern population.
BL4	Effective arrangements should be in place to support the establishment of a NI Genome Centre	The Trust's response should demonstrate plans to co-ordinate the planned investment in delivery of the NI Genome Centre to include IPT development for submission to the HSCB as required.

POC 2 Maternity & Child Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a continued increase in complex births in the Belfast LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are predicted to grow by 8% increase in the Belfast LCG /	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

	Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	

POC 4 Care of the Elderly

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be an 8% increase in the population aged over 75 years in the Belfast LCG/Trust population. This population change will impact on the demand for Care of the Elderly services.	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17.

POC 5 Mental Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[3] in prevalence within the Belfast LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. Deliver the proposed volumes of service activity for 2016/17
BL2	Effective arrangements should be in place to reduce the increasing number of people presenting to ED for Suicide and Self-Harm which are higher in Belfast area than the NI average.	The Trust's response should demonstrate plans to address the cultural / lifestyle issues that may be contributing to self-harm / suicide with partner agencies.
BL3	Effective arrangements should be in place to provide appropriate supported housing options across the Belfast LCG/Trust area.	The Trust's response should plan to review current supported housing schemes in line with the current NIHE review of Supporting People funding.
BL4	Effective arrangements should be in place to appropriately manage increasing	The Trust's response should demonstrate plans to redesign the current service to assist the

[3] Delegated Statutory Functions reports submitted by Trusts

	occupancy rates related to increased length of stay in the Medium Secure (Shannon) Unit.	implementation of the Community Forensic Service. This is to help to address case complexity, the increase in demand, adult safeguarding and assertive outreach.
BL5	Effective arrangements should be in place to appropriately manage bed occupancy rates within the Belfast which remain higher than the NI average.	The Trust's response should demonstrate plans to ensure that inpatient bed requirement are in line with the approved Business Case for the Single Unit, including development of a High Intensity Care Pathway to align and integrate the Crisis Home Treatment and Acute Inpatient Service into a single care service

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services.	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 9 Primary Care and Adult Community

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
BL1	By 2020 there is expected to be a 2% increase in the total Belfast LCG/Trust population. The population of Belfast LCG have poorer life expectancy, higher mortality rates for Cancer, circulatory and respiratory diseases and higher incidence of suicide than other LCG areas. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.
BL2	Effective arrangements should be in place to plan appropriate care for people at risk of hospital admission in the Belfast LCG/Trust area.	The Trust's response should outline plans to utilise senior community nurses to support GP Practices in the management of these patients in the Belfast LCG/Trust area.
BL3	Effective arrangements and infrastructure should be in place to support an integrated model of care across the Belfast LCG/Trust area.	The Trust's response should outline how the Trust will work closely with ICPs to design and implement a fully integrated model of care which supports GP practices, including co-location, reconfiguration of services aligned to local need.

6.2 Northern Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the Northern LCG area was 463,297 persons accounting for 26% of the Northern Ireland total. Population projections indicate an increase in population to 480,650 by 2020, with the highest increases forecast in the 75+ age group. The increase in people aged 85 and over is also significant as this group tends to have the greatest need for Health and Social Care services. The extent of deprivation in the Northern LCG area evidences that one tenth of the 228 Super Output Areas would be classified as being included in the 20% most deprived areas in Northern Ireland.

Almost all of the Northern LCG health outcomes were better than, or similar to, the NI average. There are, however, issues relating to hypertension and diabetes with obesity and meeting physical activity needs highlighted as particular risk factors in the Northern area.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a 2% increase in the total Northern LCG/Trust population, a 23% increase in the population aged over 75 years, and a 2% increase in the population of children aged less than 16. These population changes will impact on the demand for unscheduled care services.	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional unscheduled care priorities as set out section 5.1. 2. To deliver the required volumes of service activity for 2016/17.

		The response should include plans to reshape the Direct Access Assessment Service and the PAU in Antrim with opening hours better aligned in each case to meet demand. Plans should also evidence 2015/16 investments in extra Antrim Hospital capacity and the impact this will have.
NL2	Effective arrangements should be in place to ensure unscheduled care services in the Northern LCG/Trust area are safe, sustainable and accessible	The Trust's response should demonstrate how it will seek to maintain safe, sustainable, accessible unscheduled care services across the LCG/Trust area with a particular focus on Causeway Hospital.
NL3	Effective arrangements should be in place to address growth in demand for haematology and microbiology.	The Trust's response should demonstrate plans to increase capacity in haematology and microbiology to meet demographic growth and changing service patterns.
NL4	Effective arrangements should be in place to establish a nurse led service for family planning and the prevention of sexually transmitted infections	The Trust's responses should demonstrate plans to establish, in partnership with the University of Ulster, the Genito-Urinary Medicine (GUM) & Family Planning Comprehensive Sexual Health Service to be delivered across the Coleraine and Jordanstown sites.

POC 2 Maternity and Child Health

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a continued increase in complex births in the Northern LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are predicted to grow by 2% increase in the Northern LCG / Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

NL2	Effective arrangements should be in place to ensure Maternity & Child Health services in the Northern LCG/Trust area are safe, sustainable and accessible.	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17. This should include specific arrangements to: • Provide a Midwife Led facility on the Antrim and Causeway sites. • Provide safe and sustainable services on the Causeway site, to include appropriate middle medical cover in paediatrics out of hours.

POC 4 Care of the Elderly

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be an 23% increase in the population aged over 75 years in the Northern LCG/Trust population. This population change will impact on the demand for Care of the Elderly services.	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17
NL2	Effective arrangements should be in place to accommodate the increase in the older population in the Northern LCG area with an increasing range of well-being and prevention requirements	The Trust's responses should demonstrate the continued support of • the Community Navigator post • the Dalriada Pathfinder to reduce social isolation and improve access to services. • the Community Dementia Co-ordinator post Ensure appropriate links between health improvement, Falls Prevention Team and LCG/ICP to reduce the number of falls in the community.

POC 5 Mental Health

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[4] in prevalence within the Northern LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. Deliver the proposed volumes of service activity for 2016/17

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a 2% increase in the total Northern LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services.	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a 2% increase in the total Northern LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Physical Disability service priorities as set out in section 5.8. 2. To deliver the proposed volumes of service activity for 2016/17.

[4] Delegated Statutory Functions reports submitted by Trusts

NL2	Effective arrangements should be in place to manage complex high cost cases each year. These patients require to be supported in the community.	The Trust's response should demonstrate plans to ensure that additional community nursing inputs are commissioned to enable patients with complex needs to be discharged from hospital to a community environment as appropriate.

POC 9 Primary Care and Adult Community

LOCAL PRIORITY		PROVIDER REQUIREMENT
NL1	By 2020 there is expected to be a 2% increase in the total Northern LCG/Trust population. The population of the Northern LCG / Trust have high levels of hypertension and diabetes with obesity and CHD. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.
NL2	Effective arrangements should be in place to develop a Local Enhanced Service (LES) for people with dementia that will allow the release of sufficient Psychogeriatrician time to allow for interventions in Primary Care complex cases	The Trust's response should demonstrate integrated plans with the Northern ICP in supporting the Dementia Shared Care Local Enhanced Service

Within the Northern LCG area, procurement of a second MRI scanner at Antrim Hospital to improve service resilience and provide additional local MRI and CMR capacity as part of the regional CMR 'Hub and Spoke' network will not be able to be progressed at this time.

6.3 South Eastern Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the South Eastern LCG area was 346,911 persons accounting for 19% of the Northern Ireland total. Population projections indicate an increase in population to 365,384 by 2020, with the highest increases forecast in the 75+ age group. The increase in people aged 85 and over is also significant as this group tends to have the greatest need for Health and Social Care services.

The population of the South Eastern LCG area is one of the least deprived in NI. 10% of the super output areas in the south east would be classified as the most deprived while 35% would fall into the least deprived category. When comparing the locality as a whole to the region, differences across health outcomes were small but typically better in the south east than in NI. While this describes an overview position, individuals and families who live in the areas of relative deprivation fair less well than their counterparts in the least deprived communities, males who live in the 20% most deprived SOH in the south east can expect to live 3.4 years fewer than the average, while females can expect to live 1.6 years less.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 3.5% increase in the total South Eastern LCG/Trust population, a 27% increase in the population aged over 75 years, and a 3% increase in the population of children	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional

	aged less than 16. These population changes will impact on the demand for unscheduled care services.	unscheduled care priorities as set out section 5.1. 2. To deliver the required volumes of service activity for 2016/17. In responding account should be taken of investments in 2015/16 to improve flow and expand capacity at the Ulster Hospital and the impact of the Enhanced Care at Home model. Plans should also evidence recent investments into the Downe emergency department and the development of Phase B at the Ulster Hospital.
SE2	Effective arrangements should be in place to ensure unscheduled care services in the South Eastern LCG/Trust area are safe, sustainable and accessible.	The Trust's response should demonstrate how it will seek to maintain safe, sustainable, accessible unscheduled care services across the LCG/Trust area with a particular focus on the Lagan Valley and Downe Hospitals. The Trust response should include proposals for the introduction of a weekend minor injuries service at Lagan Valley.
SE3	Effective arrangements should be in place to support Sexual and Reproductive Health services.	The Trust's response should demonstrate plans to develop an integrated sexual & reproductive health service

POC 2 Maternity and Child Health

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a continued increase in complex births in the South Eastern LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are predicted to grow by 3% increase in the South Eastern LCG / Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

POC 4 Care of the Elderly

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 27% increase in the population aged over 75 years in the South Eastern LCG/Trust population. This population change will impact on the demand for Care of the Elderly services.	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17.

POC 5 Mental Health

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[5] in prevalence within the SE LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. To deliver the proposed volumes of service activity for 2016/17

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 3.5% increase in the total South Eastern LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services.	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Physical Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

[5] Delegated Statutory Functions reports submitted by Trusts

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 3.5% increase in the total South Eastern LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 9 Primary Care and Adult Community

LOCAL PRIORITY		PROVIDER REQUIREMENT
SE1	By 2020 there is expected to be a 3.5% increase in the total South Eastern LCG/Trust population. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.
SE2	Enhanced Care at Home implementation	The ICP, working with the SET should confirm full implementation of the ECAH scheme and bring forward the appropriate evaluations to inform the phased roll-out of the initiative across the Down and Lisburn localities.

6.4 Southern Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the Southern LCG area was 358,034 persons accounting for 20% of the Northern Ireland total. Population projections indicate an increase in population to 392,632 by 2020, with the highest increases forecast in the 75+ age group.

Within the Southern LCG, 16% (25) of the 157 Super Output Areas are classified as being included in the 20% most deprived areas in Northern Ireland (NI) and a tenth (15) of areas in the Trust are classified as being among the 20% least deprived areas in NI.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a 6% increase in the total Southern LCG/Trust population, a 23% increase in the population aged over 75 years, and a 7% increase in the population of children aged less than 16. These population changes will impact on the demand for unscheduled care services.	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional unscheduled care priorities as set out section 5.1. 2. To deliver the required volumes of service activity for 2016/17. In responding account should be taken of investments in 2015/16 in Frail Elderly, Respiratory, Stroke and Diabetes services.

SL2	Effective arrangements should be in place to ensure unscheduled care services in the Southern LCG/Trust area are safe, sustainable and accessible.	The Trust's response should demonstrate how it will seek to maintain safe, sustainable, accessible unscheduled care services across the LCG/Trust area with a particular focus on Daisy Hill Hospital.
SL3	Effective arrangements should be in place to ensure patients in the Southern LCG/Trust area have access to high quality ophthalmology services, to be delivered in 2016/17 by Belfast and Western Trusts.	The Trust's response should demonstrate how it will work with the LCG and Western and Belfast Trusts to ensure the seamless introduction of new ophthalmology services during 2016/17
SL4	Effective arrangements should be in place to deliver safe and sustainable breast care services.	The Trust's response should outline its plans to address current service pressures within the breast care service and the longer term plans to deliver safe and sustainable breast care services.

POC 2 Maternity and Child Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a continued increase in complex births in the Southern LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are predicted to grow by 7% increase in the Southern LCG / Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	The Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

POC 4 Care of the Elderly

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be an 23% increase in the population aged over 75 years in the Southern LCG/Trust population. This population change will	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements:

	impact on the demand for Care of the Elderly services.	1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17

POC 5 Mental Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[6] in prevalence within the Southern LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. Deliver the proposed volumes of service activity for 2016/17
SL2	Effective arrangements should be in place to meet the needs of the growing older population and those with dementia.	The Trusts response should outline plans to ensure an appropriate nurse staffing model in the Gillis Unit as a result of recent investment.

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a 6% increase in the total Southern LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for Learning Disability services.	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7. 2. To deliver the proposed volumes of service activity for 2016/17.

[6] Delegated Statutory Functions reports submitted by Trusts

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a 6% increase in the total Southern LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Physical Disability service priorities as set out in section 5.8. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 9 Primary Care and Adult Community

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SL1	By 2020 there is expected to be a 6% increase in the total Southern LCG/Trust population. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.

6.5 Western Local Commissioning Plan

Context

On Census Day (27 March 2011), the resident population of the Western LCG area was 294,417 persons accounting for 16% of the NI total. Population projections indicate an increase in population to 302,823 by 2020, with the highest increases forecast in the 75+ age group.

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.

Despite high levels of deprivation, Western population shows equivalent or better health outcomes than the NI average, apart from for respiratory conditions, i.e. asthma and chronic obstructive pulmonary disease (COPD). Mental health however is considerable worse, particularly due to anxiety and depression. Smoking remains higher than average. More people are likely to suffer pain and discomfort than for NI as a whole. There is higher rate of children in need.

Issues and Opportunities

This section provides further detail on local commissioning priorities by Programme of Care, over and above the regional priorities for all LCG / Trust areas identified in Section 5 of this plan. For each PoC, it details the issues and opportunities arising from the local assessment of needs and inequalities and outlines the associated Commissioning requirements and what actions needs to be taken to secure delivery.

POC 1 Acute

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 1.6% increase in the total Western LCG/Trust population, a 25% increase in the population aged over 75 years, with no increase in the population of children aged less than 16. These population changes will	The Trust's response should demonstrate how the change in population need and demand for unscheduled care services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional unscheduled care priorities as set out

	impact on the demand for unscheduled care services, including at both Altnagelvin and South-West Acute hospitals.	section 5.1. 2. To deliver the required volumes of service activity for 2016/17. The Trust's Response should include consideration of the introduction and impact of a Clinical Decision Unit, Acute Care at Home and the bolstering of seven day working, the continuation and evaluation of the Integrated Cardiac Ambulatory Care model, consideration of medical and nursing workforce in both emergency departments, and the role of the frail elderly hospital pharmacist. The Trust response should also outline plans to maintain a Paediatric Assessment Unit at Altnagelvin on a recurrent basis.
WL2	Effective arrangements should be in place to ensure patients in the Southern LCG/Trust area have access to high quality ophthalmology services, to be delivered in 2016/17 by Belfast and Western Trusts.	The Trust's response should demonstrate how it will work with the Southern LCG and Southern Trust to ensure that ophthalmology services are provided to the western part of the Southern area from September 2016.
WL3	Effective arrangements should be in place to address the deficit in trainee doctors in both Altnagelvin and SWA hospitals	The Trust's response should demonstrate plans to continue to work with NIMDTA for more equitable allocation of junior doctors, reflecting workload and population shares with a view to reducing capacity and financial strains on a number of acute specialties.
WL4	Effective arrangements should be in place to extend the minor surgery scheme which provides patients local access to experienced GP minor surgeons	The Trust's response should outline plans to extend the LCG minor surgery scheme including consideration of additional procedures which could be provided by GP minor surgeons.

POC 2 Maternity and Child Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a continued increase in complex births in the Western LCG/Trust area. The level of births, complicated by diabetes has increased to 5.2% of all pregnant women across NI and 15% of all pregnant women smoke across NI. Increasing pregnancies with high BMI levels also add to birth complexity. Children less than 16 years are not predicted to grow in the Western LCG / Trust area. These population changes and complexities will impact on the demand for Maternity & Child Health services.	The Trust's response should demonstrate how the change in population need for Maternity & Child Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Maternity and Child Health priorities as set out in section 5.3. 2. To deliver the required volumes of service activity for 2016/17.

POC 4 Care of the Elderly

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 24% increase in the population aged over 75 years in the Western LCG/Trust population. This population change will impact on the demand for Care of the Elderly services.	The Trust's response should demonstrate how the change in population need and demand for Care of the Elderly services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Care of the Elderly priorities as set out in section 5.5. 2. To deliver the required volumes of service activity for 2016/17
WL2	Effective arrangements should be in place to appropriately manage the increasing number of older people over 75 years which is impacting on hospital demand, length of stay and delayed discharge.	The Trust's response should outline plans to complete the establishment of 24-hour community nursing across the Western area, building on investment to date in district nursing, Rapid Response nursing and treatment rooms, and including the establishment of Clinical Intervention Centres in Enniskillen, Strabane and Limavady within the next two years.

WL3	Effective arrangements should be in place to provide an appropriate geriatric services, being cognisant of recent recruitment difficulties	The Trust's response should outline proposals to consider alternative models of care, including GP and nurse-led models, which would bolster geriatrician-led services.
WL4	There are an increasing numbers of older people who experience a fall which leads to reduce independence and increased reliance of health and social care.	Western Trust, working through Integrated Care Partnerships, to put in place a coordinated integrated falls pathway.
WL5	Effective arrangements should be in place to manage the increasing number of older people by building or restoring self-confidence and self-reliance and providing practical support to help achieve aspirations and reduce dependency.	The Trust's response should outline plans to support ICPs to further pilot the Social Prescribing scheme which seeks to offer alternatives to medicine prescription and overcome social isolation and loss.

POC 5 Mental Health

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	The population of Northern Ireland is 25% more likely to present with a mental health condition, than the rest of the United Kingdom. By 2020 there is expected to be a 1% year on year increase[7] in prevalence within the Western LCG area. These population changes will impact on the demand for Mental Health services.	The Trust's response should demonstrate how the change in population need and demand for Mental Health services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Mental Health priorities as set out in section 5.6 2. To deliver the proposed volumes of service activity for 2016/17

POC 6 Learning Disability

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 1.6% increase in the total Western LCG/Trust population. Prevalence data estimates that people with a Learning disability make up 1% to 2% of the total population of Northern Ireland. These population changes will impact on the demand for	The Trust's response should demonstrate how the change in population need and demand for Learning Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Learning Disability service priorities as set out in section 5.7.

[7] Delegated Statutory Functions reports submitted by Trusts

	Learning Disability services.	2. To deliver the proposed volumes of service activity for 2016/17.

POC 7 Physical Disability

LOCAL PRIORITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 1.6% increase in the total Western LCG/Trust population. Prevalence increases with age, from 5% among young adults to 67% among those who are 85+ years. These population changes will impact on the demand for Physical Disability services.	The Trust's response should demonstrate how the change in population need and demand for Physical Disability services will be managed in 2016/17, to include specific arrangements: 1. To address each of the regional Physical Disability service priorities as set out in section 5.8. 2. To deliver the proposed volumes of service activity for 2016/17.

POC 9 Primary Care and Adult Community

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
WL1	By 2020 there is expected to be a 1.6% increase in the total Western LCG/Trust population. The population of Western LCG/Trust have declining Mental health particularly due to anxiety and depression. Smoking remains higher than average. More people are likely to suffer pain and discomfort in the Western LCG/Trust, than for NI as a whole. There is higher rate of children in need. These population changes will impact on the demand for Primary Care and Adult Community services.	The Trust's response should demonstrate how the change in population need and demand for Primary Care and Adult Community services will be managed in 2016/17, to include the proposed volumes of service activity to be delivered in 2016/17.
WL2	Effective arrangements should be in place to appropriately manage the number of patients registered to Western GP practice as there are approximately 25,000 more patients registered with Western GP practices than live in the Western LCG area, some of which may live in ROI.	The Trust's response should demonstrate plans to keep under review requests for healthcare from residents of the Republic of Ireland and ensure these are from cross-border workers entitled to receive NI HSC services.

Within the Western LCG area, the following is unable to be fully progressed at this time:

- RCCE Omagh Project
  Scheduled to open early in 2017, the newly-built Omagh Local Enhanced Hospital will provide day surgery, outpatient clinics, intermediate care, minor injuries treatments, and cardiac assessment co-located with GP-led General Medical Services.

- RCCE Enniskillen PCI Hub
  Scheduled to open in Autumn 2016, the renovation of the Erne Health Centre in Enniskillen by a local developer will enable the co-location of GP services with Trust community services, including family support services, community nursing, primary care mental health services, and older people's services, including Reablement.

Appendix 1: Commissioning Plan Direction Outcomes Framework

COMMISSIONING PLAN DIRECTION OUTCOME	SECTION
Outcome 1. Health and social care services contribute to; reducing inequalities; ensuring that people are able to look after and improve their own health and wellbeing, and live in good health for longer.	
1.1 In line with the Departmental strategy A Fitter Future For AI by March 2022 reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.	4.1.1
1.2 In line with the Department's policy framework, living with Long Term Conditions, continue to support people to self-manage their condition through increasing access to structured patient education programmes. In 2016/17, the focus will be on consulting on and taking steps to begin implementation of the Diabetes Strategic Framework and implementation plan with the aim that by 2020 all individuals newly diagnosed with diabetes will be offered access to diabetes structured education with 12 months of diagnosis.	5.12.2
1.3 In line with the Department's ten year Tobacco Control Strategy, by March 2020 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%.	4.1.1
1.4 By March 2020, to reduce the differential in the suicide rate across NI and the differential in suicide rates between the 20% most deprived areas and the NI average. Areas of focus for 2016/17 should include early intervention and prevention activities, for example through improvement of self-harm care pathways and appropriate follow-up services in line with NICE guidance.	4.1.1
1.5 By March 2018 ensure full delivery of the universal child health promotion framework for NI, Healthy Child, Healthy Future. Specific areas of focus for 2016/17 should include the delivery of the required core contacts by health visitors within the pre-school child health promotion programme.	4.1.1
1.6 During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring that the proportion of children in care for 12 months or longer with no placement change is at least 85%.	4.1.1
1.7 During 2016/17, the HSC must ensure that as far as possible children on the edge of care, children in care, and care experienced children are protected from harm, grow up in a stable environment, and are offered the same opportunities as their peers. For 2016/17, specific areas of focus should include ensuring a three year time frame (from date of last admission) for 90% of children who are adopted from care.	5.4
Desired outcome 2: People using health and social care services are safe from avoidable harm	
2.1 In the year to 31 March 2017 secure a reduction of 25% in the total number of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over and in-patient episodes of MRSA infection compared to 2015/16.	4.12
2.2 From April 2016, ensure that the clinical condition of all patients is regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.	4.2

2.3 By March 2018, all HSC Trusts should have fully implemented the first four phases of Delivering Care, to ensure safe and sustainable nurse staffing levels across all medical and surgical wards, emergency departments, health visiting and district nursing services.	4.2.5
2.4 The HSC, through the application of care standards, should 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 receive a failure to comply notice.	4.2.5
2.5 The HSC, through the application of care standards, should 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 receive a failure to comply notice and that subsequently attract a notice of decision.	4.2.5
Desired outcome 3: People who use health and social care services have positive experiences of those services.	
3.1 To support people with palliative and end of life care needs to be cared for in their preferred place of care. By March 2018 to identify individuals with a palliative care need and have arrangements in place to meet those needs. The focus for 2016/17 is to develop and implement appropriate systems to support this.	5.13
3.2 By March 2017, 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 (or alternatively timely access to treatment).	4.3
3.3 Where patients are cared for in mixed gender accommodation, all Trusts must have policies in place to ensure that patients' privacy and dignity are protected.	4.3
3.4 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.	4.3
3.5 By March 2018, to increase by 40% the total number of patients across the region participating in the PHA Biennial Patient Experience Survey, with particular emphasis on engaging patients in areas of low participation.	4.3
Desired outcome 4: Health and Social care services are centred on helping to maintain or improve the quality of life of people who use those services	
4.1 By March 2020 to have increased access to services delivered by GP practices. The focus for 2016/17 is on developing a comprehensive baseline of such activity, to be used to inform future work.	5.9
4.2 From April 2016, 95% of acute/ urgent calls to GP OOH should be triaged within 20 minutes.	5.9
4.3 From April 2016, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.	5.15
4.4 From April 2016, 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.	5.1
4.5 By March 2017, at least 80% of patients to have commenced treatment, following triage, within 2 hours.	5.1
4.6 From April 2016, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	5.1
4.7 From April 2016, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate	5.12.1
4.8 By March 2017, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.	5.2
4.9 By March 2017, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.	5.2

4.10 By March 2017, 55% of patient should wait no longer than 13 weeks for inpatient/daycase treatment and no patient waits longer than 52 weeks.	5.2
4.11 From April 2016, all urgent diagnostic tests should be reported on within two days.	5.2
4.12 From April 2016, 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.	5.11
4.13 From April 2016, 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).	5.6
Desired outcome 5: People, including those with disabilities or long term conditions, or who are frail, are supported to recover from periods of ill health and are able to live independently and at home or in a homely setting in the community.	
5.1 From April 2016, 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.	5.6/5.7
5.2 By March 2017, reduce the number of unplanned admissions to hospital by 5% for adults with specified long-term conditions.	5.6/5.7/5.8/5.12
5.3 By March 2017, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional	5.2
5.4 By March 2017, secure a 10% increase in the number of direct payments to all service users.	5.6/5.7/5.8
5.5 By March 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.	4.1.1/5.6/5.7/5.8
Desired outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and well-being	
6.1 By March 2017, secure a 10% increase in the number of carers' assessments offered to carers for all service users.	5.6/5.7/5.8
6.2 By March 2017, secure a 5% increase in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	5.6/5.7/5.8
6.3 By March 2017, establish a baseline of the number of carers who have had a carers assessment completed and: • the need for further advice, information or signposting has been identified; • the need for appropriate training has been identified; • the need for a care package has been identified; • the need for a short break has been identified; • the need for financial assistance has been identified.	5.6/5.7/5.8
Desired outcome 7: Resources are used effectively and efficiently in the provision of health and social care services.	
7.1 By March 2017, reduce by 20% the number of hospital-cancelled consultant-led outpatient appointments.	4.4.2
7.2 From April 2016, 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.	5.1

7.3 By March 2017, attain efficiencies totalling at least £20m through the Pharmacy Efficiency Programme, separate from PPRS receipts.	5.9.4
7.4 By March 2017, to reduce the percentage of funded activity associated with elective care service that remains undelivered.	4.4.2
Desired outcome 8: People who work in health and social care services are supported to look after their own health and wellbeing and to continuously improve the information, support, care and treatment they provide	
8.1 By December 2016 ensure at least 40% of Trust staff have received the seasonal flu vaccine.	4.4
8.2 By March 2017, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2015/16 figure.	4.4
8.3 During 2016/17, HSC employers should ensure that they respond to issues arising from the 2015 Staff Survey, with the aim of improving local working conditions and practices and involving and engaging staff.	N/R
8.4 By March 2017, Trusts are required to develop operational Workforce Plans, utilising qualitative and quantitative information that support and underpin their Trust Delivery Plans.	4.4.3
8.5 By March 2017, 10% of the HSC workforce should have achieved training at level in the Q2020 Attributes Framework.	N/R
8.6 By March 2017, to have reduced the number of patient and service user complaints relating to attitude, behaviour and communication by 5% compared to 2015/16. This will require renewed focus on improving the Patient and Client Experience Standards.	N/R

Glossary of Terms

Acute care– Traditionally refers to services provided in a major hospital setting including unscheduled (or emergency) care, elective (or planned) care and specialist services

Bamford Report – a major study commissioned by the DHSSPS in N Ireland to provide a long term strategic plan for the development of mental health and learning disability services. It takes its name from its former Chairman, the late Professor David Bamford of the University of Ulster.

Chronic / 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 HSCB and PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction – A document published by the Minister on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not publicly funded. Also referred to as the 'third' sector.

Comorbidity – Where a person is living with two or more conditions or diseases in addition to a primary diagnosis (e.g. someone with diabetes who is also suffering from asthma and hypertension).

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 (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the NI Executive

Integrated Care - progresses "joined up" health and social care; the overarching theme being a more efficient patient journey secured through co-operation of a range of practitioners including GPs, community pharmacists, dentists and opticians.

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in each area including GPs, pharmacists, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector as well as service users and carers.

Lesbian, Gay, Bisexual & Transsexual (LGBT) – abbreviation that collectively refers to "lesbian, gay, bisexual, and transgender" people.

Local Commissioning Groups – committees of the regional Health and Social Care Board and are comprised of GPs, professional health and social care staff and community and elected representatives. Their role is to help the HSCB arrange or commission health and social care services at local level.

Local Health Economies – the term most commonly used for collaborative working between Local Commissioning Groups and Trusts.

Looked after children - The term 'looked after children and young people' is generally used to mean those looked after by the state, according to relevant national legislation. This includes those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks.

Managed Clinical Networks – the provision of clinical services to patients through expert, closely linked and effective teams of staff

National Institute for Health and Care Excellence (NICE)– NICE develop guidance and other products by working with experts from the NHS, social care, local authorities as well as the public, private and voluntary sectors - including patients and the public.

Palliative Care – The active, holistic care of people with advanced, progressive illness such as advanced cancer, heart failure, COPD, dementia, stroke or other chronic conditions.

Patient and Client Council (PCC) – this is a separate organisation from the HSCB and PHA which provides a strong independent voice for the people of N Ireland on health issues.

Personal and Public Involvement (PPI) – the process of involving the general public and service users in the commissioning of services

Primary Care – the care services that people receive while living at home in the community from people such as their GP, district nurse, physiotherapist or social worker.

Primary Care Partnerships (PCPs) – these pre-date the concept of Integrated Care Partnerships and were envisaged to be a networked group of service providers who work to make service improvements across a care pathway.

Public and stakeholder engagement – the process of meeting, discussing and consulting with people and communities who use the health and social services.

Public Health Agency (PHA) – the role of the PHA is described under its four primary functions; health and social wellbeing improvement, health protection, public health support to commissioning and policy development, research and development.

Reablement - range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and the confidence to live at home.

Secondary Care – services provided by medical specialists usually delivered in hospitals or clinics and patients have usually been referred to secondary care by their primary care provider (usually their GP).

Technology Appraisal (NICE TA) – A drug, medical device or surgical procedure is appraised by NICE to determine if they should be funded by the NHS, based on its cost-effectiveness (in most cases a TA refers to high cost drugs).

Transforming Your Care – Published in 2011 the Review of Health and Social Care in NI "Transforming Your Care", sets out a model of care for health and social care which makes recommendations about how we change our services to enhance prevention, early intervention, care closer to home, and greater choice and access. The HSCB is taking forward the implementation of around 70 of the 99 proposals sets out in the TYC Report.

Trust Delivery Plans – In response to the Commissioning Plan and Local Commissioning Plans, the six Trusts detail how they plan to deliver the Ministerial targets, key themes and objectives outlined for the year ahead.