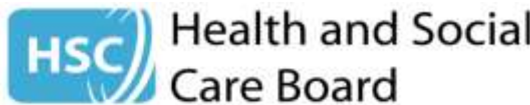

Draft Commissioning Plan 2018/19

FINAL

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FOREWORD

The 2018/19 Commissioning Plan (the Plan) describes the actions that will be taken across health and social care during the 2018/19 financial year to ensure continued improvement in the health and wellbeing of the people of Northern Ireland, within the available resources. The Plan has been developed in partnership by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA), and responds to the Department of Health (DoH) Commissioning Plan Direction.

Driving improvement in population health and in health and social care services underpins all the objectives contained within the Plan. The 2018/19 Plan sets out measures to promote good health and well-being, prevent illness, prevent harm to those receiving care and prevent complications of long term conditions. In essence the Plan sets out the priorities for health and social care to improve the experience of people at all stages of their life and their healthcare journey.

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

It should be noted that the Plan does not seek to include all of the work being taken forward by HSCB & PHA in 2017/18. Rather, the Plan focusses on a number of key strategic and service priorities which are likely to yield the greatest benefit in terms of patient outcomes and experience of health and social care services at both a regional and local level.

The Commissioning Plan has been produced within a challenging commissioning and financial context with continuing direct oversight by the Department. The Plan outlines a number of key investments to be made in 2018/19 consistent with prior discussion with the Department. Trusts have already been provided with indicative financial allocations for 2018/19 – from these allocations Trusts are

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

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

VALERIE WATTS
Chief Executive,
HSCB & PHA

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1.0 INTRODUCTION AND CONTEXT

1.1 The Purpose of the Plan

The Commissioning Plan sets out the priorities to be taken forward by Health and Social Care (HSC) and providers. The Plan has been developed in partnership by the Health and Social Care Board (HSCB) and the Public Health Agency (PHA), and responds to the Department of Health's 2018/19 draft Commissioning Plan Direction (CPD). In compiling the Commissioning Plan, a collaborative approach was adopted by the HSCB and PHA with information, input and guidance drawn from a very diverse and wide range of reference groups. The priorities outlined within the Commissioning Plan also take account of the 2018/19 investments.

The Commissioning Plan (the Plan) also aims to respond to the 2018/19 CPD which sets out a number of themes, aims, outcomes and objectives. The Plan specifically responds to each of the themes within Section 4.In line with established commissioning arrangements, the Plan provides an overview of system wide commissioning priorities for 2018/19 (Section 5) together with detail on the priorities at a local level (Section 6) as identified by the Local Commissioning Groups (LCG). A summary of how the Plan responds to each of the CPD objectives can be found in Appendix 1. The Plan does not seek to highlight all of the work being taken forward by the HSC sector in 2018/19. Rather it aims to set out priority areas for development.

Within these sections, the Plan makes explicit reference to areas of service development, service delivery, service reform and modernisation required from providers, who will be expected to provide detailed Trust Delivery Plans (TDPs) for 2018/19. The HSCB and PHA will, through existing mechanisms, monitor the performance of providers against these plans.

The financial allocation for 2018/19 includes a block sum to Trusts and as such the Plan outlines the 2017/18 commissioned values and volumes as a baseline. It is expected that values and volumes will be amended following the submission of the TDPs, which should reflect planned services and associated activity..

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1.2 Emerging issues within Health and Social Care

The context in which Health and Social care services are delivered continues to change year on year and at an increasing pace. Examples of these changes include:

- Increasing public expectations
- Increasing demand for services
- Insufficient capacity to meet demand
- Aging population, particularly those over 85 including frail elderly.
- Increase in people with co-morbidities and long term conditions
- Developing technological advances (Artificial Intelligence and pharmaceutical)

The role of the HSCB/PHA, through the Commissioning Plan, is to respond to these changes by commissioning services which meet the changing needs and expectations of the local population. More information on demographic and social changes can be found in Section 2.

1.3 Delivering Together

The Plan provides a view of the strategic transformation, reform and modernisation aims across all programmes of care both regionally and locally, reflecting the strategic direction of services as set out in *Delivering Together*.

The Plan includes non-recurrent funding as part of the Confidence and Supply Agreement to support the transformation agenda outlined within *Delivering Care* and other service pressures. These investments, totalling £70m, are reflected across both the regional and local Commissioning sections.

1.3.1 Transforming Services

Delivering Together provides the roadmap to take forward the work of transformation, reform and modernisation with the overarching aim to:

- Improve the health of the population;
- Improve the quality and experience of care;
- Ensure the sustainability of the services delivered; and
- Support and empower the staff delivering health and social care services.

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The Transformation Implementation Group (TIG) oversees the design, development and implementation of the Transformation Programme.

1.3.2 Commissioning for Outcomes

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

The HSCB and PHA will work with other partners, including through Community Planning partnerships, to commission and evaluate an increasing range of services on the basis of their contribution to improved outcomes.

1.3.3 E-health

Investment in eHealth solutions and services is critical to supporting safe, efficient and resilient services, and maximising opportunities for innovation. The HSCB is responsible for the development and maintenance of implementation plans across the HSC to deliver the objectives in the HSC eHealth and Care Strategy, published in March 2016.

For 2018/19 and beyond, major developments that will require HSC organisational support include:

- The procurement of an integrated Health and Care platform, via the Encompass programme, to further embed the successes of the Northern Ireland Electronic Care Record (NIECR) and other programmes, to establish an integrated digital platform to provide world-class support for digital service management for sustainable health and wellbeing services.

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- The procurement of a Laboratory Information Management System (LIMS) as part of the wider Pathology Modernisation programme, replacing existing systems approaching end of life.
- The procurement of a new NIPACS solution with the existing contract due to end in September 2022 enabling the recommendations of the Regional Imaging Review to be taken forward.
- Further development and roll out of community information systems and deployment of mobile devices to support care delivery in both the community and acute settings.
- Establishing a 'patient portal' as a 'pathfinder' project to support those who have Dementia, and their families and carers, and to further develop a one-stop patient portal for other conditions.
- Further development, and roll out of eReferral, eDocument transfer, and eTriage to support safer, faster care.
- A process of guided self-assessment of organisational digital maturity in order to support the delivery of the eHealth & Care strategy.
- The development of an eHealth blueprint to support and guide future investment plans and governance.

Trust support for the eHealth governance and project structures, and for staff and citizen engagement is critical to the success of the programme.

1.3.4 Partnership Working

In Delivering Together, the concept of involvement and partnership working is further endorsed, as is the move towards co-production. Co-production is the pinnacle of involvement, enhancing the partnership approach set out in Delivering Together. A model of person centred care, designed for and with people and communities rather than by organisations and services will be embraced and creative and innovative ways to maximise involvement will be adopted. Further information on partnership working supported by Personal & Public Involvement (PPI) and co-production can be found in Section 4.2.2.

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1.4 Delivering on Key Policies and Strategies

There are 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 existing policies, frameworks, guidance and strategies many of which can be found at Appendix 1.

Achievement of Departmental Objectives 2018/19
The CPD sets out the key aims, outcomes and objectives for the HSC for 2018/19, in many cases building on the targets and standards in 2017/18.

While there are a number of performance targets within the CPD which, due to the current level of performance and the wider financial challenges, will not be achievable in 2018/19, the HSCB/PHA will continue to work with Trusts to secure performance improvement trajectories, as required. The HSCB and PHA will continue to work with Trusts to identify and share good practice to improve services and to facilitate regional approaches and collaboration to address service delivery challenges. A Commissioning Plan Direction Outcomes Framework detailing where information can be found on specific objectives is at Appendix 2.

1.5 Supporting the HSC Workforce

The *Delivering Together* strategy re-affirmed that effective workforce engagement and planning are key enablers for transforming HSC services. As part of this vision the HSCB and PHA will continue to work with the DoH and key stakeholders in the implementation of the *Health and Social Care Workforce Strategy 2026*[1] for Northern Ireland.

This workforce strategy is just one of the components required for successful transformation; central to it will be how services will be reconfigured. The aim of

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

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the strategy is that by 2026, the HSC meets its workforce needs and the needs of the workforce. The three key objectives within the strategy are:

1. By 2019, the Department and health and social care providers are able to monitor workforce trends and issues effectively, and be able to take proactive action to address these before problems become acute.
2. By 2021, health and social care is a fulfilling and rewarding place to work and train, and our people feel valued and supported.
3. By 2026, the reconfigured health and social care system has the optimum number of people in place to deliver treatment and care, and promote health and wellbeing to everyone in Northern Ireland, with the best possible combination of skills and expertise.

Whilst the overall workforce numbers have increased in recent years, there is still a need for additional staff. The March 2017 HSC Vacancy Rate was approximately 5% for posts currently in the system (actually being filled). Further examination of these figures highlights specific challenging areas including nursing, midwifery and medical staffing.

1.6 Improving Care Pathways

Care pathways are structured multidisciplinary care plans which detail how patients should expect to receive treatment/care for a specific issue.

How care pathways are developed, implemented and reviewed can have a significant impact on the care a patient will receive. It is important that care pathways are reviewed and updated in line with best practice guidance, using innovative service improvement methodologies. During 2018/19, plans will be put in place to continue to improve and transform care pathways across elective care, unscheduled care, community services, social services and primary care settings.

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1.7 Community Planning

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

Community Planning Partnerships have been established comprising the council, statutory bodies, agencies and the wider community, including the community and voluntary sector. All eleven Community Plans, which typically range from ten to fifteen years in scope, have now been agreed and launched.. Local councils are all at different stages in action planning, using working groups and engagement and consultation to develop the plans. Each of the structures include a sub group with a focus on health and wellbeing and HSC colleagues are working locally and regionally to maintain a consistent approach ensuring that actions are reflective of strategic direction and are evidence based.

Work will continue to roll out approaches such as Ageing Well/ Age Friendly/Dementia Friendly; Take Five; initiatives which increase opportunities for participation in physical activity and promote healthy eating; the promotion and expansion of health literacy; the development of local environmental assets to increase physical activity and improve mental health and the promotion of volunteering, together with many more initiatives which will impact on the health and wellbeing of local communities over the coming years.

Further detail on how LCGs and wider partners are involved in Community Planning can be found within Section 6 of the Plan.

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2.0 CHANGING CONTEXT OF HEALTH AND SOCIAL CARE

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

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

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

2.1 Current Population

According to the recently published Mid-Year Estimates for 2016, Northern Ireland has the fastest growing population in the UK. Some of the key demographic changes are noted below:

- There are approximately 1.862m people living in Northern Ireland.
- There are estimated to be a total of 297,800 older people (65+ years) living in Northern Ireland – approximately 16% of the population.
- There are estimated to be a total of 388,000 children (0-15 years) living in Northern Ireland – approximately 20.8% of the population.

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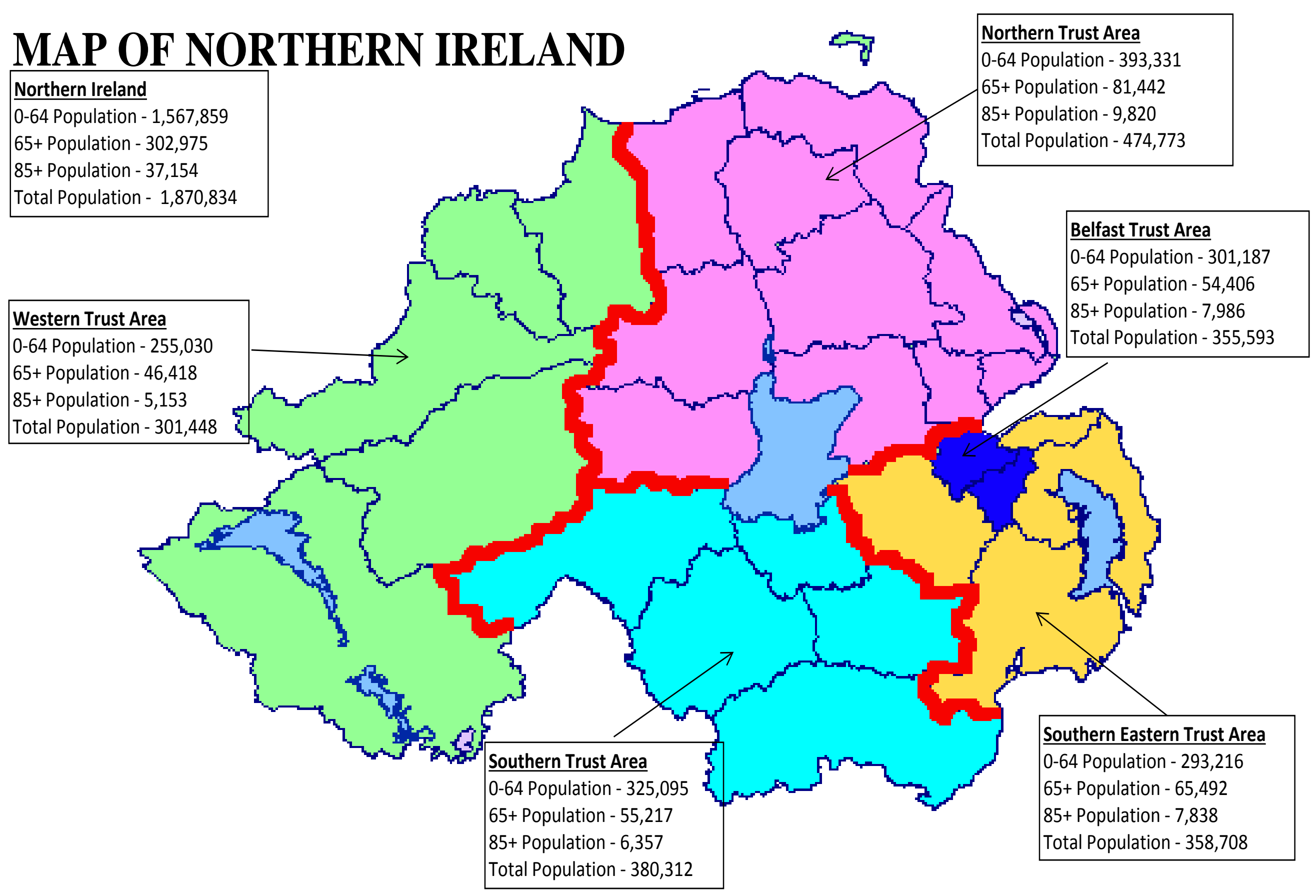
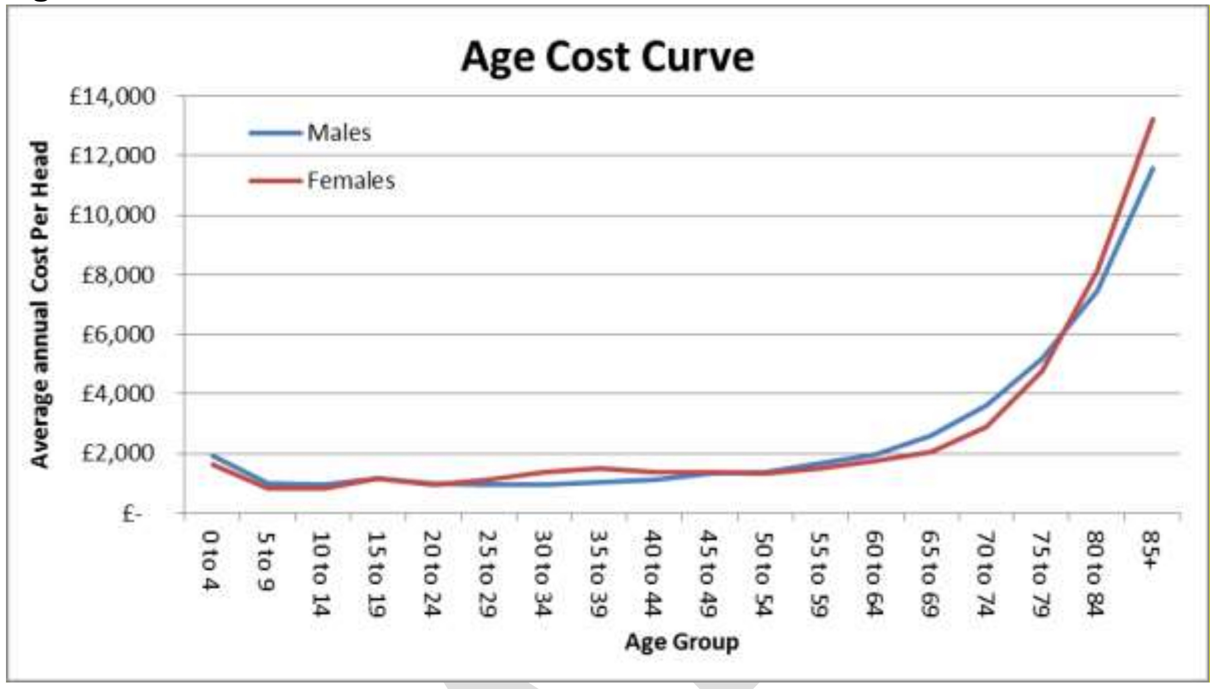
The tables and charts below illustrate the demographic changes over the last 10 years in each of the LCG/Trust areas. A breakdown of the population split by each LCG/Trust area is mapped in Figure 1:

Figure 1
Population Split by each LCG/Trust Area



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

Age Cost Curve
Figure 2



All PoCs age gender cost curve from 2016/17 Model

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

Total population percentage across age bands by area
Table 1

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

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

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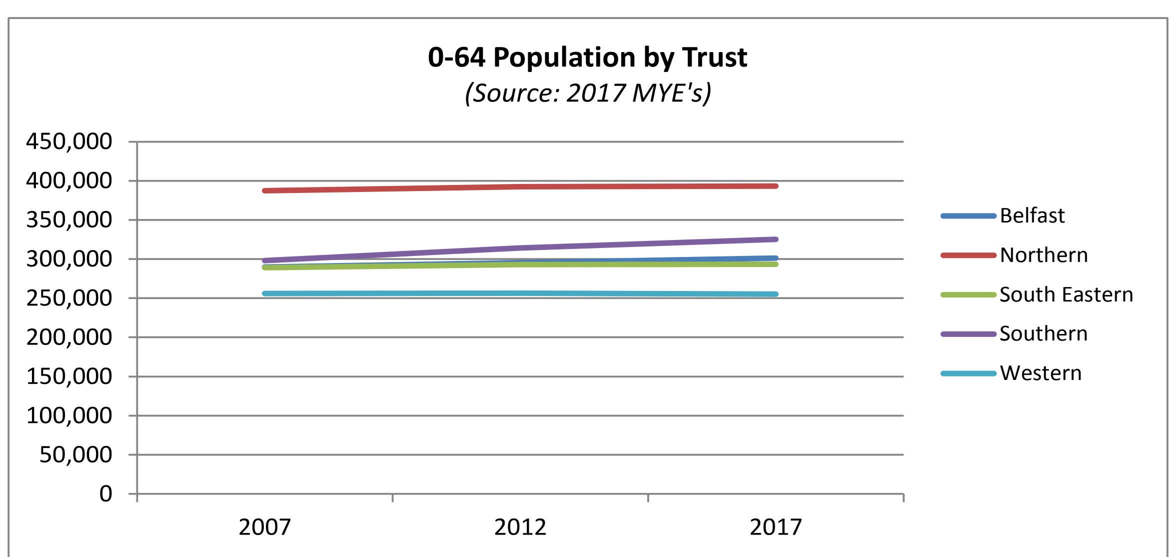
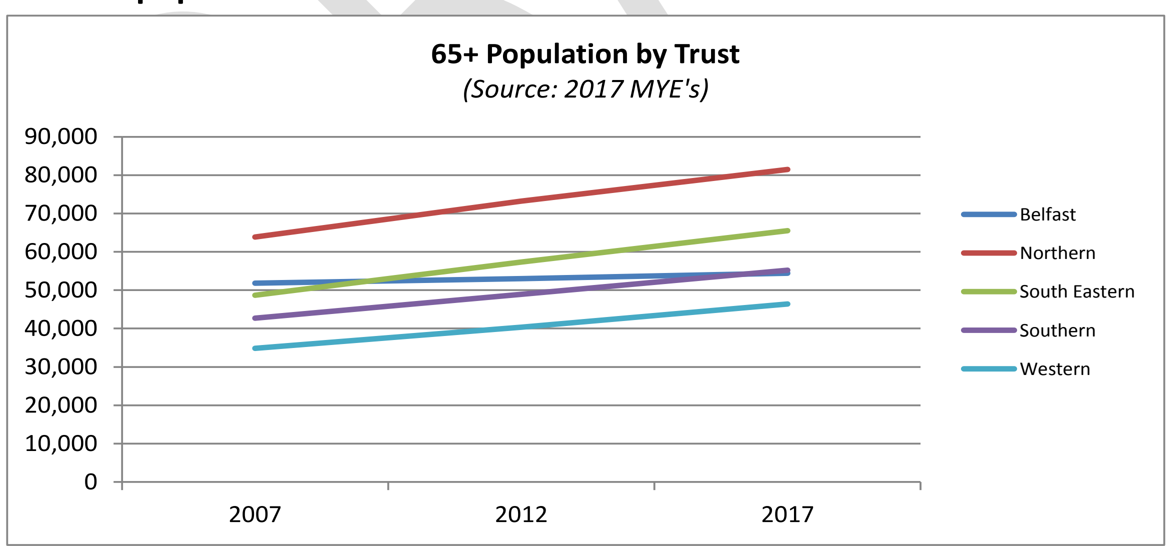
Figure 3
Under 65 population



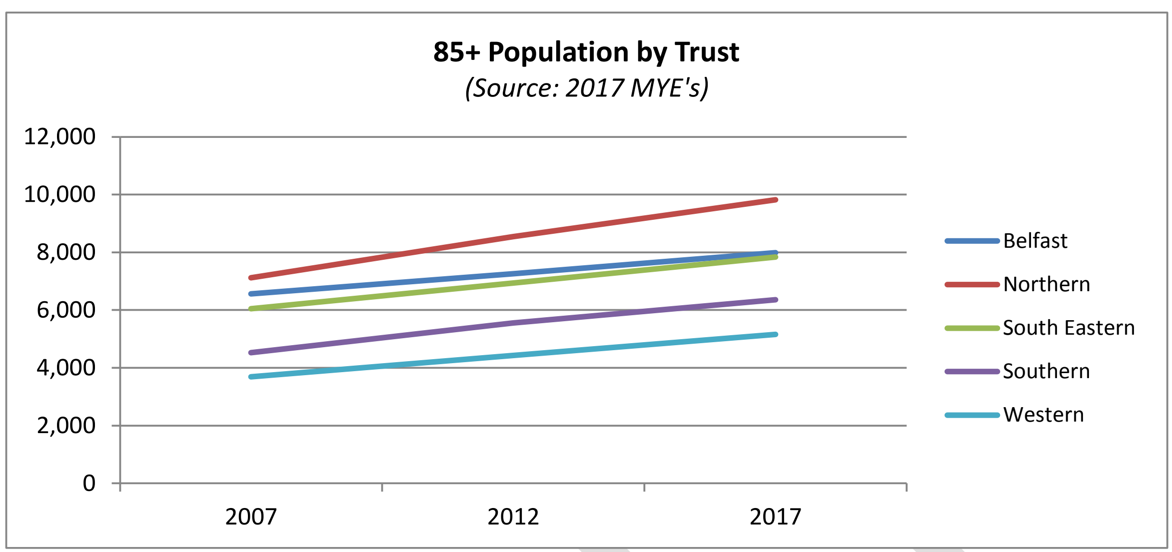
According to the 2017 Mid-Year Estimates 84% of the population are aged 0-64 years. Of the 0-64 population, the Northern Trust/LCG area has the highest proportion at 25.1% with the Western Trust/LCG area having the lowest proportion at 16.3%

Figure 4
Over 65 population



According to the 2017 Mid-Year Estimates, 16% of the population are aged 65+ years. Of the 65+ population, the Northern Trust/LCG area has the highest proportion at 26.9% with the Western Trust/LCG area having the lowest proportion at 15.3%.

Figure 5
Over 85 population



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

2.2 Population Projections

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

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

The population is projected to increase to 2.007 million in the 25 year period from mid-2017 to mid-2042, an average annual rate of growth of 0.3 per cent. Natural growth is projected to be the main driver of this 136,000 population

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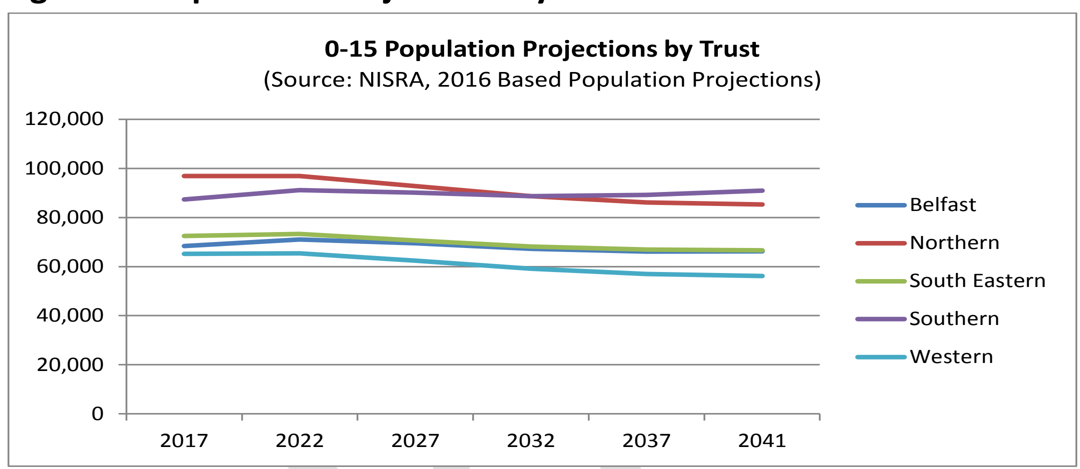
increase, with 127,300 more births projected than deaths. The Northern Ireland GP population is greater than the Northern Ireland population due to Cross Border patients on GP Registers at 197,162.

Local Population Projections

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

Figure 6

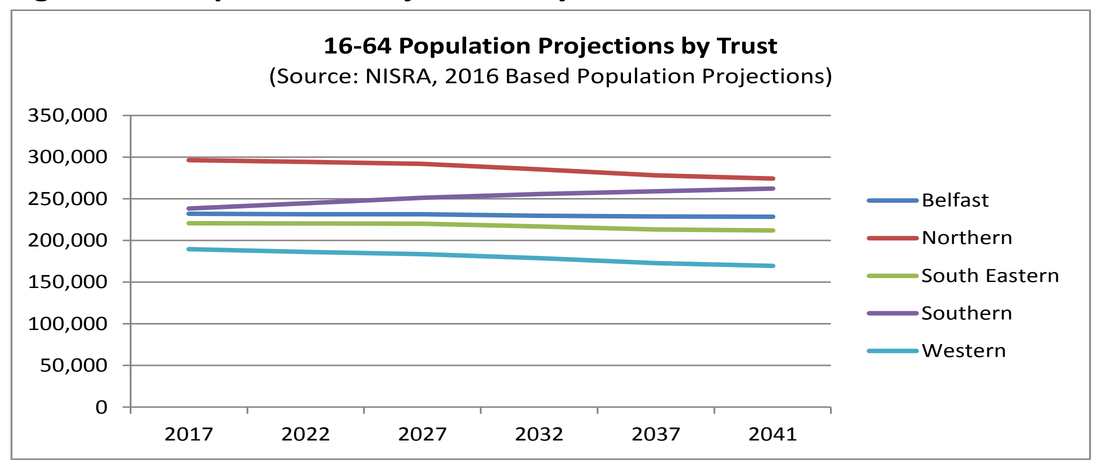
Age 0-15 Population Projections by Trust



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

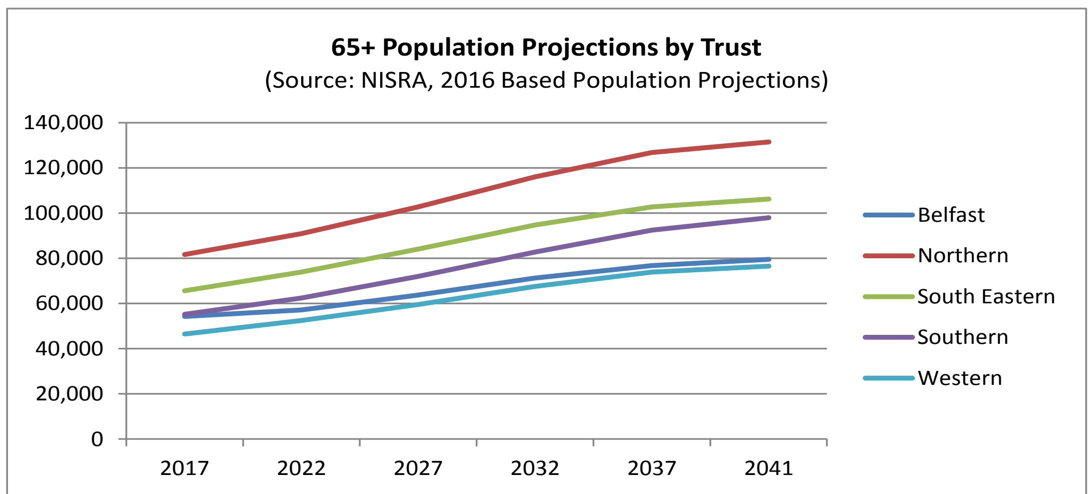
Figure 7

Age 16-64 Population Projections by Trust



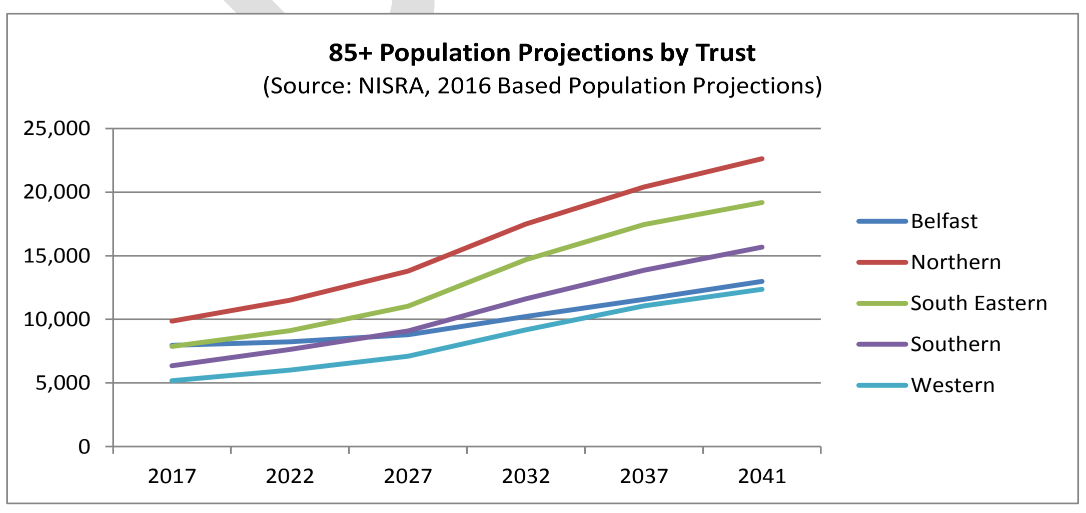
By 2041, it is projected that the 16-64 population in Northern Ireland will be approximately 1.15 million, an estimated decrease of 3% from 2017. The Southern Trust/LCG area is projected to have an 10% growth and the Western Trust/LCG area a projected decrease of 11%.

Figure 8
Age 65+ Population Projections by Trust



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

Figure 9
Age 85+ Population Projections by Trust



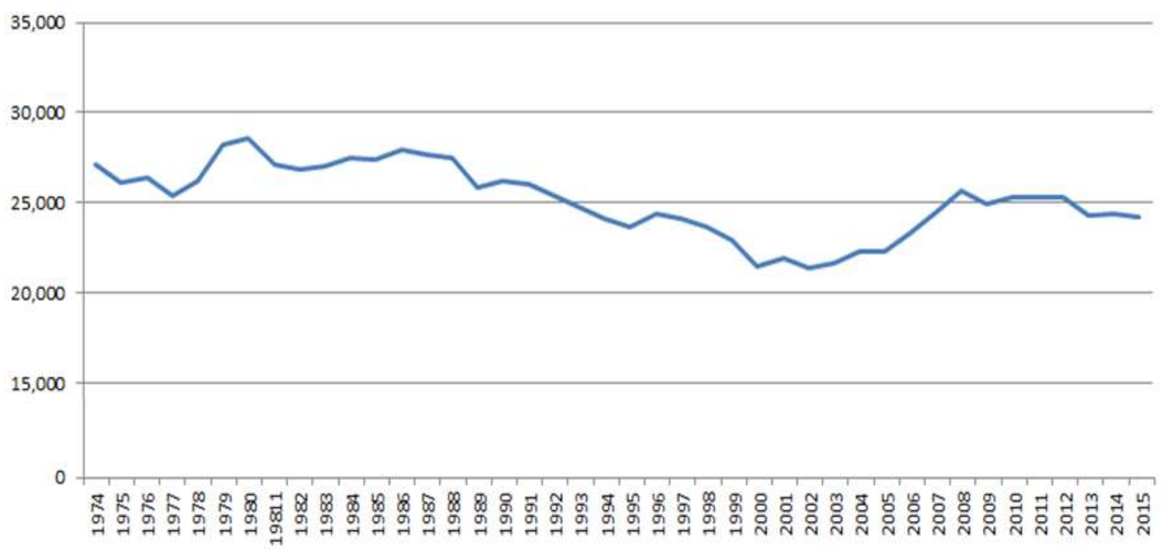
As widely expected, by 2041, it is projected that the 85+ population in Northern Ireland will be approximately 83,000, an estimated increase of 122% from 2017. By 2041, 4.1% of the population will be in this age bracket. All Trust/LCG areas will experience significant increases in this population with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

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

Births in Northern Ireland

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

Figure 10
Births in Northern Ireland (1974-2015)



Deaths in Northern Ireland

In 2016, there were 15,430 deaths registered in Northern Ireland (7,430 males and 8,000 females), slightly less than in 1999 (15,663) when the severe flu epidemic occurred.

There were 108 female deaths for every 100 male deaths, exceeding the female to male ratio in the population as a whole (103 females: 100 males). The average age at death for men was 73.7 years and 79.3 for women. This compares with 68.3 and 74.6 respectively three decades ago.

Life expectancy for females (82.3 years) was almost 4 years higher than for males (78.5 years). This gap has continued narrow over the last 30 years. Of the 15,430 deaths, the leading cause of death was cancer (29%), followed by circulatory disease (24%).

In 2016, 297 deaths by suicide were registered in Northern Ireland which decreased from the highest number of deaths registered in 2015. However, provisional figures for 2017 show an increase from 2016 to 305 deaths.

2.3 Health Inequalities

As part of the Northern Ireland Health & Social Care Inequalities Monitoring System (HSCIMS), the DoH produces an annual Health Inequalities report[2] which provides analysis of health inequality gaps between the most and least deprived areas of Northern Ireland, across a range of indicators. Specific information on these indicators can be found in Appendix 3. Actions to be taken forward in 2018/19 can be found in Section 4.1 and Section 6 of the Plan.

Life Expectancy and General Health

Between 2014 and 2016 the life expectancy gender gap between males and females in Northern Ireland was 3.8 years. For males, life expectancy at birth improved across all areas of Northern Ireland, with a faster rate of

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

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improvement observed in the most deprived areas, resulting in a narrowing of the inequality gap over the period.

For females, life expectancy remained constant in Northern Ireland and the most deprived areas and although it increased in the least deprived areas, the gap remained fairly constant. Healthy Life Expectancies and Disability Free Life Expectancies either declined or remained constant, and no changes to the inequality gaps were observed with the exception of male disability free life expectancy where the gap widened.

Premature Mortality

Rates of premature mortality generally decreased over 2010-2016in Northern Ireland and both its most and least deprived areas. Inequality gaps narrowed or remained broadly similar, with the exception of death rates among under 75s due to respiratory disease, where the gap between the most and least deprived areas widened by almost a fifth due to an improvement in the least deprived areas. Despite the improvements observed for premature mortality indicators, the inequality gaps remained large with the most deprived areas continuing to experience higher mortality rates than the least deprived areas. The largest inequality gap was seen for respiratory mortality among under 75s, with rates in the most deprived areas being almost three and a half times that seen in the least deprived.

Major disease

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

Despite an improvement in cancer outcomes in Northern Ireland the inequality gap widened over recent years. Inequality gaps for admissions due to respiratory disease widened between the most and least deprived areas and were the largest inequality gaps among the major disease indicators. The respiratory admission rate in the most deprived areas was double the rate in

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the least deprived for all ages, and more than double for those aged under 75 years.

Hospital Activity

Inequality gaps for emergency, elective inpatient, day case and all admissions remained fairly constant over the period 2012/13 to 2016/17. Emergency admissions continued to show the largest inequality of the four indicators analysed, with the rate among those living in the most deprived areas remaining almost three-quarters higher than that seen in the least deprived areas.

Mental Health

Large inequality gaps continue to exist for mental health indicators, with the latest position showing that rates of suicide and self-harm admissions in the most deprived areas were around three and a half times the rates seen in the least deprived areas. The inequality gap in self-harm admissions narrowed by a quarter over the period with improvements observed for Northern Ireland and its most and least deprived areas. Prescription rates for mood and anxiety increased across all areas, with the rate in the most deprived areas two-thirds higher than in the least deprived in 2016.

Alcohol, Smoking and Drugs

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

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Pregnancy and Early Years

Changes in inequality gaps for health outcomes related to pregnancy and early years tended to vary over the period analysed. The under 20 teenage birth rate and smoking during pregnancy gaps widened over the period, despite improvements in rates across both the most and least deprived areas. In 2016, the under 20 teenage birth rate in the most deprived areas was almost six times the rate in the least deprived and the proportion of mothers reporting smoking in pregnancy in the most deprived areas was almost five times that in the least deprived.

Diet and Dental Health

Inequality gaps relating to the proportion of primary 1 children classified as obese and those considered overweight or obese narrowed over the period analysed, due to a relative worsening in the least deprived areas. Conversely a widening of the inequality gaps relating to levels of Year 8 overweight or obesity was seen, due to improvements in rates in the least deprived areas.

Figure 11
Summary of Regional Inequality Gaps

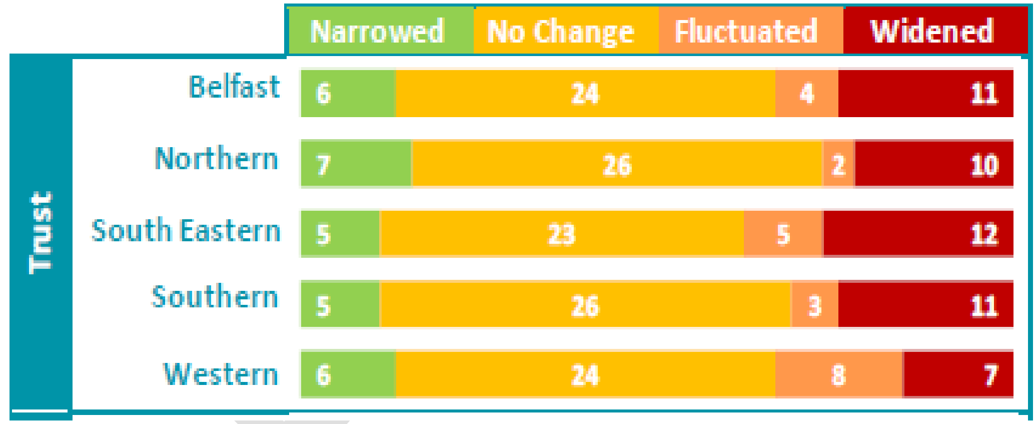
Most Notable Inequality Gaps	Most Notable Narrowing of Gaps	Most Notable Widening of Gaps
Teenage Birth Rate	Self-harm Admissions	Drug Related Mortality
Drug Related Mortality	Primary 1 Obesity	Male Disability Free Life Expectancy
Healthy Life Expectancy	Alcohol Related Admissions	Teenage Birth Rate
Disability Free Life Expectancy	Primary 1 Overweight or Obese	Year 8 Obesity
Smoking in Pregnancy	Male Life Expectancy at Birth	
Alcohol Specific Mortality	Drug Related Admissions	
Alcohol Related Admissions		

2.4 Deprivation

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

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

Figure 12
Summary of Regional Deprivation



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

<u>Largest Deprivation Inequality Gaps in each Trust/LCG Area</u>
The table below indicates the five largest deprivation inequality gaps in each Trust/LCG Area. Recent information contained in the 2018 Health Inequalities Annual Report highlights the main health inequality gaps within the five Trust/LCG areas.

Figure 13
Largest Deprivation Inequality Gaps in each Trust/LCG Area

Belfast HSCT	SDR Drug Related (113%)	SAR Alcohol Related (107%)	SAR Drug Related (104%)	Teenage Birth Rate (U20) (104%)	SDR Respiratory (U75) (93%)
Northern	SDR Drug Related (143%)	SDR Drug Misuse (138%)	SAR Drug Related (108%)	SAR Alcohol Related (107%)	SAR Self-Harm (106%)
South Eastern	SDR Drug Related (138%)	SDR Drug Misuse (115%)	SDR Alcohol Specific (114%)	Smoking During Pregnancy (95%)	SAR Alcohol Related (93%)
Southern	SDR Alcohol Specific (101%)	SAR Self-Harm (97%)	SAR Drug Related (94%)	SAR Alcohol Related (89%)	Teenage Birth Rate U20 (87%)
Western	SDR Drug Misuse (159%)	SAR Alcohol Related (138%)	SDR Drug Related (122%)	SDR Alcohol Specific (121%)	SAR Drug Related (111%)

2.5 Rurality

The *Rural Needs Act* came into operation for Government Departments and District Councils on 1 June 2017 and for public authorities including the HSCB and PHA on 1 June 2018. The Act defines 'rural needs' as "the social and economic needs of persons in rural areas". A need can be considered to be something that is essential to achieve a standard of living comparable with that of the population in general. For example, it can relate to the ability to access key public services such as health and education, the ability to access suitable employment opportunities, and the ability to enjoy a healthy and active lifestyle. Generally, the Act classifies settlements with fewer than 5,000 residents together with the open countryside as rural. Figure 14 below shows the geography of Northern Ireland, highlighting that a large proportion of the population live in rural settings.

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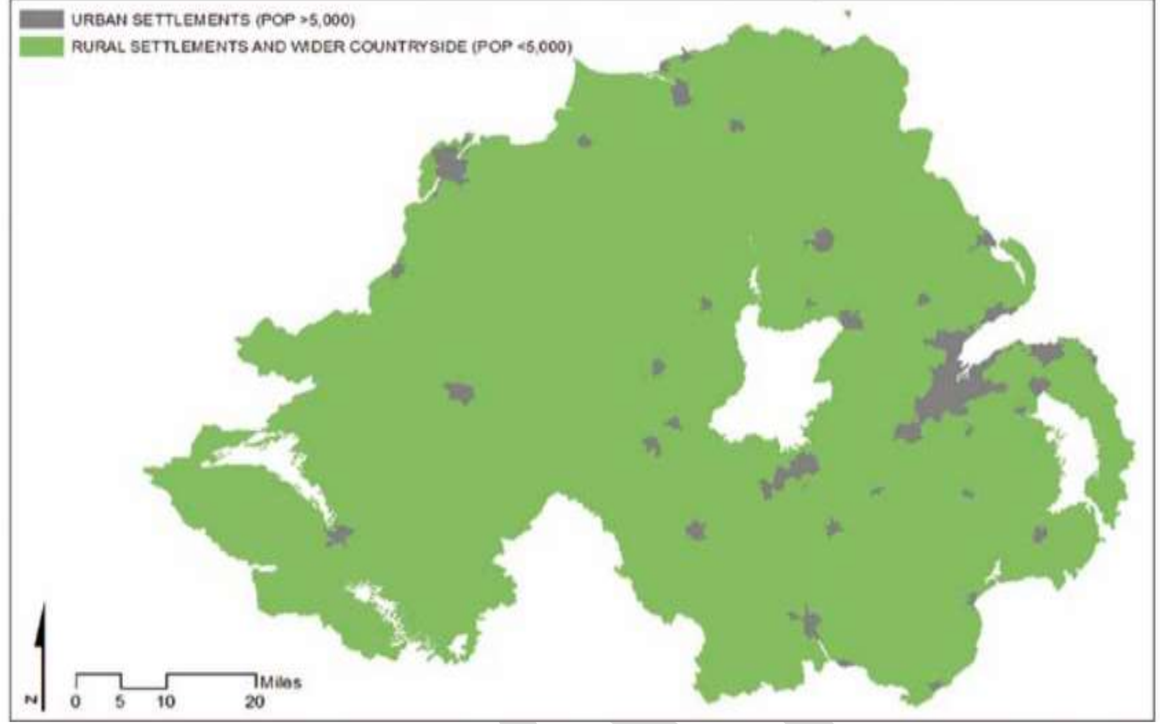
Figure 14
Rural Settlements and wider countryside



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

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

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

significant and, where appropriate, to make adjustments to the policy or strategy to take account of rural circumstances.

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

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3.0 COMMISSIONING AND THE USE OF FINANCIAL ALLOCATIONS

The financial outlook for 2018/19 and beyond is increasingly constrained, particularly in respect of resource funding. The Secretary of State for Northern Ireland announced the Budget position for 2018/19 for Northern Ireland departments on 8 March 2018 and while the Budget provided a measure of protection for Health and an increase of 2.6% compared to the comparable actual funding levels in 2017/18, total cost pressures are 5% to 6% per annum and difficult challenges remain in meeting demand to maintain existing services.

The CPD requires the Commissioning Plan to explain what services will be commissioned within the available budget. This includes providing details of how the total available resources, as specified by the DoH in its respective financial allocation letters to the HSCB and PHA for the financial year 2018/19, have been committed to Trusts and other organisations.

Given the financial context, extensive budget planning work to support the development of the 2018/19 financial plan has taken place between the DoH and the HSCB and Trusts.
This chapter sets out:

- A summary of income sources for the HSCB and PHA in line with DoH 2018/19 Financial Allocation letters.
- A summary of HSCB and PHA expenditure areas for the planned additional investments in 2018/19.
- An analysis of HSCB and PHA allocations by Provider including Trusts.
- An analysis of HSCB and PHA allocations by Programme of Care.

In response to the Commissioning Plan, Trusts are required to provide Trust Delivery Plans (TDPs) which will incorporate individual financial plans for each Trust. These plans will provide further information for the HSC on the details behind pressures and savings plans and are analysed by Programme of Care. These plans can then be incorporated into an overall Strategic Resource Framework (SRF) for the whole HSC. The SRF is an annual document produced

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later in the year which provides supplementary detail on planned expenditure areas included in the draft Commissioning Plan.

Summary of Income Sources - Budget Allocations HSCB and PHA

The DoH issued separate financial allocation letters for 2018/19 to the HSCB and PHA. These are summarised in **Table 2** below:

Income 2018/19

Table 2

Income 2018/19 - based on allocation letters	**HSCB £m**	**PHA £m**	**TOTAL £m**
Opening Allocation	4,575.3	88.6	4,664.0
DOH Additional Funding	204.6	2.5	207.1
Confidence & Supply Funding Non Recurrent	60.0	0.0	60.0
Confidence & Supply Non Recurrent Mental Health	10.0	0.0	10.0
Additional in year adjustments	1.7	(3.2)	(1.5)
TOTAL	**4,851.7**	**88.0**	**4,939.6**

HSCB and PHA expenditure areas and funding sources

The DoH financial allocation letters set out how the additional resources available are to be applied in the financial year beginning April 2018. **Table 3** summarises the expenditure areas and funding sources.

Transformation of the HSC is critical to the long term sustainability of services. The Transformation Fund is a £200m non recurrent investment over a two year period beginning 2018/19. This Transformation Funding will offer a unique opportunity to progress key actions which will enable the broader change agenda within the vision for transformation, as set out in the strategic document Health and Wellbeing 2026: Delivering Together.

The first £100m was confirmed in March 2018 as part of the 2018/19 budget settlement. The high level breakdown of investment is as follows:

- £30m targeted at stabilising the system by stemming the increase in waiting times for diagnostic and elective care;
- £15m for primary care, including £5m for the initial rollout of Multidisciplinary Team model;

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- £15m for workforce development across the HSC;
- Up to £30m investment in reforming Hospital and Community Services including investment in new Elective Care Centres;
- £5m investment in building capacity in communities and prevention;
- £5m investment in the enablers for Transformation including investment in Co-production and QI development.

This financial plan does not include the Transformation Fund element of the budget settlement in 2018/19 .

2018/19 Summary of expenditure areas and funding sources

Table 3

2018/19			
PRESSURES		**£m**	**£m**
	Carried Forward Pressures 2017/18	226	
	HSCB/PHA Inescapable pressures 2018/19		
	Inescapable Service Pressures	25	*Table 4*
	Drugs and Therapies	22	
	Demography	19	*Table 5*
	Family Health Services	29	
	National Living Wage, Apprenticeship Levy & Non Pay	61	
	Revenue Consequences of Capital Schemes	9	
	Mental Health Pressures	10	*Table 6*
	Total Pressures		**401**
SOURCES	Allocation from DOH	207	
	Confidence & Supply	60	
	Confidence & Supply Mental Health	10	
	Medicine Optimisation Regional Efficiency Programme (MORE)	40	
	Savings/Opportunities in Trusts	45	
	Departmental Savings Opportunties	8	
	Control Total	31	
	Total Sources		**401**

Following the Secretary of State's budget announcement, a funding gap remained for 2018/19. Consequently, the DoH has authorised overspends totalling £31m in the form of a Control Total to address remaining residual pressures to maintain existing services. The Department of Health will work with the HSC and the Department of Finance to address this funding gap.

Pressures

Carried forward pressures

Carried forward pressures from 2017/18 are the full year effect of inescapable pressures for which funding was not recurrently secured in 2017/18. This includes the 2017/18 Pay award, revenue consequences of capital expenditure, specialist hospital and drug pressures and Trust savings targets not delivered recurrently.

Inescapable service pressures

There are a range of inescapable and unavoidable service pressures for 2018/19. These are summarised in **Table 4**.

Inescapable service pressures

Table 4

Inescapable Pressures	£'000s
Acute & Specialist Hospital Services	6,448
Children	6,278
Older People	2,327
Learning Disability	4,800
Physical Disability	156
Non Programme of Care specific	5,064
TOTAL	**25,073**

Investment is required to support the following:

- Specialist paediatrics
- Plastic surgery
- Immunology/spinal bracing/neurosurgery
- New and growth in existing UKGTN approved tests
- Implementation of the Special Educational Needs and Disability Act (Northern Ireland) 2016
- Finalisation and implementation of autism framework for children
- Adults with learning disability whose family arrangements breakdown

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- Learning disability young people transitioning to adult services
- Community infrastructure for learning disability
- Public health programmes including screening, vaccination and early years
- GEM Scheme – allowing more young people to remain with foster carers post 18 years
- Bespoke individual wraparound outreach into single accommodation (rentals etc) for young people who cannot return home from care or be placed in supported accommodation

Drugs and therapies

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

Demography

Table 5 provides an indicative split of demographic pressures across Programme of Care. These are informed by extrapolating per capita expenditure and population projections by Programme of Care and they reflect the projected reduction in births and increase in the older population.

Demography by Programme of Care

Table 5

	TOTAL
POC	**£'000s**
Acute Non Elective 1	7,350
Maternity 2	(204)
Family & Child Health 3	241
Elderly Care 4	10,651
Mental Health 5 *	0
Learning Disability 6	472
Physical and Sensory Disability 7	300
Health Promotion and Disease Prevention 8	295
Primary Health and Adult Community 9	69
TOTAL	**19,174**

*Mental Health demography is included separately in Table 5

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Demography funding is specifically to allow Trusts to maintain the same level of service as in prior years whilst recognising this must be done within changes to the population numbers. Where population projections indicate that these numbers will increase within specific Programme of Care the associated funding requirements are reflected in the pressures assessment. For most Programmes of Care population numbers are increasing, however the negative line in Table 5 for Maternity reflects the decrease in projected number of births.

Family Health Services

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

National Living Wage, Apprenticeship Levy and Non Pay

The introduction of National Living Wage and Apprenticeship Levy creates further pressures in 2018/19. Non pay pressures take account of the impact of inflationary pressures on health and social care, which are estimated at a 2.6% increase.

Revenue consequences of capital expenditure

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

Mental Health Pressures

There are £10m pressures for Mental Health to be covered by the Confidence and Supply Mental Health ring fenced funding. These are set out below in **Table 6.**

Mental Health Pressures

Table 6

Mental Health ring fenced funds	£'000s
Mental health inescapables	1,700
To support current level of psychological therapies	4,600
BHSCT Acute Mental Health Facility	900
General demography growth and inflationary pressures	2,800
TOTAL	**10,000**

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Sources

Allocations from DoH
The DoH issued separate financial allocation letters for 2018/19 to the HSCB and PHA. These allocation letters show the budgeted income for each respective organisation.

Confidence & Supply funding
The 2018/19 budget includes Confidence & Supply Agreement funding of £60m to address health pressures and a further £10m ring-fenced for Mental Health. These were separately identified in the DoH allocation letters.

Medicines Optimisation Regional Efficiency Programme (MORE)
DoH has set a regional target of £40m. This challenging savings and efficiencies target has been established for medicines optimisation / prescribing across both primary care (£25m) and secondary care (£15m). Non-recurrent in-year funding of £7.5m Primary Care and £2.5m Trusts will be provided from the HSCB to support delivery of MORE target. The secondary care element in relation to medicines optimisation is shown in **Table 7** below.

Savings/Opportunities in Trusts
As part of the overall financial plan for 2018/19, Trusts have been tasked by DoH with developing draft savings plans to deliver their respective shares of a total of £44.7m of savings. Trusts are required, as part of this process, to inform the public about all savings options under consideration, and specifically indicate those that are considered to be major and/or controversial.

Table 7 provides the detail by Trust. The allocation of Trust shares takes account of relative cost efficiencies of local Trusts. It also takes account of each locality's planned share of available HSC resources. To address relatively lower levels of Health and Social Care expenditure on the Southern local population area generally and the gap from its target capitation expenditure, the Southern Trust (SHSCT) has not been allocated a savings target.

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Savings/Opportunities in Trusts

Table 7

TRUST SAVINGS	Savings/Opportunities in Trusts £m	Medicines optimisation efficiencies in Trusts £m	Medicines optimisation efficiencies in Trusts Non Recurrent Support £m	TOTAL £m
BHSCT	(17.2)	(7.2)	1.2	(23.2)
NHSCT	(8.1)	(2.2)	0.3	(10.0)
SEHSCT	(6.9)	(1.9)	0.3	(8.4)
SHSCT	0.0	(1.9)	0.3	(1.5)
WHSCT	(11.7)	(1.9)	0.3	(13.3)
NIAS	(0.8)			(0.8)
Total	(44.7)	(15.0)	2.5	(57.2)

HSCB Allocations to Providers

Table 8 shows how the total of the HSCB and PHA allocations of £4,940m are indicatively allocated across providers at the time of the Commissioning Plan. The 'Other' category includes element of funding which will be attributed to providers at a later stage in the year when plans are fully formulated.

Indicative Allocations to Providers

Table 8

Indicative allocations to Providers	£m
HSC Trusts	3,773
FHS	892
Other*	275
Total	**4,940**

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

Figure 15 provides a sub analysis of the indicative allocations to Trusts.

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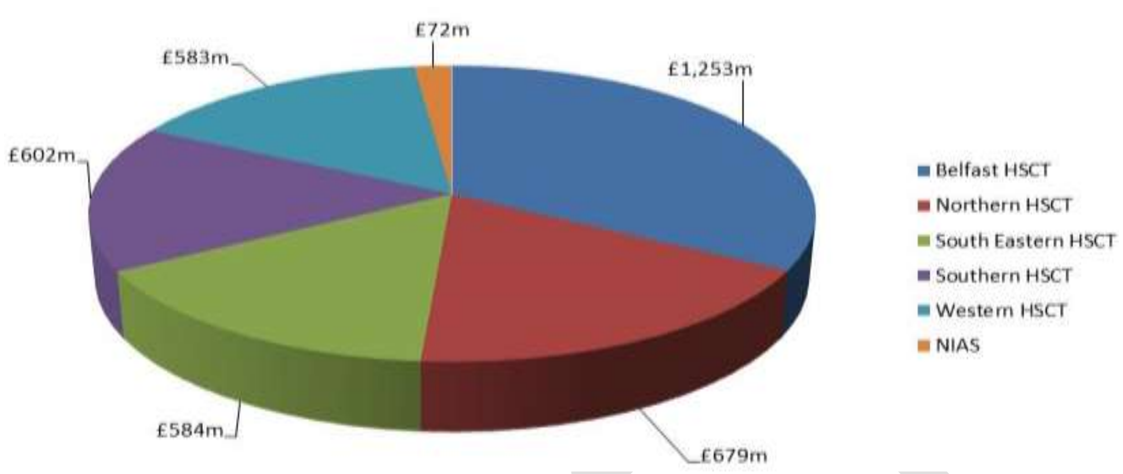
Figure 15
Planned Allocations to Trusts



It is anticipated that the planned allocations to Trusts will not be sufficient to address all Trust pressures. While the DoH works to resolve the funding shortfall, it has set a control total which allows the Trusts to spend in total up to an additional £31m to cover unfunded prior year pressures. The TDP process will reflect this.

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 (taking account of the control total agreed by DoH), safety and quality considerations.

Planned spend by Programme of Care

Figure 16 provides an analysis of the HSCB and PHA planned allocations of the baseline across Programmes of Care. A more accurate picture of planned investment across the HSC by Programme of Care will be available when Trusts have completed their TDPs and this will then be incorporated into the SRF.

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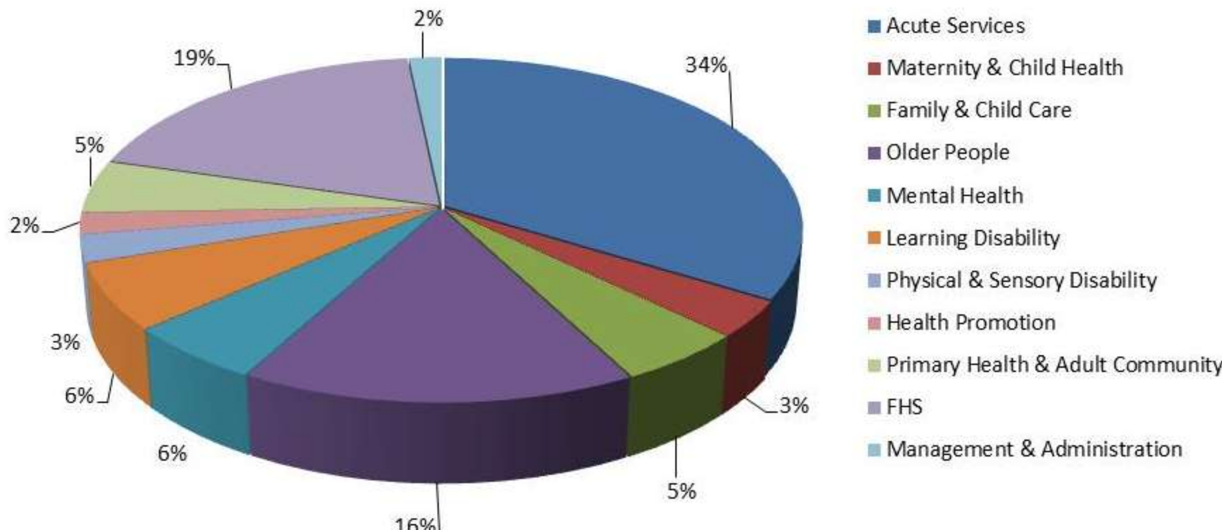
Planned spend by Programme of Care
Figure 16



Despite significant financial challenges and increased demand for services across the Trusts, all Trusts achieved financial balance in 2017/18; however, this was attributable to a significant level of one off non recurrent funding and a range of savings measures. It is expected that both will be required in 2018/19 to address the constrained financial position. To address these pressures, further funding is required through in year monitoring rounds or the implementation of savings measures.

TDPs are expected to be available in September. These will include an assessment of their financial position and savings measures, and will identify any residual deficit position.

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4.0 OVERARCHING STRATEGIC THEMES

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

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

4.1 Improving the health of the population

4.1.1 Reduction of Health inequalities

Section 2.3 of the Plan highlighted a range of health inequalities across various service areas. Improving health and reducing health inequalities requires coordinated action across health and social care, government departments and a range of delivery organisations in the statutory, community, voluntary and private sectors.

The Department of Health 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. The draft Programme for Government (2016-21) also fosters such a whole system approach.

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. *Delivering Together* further underlined the importance of prevention and the active participation of communities in achieving these goals. In particular, the need to expand and support community development approaches to health

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has been progressed as a key work stream of the HSC Transformation and Reform agenda.

The HSCB/ PHA aims to improve the health and wellbeing of the population of Northern Ireland 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.

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 2018/19 the PHA will advance these objectives by building strong connections across society to improve health and wellbeing and reduce inequalities.

In particular, these objectives are an essential part of community planning processes with the eleven local councils. Health improvement goals have been embedded in Local Community Plans which will move forward with implementation during 2018/19. A number of Delivery Plans for Programme for Government offer new opportunities to improve health and wellbeing and influence the determinants of health inequalities, for example, Healthy Places offers an opportunity to develop a coordinated approach across Government to improving health with local communities. More information on Community Planning can be found in Section 1.7 and Section 6 of the Plan.

The HSCB/ 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

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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. The Community Development Framework developed as part of the HSC Transformation process will advance this practice.

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

Giving Every Child the Best Start

The PHA will continue to prioritise investment in early years' interventions including:

- Expansion of the Family Nurse Partnership Programme, within all five Trusts to cover the whole population of Northern Ireland, ensuring an increased level of availability to eligible mothers to provide "a healthier pregnancy" and give our children and young people the best start in life, providing developments in health visiting, early intervention services and family support hubs.
- Expansion of evidence based parenting support programmes which will support the implementation of the Infant Mental Health Action Plan and 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 maintaining the accreditation of facilities to meet the World Health Organisation UNICEF Baby Friendly standards, and expansion of the Breast Feeding Welcome Here scheme (helping to normalise breast feeding).
- Expansion of evidence based training and practice in implementing the Infant Mental Health Action Plan and addressing Adverse Childhood Experiences (ACEs).
- Ensuring the delivery of the universal child health promotion programme for Northern Ireland, "Healthy Child Healthy Future."

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

- Falls prevention.
- Promotion of continence.
- Management of mild cognitive impairment.
- Social isolation.
- A range of local health development programmes through community networks.
- 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 including:

- 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 including the 'Choose to Lose' community weight loss programme.
- Expanding the Weigh to a Healthy Pregnancy to women with a BMI over 38.
- Implementation of the "Tobacco Control Strategy" including smoking cessation services, which plan to reduce the population of 11-16 year olds, adults and numbers of pregnant women who smoke.
- Continuing to work with DoH in implementing a new strategy for the prevention of suicide and self-harm and the promotion of positive mental health.

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Creating the Conditions

Specific commissioning intentions for 2018/19 include:

- Building capacity of local people to support vulnerable adults to live independently in caring and responsive communities, such as Creative Local Action Response and Engagement (C.L.A.R.E.).
- Leading and implementing programmes which tackle poverty (including fuel, food and financial poverty) and maximise access to benefits, grants and a range of social inclusion services for vulnerable groups.
- Developing and implementing a consistent approach to health and social wellbeing programmes, working with local government and other partners.

Empowering Communities

The 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 2018/19 include:

- Implementation of Outcomes Based planning and agreed action of the Regional Travellers Health Forum.
- Expansion of the Northern Ireland New Entrants service; and support to a range of community development and health programmes.
- Improving access to primary care and other health and social care services for people experiencing homelessness.

Developing Collaboration

Strengthening community development approaches as part of HSC Transformation highlights the importance of engaging meaningfully with communities. The HSCB and PHA will continue to support and extend strategic multi-agency partnerships in 2018/19, in particular making a full contribution to community planning processes with local government, to improve health and social wellbeing and reduce health inequalities. A key focus of developing collaboration will include strengthening and embedding Making Life Better across all HSC organisations.

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In addition, members of the public especially those at most risk of a preventable hospital admission, will be encouraged to take actions that will help them stay well during winter, and, when they need care, assist them, their families and carers to make informed decisions on the best services to use. This includes getting a flu vaccination, keeping homes warm and getting advice from a pharmacist as appropriate at the first sign of illness. It aims to help reduce hospital admissions and ease pressures on finite services.

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 2018/19 specific commissioning intentions include:

- Expansion of the Newborn Blood Spot Screening Programme to test for a number of new conditions (namely Glutaric aciduria type 1 (GA1), Isovaleric acidaemia (IVA), Maple syrup urine disease (MSUD) and Homocystinuria (pyridoxine unresponsive) (HCU)). This will involve procurement of new equipment to carry out testing and an enhanced Laboratory results review service.
- Commissioning of a managed service to support the Newborn Hearing Screening Programme to reduce the risk of adverse incidents, improve quality assurance and eliminate the need for manual processes within the programme.
- Introducing surveillance clinics within the Diabetic Eye Screening Programme and consulting on a new model of service delivery.
- Planning for the introduction of a new screening test (quantitative FIT) within the Bowel Cancer Screening Programme.

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- Planning for the introduction of human papilloma virus (HPV) testing, as the primary screening tool in the Cervical Screening Programme.

4.1.3 Health Protection

The Health Protection Service delivers on the statutory responsibilities of the Director of Public Health, with respect to protecting the health of the Northern Ireland population from threats due to communicable diseases and environmental hazards. The Health Protection Service is a multidisciplinary service in the Public Health Directorate in the PHA. It comprises consultants in health protection, nurses in health protection, epidemiology and surveillance staff, and emergency planning staff. It provides the acute response function to major issues, such as outbreaks of infection and major incidents. The 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 2018/19 the PHA will continue supporting the introduction of a surveillance system for antimicrobial resistant organisms and a region wide programme on antimicrobial stewardship.

Communicable diseases disproportionately affect certain groups in the population including those at social disadvantage, living in poor housing conditions, migrants from countries that have higher prevalence of infectious diseases, and those with drug and alcohol problems. Thus, prevention and control of communicable diseases is a key component of tackling health inequalities. Healthcare Associated Infections (HCAIs) are an important cause of morbidity and mortality. Levels of infections are increasing across Trusts. Tackling antimicrobial resistance is a key priority for the Chief Medical Officer and DoH. Specific commissioning priorities for 2018/19 include:

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

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- Trusts, supported by PHA should continue to develop and deliver improvement plans to reduce infection rates for all HCAIs including Esherichia coli, Klebisella spp. and pseudomonas aeruginosa in line with the Departmental objectives. This will be monitored via PHA surveillance programmes for HCAIs and SSIs.

- *Flu immunisation:*
  - Implementation of standardised data collection guidance on flu vaccine uptake in health care workers, from whatever source, for Trusts.
  - Commission NHS Employers for a second year to deliver the flu fighters® campaign for the 2018/19 season to increase uptake of flu immunisation among healthcare workers.

- *Childhood immunisations:*
  - Work with GPs and Trusts to increase childhood immunisations where uptake is below target levels.

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

- *Clostridium Difficile:*
  - Reduce the number of in-patient episodes of Clostridium Difficile infection in patients aged 2 years and over and in-patient episodes of MRSA infection compared to 2017/18.

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4.2 Improving the quality and experience of Health and Social Care

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

Patient Safety is the avoidance of unintended or unexpected harm to people during the provision of health and social care. Patients should be treated in a safe environment and protected from avoidable harm. The HSCB/PHA place patient safety above all other issues and are continually working to monitor and review services. This is more important than ever in the context of the current unprecedented resource difficulties. While health and social care is both complex and pressurised, the HSCB/PHA are focused on ensuring that the experiences of patients, clients and carers are shared, understood and acted upon; appropriately influencing commissioning.

In line with the goals of *Q2020 Strategy*, the recommendations from both '*Systems Not Structures'* and '*Delivering Together*', the need to take a strong position on Quality Improvement, with the patient and service user represented as part of this, is fundamental to our aspiration to transforming and delivering a sustainable world class service.

During 2018/19 and beyond, the HSCB and PHA working closely with Trusts and other organisations through existing regional structures will continue to lead and support the implementation of key quality improvement priority areas.

Quality Improvement Plans (QIPs)

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

The HSCB/PHA provide support to Trusts and gain assurances on progress with regional safety and quality priorities through Quality Improvement Plans (QIPs). During 2018/19 the PHA and HSCB will link closely with Trusts to improve the following areas:

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QIP reporting
Transform the regional QIP reporting and improved detection and learning from causes of variation. By March 2019, the PHA will review and regionally agree standardised operational definitions and reporting schedules for falls and pressure ulcer priorities.

Falls
Falls are a significant cause of harm to patients in receipt of HSC services. Effective arrangements should be in place to implement and measure falls safe interventions to reduce harm.

- During 2018/19, Trusts should continue to monitor and report the total number of falls and measure the incidents of falls resulting in moderate to major/Catastrophic.
- During 2018/19 Trusts should continue to improve compliance with agreed elements of Part A and Part B of the falls safe bundle and demonstrate a percentage reduction in those which cause moderate to major/Catastrophic.
- By March 2019, the PHA and Trusts will link with regulated services to develop a regional sign posting guide in respect of falls management.

Pressure Ulcers
Pressure ulcers are a largely preventable adverse event and an important measure of the quality of care within organisations.

- Effective arrangements should be in place to adhere to the SKIN bundle requirements in order to reduce harm from pressure ulcers.
- During 2018/19, Trusts should continue to monitor and report the number of pressure ulcers grade 2 and above; and measure the incidents of pressure ulcers grade 3 and 4 and the number of those which were avoidable from current baseline data.
- During 2018/19, the PHA will work with Trusts and the HSC Leadership Centre to support the development of a regional prevention of pressure ulcer online training tool.

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- By March 2019, the HSCB/PHA will work with Trusts to support the development of regional guidance in relation to adult safeguarding and pressure ulcer care.

Venous Thrombosis Embolism (VTE)

VTE is a recurring cause of death in hospital patients, and treatment of non-fatal symptomatic VTE and related long-term morbidities is associated with considerable cost to the health service. NICE guidance has been endorsed by DoH and implemented in Northern Ireland. Specific priorities for 2018/19 include:

- Trusts should have effective arrangements in place to assess the risks of VTE and bleeding which is a key priority for implementation of the guidelines.
- By March 2019 Trusts should continue to measure and improve compliance with VTE risk assessment across all adult inpatient hospital wards.

National Early Warning Scores

Identifying early deterioration in patients' conditions is an important factor in improving outcomes. Specific priorities for 2018/19 include:

- Effective arrangements should be in place to implement and measure National Early Warning Scores (NEWS) to identify early deterioration and prompt specific action.
- Work with Trusts to develop arrangements to implement NEWS2.
- Ensure the clinical conditions of all patients are regularly and appropriately monitored in line with the NEWS KPI audit guidance and timely action taken to respond to any signs of deterioration.

Sepsis6

The Safety Forum will work with Trusts to scale and spread implementation of Sepsis 6 in pilot wards in each Trust, in the following settings:

- Emergency Departments
- Medical Units

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- Surgical Units
- HDU/ICU

The PHA will work with community nursing in each Trust to identify priorities for sepsis identification in community settings.

Implementing Quality and Safety Standards

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

Q2020

The PHA will continue to work with Trusts and other HSC organisations to lead the implementation of the Q2020 strategy. This includes working with key stakeholders to take forward the identified tasks for 2018/19 including:

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

4.2.2 *Improving the quality of the Healthcare experience*

Patient experience encompasses the range of interactions that patients have with the health and social care system, including their care from health and

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social care plans, from doctors, nurses, staff in hospitals, GPs and other health professionals.

Patient Client Experience and 10,000 Voices

Listening to and acting upon patient and client experience is recognised as a key element in the delivery of quality HSC. The HSCB/PHA is responsible for monitoring and reporting to the DoH on the Patient Client Experience (PCE) Standards. Through the regional Patient and Client Experience Steering Group, HSC organisations continue to implement a comprehensive programme of work, including the continued roll out of 10,000 Voices to measure experience, drive quality improvement, inform commissioning and ultimately enhance overall experience.

Based on the outcomes from the Patient Client Experience /10,000 More Voices work streams, the HSCB/PHA is committed to the following priorities in 2018/19:

- NIAS should take forward an Always Event relating to respect & attitude, using the appropriate methodology and should test this on a small scale using quality improvement techniques.
- Trusts should have effective arrangements in place to adhere to their policy for the provision of safe and effective care and treatment in mixed gender accommodation
- A priority for 2018/19 will be to undertake an improvement project in relation to Mixed Gender Accommodation to improve on the following areas:
    - A thematic review of Mixed Gender Accommodation
    - Measurement, display and interpretation of improvement data;
    - Consistent application of operational definitions
    - Development of targeted root cause analysis
    - Ensure local and regional learning is identified and shared

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- By March 2019, the PHA will work with Trusts to measure and report compliance with their policy for mixed gender accommodation in **100%** of inpatient areas.
- By March 2019, the PHA will work with Trusts to develop regional guidelines in relation to Family Presence and develop a scale and spread plan for this.
- Undertaking a comprehensive PCE work programme using various methodologies to capture the experiences of patients/clients and staff in a range of settings.
- Working with Trusts to continue to roll out the 10,000 Voices programme of work in a range of settings during 2018/19, highlighting themes and trends, identifying areas for improvement and implementing these into local and regional commissioning priorities.
- Ensuring the analysis of Patient Client Experience feedback is communicated to the relevant 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.

The HSCB/PHA will continue to work with the Trusts to enable people using mental health services to participate as equal partners in their treatment for serious mental illness, and support them to take responsibility for ensuring their own health and wellbeing. This includes:

- Rolling out Wellness Recovery Action Planning (WRAP) for co-developed/ co-delivered care and treatment planning.
- Delivery of co-developed/co-delivered education and support through Recovery Colleges.
- Support the development of self-sustaining, peer led relapse prevention and carer support services.

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Involvement and Co-production

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

Co-production is based on the sharing of information and on shared decision making between service users and providers. It builds on the assumption that both parties have a central role to play in the process as they each contribute different and essential knowledge.

As the HSC system further embeds PPI and adopts co-production, working within the Department's PPI framework and the legislative context for involvement, further guidance and resources will be required to enable the system and the service to achieve the transformation required.

Working through the Regional HSC PPI Forum, the PHA will continue to lead and support the HSC system to embrace involvement and co-production into its ethos, culture and practice. A range of involvement and co-production advice, guidance and support has been provided and has been instrumental to ensuring meaningful involvement in critical work areas, such as a number of transformation work stream projects, unscheduled care and the electronic health and care record.

Ongoing work is required within the culture of the wider HSC system to further embed partnership working. To this end, the Commissioning Plan Direction highlights co-production as a key objective for 2018/19.

Specific actions in 2018/19 include:

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- The PHA will continue to work with the DoH, other partners, service users and carers to collectively drive forward the embedding of involvement and co-production into HSC culture and practice.
- The provision of strategic professional involvement advice, guidance and leadership by the PHA.
- The PHA working through the Regional HSC PPI Forum will further enhance the Engage website with additional resources, materials and information alongside associated outreach and developmental work.
- HSC organisations should examine their mechanisms for service user/carer voice to ensure it is heard at the highest levels within their governance and decision making arrangements.
- Trusts should continue to address the recommendations from their last PPI monitoring report.
- HSC organisations should have in place a PPI training action plan. The plan should set appropriate goals in relation to the delivery and uptake of the Engage & Involve e-learning and taught modules with numbers of staff trained being captured and reported annually.
- By March 2019, the PHA will work with HSC organisations to ensure that the co-production model is adopted when designing and delivering transformational change. This will include integrating PPI, co-production, patient and client experience into a single organisational plan.

Patient and Client Council (PCC) Projects

The PCC's vision is to support and promote a health and social care service that is shaped by the experiences of patients, clients, carers and communities. To achieve this aim it continues to be an independent and influential voice that makes a positive difference to the health and social care experience of people across Northern Ireland.

The PCC continues to produce a range of reports on the experience of service users which help to inform service planning both regionally and locally. Service areas which the PCC have recently reported on include:

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- Experience of living in a nursing home
- Experience of living with early onset dementia
- Experience of waiting on healthcare
- Experience of end of life care.

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

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

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

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

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

This section highlights a number of drivers which help to improve the quality of service in specific programmes of care and more generally across all service areas:

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Participation in Audit

Participation in local, regional and national audits is key to improving the quality of care to patients. The national Sentinel Stroke National Audit Programme (SSNAP) audit for stroke care is driving improved quality in stroke care across the stroke care pathway with Belfast Trust and SWAH achieving higher scores on the SSNAP audit compared to other centres in Northern Ireland. Participation in the national stroke audit has highlighted numerous areas for all stroke services (hospital and the community) where improvement is possible on the stroke care pathway so that Northern Ireland performance matches other parts of the NHS.

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

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

Trusts are to develop action plans/quality improvement approaches to address the issues identified in the audit.

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

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

Recent NCEPOD reports covered the topic areas of chronic neurodisability, non-invasive ventilation, mental health in general hospitals, acute pancreatitis and sepsis. The HSCB/PHA through the SQAT will work with providers either through existing groups/networks or task and finish groups to address recommendations in these reports and aim to improve standards of care.

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

Implementation of quality standards and guidance supports the delivery of care in line with the best available evidence of clinical and cost-effectiveness; enables people to be accountable for their care, knowing how they will be cared for in a consistent evidence-based way and helps improve population health and prevent disease.

Learning Disability
HSCB and PHA will continue to support Trusts to deliver person centred care in line with the Bamford vision for people with a learning disability to be living integrated into their own communities and supported to enjoy opportunities for work, social relationships and activities according to their individual interests and priorities. To this end HSCB and PHA will continue to represent the needs of people with a learning disability across government Department to develop Day Opportunities, independent travel, and housing support. Supporting family carers, improving access to physical health care, and rolling out self-directed support will also be priorities.

Recovery in Mental Health
HSCB and PHA will continue to work with the Trusts to enable people using mental health services to participate as equal partners in their treatment for serious mental illness, and support them to take responsibility for ensuring their own health and wellbeing. This includes:

- Rolling out Wellness Action Recovery Planning (WRAP) for co-developed / co-delivered care and treatment planning.
- Delivery of co-developed / co-delivered education and support through Recovery Colleges.

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- Support the development of self-sustaining, peer led relapse prevention and carer support services.

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

Everyone receiving health and social care should have the levelof care appropriate to their needs. This is particularly important for those who may be in their later years or where there are co-morbidities such that decisions regarding the type of care and where that care is provided should take account of the individuals' clinical needs but also their personal choices and their priorities.

Self-Directed Support

Self-Directed Support and Personalisation seeks to enable people to plan and choose health and social care support that is more flexible and can better suit their individual needs. As part of personalisation, individuals are supported to make informed choices about meeting their assessed needs and, where they wish to, are supported to manage the support they receive.

Self-Directed Support empowers people to direct their own care and support and to make informed choices about how their support is provided. Regardless of the care setting, services can be tailored to become more suited to individuals' choices and preferences. There are a number of key actions to be taken in 2018/19 including:

- Continuing to develop and implement Self-Directed Support service arrangements that create real choice and control for services users and Carers to manage or commission social care support.
- Ensuring the four SDS funding options will provide service users and carers with an opportunity to become direct commissioners of services.
- Developing a regional Recognised Provider Directory to support individuals to source appropriate services locally to meet their identified needs.

Regional Implementation of Adult Social Care Outcome Tool (ASCOT)
The Adult Social Care Outcomes Framework (ASCOF) is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.

As part of the Department's key priorities for Social Care, the DoH is utilising ASCOT to support the outcome measure in relation to PfG indicators, particularly Indicator 9. ASCOT is suite of measures designed to capture information about an individual's social care related quality of life. ASCOT is a validated tool developed by PSSRU (Kent University) widely used across England Wales and Scandinavian countries as the tool of choice to measure Social Care related outcomes.

Trusts in Northern Ireland will implement ASCOT in support of the Self-Directed Support Initiative to measure individual outcomes, and the impact of support service provision via their Social Care Related Quality of Life score (SCRQoL). There are a number of key actions to be taken forward in 2018/19 including:

- Developing and rolling out a regional outcomes support planning approach that delivers personalised services to support service users and those who care for them.
- Supporting Trusts to integrate ASCOT into Community Information Systems
- Scoping an appropriate regional Social Care Outcomes tool specifically for use within children's services

Pain Management
Pain accompanies many acute and long term or chronic illnesses as a symptom and is regarded as the most important one by many people because of the distress it causes and the far reaching consequences it has for individuals, families, communities and societies when it becomes persistent.

Not all pain that is felt physically can be explained or is accompanied by recognisable physical changes or processes in the human body, just like

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emotional distress or mental anguish can be felt physically. Persistent pain encompasses biological, psychological and social features in a unique way that remains poorly understood by many.

Persistent pain is commonly described as the largest unrecognised global epidemic of our time, and because its impact and the kind of services that are needed to meet the needs of those who experience it, it can serve as a model for other disabilities and long term conditions that disproportionately affect the poorest and most vulnerable and tend to be compounded by increasing age.

Persistent pain is defined as lasting longer than three months and affects at least one in five people at any given time. In Northern Ireland alone this means almost half a million children, adults and older people. Of these, many try to help themselves and recover over time but for just as many it becomes a permanent, determining and potentially destructive factor.

In 2014 the PCC published its report The Painful Truth and prompted the HSCB and PHA to set up the Northern Ireland Pain Forum, which brings together patients, community and voluntary organisations, Trusts and others that can help to improve support and services for people living with pain.

The Pain Forum has developed a comprehensive five year plan to provide more local and on line support groups, information and complementary therapies to help people to help themselves and others, because this is what seems to matter most especially in the beginning and to prevent pain worsening.

General Practice is hugely important for good pain services because medication can be harmful and is never enough on its own; physiotherapy is needed promptly to keep people as mobile as possible and help recovery; support for good mental health and overall wellbeing is essential in effective pain management, as is help to succeed in education and work and remain an active member of society.

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Much remains to be done but pain management services are prepared and ready to grow into their large role as an important component of public services that endeavour to reach everyone in need regardless of where and how they live in Northern Ireland.

Endometriosis

Endometriosis is described by NICE as a condition whereby tissue which is usually only found inside the womb starts to grow in other parts of the body. This can cause severe symptoms, including painful periods and pelvic pain, and could mean that women have difficulties getting pregnant (up to 40% women have subfertility issues). Endometriosis can have a huge impact on women's quality of life, work and relationships.

Endometriosis is estimated to affect one woman in ten through the reproductive years (age 25 - 45) and there is often a long delay between the onset of symptoms and diagnosis/treatment. The condition is progressive and by the time of diagnosis approx. 5-10% of sufferers have severe disease which affects the non-gynaecological pelvic organs (bowel/bladder/ureter).

Generally, endometriosis services across Northern Ireland are provided as a sub-specialty within gynaecology services. Work is ongoing to strengthen existing services within the Belfast and Western Trust areas where the majority of patients are referred. During 2017/18 provision of additional specialist nurses has been secured. In addition to these improvements, further work is required to improve the patient pathway and experience.

The HSCB and PHA have also been involved in group discussions with the PCC and service users to further understand the issues associated with the condition and the provision of existing services.

Diabetes Care

People and patient power has been a driving force in improving the approach to diabetes care in Northern Ireland. The work of Diabetes UK, the patients association that draws membership from people and carers of people living with diabetes, has been instrumental in delivering the Diabetes Strategic Framework.

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The launch of the Strategic Framework in 2016 included a three year plan for improvement and investment. People living with diabetes are represented at every level and in every working group within the Diabetes Network that is responsible for taking the improvements forward and these cover the following areas:

- Children and their families through a dedicated Paediatric Network
- Young Adults (aged 13-25) living with diabetes
- Technology to support care and treatment
- Inpatient care
- Feet care
- Women experiencing diabetes in pregnancy
- Structured diabetes education
- Prevention of Type 2 diabetes

Frailty

For many older people, advancing age is associated with frailty, which is not a diagnosis, but is a useful term that describes the state of 'limited functional reserve'.[3] The PHA will continue to promote the 'frailty' agenda in collaboration with AgeNI and other partners following a successful Frailty Symposium held in March 2018. Frailty is one of the most significant challenges facing our ageing population. Work will continue to ensure older adults are enabled to live healthier and more fulfilling lives. Specific commissioning intentions for 2018/19 include:

- Establishment of a Frailty Network
- Agreement on a suite of tools used to measure frailty
- Better identification and stratification of frailty
- Continue to test a range of pilot models across the frailty pathway
- Develop partnerships nationally and globally

[3] https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/the-care-of-frail-older-people-with-complex-needs-mar-2012.pdf

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Multiple Sclerosis (MS)
MS is an acquired chronic inflammatory condition of the central nervous system, affecting both the brain and spinal cord. There are around 4,500 people in Northern Ireland with a confirmed diagnosis of MS. Patients diagnosed with MS can access elements of their care in primary, community and secondary / specialist care and there is a need to ensure a co-ordinated and integrated multi-disciplinary approach to the provision of care.

The HSCB/PHA has worked with a Regional MS Stakeholder Group to develop a service specification for the provision of services for patients with MS in Northern Ireland, consistent with NICE clinical guidance. The aim of the MS Service Specification is to set out the expectations for services in Northern Ireland, to promote standardisation of care across Northern Ireland and whilst being ambitious, be realistic in terms of managing expectations given current financial challenges and planned organisational changes.

The HSCB/PHA has been working with Trusts to ensure continued progress with implementing the services specification for patients with MS. In particular, there will be a focus on implementing the key priorities from the specification namely; the provision of dedicated multi-disciplinary clinics for patients with MS, the local presence of specialist MS nursing staff in all Trusts and the local provision of infusion delivered disease modifying therapies.

Palliative Care
"*You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die.*"
Dame Cecily Saunders

Palliative Care is about improving the quality of life for those with needs and improving the experience of those important to them. The Regional Palliative Care Programme – *Palliative Care in Partnership*, brings together people with palliative care needs, those who care from them, clinicians and other professions, service providers, planners and DOH to ensure we deliver a whole system, holistic approach to support and care. Ensuring that 'what matters to

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me‘ is addressed for each person with needs, whether the need be physical, psychological, social or spiritual.

For some people, where they are cared for, matters to them. Given the choice most people would prefer to be cared for in their own home (which includes residential and nursing home) at the end of life. In 2016, 47% of all deaths occurred in hospital, 20% in nursing homes, 4% in hospices and 29% in other places (home). The HSCB/PHA aim to support a greater number of people who wish to be supported in their own home.

To help people achieve their preferred place of care and ensure they have an optimal quality of life *Palliative Care in Partnership* is working to:

- Raise awareness of Palliative Care
- Implement processes to have proactive earlier identification of palliative care needs
- Allocate those with identified palliative care need a keyworker to help co-ordinate care across the system
- Provide tools to enable the opportunity for all our public to have advance care planning conversations and record them if they wish to do so
- Improved access to generalist and specialist palliative care services

4.2.5 Supporting those who care for others

Families and friends take on significant levels of caring for their loved ones, making enormous contributions both to the HSC system and to our society as a whole. For many such ‘informal’ carers, this is a life-long commitment. As our society changes, so too must the nature of the support offered to carers.

It is vital that carers have access to reliable, accurate information at a time and in a manner that best suits their needs. This can be provided in a range of ways, both traditional and new, and can involve public ‘carer engagement’ events. In 2018/19, work will continue with NI Direct to ensure that information to support carers is available through this website. Many carers do not identify themselves as carers and therefore do not access the advice and support they need. Good

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quality and accessible information is an important step towards helping to identify and support such 'hidden' carers.

Identifying support needs in partnership with carers should be as straightforward as possible. In 2018/19, the electronic version of the NISAT Carers' Assessment tool will continue to be rolled out regionally, improving the processes by which carer needs can be identified and addressed.

Promotion of carers' assessment and support planning as a means of ensuring carers receive support in their caring role will remain a key priority. Trusts will also continue to provide staff awareness training, with carer input, to ensure assessments are routinely offered and support planned with carers treated as active participants and knowledgeable partners throughout.

The HSCB and PHA will ensure that the Standards and Key Performance Indicators in relation to supporting carers as contained in all Service Frameworks are adhered to and reported on regularly by Trusts so that improvements can be identified.

The needs of young carers will continue to receive a particular focus, building on links with the voluntary sector who can offer support to meet the specific emotional and practical needs of young people who find themselves in the caring role. During 2018/19, the HSCB and PHA will seek to increase the number of Understanding the Needs of Children in Northern Ireland (UNOCINI) assessments provided to young carers.

Finally, the range of flexible short-break options for carers will continue to be expanded. Regional work will continue to ensure that the needs and views of carers are central to the development of new and innovative ways of providing support, including the use of self-directed support approaches where appropriate.

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4.3 Ensuring the sustainability of Health and Social Care services

A sustainable health and care system works within the available environmental, financial and social resources in order to meet the needs of the population today and into the future. This requires the HSC system to adapt how it delivers services, promotes health, improves prevention, understands it's corporate social responsibility and develops more sustainable service models.

A sustainable health and care system is achieved by delivering high quality care and improved public health without exhausting these resources. This section of the Commissioning Plan sets out examples of service model redesign and workforce requirements to better utilise resources to meet the needs of the Northern Ireland population.

Links to other specialist providers

A sustainable health and care system should provide services which are evidence-based, available 24 hours a day / 7 days a week, providing good patient outcomes at all times. Due to the size of the population and changing demographics in Northern Ireland (see Section 2), some regional and local services find it difficult to sustain current service provision.

Specific issues affecting a range of services include the recruitment and retention of staff, the size and skill mix of the workforce and the ability to provide the minimum activity required for clinicians to maintain their skill level. In some cases where the numbers of patients are particularly low for some specialist services, the HSCB will seek to establish links with other providers within GB and ROI.

Maintaining safe and effective acute specialist services is best supported through establishing a range of formal and informal clinical alliances with tertiary and quaternary providers in GB/ROI. These arrangements provide resilience to services locally as well as supporting clinical staff in areas such as peer review and participation in wider MDTs for more complex cases. Good progress has been made on this with over 30 in reach arrangements now in

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place in specialist paediatrics. This work will continue to develop for vulnerable areas of specialist acute care.

Imaging Services

A system wide, clinically led review of imaging services has been completed which took account of advances in technology, demographics, demand and looked to both national and international best practice. Following public consultation, the DoH has now published the final Strategic Framework for imaging services in Northern Ireland.

The Framework proposes a number of important recommendations aimed at ensuring imaging services remain safe, effective and sustainable in the long term. It will require new ways of working as well as investment in workforce and underpinning information technology services. The recommendations set a challenging agenda, but they are the right thing to do if we wish to ensure that every patient can access the same high quality imaging services regardless of where they live in Northern Ireland. Three early recommendations emerged from the review:

- Radiology training places - The number of places on the radiology training scheme has increased from 37 to 49 during the period of the review, with plans for further expansion.
- Imaging Services Accreditation Scheme (ISAS) - Currently, no diagnostic imaging services are independently accredited. A regional programme is now in place with Lead ISAS Radiographers and Lead ISAS Radiologists in each Trust, and a regional ISAS Lead from HSCB.
- Single Northern Ireland Picture Archiving and Communications System (NIPACS) - A Programme Board has been established to lead the replacement of the current NIPACS system, which will include the option for a single system across Northern Ireland.

The review has highlighted opportunities for excellence in imaging and there are many examples of high quality service delivery across the region, with an imaging workforce that is well trained and highly regarded. There are

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opportunities for greater co-operation and learning between Trusts and sharing of expertise, with the use of NIPACS, NIECR and the universal use of the health and care number. This is essential to optimise skills and equipment and support patient care. This willingness to collaborate for shared benefits has been fostered by the Modernising Radiology Clinical Network.

Modernising Radiology Clinical Network (MRCN)
The MRCN was established in 2013 following the 2011/12 RQIA investigations into unreported plain film examinations. Its initial remit was to identify and address the key local issues pertaining to plain film services as identified in the RQIA recommendations, and consider improvements in imaging services as a whole. It functions as a clinical advisory group through which key stakeholders can engage in partnership to develop strategic and operational plans for the development and modernisation of diagnostic imaging services in Northern Ireland. The MRCN worked closely with the DoH in the Review of Imaging Services, provided clinical leads for the workstreams and provided peer review of all the clinical workstream reports prior to submission to the DoH.

The MRCN meets monthly and is a multi-disciplinary group comprising of the clinical directors of radiology, radiology service managers, NIPACS manager, GPs, medical physics and colleagues from the HSCB, PHA and Trusts. Standing items include:

- SAIs
- Imaging Services Accreditation
- NIPACS
- Paediatric / Breast / Interventional / Neuro Radiology

Daisy Hill Pathfinder
Recruiting and retaining staff to stabilise the Daisy Hill Emergency Department is only one part of the answer for longer term sustainability. There is a need to transform ways of working across primary, community and hospital care to deliver a whole system unscheduled care service to meet the needs of people living in the catchment area. The new service model reflects this approach and includes six work streams that are interrelated and interdependent:

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- Strong links with primary care, both in and out of hours in the local area;
- Developing close links with the ‘Acute Care at Home’ team and rapid access to other acute services;
- Developing a five year workforce plan to include recruitment of more ED consultants and other specialist clinicians;
- Development of a Direct Assessment Unit to provide ‘same day’ emergency/urgent care services, including telephone advice to GPs and NIAS in a non-inpatient setting;
- Improving clinical work flow including new ‘discharge to assess’ processes, timely discharge and alternative pathways;
- Strengthening high dependency care –supporting four ‘Level 2’ HDU beds co-located with four ‘augmented care’ beds for patients requiring post-surgery care or non-invasive ventilation.

Breast Assessment

Breast assessment services in Northern Ireland have, over the past number of years, at different times and in different locations, encountered difficulties in delivering consistent access to breast assessment. These challenges have arisen largely as a consequence of issues with the recruitment and retention of key clinical staff, in particular consultant radiologists.

Recognising the ongoing challenges with recruitment and retention, a Project Board was established to take forward a review of the current service model with a view to developing a more sustainable model which would provide consistently timely access to breast assessment in the future. The work of the Project Board will be completed in 2018 after which a public consultation is anticipated. The HSCB/PHA have allocated funding to expand radiography skills mix within breast services over the next two years to reduce the reliance on the restricted consultant radiologist workforce. That investment is proceeding in year without prejudice to the outcome of the public consultation on the final service model.

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Stroke Services

The reorganisation of stroke services is required to address the known deficits in care highlighted by the RQIA inspection report and the successive Stroke Sentinel Audit reports.

It is known that the current distribution of services across a large number of sites could impede the development of highly specialist, modern services where staff see sufficient volumes of stroke patients and skills required to consistently deliver protocols for time dependent interventions. This reorganisation will require a whole pathways approach and a particular focus on prevention of stroke and building capacity within communities to support stroke survivors.

Clinical Networks

Clinical Networks continue to play a vital role in ensuring the sustainability of our services. Through Networks we seek to:

- Reduce variation in practice through the agreement of regional policies and guidelines and in doing so optimise the application of existing resources and contribute to patient safety;
- Contribute to the development of information systems that will enable us to develop the cost and activity data that we need to plan effectively for the future (e.g. pathology LIMs system, radiology NIPACS system);
- Advise on workforce planning;
- Identify new ways of working, service models or technologies which can improve efficiency and flow (e.g. acute oncology service model);
- Identify opportunities where skills mix initiatives could create additional capacity (e.g. skills mix within both diagnostic and therapeutic radiography services).
- Create a clinical environment that fosters collaborative working and cross Trust communication and working on both strategic and operational issues including the management of outbreaks, capacity issues and emergency planning; and
- Provide resolved clinical advice to support service planning.

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Effective Use of Resources
In 2006, the DoH produced a policy to make best use of resources in plastic surgery and related specialties, known as 'The Effective Use of Resources (EUR)' policy. This policy sets out the referral criteria for a small number of procedures, most of which relate to the plastic surgery service.

The HSCB is now proposing to expand the range of procedures / treatments which will be commissioned within defined criteria or will not be routinely commissioned. Subject to a planned public consultation, the EUR policy will guide the allocation of limited resources to those areas of greatest clinical benefit and support clinical staff to better manage patient expectations.

4.4 Supporting and Empowering Staff delivering Health and Social Care Services

The workforce is the most valuable asset in Health and Social Care Services and can, at its best, be at the forefront of a high quality, safe and effective service. Attracting, recruiting and retaining staff continues to be an issue across a range of service areas. Recognising and valuing the contribution of the workforce, improving workforce intelligence and workforce planning will be a key theme in the *Health and Social Care Workforce Strategy 2026*[4] for Northern Ireland.

The strategy focuses on delivering on actions across ten themes:

1. Attracting, recruiting and retaining
2. Sufficient availability of high quality training and development
3. Effective workforce planning
4. Multidisciplinary and inter-professional working and training
5. Building on, consolidating and promoting health and wellbeing
6. Improved workforce communication and engagement
7. Recognising the contribution of the workforce
8. Work-life balance
9. Making it easier for the workforce to do their jobs
10. Improving workforce business intelligence

It will also be important that this is supported by systems that promote multidisciplinary training, multidisciplinary blended skill mix and attracting, recruiting and retaining enough of the right people, with the right skills into Health and Social Care.

In line with the relevant Departmental Objectives, the HSCB/PHA will support work to:

- Establish a health and social care careers service,
- Implement the domiciliary workforce review
- Develop a HSC workforce model.

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

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- Ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.
- Reduce Trust staff sick absence levels by a regional average of 5%.
- Develop an action plan to create a healthier workplace across HSC.
- Pilot an outcomes based approach to strengthen supports for the social work workforce.
- Provide Q2020 Attributes Framework Level 1 and 2 training.
- Develop and commence implementation of a training plan on suicide awareness and suicide intervention for all HSC staff.

A number of other specific areas of development are outlined below and within the programmes of care detailed in Section 5.

Delivering Care Nursing Framework (Normative Nursing)

Delivering Care is a policy framework, commissioned by the Chief Nursing Officer, Department of Health as the policy lead in Northern Ireland. The aim of the policy framework is to support the provision of high quality care which is safe and effective in hospital and community settings through the development of a series of phases to determine staff ranges for the Nursing and Midwifery workforce in a range of major specialities.

Delivering Care is a collaborative regional project led by the PHA which engages a range of stakeholders in developing, proposing, testing, implementing and monitoring nurse and midwifery staffing levels in Northern Ireland. The approach is based on best evidence and promotes a quadruple aim methodology with a focus on a population based workforce model.

The methodology for the Delivering Care Framework involves:

- Applying current evidence
- Data gathering of workforce intelligence and benchmarking nationally
- Engagement and co-production with nursing and midwifery experts and practitioners
- Robust project governance
- Department of Health policy endorsement
- Implementation and monitoring process with HSC providers.

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Currently there are eight phases underway within the Delivering Care Framework:

Phase	Service Area	Staffing Model
Phase 1	Acute Medical & Surgical Wards	Staffing range
Phase 1A	Elective Care Treatment Care Environments	Recommended range for 24/7 wards including day and short stay wards
Phase 2	Type 1 Emergency Departments	Nurse to annual attendance ratio
Phase 3	District Nursing	Population based model
Phase 4	Health Visiting	Population based model – Caseload weighting
Phase 5 5A 5B	Mental Health Acute settings Community settings	Acute – Nurse/Bed Ratio Community – Caseload and population based model
Phase 6	Neonatal Nursing	Based on level of activity
Phase 7	Primary Care Nursing	Population based model from the GPN Framework 2016
Phase 8	Independent Sector Nursing Homes - currently underway	

During 2018/19, the HSCB/PHA will continue to work with Trusts to further develop each phase in line with the Delivering Care Nursing Framework.

Enhanced role of AHPs

Allied Health Professions (AHPs) are critical to the ongoing assessment, treatment and rehabilitation of patients throughout the illness episodes whether transient or long lasting. AHPs enable children and adults to make the most of their skills and abilities and to develop and maintain healthy lifestyles. They play a crucial role in 'transitioning' patients between different care settings and across service boundaries within health services, e.g. from secondary care to primary care.

In Northern Ireland, 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

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tertiary services and in hospital outpatient settings. Specific areas for development in 2018/19 are as follows:

- ensuring that by March 2019, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional
- implementing non-medical independent prescribing for physiotherapists and podiatrists
- completing Statutory Assessment reports to the Education Authority (EA) for children with possible Special Educational Needs (SEN)
- embedding the regional podiatry led diabetic feet-care pathway
- implementing the recommendations of the DOH AHP workforce reviews and the AHP element of the Interdisciplinary Specialist Palliative care workforce review
- extending the rollout of Direct Access Physio across all Trusts
- piloting first contact physiotherapy in primary care
- developing dysphagia services
    - Develop baseline definition data to ensure patients have timely access to a full swallow assessment.
    - Design dysphagia awareness training and make available to staff in all Trusts.
    - Provision of Adult Dysphagia support teams in each Trust locality.

Enhanced role of Pharmacists

The use of medicines is the most common healthcare intervention with over 40 million prescriptions for medicines issued in primary care alone each year. The cost and complexity of medicines use has increased over the past 20 years in line with demographic changes. Those demographic changes have seen the rise in long term conditions and it is now common to see patients taking greater than ten medicines in order to manage a range of conditions. Such polypharmacy may be necessary in certain cases. However with polypharmacy, there is a need for patients, carers and healthcare professionals to know about

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the medicines that are prescribed, understand the treatment goals and monitor their effects so that positive outcomes are achieved. The need for greater management of medicines has been well recognised given the inherent risks associated with medicines treatment. To that end, there has been a shift in emphasis for the pharmacy workforce. Pharmacists are respected for their broad knowledge around medicines. The use of their skills in more patient facing roles has developed over the years and this has seen pharmacists being moved into clinical pharmacy roles including roles in which they can prescribe.

In Northern Ireland, each Trust has a designated Medicines Optimisation in Older People (MOOP) Team headed up by a consultant pharmacist. In primary care, there has been a significant development of the role of pharmacists based in GP practices. These staff undertake clinical medication review, medicines reconciliation and support more effective management of repeat prescribing. In order for pharmacists to take on these more clinical roles, there has been the development of the role of pharmacy technicians to support the dispensing function.

The introduction of dispensing robots has also supported the development of the workforce with automation replacing some of the routine dispensing tasks. For the future, it is anticipated that there will continue to be a focus on clinical pharmacy services in primary and secondary care and developing the workforce appropriately to ensure the delivery of both new clinical roles and the maintenance of safe and effective dispensing practice.

Enhanced role of nurse prescribers

A UK study (2011) [5] highlighted the growing evidence of the competency of nurse prescribers, and the need to focus more on the impact that the role may have on enhancing the quality and safety of patient care. A Review into the Impact and Status of Nurse Prescribing in Northern Ireland 2014[6] included patients'/service users' experience and impact on patients of nurse prescribers.

[5] Jones K. , Edwards M. & While A. (2011) *Nurse prescribing roles in acute care: an evaluative case study*. Journal of Advanced Nursing 67(1), 117–126. doi: 10.1111/j.1365-2648.2010.05490.x

[6] http://www.nipec.hscni.net/download/projects/previous_work/provide_adviceguidanceinformation/impact_nurseprescribing/publications/NursePrescribing-Final.pdf

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Patients were asked through an adapted questionnaire to evaluate both the benefit and the impact of the nurse prescribing role. A total of 150 responses were received from patients who were in contact with nurse prescribers from cardiology; primary care; mental health; respiratory; dermatology; acute pain clinic and through Macmillian services; smoking cessation; catheterisation laboratory; vascular and diabetes. The positive messages received were found to be similar to findings in other studies, and clearly indicated the impact on patients. The benefits include improved access to appropriate advice and medication, greater understanding and ability to self-manage.

During 2018/19 there will be a greater emphasis on enhancing the role of nurse prescribers in primary and secondary care, and additional non-medical prescribing places will be commissioned, which will also support the transformational agenda.

Multi-disciplinary working in Primary Care

Delivering Together sets out a vision for an enhanced primary care service, within a set of reformed HSC services. It highlights the need to move towards a system that seeks to deliver mental, physical and social wellbeing. Delivery of this vision requires a focus on prevention and early intervention, on population health and on activating individuals to proactively manage their own health and wellbeing. This will require a move away from a system based on GPs working largely independently with some input from other disciplines to a genuinely multi-disciplinary form of working.

During 2018/19 expressions of interest will be sought from Health and Social Care Trusts together with a local GP Federation to become a primary care Multi-Disciplinary Team (MDT) initial roll out sites. Each roll out area will receive investment in 2018/19 to deliver this different approach to primary care.

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5.0 HSC SYSTEM WIDE COMMISSIONING

The HSCB/PHA have a responsibility for assessing the needs of the population in Northern Ireland. Whilst LCGs assess the need of their locality populations, given the scale and complexity of some service areas, these are organised at a regional, system wide level. Some of the HSC wide regional commissioning planning is organised at programme of care level, by long term condition and by a regional specialist/tertiary level as set out in Section 5. Strategic planning organised across the HSC allows planning to be equitable and where possible, standardised across HSC providers. LCGs are integral to this HSC wide strategic planning to ensure the needs of their local population are addressed.

HSC Strategic planning embeds co-production with service providers and service users at a macro level. This planning also seeks input from a range of community and voluntary organisations, primary and secondary care and will utilise LCG networks, where required to agree service models. It is recognised that a broad range of individuals and teams collaborate in the commissioning and achievement of specific priorities within the Plan. Each priority is located under the programme of care to which it is most closely aligned. To avoid duplication, priorities are reflected once in the Plan, either locally or regionally.

Commissioning priorities for 2018/19 are listed under the following headings:

Service Area	Pg.	Service Area	Pg.
Unscheduled Care	78	Family Practitioner Services	113
Elective Care	81	Specialist Services	125
Maternity and Child Health	86	Cancer Services	131
Family and Childcare Services	92	Long Term Conditions	135
Care of the Elderly	98	Sexual Health	150
Mental Health Services	102	Palliative and End of Life Care	154
Learning Disability	107	Prisoner Health	157
Physical Disability	110	NI Ambulance Service	160

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5.1 Unscheduled Care Services

Service Context

The delivery of safe and effective unscheduled care remains a challenge for commissioners and providers. In the last five years the overall number of Emergency Department (ED) attendances has increased by 24%, and improving performance as well as the patient experience remains a priority for the HSCB/PHA and it will continue to work with Trusts under the regional unscheduled care arrangements, jointly led by the HSCB/PHA to take forward this work in 2018/19.

Service Challenges in 2018/19

During 2018/19 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 unscheduled care services.

There are particular and growing pressures in the provision of unscheduled care along the patient pathway from attendance at ED through to discharge into the community. The drivers for change include demographic changes and the ageing population; workforce pressures within nursing and domiciliary care; challenges sustaining the current service delivery model and patient expectations.

Achievement of Departmental Targets

The main challenges relate to the achievement of the 2, 4 and 12 hour ED standards. The HSCB/PHA will continue to work with Trusts through the established local and regional groups in place to embed and further develop services that avoid ED attendances, provide alternatives to admission to hospital, provide care in the community and take forward the unscheduled care agenda during 2018/19.

Areas for development in 2018/19

During 2018/19 and beyond, the HSCB/PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to services for unscheduled care. The

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HSCB/PHA will continue to deliver the Neurology Modernisation Agenda, developing new pathways and capacity across primary and secondary care.

The HSCB/PHA will also commission alternatives to reduce ED attendance for patients with conditions / symptoms that can be appropriately managed elsewhere.

Specific areas for development in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to enhance a therapeutic frontline home based intermediate care team, responding rapidly and with a focus on recovery, independence and patient experience.	Trust responses should demonstrate plans to deliver rapid response with professional review at home by a member of the team within 4 hours, bed days saved, re-admission avoidance & admission avoidance.
2.	Effective arrangements should be in place to ensure availability of a regional Outpatient Parenteral Antibiotic Therapy project	Trust responses should demonstrate how the service will enhance the governance and stewardship of intravenous antibiotic prescriptions and reduce the number prescribed, as well as reduce the number of patients waiting in hospital be discharged on appropriate IV antibiotics.
3.	Effective arrangements should be in place to build on the 7 day working for Physiotherapists, Occupational Therapists, Pharmacists and Social Workers in base wards building on the 2014 paper "Improving Patient Flow in HSC Services".	Trust responses should demonstrate a reduction in time from referral to / request for AHP support to first contact; a reduction in patients declared as a complex delay over 48 hours; increased AHP contacts at weekends and over holiday periods.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to ensure Trusts have in place local arrangements for site co-ordination / control room to manage patient flow.	Trust responses should demonstrate a sustainable robust rota over 7 days, 365 days of the year that provides a single point of contact for system control.

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5.	Effective arrangements should be in place to provide Acute / Enhanced Care at Home that provides active treatment by health care professionals in the persons own home for a condition that would otherwise require acute hospital in-patient care.	Trust responses should demonstrate how, working with appropriate partners Acute / Enhanced Care at Home services will be made available 24/7 and linkages to core primary / community care teams and NIAS.
6.	Effective arrangements should be in place to provide care to seriously injured patients at a regional Major Trauma Centre with the aim of increasing survival following major trauma and reducing the incidence of long-term disability from injuries.	Trust responses should demonstrate how arrangements will be put into place to provide a consultant-led service for the care and coordination of patients including rapid access to specialist services related to trauma.
7.	Effective arrangements should be in place to ensure patients receive access to rehabilitation services to maximise their recovery following major trauma.	Trust responses should demonstrate how patient care will be enhanced by arrangements for AHP resources to support timely access to rehabilitation services in acute and general care settings.
8.	Effective arrangements should be in place to ensure Trusts are able to respond to major trauma in their local Emergency Department as part of a regional Major Trauma Network.	Trust responses should demonstrate how processes will be implemented to alert local Trust trauma teams to respond to major trauma calls and ensure teams have adequate and up to date training. Process should also include 'call and send' for patient requiring onward transfer to the Major Trauma Centre.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to increase the number of unscheduled care patients managed on ambulatory pathways avoiding the need to be admitted to hospital	Trust responses should demonstrate the ambulatory care pathways prioritised for implementation / enhancement in 2018/19 plans for same day / next day referrals to services as well as direct GP access for patient management advice.

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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 Northern Ireland. Until mid-2014, a programme of planned recurrent and non-recurrent investments had the effect of reducing outpatient, diagnostic, inpatient and day case waits, however the challenging financial position and underperformance since then has resulted in a deterioration in waiting times.

In March 2018, the DoH announced that resources would be targeted towards stabilising current hospital waiting lists. Consistent with the approach in 2017/18, this funding will be targeted at those patients with the highest clinical priority in the first instance and thereafter to assess/treat the longest waiting routine patients.

While non-recurrent funding enables Trusts to undertake additional activity, benefits large numbers of patients and reduces waiting lists in the short term, this approach does not provide a sustainable solution. The long-term solution is to reform elective care services to meet current and future demand through the transformation of secondary, primary and community care services as set out in the DoH's Elective Care Plan published in 2017. Since its publication, a number of initiatives have been taken forward consistent with the direction of travel set out in the Plan as outlined in the Department's one-year Elective Care Progress Report published in February 2018.

While this work has been supported by limited additional funding, it nonetheless provides a strong foundation for further reform and transformation. It is recognised that long-term sustainability will be achieved only through radical change, supported by investment. In this context, the HSCB/PHA will continue to work with Trusts, Integrated Care Partnerships and GP Federations to further develop and implement plans to reform and modernise elective care services consistent with the commitments set out in the Elective Care Plan.

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In parallel, the DoH led working group is taking forward the establishment of elective care centres, for varicose veins and cataract surgery in the first instance.

It is important to note that the planned Transformation, Reform and Modernisation agenda will take several years to deliver across all specialties. In parallel, there will be a continued need for substantial non-recurrent funding to reduce the backlog of patients waiting.

Service Challenges in 2018/19

A growing elderly population, increasing patient expectations and advances in medicine and technology, coupled with the current recruitment and retention challenges will have a direct impact on service delivery in 2018/19.

Achievement of Departmental Targets

The HSCB plans to further invest, subject to the availability of funding, in both core service and waiting list initiatives to reduce waiting times and deliver sustainably shorter waiting times by ensuring capacity is sufficient to meet demand. 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 day case treatment. Additional inpatient beds, theatres and scanning equipment, supported by consultants, nursing, imaging, AHP and other clinic staff will be required to meet the current capacity gaps.

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.

Areas for development in 2018/19

During 2018/19 and beyond, the HSCB/PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to services for elective care.

One such development includes the progression of elective treatment centres across the HSC to improve access to day case procedures, improving patient experience and outcomes, whilst reducing existing waiting times.

The Department has recently indicated its intention to proceed with a regional programme of Pathology Transformation, the key elements of which are to:

- establish a regional management structure for Pathology services, including the Northern Ireland Blood Transfusion Service;
- continue to replace LIMS and blood production / tracking systems; and
- build on the existing programme of work in Northern Ireland Pathology Network Plan.

Specific areas for development in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to establish a regional programme of pathology transformation.	Trust responses should demonstrate how they are supporting delivery of regional pathology transformation programme objectives, which are broadly as follows: • To enable managerial reform, including necessary regional standardisation; • To ensure future workforce & service sustainability; • To further develop the quality, performance & regulatory framework for pathology; • To develop a strategy for Pathology to support delivery of effective clinical services; • To procure & implement replacement regional LIMS, blood production and tracking systems, and an interim digital pathology solution.
2.	Effective arrangements should be in place to make the best use of resources in surgical and related specialties.	Trusts should demonstrate plans to ensure that existing effective use of resources guidance is being adhered to. Trust should also provide plans, subject to consultation, on the proposed expansion of this guidance in 2018/19.

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Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	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: • Minor Surgery • Gastroenterology • ENT • Gynaecology • Dermatology • Dermatology Photo Triage • Rheumatology • MSK/Pain Management • Trauma & Orthopaedics • Cardiology • Neurology • Urology • Ophthalmology • Vascular surgery • Vasectomy
4.	Effective arrangements should be in place at the interface between primary and secondary care, organised around the needs of patients with effective communication between GPs and 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. Actions should improve the efficiency and effectiveness of outpatients, diagnostics and treatment services in line with the Transformation, Reform and Modernisation agenda, which includes partnership working with ICPs.
5.	Effective arrangements should be in place to ensure the regional priorities for Endometriosis and vaginal mesh services are implemented by Trusts.	Trust response should detail plans that complement the regional strategic direction for both endometriosis and vaginal mesh services.

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Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
6.	Effective arrangements should be in place to improve further the efficiency and effectiveness of elective care services (outpatients, diagnostics and inpatients/day case treatment) delivered by Trusts.	Trust responses should demonstrate the specific actions being taken in 2018/19, working with appropriate partners, to improve elective care efficiency and effectiveness including: • Development of one stop 'see and treat' services, linked to unscheduled care services as appropriate • The rollout and uptake of e triage to help streamline the patient pathway • Application of Transforming Cancer Follow Up principles to transform review pathways • Maximisation of skill mix opportunities in the delivery of assessment, diagnostic and treatment services • Direct access diagnostic pathways to improve patient access to appropriate tests.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to ensure the appropriate volume and case mix of staff are in place to deliver the agreed strategic priorities	Trust responses should demonstrate that all reasonable steps have been taken to fill all vacant posts and where clinically appropriate maximise the use of available skill mix

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5.3 Maternity and Child Health

Service Context

The Maternity Strategy 2012-2018 sets the context for the delivery of maternity services across Northern Ireland, promoting improvements in care and outcomes for women and babies from pre-conception through to the postnatal period. The HSCB/PHA will continue to take forward the recommendations of the RQIA review into the implementation of the Maternity Strategy.

The HSCB/PHA have recently completed a review of neonatal services. It will be used to inform the future planning of safe, high quality, sustainable neonatal services for the population.

The Department has launched two new strategies: *A Strategy for Paediatric Healthcare Services Provided in Hospitals and in the Community 2016-2026* and *A Strategy for Children's Palliative and End of Life Care 2016-26.*

The Paediatric Strategy focuses on acute hospital services (both generalist and specialist), the management of transition of such services into adult services and the interface between hospital and community services. It is recognised that the majority of children and young people are, and will continue to be, treated in the community, usually by GPs and other primary care professionals such as children's nurses, midwives, health visitors, social workers, allied health professionals, community pharmacists and general dental practitioners. There is a clear association between the start a child gets in life and their future health and wellbeing. As such, the links between the Paediatric Strategy and the Strategy for Maternity Care 2012-18 are recognised and promoted.

The Paediatric Palliative Care Strategy sets the strategic direction for the palliative and end of life care with the aim of improving the existing care and support for children and young people with life-limiting or life-threatening conditions, as well as their families. It focuses on the enhancement of the child's quality of life and support for the family and includes also symptom management, provision of short breaks and care through death and

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bereavement. Children's palliative care is different to adult palliative care as children often need to be cared for over extended periods of time. Each year around 150 children in Northern Ireland with life limiting or life threatening conditions pass away.

The HSCB/PHA will progress the implementation of the recommendations contained within these strategies.

Northern Ireland has higher rates of congenital anomaly than many other areas across the UK in part due to differences in the legal framework around terminations of pregnancy. When perinatal mortality rates are corrected to take this into account, Northern Ireland's rates are currently in line with those experienced elsewhere in the UK.

Service Challenges in 2018/19

In maternity services, while the number of births has largely remained static, the increasing social and medical complexity of mothers has been a challenge for the service. With a continuing rise in the number of women with diabetes and other long term conditions and the impact also of more mothers with high BMI rates, multiple pregnancies and older mothers, services and staff have been challenged.

Furthermore, workforce challenges continue in midwifery with vacancies across all Trusts. The lack of funding for additional maternity support workers who could work alongside and support midwives and mothers has made those challenges more acute.

Areas for development in 2018/19

During 2018/19 the HSCB/PHA, working through the existing regional structures, will continue to seek to improve the patient experience in relation to maternity, neonatal, paediatric and child health services.

Specific areas for development in 2018/19 are as follows:

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Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that appropriate pre-conceptual advice and care is available to women at low and higher risk to ensure women are supported to be as healthy as possible at the time of conception to improve outcomes for mother and baby.	Trusts should work with the HSCB, PHA and other partners through the maternity strategy implementation group to develop population based approaches and pre-conceptual pathways for women who may become pregnant.
2.	Effective arrangements should be in place to ensure that care is provided as close to home as possible with children only being transferred to the regional children's hospital for a tertiary service which is not provided locally.	Trust responses should describe arrangements for primary care to access senior decision makers and how same day and next day assessment is facilitated. Trusts should continue to work with the HSCB/PHA to develop and test models of care which reduce the reliance on in-patient and secondary care paediatric services. Trust responses should demonstrate how they will work through the developing Child Health Partnership and the existing Critical Care Network to develop pathways of care and ensure they can safely provide a range of interventions including high flow oxygen for children in line with the regional pathway being developed.
3.	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. Assurance should be provided on the collection of data to facilitate the regional outcome focused dashboards developed for maternity and neonatal care under the Maternity Collaborative and Neonatal network.
4.	Effective arrangements are in place to support multidisciplinary learning and service improvement through regular multi-disciplinary morbidity and mortality review.	Trust responses should evidence how they are taking forward Departmental direction to implement a child death process which is based on multi-disciplinary mortality review. Trust responses should detail how

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		the multi-disciplinary aspect of this is being developed.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to ensure that the agreed regional antenatal care pathway is delivered. This pathway, developed by the Maternity Strategy Implementation Group, is designed to promote a healthy pregnancy and improve outcomes for mothers and babies – including a reduction in low birth weight – through a range of actions including reducing smoking and high quality antenatal care.	Trust responses should demonstrate how they will implement the agreed regional care pathway for antenatal care for women with low risk pregnancies. Responses should evidence how they are taking forward antenatal group-based care and education. Responses should also evidence that Trusts are implementing UNICEF Baby Friendly Initiative Standards.
6.	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.	Trusts should also demonstrate how they will deliver services to meet the needs of more complex pregnancies. Responses should evidence: • Recent investment in ante-natal diabetic services. • Plans to implement the 'Weigh to a Healthy Pregnancy' programme targeting women with a BMI of >40. • Progress in implementing the NICE guidelines on multiple pregnancies, including the delivery of dedicated 'twin clinics'. • Plans to implement the regional care pathway for women with epilepsy.
7.	Effective arrangements should be in place to offer early pregnancy assessment pathways for women.	Trusts should continue to work with the HSCB/PHA on the development and implementation of early pregnancy assessment pathways based on NICE guidelines.
8.	Effective arrangements should be in place to offer short stay assessment and ambulatory models of care in all paediatric units. These should be available during times of peak	Trusts should provide direct access to senior decision makers to support primary care in the management of acutely unwell children. Trusts should have arrangements for same day and next day assessment of

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	demand.	children where this is deemed appropriate
9.	Effective arrangements should be in place to ensure that there is appropriate monitoring of transfers to the RoI that take place because of capacity constraints.	Trust should put in place effective processes to monitor the number and care pathway for in-utero and ex-utero transfers from NI to the RoI that take place due to lack of local neonatal capacity. Data collected should be collated regionally and reviewed jointly by the Maternity Collaborative and the Neonatal Network.
10.	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 being deployed and how they will ensure that the input will focus on neurodevelopment and nutritional support.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
11.	Effective arrangements should be in place to care for women who have recurrent miscarriages	Trusts should continue to work with the PHA and HSCB to standardise and implement an agreed clinical pathway for women who have recurrent miscarriage.
12.	Effective arrangements should be in place to ensure children and young people receive age appropriate care up to their 16th birthday.	Trust responses should demonstrate that their paediatric services can accommodate children up to their 16th birthday. Trust responses should also demonstrate how they ensure that children's care is supported by all specialties and support services required to provide high quality and safe care only transferring to the regional centre to access a tertiary service. 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.

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13.	Effective arrangements should be in place to ensure that mothers and babies are not separated unless there is a clinical reason to do so.	Trusts should demonstrate how antenatal, postnatal and neonatal services aim to prevent avoidable admissions to neonatal units and paediatric services. Whilst funding has not been identified, Trusts should continue to work with PHA and HSCB to scope out the requirement for transitional care and outreach services.

Skill Mix/Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
14.	There would be an opportunity to enhance skill mix further with the appointment of additional maternity support workers to work alongside midwives to support mothers	Trusts should demonstrate plans to work with PHA and HSCB to scope out the requirement for additional maternity support workers and how they could be best utilised to support services.

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5.4 Family and Childcare Services

Service Context

The Child and Family Care Programme is a 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. This will be supported by the delivery of the Children & Young People's Developmental & Emotional Wellbeing Framework.

Regional and Trust based care placement services are integral to meeting need and the provision of care and accommodation to children and young people who become subject to care arrangements under the Children (Northern Ireland) Order 1995.

At March 2018 there were 3,109 children in the care of Trusts (5.3% in residential children's homes and 78.8% in kinship and non-kinship foster care). On occasions and based on assessed needs and risk a small number of children are placed in regional specialist facilities or in placements outside of the jurisdiction.

Service Challenges in 2018/19

The number of children in care is steadily increasing year on year. Placement capacity to respond effectively to increasing demand is evident across all Trusts. A key challenge going forward is to meet the increasing need for appropriate placements that will effectively meet the increasingly complex needs of children who require a care placement

The HSCB, and in particular the Social Services directorate, will continue to work with Trusts to discharge a number of Statutory Functions including

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Safeguarding. During 2018/19, the reporting arrangements for these Delegated Statutory Functions will be reviewed.

Achievement of Departmental Targets
The increasing demand for Child and Adolescent Mental Health Services (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.

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 in actively reviewing and redesigning the regional facilities and promoting residential care structures. Trusts will also complete the Review of UNOCINI which the DoH will lead on as part of the roll out of the implementation of Signs of Safety Framework.

Areas for development in 2018/19
During 2017/18 and beyond, the HSCB/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. The Signs of Safety Framework will be part of this improvement process into 2018/19.

Implementation of the recommendations of the review of regional services for children and young people is an immediate requirement which will be paralleled with progressing the priorities identified for mainstream care placement services. Funding available through the Transformation Funding will be invested to progress transformative change and test innovative and alternative models and approaches and assess their impact. The HSCB will be

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closely involved in leading on aspects of these developments alongside Trusts, DoH and other key partners.

Specific issues and opportunities in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to implement the Managed Care Network for Children and Young People with Acute and High Intensity Care Needs as recommended by the independent review into CAMHS Inpatient Services	Trust responses should demonstrate plans to contribute to the development and establishment of a Managed Care Network for Acute CAMHS which includes Secure Care, Youth Justice and Forensic CAMHS to deliver a more consistent service across the region and equitable access to acute services.
2.	Effective arrangements should be in place to prevent the increasing threat of Child Sexual Exploitation (CSE) as identified by the Marshall Inquiry.	Trust responses should detail their reporting arrangements to the HSCB in relation to the regional action plan.
3.	Effective arrangements should be in place to safeguard children and promote their welfare in line with Co-operating to Safeguard Children (2017).	Trust responses should demonstrate plans to • provide effective safeguarding services • ensure robust HSC child protection processes are in place • ensure safeguarding policy and procedures are in place relating to referrals, assessment, service planning, case management and record keeping • monitor and audit effectiveness of policy, practice and service provision in achieving specified outcomes for children and young people. • to ensure access to an effective range of therapeutic supports based on assessed needs.
4.	Effective arrangements should be in place to improve data collection in CAMHS services to capture need, demand activity, outcomes and service user experience.	Trust responses should demonstrate how they will use information to assess the effectiveness of CAMHS and evaluate outcomes, fully implement CAPA and ensure effective case management in line with NICE guidance. Trusts responses should demonstrate plans to strengthen NICE approved Psychological Therapies to include a skills analysis and workforce plan to identify gaps in the delivery of evidenced based therapies and skill mix

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		requirements to deliver a range of therapeutic interventions. Trusts should demonstrate how the findings from the Sensemaker Audit on service user experience of CAMHS will drive any required service improvements.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to appropriately manage the increasing number of children with complex health care needs and challenging behaviour.	Trust responses should demonstrate how service provision will meet the needs of children with complex health care needs and challenging behaviour.
6.	Effective arrangements should be in place to appropriately manage the increasing number of Looked After Children (LAC) entering the system.	Trust responses should demonstrate how: • criteria will be set to ensure children become looked after where there is a clear indication that their long term outcomes will be improved or removal is required in order to safeguard the child/young person; • 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 2018/19 will be delivered.

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7.	Effective arrangements should be in place to ensure the stability of mainstream care placement arrangements for children in care	Trust responses should demonstrate a reduction in unplanned care placement moves for children in care and use of effective interventions to deescalate crisis and prevent moves for children in care, particularly into high end regional facilities
8.	Effective arrangements should be in place to appropriately manage the increasing number of unplanned/emergency placements where children are known to a Trust.	Trust 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.
9.	Effective arrangements should be in place to ensure a seamless care pathway for LAC which promotes stability and permanency for children.	Trust responses should demonstrate how effective arrangements are in place to ensure a stable care pathway for LAC (where placement moves are kept to an absolute minimum) and to deliver permanency for them within the quickest possible timeframe. Trusts should have effective arrangements and monitoring should be put in place to ensure LAC have plans for and can achieve permanence in line with the agreed policy. Trusts should also report on challenges to achieve these and plans to address these.
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, the child and young person's views about their care plan, what is expected from parents in order for the child to return home and the anticipated duration of the placement.	Trust 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. This assessment should outline how the child/young person's views have been taken into account in agreeing the care plan.
11.	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 care, 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.

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Transforming Services

	ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
12.	Effective arrangements should be in place to meet the increasing demand for Autism Services to include the creation of an integrated care system for Children, Young People with Developmental, Emotional and Mental Health services.	Trust responses should demonstrate plans to address autism waiting lists in line with the Autism Access Standard and support the development of an integrated service model to include assessment, early intervention, diagnostic and transitional services.
13.	Effective arrangements should be in place to manage the increasing demand in CAMHS and the continued implementation of the stepped care model focusing on: improvement of the interfaces between acute and CAMHS community care including secure care and Youth Justice; integration of CAMHS and children's neurodevelopmental (autism and ADHD) provision.	Trust should demonstrate plans to: • Demonstrate the management of service demand • Improve interface arrangements between CAMHS acute and community care, secure care and with Youth Justice • Integrate CAMHS, Autism and ADHD services to ensure effective access based on assessed needs to children, young people and their families • Ensure implementation of the CAMHS Integrated Care Pathway (March 2018)

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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. Although 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.

Service Challenges in 2018/19

- Supporting the development of services and care pathways for older people to better enable them to live full and independent lives in the community.
- Ensuring the achievements of the Dementia Strategy are resourced and further embedded into Trust services as a best practice model.
- Improving patient flow within the acute sector - addressing avoidable discharge delay issues.
- Working with the independent care home and domiciliary care sector to ensure the market has the flexibility and capacity to respond to increasing demands for service.
- Ensuring the required workforce expertise and skill mix are available to support the new models of care and support developed as part of the reform of adult social care agenda.
- Cascade peer education/self- protection programmes such as “Keeping Yourself Safe” or equivalent training for Adults at Risk of Harm across services and settings.

Areas of development in 2018/19

During 2018/19 and beyond, the HSCB/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 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure the implementation of requirements contained in Adult Safeguarding and Protection in Partnership (2015).	Trust responses should demonstrate plans to promote the development of the Adult Protection Gateway model.
2.	Effective arrangements should be in place to 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.
3.	Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with dementia.	Trust responses should outline plans to work with ICPs to implement the New Stepped Care Model for Older People and for people with dementia.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	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.
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 ensure capacity within the community /domiciliary sector to accommodate timely hospital discharge.
6.	Effective arrangements should be in place to support services for carers that can be	Trust responses should demonstrate plans to expand and promote the assessment of needs

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	developed to maintain individuals to live as independently as possible in their own home.	and the availability and uptake of short breaks.
7.	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.
8.	Effective arrangements should be in place to support the full implementation of the regional model of reablement.	Trust responses should demonstrate a review of local progress with reablement, in line with the regional model and targets.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to optimise recent demography funding to meet domiciliary care demand and wider demographic demand.	Trust responses should demonstrate plans to deliver the recent investment in demography to meet the needs of the aging population.
10.	Effective arrangements should be in place to optimise capacity to support the numbers of people aged over 65 and over 85 which are projected to increase by 12% and 22% by 2022 respectively, to maintain healthy lifestyles.	Trust responses should demonstrate plans to actively promote a range of healthy ageing initiatives in areas such as promoting good nutrition, social inclusion and falls prevention.
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.	Trust responses should demonstrate a commitment to remain engaged with both the current reform of statutory residential care, domiciliary care and the Reform of Adult Social Care. These projects are seeking the most appropriate balance and focus of statutory/independent sector domiciliary and social 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 developing new services to increase availability of these services.

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Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
13.	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 deliver progress with the regional project implementation targets to optimise opportunities for services tailored to user needs and include the training and development needs of staff.

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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.

It is anticipated that resources will be made available for mental health services. Whilst this will not address the underlying demand / capacity gap within core and specialist mental health services it will enable a number of key service improvement projects and the testing of prototype innovative services supporting peer led recovery and relapse prevention.

Further funding will be made available to ensure the appropriate treatment and care of people with mental health conditions in the acute hospital setting through the roll out of the rapid assessment, interface and discharge (RAID) services.

Service Challenges 2018/19

It is anticipated that the trend of increased demand for services to treat substance misuse and associated health problems will continue; therefore work to review and streamline these services to meet future demand is scheduled for 2018/19. Mental health services have also been challenged with increasing delays in achieving discharges from hospital in a timely manner. This is largely due to insufficient housing options and community infrastructure to support people who require long term support to achieve recovery. The HSCB/PHA will continue to work with Northern Ireland Housing Executive

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(NIHE) partners to try to address the former, and investment in community based rehabilitation services will be prioritised for any investment received.

Demand for treatment of common mental health problems has also risen. Support for GP practices and community and voluntary sector partners providing treatment and support for these conditions will also be addressed.

Achievement of Departmental Targets

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. This is likely to result in significant numbers continuing to wait longer than 13 weeks, particularly in adult mental health services. Growing demand for core and specialist mental health and addictions services, alongside the funding gap noted above, is also likely to impact negatively on people having to wait longer than 9 weeks for a routine appointment, and the discharge from hospital target of within 7 days of being declared medically fit. This is being further compounded by cuts to funding in other sectors such as housing.

The HSCB/PHA will continue to work with Trusts to identify opportunities to address this position, including plans to strengthen the range and scope of psychological therapies in line with the *Strategy For The Development Of Psychological Therapy Services (2010)*, 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.

The HSCB will also continue to highlight areas of service pressures within core and specialist mental health services and invest in enhancing the capacity of these services if resources allow.

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Areas of development in 2018/19

During 2018/19 and beyond, the HSCB/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 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to improve the physical health care of people with serious mental illness	Trusts responses should demonstrate how they will develop medical monitoring and physical health care support for people undergoing treatment for an eating disorder. The Trust should also demonstrate how they are supporting people with long term mental health conditions to support their physical health outcomes.
2.	Effective arrangements should be in place to provide evidence of the impact on 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.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
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 2018/19 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.

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4.	Effective arrangements should be in place to improve the effectiveness of Acute Inpatient Services through the provision of modern therapeutically focused inpatient care to safeguard those people who are experiencing acute mental health needs	Trusts should participate proactively in the review of acute mental health care pathway to ensure regional consistency with best practice benchmarks and standards.
5.	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.	Trusts should support the development of peer led self-sustaining relapse prevention groups and family carer support groups

Transforming Services

	ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
6.	Ensure the effective provision of community based Addiction services to address growing demand, including opiate substitute prescribing (Tier 3). Likewise, in-patient and residential rehabilitation services (Tier 4A & 4B) must be provided within a regional Network arrangement accessible by all Trusts.	Trusts should participate in the planned review of community based Addiction services, the outcome of which should be to ensure that a more effective service provision model is in place given increasing demand (this will include exploring the potential for service coordination regionally). A key focus will be the future design of opiate substitute prescribing services (encompassing appropriate harm reduction measures). Additional investment, being deployed promptly, should be evidenced through increased service activity and reduced waiting times.

Skill Mix/ Workforce

	ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to support the new Regional Mental Health Trauma Network.	Trust responses should demonstrate plans to support and participate in the development and implementation of the Network.

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8.	Effective arrangements should be in place to support the new Forensic Managed Care Network.	Trust responses should demonstrate plans to support the development and implementation of the Network including: • advancing training and education of the forensic workforce • research and quality improvement, • improving interagency collaboration and learning from clinical practice
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 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 releasing core mental health staff to avail of training opportunities to develop skills in various modalities of psychological therapies and improve psychological approaches underpinning mental health treatment.

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5.7 Learning Disability

Service Context

The number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in Northern Ireland. A 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 Northern Ireland continue to provide the bulk of care and support which people need.

Service Challenges in 2018/19

The success of better health and social care is that people with learning disabilities are increasingly living into older age. The service challenges arising from this is ensuring that services designed to meet the needs of older people (including dementia services) are accessible and appropriate for people with a learning disability. The trend also means that there are increasing numbers of older, frailer family carers. Therefore supporting family carers will continue to be a priority.

Transitioning individuals from children's services into adult services continues to be a challenge.

Areas of development in 2018/19

During 2018/19 and beyond, the HSCB/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. To this end the HSCB/PHA will work with stakeholders to develop a new regionally agreed service model for people with learning disabilities based on the Bamford principles of integration and empowerment. Specific issues and opportunities in 2018/19 are as follows:

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Strategic Priorities

	ISSUES/OPPORTUNITIES	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 to increase the number of Day Opportunity placements in partnership 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 complete the resettlement of people from learning disability hospitals to appropriate places in the community.	BHSCT, NHSCT and SEHSCT 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.

Patient Pathways

	ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
3.	Effective arrangements should be place to improve physical health care for people with a learning disability.	Trusts should continue to ensure key information gathered through the annual health check initiative is collated, analysed and shared. Trusts should participate in the evaluation of the “health passport” for people with a learning disability. Trusts should continue to support people with a learning disability to access mainstream health screening initiatives.
4.	Effective arrangements should be in place to appropriately manage people with a learning disability 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.
5.	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.

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Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
6.	HSCB & PHA will work with people who use services, their families, Trusts and other stakeholders to develop a regionally consistent service model for people with a learning disability and costed implementation plan.	Trust responses should demonstrate plans to work collaboratively with service users and to develop a new NI service model for learning disability services and costed implementation plan.

5.8 Physical Disability and Sensory Impairment

Service Context

Work continues to implement the DoH 2012-2015/18 Physical and Sensory Disability Strategy and Action Plan which was the first major strategy of its type for this service area. This strategy is due to conclude on 30 September 2018.

Physical and Sensory Disability caters for people with congenital disabilities through to those who acquire disability as a result of trauma or chronic degenerative and possibly life limiting conditions. There are many Physical and Sensory Disability service users with co-complexities which requires services to work together e.g. people with neurological conditions, Motor Neurone Disease, Muscular Dystrophy, Huntington's Disease etc. This population is impacted on by numerous strategies e.g. rare diseases, palliative care etc. and there remains a lack of synergy within the HSC system to empower people with PSD to live their lives as independently as possible.

Service Challenges in 2018/19

The following challenges are ongoing for people with PSD:

- Corporate ownership of Access to Health and Social Care for people with PSD in its widest sense.
- Need for HSC staff training to understand the disparate needs of people with physical and /or sensory disabilities.
- Transition between traditional POCs particularly for many adults approaching the age threshold for Older People's services.
- Trusts continue to highlight the need of age appropriate accommodation/care facilities.
- Independent living for people who require a mobility aid, such as a wheelchair, requires swift access to AHP services.
- Accessible accommodation.
- Access and control of support services.
- Adaptive and/or assistive technologies.

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Areas of development in 2018/19

During 2018/19 and beyond, the HSCB/PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to PSD impairment services.

Specific issues and opportunities in 2018/19 are as follows:

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure the seamless transition of people with Physical and/ or Sensory Disability from children's services to adult services and from adult services to Older People's services.	Trust responses should demonstrate plans that ensure seamless transition for people with Physical and Sensory Disability who are approaching age thresholds for Adult services and Older People's services.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to develop a Physical and Sensory Disability structure/ network which facilitates regional, multi-agency strategic planning for the needs of people with Physical and/ or Sensory Disability.	Trust responses should demonstrate equitable access to Health and Social Care for people with Physical and Sensory Disability including: **Access** • Trusts to ensure people with Sensory loss/ Disability are empowered to access HSC services (i.e. statutory HSC services and services provided by Community & Voluntary / Independent sectors). • Trusts should ensure communication with people with sensory loss is in an accessible format to include appointments, access to interpreting, signage and access to healthcare information **Buildings** • Trusts should ensure all HSC facilities have visual display units and hearing loops which are working and ensure HSC staff are fully trained in use.

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		• Signage in HSC facilities should meet HSC accessibility standards. **Equipment** • Trusts should ensure equitable access to equipment (including adaptive/ assistive technologies) and accessible, age appropriate accommodation/ care facilities for people with Physical and/or Sensory Disability.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Trusts and Arm's Length Bodies should have effective arrangements in place to ensure staff are trained to understand the disparate needs of people with Physical and/or Sensory Disability.	Trust responses should demonstrate plans to ensure all HSC staff including HSC provider staff in Community & Voluntary / Independent sectors receive mandatory disability training.

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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

In Northern Ireland around 1.9 million patients are registered with approximately 336 GP practices. General Practice is often the first point of contact with the health and care system, GPs often manage patients' care needs but are also the gateway for appropriate referral to secondary care. As the population ages and as people live longer with complex health needs, the demand on GP services increases.

Service Challenges in 2018/19

During 2018/19 and beyond, the HSCB working closely with General Practitioners will continue to seek to ensure the provision of safe and effective general medical services.

Achievement of Departmental Targets

Work will continue to increase the number of available appointments in GP practices across Northern Ireland. However, the increasing demand combined with workforce issues require further collaborative work through:

- GP practices supported by other professions including nurses, pharmacists, physiotherapists and social workers working as multi-disciplinary teams.
- GP practices working together as Federations.
- GPs contributing to wider healthcare plans as part of Integrated Care Partnerships.

Areas of development in 2018/19

During 2018/19 and beyond, the HSCB/PHA working through the existing structures will continue to seek to improve the availability, accessibility and patient experience in relation to general medical services. The head of GMS service will lead and support the local implementation of 'Making Every Contact Count'.

"Making Every Contact Count" (MECC) is an approach to behaviour change that uses the thousands of day-to-day interactions that health professionals have with clients to support them in making positive changes to their health and wellbeing. It recognises that staff across health care organisations and the community and voluntary sector are ideally placed to utilise these opportunities both to encourage people to change their behaviour and direct them to local services that can support them.

MECC aligns with and enhances implementation of the two key overarching frameworks– *Health and Wellbeing 2026: Delivering Together* and *Making Life Better 2013-2023* – and has also been identified as a supporting action for the *Programme for Government Delivery Plan.*

Specific areas for development in 2018/19 are as follows:

Strategic Priorities

	ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure multi-disciplinary teams are embedded within Primary Care.	Participating Trusts and Federations should demonstrate plans for a new primary care MDT model, which will include;

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		• practice based social workers • increased nursing and health visitor capacity • practice based first contact physiotherapists and • practice based mental health support
2.	Effective arrangements should be in place to ensure the implementation of Phase 7 Delivering Care (Practice Nursing Workforce).	Federations should demonstrate plans to receive additional nursing staff as part of the recommendation of the review of the general practice nursing workforce and training profiles. An additional 16 places will be commissioned for Advanced Nurse Practitioners in Primary Care.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Effective arrangements should be in place to ensure that patients with Palliative and End of Life Care needs are identified.	Integrated Care should demonstrate plans to implement a New Enhanced service to support practices to identify patients with potential palliative care needs and ensure appropriate support is put in place.
4.	Effective arrangements should be in place to provide proactive care planning for patients with complex needs	Integrated Care should demonstrate plans to implement an enhanced service for the proactive management of the care needs of patients with chronic conditions including individual care plans and appropriate referral for secondary care and social support.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to ensure an appropriate interface between GP day time and out of hours services.	Integrated Care should demonstrate plans to develop an innovative enhanced service to manage demand for Urgent Care in General Practice. This is an opportunity for GPs to develop and test new ways of working with the initial focus on managing demand for urgent care in the late afternoon/early evening.

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6.	Effective arrangements should be in place to introduce the Key Information Summary across GP Practices	Integrated Care should demonstrate plans to implement an enhanced service to introduce GP Practices to the concept of the Key Information Summary which is a summary of medical history and patient wishes. This information being available in unscheduled care will provide accurate information and result in improved continuity of care for the patient.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to ensure there are an appropriate number of training places available.	Integrated Care in partnership with NIMDTA should demonstrate plans to facilitate a further increase in GP training places to 111 places in 2018/19.
8.	Effective arrangements should be in place to encourage the retention of GPs in Northern Ireland.	Integrated Care should demonstrate plans to implement the GP Retainer scheme which is popular with both participating GPs and practices alike. It was designed to assist in the retention of GPs in primary care in NI and has been very successful in helping to encourage sessional doctors to take up substantive posts in practices, building long term sustainability in the workforce. 2018/19 should see the rollout of a further 25 places under this scheme. These places will be targeted at GPs thinking of leaving practice or retiring. This will make a total of 50.

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5.9.2 General Ophthalmic Services

Service Context

General Ophthalmic Services (GOS) are commissioned through contracting arrangements with 270 high street optometry and optical practices where approximately 600 optometrists carried out in excess of 470,000 HSC-funded sight tests in 2017/18. As GOS practices are generally the first port of call for

primary eye care, these members of the extended primary care team are an important resource in both helping people to see well and live independent lives. Importantly, in line with *Delivering Together*, these optometrists also play a key role in expanding capacity and capability in primary care, managing more people closer to home and away from acute hospital settings where possible.

Service Challenges in 2018/19

Delivering Together and the *Elective Care Plan* set out the blueprint for how services should be delivered, integrating systems and services to offer improved outcomes centred on the needs of individuals. Through the eye care partnerships strategy this challenge has been taken up and embedded in ophthalmic services, where a pathway approach seeks to ensure that the user is seen by the right person, in the right place, at the right time. As ophthalmology is a high demand specialty, accounting for ten percent of all outpatient activity, much of it for long-term conditions, major challenges remain in meeting this need and offering timely access to appropriate ophthalmic care.

Areas for development in 2018/19

The HSCB/ PHA will work to establish a Northern Ireland Eyecare Network aimed at continuing the work of Developing Eyecare Partnerships. The Northern Ireland Eyecare Network will provide a framework to support a collaborative and regional approach to support the planning and delivery of current and future ophthalmic service transformation, integration and innovation; reducing variation and improving patient outcomes and experience.

Specific areas for development in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure transformation and integration of eyecare services is supported aligned to Developing Eyecare Partnerships and *Delivering Together*.	Integrated Care should demonstrate plans to establish the NI Eyecare Network representative of all stakeholders.

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2.	Effective arrangements should be in place to provide IT integration of independent primary care ophthalmic contractors to the HSC network; improving the interface between primary and secondary care aligned to HSCB eHealth strategic priorities.	Integrated Care should demonstrate plans to ensure: • Optimal uptake of eReferral within primary care ophthalmic contractor practices and work to implement referral for advice and eTriage is progressed • Plans are progressed in 18/19 to implement access to NIECR for primary care ophthalmic professionals • Project ECHO is embedded to support innovation in service transformation

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Effective arrangements should be in place to facilitate the planning and delivery of optometry-led enhanced services aligned to identified eyecare pathways (glaucoma, acute eye). These services will assist in managing demand within the primary care setting.	Integrated Care should develop and implement plans to: • Introduce a primary care service for the monitoring and review of patients with Ocular Hypertension (OHT) • Extend the current enhanced service for the management of acute non-sight threatening eye conditions (NI PEARS) to all LCG areas

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to provide opportunities and to support ophthalmic professionals to integrate both within MDT and across primary care and secondary care. This will support service transformation by transferring care of patients who were traditionally cared for in secondary care to skilled primary care professionals.	Integrated Care should develop and implement plans to: • Embed Project ECHO as the platform to support the delivery of a new enhanced service for OHT monitoring and review in primary care. ECHO will enable ‘within-sector’ and ‘cross-sector’ collaboration. • Develop a business case to build on the initial pilot in 2017 for optometrists to access their Non-Medical Prescribing (NMP) clinical training in secondary care.

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5.	Effective arrangements should be in place to ensure capability and the knowledge and skill mix in ophthalmic services is optimised.	Integrated Care should develop and implement plans to promote and provide training opportunities for primary care ophthalmic professionals, create opportunities for collaboration and integration with secondary care professionals to support demand management and transformation initiatives.

5.9.3 Dental Services

Service Context

There are 1,050 General Dental Practitioners (GDPs) in Northern Ireland working across 380 practices. Approximately 1.1m people are registered with a GDP for health service care and each year under the General Dental Services (GDS) over 1.7m courses of treatment are provided. In the past, the Northern Ireland population had poor oral health, however, in recent years significant improvements have been observed in both children's and adult's dental health.

Service Challenges in 2018/19

Article 10 (2) of the EU Directive on mercury comes into force on 1 July 2018 and will mean that in children aged under 15 years, amalgam restorations may only be placed in exceptional circumstances. The implementation of this element of the Directive will require changes to the GDS Statement of Dental Remuneration, the BSO payment system and in practice software systems.

Areas for development in 2018/19

The oral surgery pilot will be further refined in 2018/19 with the intention of inviting expressions of interest for a standardised new primary care oral surgery contract in Quarter 4. The HSCB will also work with Trusts to ensure referral criteria for secondary care oral surgery services are in place before the end of the year.

Specific issues and opportunities in 2018/19 are as follows:

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ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to reduce the number of patients referred to Trust Oral Surgery/OMFS services.	Integrated Care should demonstrate plans to: • continue the existing pilot PDS in Oral Surgery to increase the amount of treatment provided by High Street Oral Surgery Specialists and therefore reduce Trust referrals • Provide training to General Dental Practice trainers in enhanced Oral Surgery techniques to reduce referrals from dental practices to High Street Oral Surgery Specialists and Trusts • Work with Trusts to ensure that appropriate Oral Surgery referral criteria are in place
2.	Effective arrangements should be in place to improve the turnaround times for prior approval treatment requests in the GDS.	Integrated Care should demonstrate plans to pilot a new, electronic prior approval process in 2018/19 with the aim of reducing the number of submissions breaching the 8-week turnaround target time and the current resources required to deliver the service.
3.	Effective arrangements should be in place to allow secure electronic communications with GDS practices and to facilitate electronic referrals between dental practices and Trusts.	Integrated Care should demonstrate plans to roll out the email and CCG elements of the eDentistry Strategy to 75% and 25% of all GDS practices respectively by the end March 2019.

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

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quality standards associated with its Medicines Optimisation Quality Framework and it is expected that services will be commissioned to take this forward in 2018/19.

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. 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.

Service Challenges in 2018/19

During 2018/19 and beyond, the HSCB working closely with Community Pharmacy Contractors, General Practitioners, Trusts, other service providers and patients will continue to seek to ensure the provision of safe and effective medicines supported by effective pharmaceutical service provision. Given the competing demands, financial and workforce issues, collaborative working will be key. This will include the implementation of new contractual arrangements for community pharmacy services.

In 2018/19, a target of £25m prescribing efficiencies has been identified for primary care with a further £15m for secondary care. In addition to the £25m prescribing efficiencies, there is a carry forward of £4.5m relating to efficiency under-delivery from 2017/18 and £2.5m to invest in practice based pharmacists. The overall target for 2018/19 for primary care prescribing efficiencies is therefore £32m.

Achievement of Departmental Targets

There are many challenges to overcome to fully deliver against each of these ambitious targets. Good progress has been made in 2017/18 and the HSCB will attempt to build on this in 2018/19. The target for prescribing efficiencies for

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2018/19 has been set at £40m with £25m from primary care and £15m from secondary care.

Areas for development in 2018/19

During 2018/19 and beyond, the HSCB/PHA working through the existing regional structures will continue to seek to improve availability, accessibility and patient experience in relation to pharmaceutical services in line with the objectives of *Delivering Together*.

Specific areas for development in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to commission Practice based Pharmacists services within General Medical Services to improve capacity within GMS to meet additional demand and improve the safety and effectiveness of service	Integrated Care should demonstrate plans to work with GP Federations to facilitate the development of this practice model through support for evaluation and service improvement.
2.	Roll-out access to the electronic care record (NIECR) to community pharmacists	Integrated Care should demonstrate plans to roll-out secure access to the HSC net; access to NIECR; and access to HSC mail.
3.	Effective plans should be in place to deliver £25m efficiencies (plus additional £7m) in primary care through the Pharmaceutical Clinical Effectiveness programme (requiring support from secondary care) and deliver further additional efficiencies of £15m in secondary care.	Integrated Care should demonstrate plans to work achieve the maximum efficiencies possible within 2018/19.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Emergency supply of medicines in Out of Hours	Integrated Care should demonstrate plans to commission the emergency supply of medicines via community pharmacy

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Prescribing and medicines supply models across primary and secondary care	Integrated Care should demonstrate plans to provide input into the development of reconfigured models

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
6.	Pharmacy workforce development	Integrated Care should demonstrate plans to secure Student pharmacy technicians that will be recruited for a two year student training position which will improve opportunities for skill mix such that pharmacists can be deployed on clinical, patient facing duties.

5.9.5 Primary Care Infrastructure Development

Service Context

The Primary Care Infrastructure Development (PCID) 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 and supports multi-disciplinary working. This model will improve access to, and responsiveness of, primary and community care services, particularly making available more specialised services nearer to

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where people live and work. This includes provision of an enhanced diagnostic and treatment capability where appropriate.

Service Challenges in 2018/19

The pressures being witnessed by the GP workforce is exacerbated by poor premises. Investment in spokes premises will be a key part of securing the model of primary care into the future. These premises are GP owned, Trust owned and leased from third parties. All parties have a responsibility to provide premises that are fit for purpose and will support the continued delivery of General Medical Services into the future.

In addition, the design of the next tranche of hub developments must meet the needs of the population now and into the future through supporting new ways of working and flexibility in design.

Areas of development in 2018/19

Specific areas for development in 2018/19 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements to ensure appropriate infrastructure is in place to support the delivery of Multi-disciplinary working arrangements and an increase in capacity with GMS	Integrated Care should demonstrate plans to develop business cases for increased capacity within Trust premises and support applications for improvement grants for GP owned/ leased premises. Trusts will support the development of business cases for improvements to Trust owned premises and explore opportunities for increasing capacity for the delivery of General Medical Services.
2.	Effective arrangements should be in place to ensure the delivery of Hub and Spoke model to support the Minister's Vision	Integrated Care should demonstrate plans to develop business cases for Hub developments which will be taken forward by the Trusts supported by the HSCB.

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5.10 Specialist Services

Service Context

Specialist acute hospital services include tertiary or quaternary level services, normally provided as a single service for the population of Northern Ireland, commissioned through a single provider in Northern Ireland or through designated centre/s in Great Britain/ROI. There are around 70 specialities and sub specialties covered by the current commissioning arrangements. High cost specialist drugs are also commissioned as a specialist service.

Many of the specialist acute hospital services have interfaces with other service areas. In commissioning specialist services the HSCB/PHA ensure a collaborative approach across relevant commissioning teams which take cognisance of those interfaces and aims to provide consistent and equitable services for the population. In this regard, specialist Acute Hospital services will continue to develop strong clinical alliances with specialist providers in GB and ROI, making best use of available information and communication technologies to facilitate a partnership approach delivery of care, where it is required.

Service Challenges in 2018/19

During 2018/19 and beyond, the HSCB/PHA, working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to specialist services. Some specialist services will need to be commissioned from providers in GB, particularly if the service required is very specialist and the anticipated activity for the population of Northern Ireland means it is not possible to provide the service locally in line with best practice.

Building resilience in specialist services provision for the future

The biggest challenge for this area of commissioning is recruitment of specialist clinical staff to sustain safe and effective services in Northern Ireland. Good progress has been made in building resilience in local services through clinical alliances with the wider NHS and ROI.

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Areas for Development in 2018/19

During 2018/19 and beyond, the HSCB/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 areas for development in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure: • New patients continue to access previously approved specialist drug therapies • Access to new NICE TAs and other NICE recommended therapies approved during 2018/19	Trust 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. Responses should also demonstrate how Trusts will deliver on the requirements of new NICE TAs in line with planned investments.
2.	Effective arrangements should be in place to continue to progress the implementation of the Northern Ireland Rare Disease Plan working in partnership with the NI Rare Disease Partnership HSCB/PHA membership of the national Rare Disease Advisory Group ensuring that Northern Ireland is fully engaged in the planning and evaluation of highly specialist services	Belfast Trust should outline, by the end of September 2018, the key priorities for development to further support the delivery of the Northern Ireland Rare Disease Implementation Plan. This may cross reference to developments in progress in other specialist services areas as support of rare disease commissioning is common to other areas of work. The Belfast Trust is asked to bring forward options and proposals to identify a clinical lead/leads for adult specialist services for consideration and agreement in 2018/19. The Belfast Trust is asked to bring forward options and proposals for interface with the Northern Ireland Rare Disease Partnership for consideration and discussion in 2018/19.
3.	Effective arrangements should be in place to provide a specialist adult pulmonary	Belfast and South Eastern Trusts are requested to agree and bring forward detailed

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	hypertension service for Northern Ireland.	proposals for a specialist adult pulmonary hypertension service for the population of Northern Ireland. This will take into account the recommendations of the National Peer Review of Pulmonary Hypertension Services, 2016/17.
4.	Effective arrangements should be in place for the provision of Paediatric Cardiac Services in line with the Ministerial decision on the establishment of an All-Island Network. A range of elective cardiac procedures, as well as emergency and urgent cases are now being accommodated in the ROI.	Belfast Trust should demonstrate how it will work with the HSCB/PHA through the specialist paediatrics group and all-island structures to take forward the implementation of the service model for congenital cardiac services set out in the full business case for the All-Island CHD Network. This should include local developments as well as developments planned on an all-island basis.
5.	Effective arrangements should be in place to improve the resilience, sustainability and access to specialist paediatric services	Belfast Trust should demonstrate arrangements which improve resilience, sustainability and access to specialist paediatric services including: • Planned arrangements for the paediatric lead for rare disease by 30 September 2018. • Plans for a Paediatric Waiting List Office. This will ensure equity of access for patients waiting for tertiary services. • New arrangements for the management of children with hepatitis B in conjunction with Birmingham Children's Hospital. • A framework to support leads in paediatric cardiology, specialist paediatrics, paediatric network, NISTAR and the critical care and trauma networks in improving communication and ensuring complementary service planning and delivery for the paediatric population.
6.	Effective arrangements should be in place to deliver an Adult Infectious Diseases (ID)	Belfast Trust should work with HSCB/PHA and DoH in developing a plan to improve the

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	service specification and phased investment within available resources.	resilience and sustainability of the Adult Infectious Disease Service. By Autumn 2018, the Trust will have agreed with HSCB/PHA a service specification for Northern Ireland including both specialist care and the role and function of local DGH acute medicine in the management of ID conditions with a view to establishing the new model from April 2019.
7.	Effective arrangements should be in place to appropriately manage the service need of patients requiring specialist services.	Belfast Trust's 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 2018/19. Belfast Trust should also advise of any emerging vulnerabilities in specialist services including proposed contingency arrangements.
8.	Effective arrangements should be in place to progress the work of the Plastics & Burns Project Board which will provide strategic direction for the service and respond to the RQIA recommendations (2017) In particular, the Project Board will agree a service specification and develop options for the future configuration of plastics and burns services, including consideration of a single service/site model.	Belfast and South Eastern Trusts should continue to take forward actions in the RQIA review, reporting progress to the Plastics and Burns Project Board. The Trusts should input to project products, including: • Needs assessment • Service profile • Service specification • Gap analysis

Patient Pathways

	ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to deliver a sustainable scoliosis service.	Belfast Trust should demonstrate plans to: • deliver a timely, accurate and effective monitoring of programme of activity and waiting lists consistent and compliant with extant DoH guidance • ensure commissioned capacity is fully

		utilised (RVH, MPH and RBHSC) and is accessible, for appropriate cases, within the clinically recommended timescale. • deliver scoliosis surgery within ministerial targets detailing any short to medium term subvention required to fully deliver these. • submit a formal escalation plan for any projected breach outwith the specified clinically determined window for treatment detailing the process by which this will be addressed to secure treatment within the planned timescale. • detail proposed service models, level of investment to meet any gap in service, both in RVH and RBHSC, expected volumes to be delivered in 2018/19 from new investment by September 2018.
10.	Effective arrangements should be in place to ensure the continued progress with implementing the service specification for patients with Multiple Sclerosis (MS)	Trust responses should identify how the Trust will implement the key priorities from the specification namely; the provision of dedicated multidisciplinary clinics for patients with MS, the local presence of specialist MS nursing staff and the local provision of infusion delivered disease modifying therapies.
11.	Effective arrangements should be in place to ensure the transfer of the management of immunoglobulin therapies to Trust pharmacies from the Northern Ireland Blood and Transfusion service	Trust responses should identify how Trusts will ensure that arrangements are in place to manage the transfer of the management of these therapies by October 2018 to improve the governance arrangements in line with medicines management principles.
12.	Effective arrangements should be in place to improve the pathway for patients accessing Gender Reassignment Services including: • Setting out the arrangements for specialist surgery as part of the pathway • Improving referral and assessment of	Belfast Trust's response should demonstrate plans to: • consider issues arising from the HSCB's Gender Reassignment Surgery consultation with a view to outlining how the Trust will address and implement these in the future, as appropriate. • develop options to ensure the continued delivery of the Regional Gender Identity

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	patients to improve the pathway and ensuring workforce issues are addressed.	Service including recruitment to fill key staff vacancies.

Transforming Services

	ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
13.	Effective arrangements should be in place to ensure the opening of the Phase 2B Critical Care Unit to accommodate the transfer of ICU/HDU capacity with the service to be fully operational in 2018/19. Work will continue to progress during 2018/9 on the current role, scope of responsibility and accountability arrangements offered by the Northern Ireland Critical Care Network and how it might best develop consistent with the vision set out in *Delivering Together*.	Belfast Trust should demonstrate, via a project plan, how it will secure the balance of the Phase 2B staffing to deliver a full bed complement of 8 HDU and 17 ICU beds as well as the 2 ICU beds associated with trauma which will also transfer into Phase 2B. All Trusts should demonstrate full commitment to collaborate in the provision of safe, effective, clinically equitable access to ICU. The Northern Ireland Critical Care Network will support this with improvements in timely monitoring of bed availability, clear escalation protocols, timely discharge and staffing levels.
14.	Effective arrangements should be in place to deliver a sustainable neuromuscular service for Northern Ireland.	Belfast Trust's response should detail proposals for a sustainable service model by December 2018 including a phased implementation approach.

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5.11 Cancer Services

Service Context
Cancer is primarily a disease of older people. As our population both ages and grows, so too does the incidence of cancer. Around 24 people are diagnosed with cancer each day in Northern Ireland, around 8,500 per year. By 2020 one in every two people will experience cancer at some point in their lives. Current estimates suggest that around 87,000 people have lived with cancer over the last 10 years. With more new diagnoses and improvements in care and survival, 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.

Service Challenges in 2018/19
During 2018/19 and beyond, the HSCB/PHA, working through the existing regional structures, will continue to seek to improve the availability, accessibility and patient experience in relation to cancer services.

There are particular and growing pressures in the provision of non-surgical oncology. The drivers for this are: demographic changes and the ageing population; emerging treatments; workforce pressures within oncology; challenges sustaining the current service delivery model; and patient expectations.

The delivery of 14 day breast performance and 62 day waiting times in urology, skin, upper GI and lower GI cancer pathways continues to be a challenge.

Achievement of Departmental Targets
The HSCB/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 Forum to share best practice across the region and identify opportunities for

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delivering improved performance, specifically in relation to cancer referrals and treatment times.

Areas for development in 2018/19

A project structure has been established, under the auspices of the TIG at the DoH, to take forward the transformation of non-surgical oncology services and this will be a major focus of work during 2018/19. Critical to this will be the expansion of non-medical prescribing.

Work to review how we deliver breast assessment services is ongoing. It is anticipated that a document proposing a new, more sustainable service model for Northern Ireland, will be issued for public consultation in the autumn.

Specific areas for development in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to deliver cancer access targets	Trust responses should demonstrate plans to improve compliance against cancer access standards across all relevant services.
2.	Effective arrangements should be in place to take forward recommendations from the Review of Breast Assessment Services	Trust responses should demonstrate how they will support the implementation of recommendations arising from the Review of Breast Assessment Services.
3.	Effective arrangements should be in place to support the transformation of non-surgical oncology services, to include the development and delivery of local quality improvement projects.	Trust responses should demonstrate how they will support the review of non-surgical oncology to include the development and delivery of local quality improvement projects.
4.	Effective arrangements should be in place to ensure implementation of the Regional Information System for Oncology & Haematology (RISOH) within haematology services.	Trust responses should demonstrate how they will fully implement the electronic patient record and electronic prescribing modules of RISOH within haematology services in line with the agreed regional project plan.

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Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place to establish a regional coordination service for Metastatic Spinal Cord Compression.	Belfast Trust should demonstrate a commitment, working in partnership with all Trusts, to taking forward this service development on behalf of the region.
6.	Effective arrangements should be in place for the treatment of basal cell carcinoma to include Mohs surgery and the provision of radiation therapy.	Belfast Trust should demonstrate plans to take forward an expansion of Mohs provision. NWCC to develop a regional radiation therapy service for Basal Cell Carcinoma (Superficial X-Ray).
7.	Effective arrangements should be in place for the developments within radiotherapy services.	Northern Ireland Cancer Centre (NICC) and NWCC to roll out delivery of DIBH across Northern Ireland to people with breast cancer who would benefit from this Radiotherapy technique. Belfast Trust response should confirm the establishment of a regional service to deliver SABR for Oligometastatic disease and people with lung cancer at NICC during 2018/19.
8.	Effective arrangements should be in place to improve the patient experience of cancer services. Commissioners will take forward a further regional Cancer patient Experience Survey in June 2018.	Trust responses should demonstrate plans to take forward any actions arising from the findings of the 2018 survey, which will report in the Autumn 2018.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place to establish a testing service for Lynch Syndrome in line with NICE Diagnostic guideline DG27.	Belfast Trust response should demonstrate a willingness to take forward the establishment of a regional testing service during 2018/19.
10.	Effective arrangements should be in place for the centralisation of partial nephrectomy, hemi nephrectomy and	Belfast Trust response should demonstrate a commitment to taking forward the centralisation of this surgery within the

	pyeloplasty to the specialist urological centre in Belfast Trust.	specialist team.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
11.	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce in Northern Ireland in line with national benchmarks and the agreed regional CNS development plan.	Trust responses should demonstrate the particular actions to be taken in 2018/19 to expand the CNS workforce, and in doing so, how this will increase opportunities to modernize care pathways and improve the patient experience of care.
12.	Effective arrangements should be in place to take forward the expansion of non-medical prescribing of Systemic Anti-Cancer Therapy (SACT).	Trust responses should demonstrate how they will take forward plans for the expansion of non-medical prescribing of SACT.
13.	Effective arrangements should be in place to bring forward radiographer skills mix within breast assessment services.	Trust responses should demonstrate commitment to the development of advanced practitioner and consultant radiographer roles within breast assessment services.

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5.12 Managing Long Term Conditions

Maintaining good health requires people to be empowered to make healthy lifestyle choices and to be aware of risk factors for preventable diseases e.g. heart disease, stroke and Type 2 diabetes. When patients are diagnosed with a long term condition (LTC), they need to be supported in managing their condition effectively through the provision of information and patient education programmes and develop the knowledge and skills they need to maintain or enhance their health and well-being as well as their clinical, emotional and social outcomes.

There are a number of regional and local forums that provide an opportunity for professional staff, service users and carers to meet regularly to discuss areas of concern and need for development. Examples of regional groups include the stroke network, the chronic pain forum and the respiratory forum. Locally in each of the five Trust areas there are Integrated Care Partnerships (and GP Federations in the future) involving Trust, primary care staff and users in the design and delivery of local services.

Using data to improve outcomes of care for people with LTCs is now a reality through projects such as the Data Quality in Practice (DQIP) initiative which uses pseudo anonymised data extracted from general practice, which is risk stratified for diabetes, respiratory, stroke and frail elderly. This will facilitate the targeting of services to those in greatest need and those most likely to benefit from interventions.

With an aging population, the need to design services to deal with co-morbidity (patients with more than one LTC) will increase as LTCs are more common in older age groups. The HSCB/PHA have selected three LTC clinical areas for outcomes based accountability (OBA) in 2018/19 to promote health and improve outcomes for patients, namely:

- Prevention and treatment of stroke
- Diabetes in Pregnancy
- Chronic Obstructive Pulmonary Disease

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It is planned to expand the number of clinical areas subject to OBA in the next few years.

5.12.1 Stroke

In Northern Ireland 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 Northern Ireland. Current community stroke services treat around 2,000 new stroke patients every year. There are many opportunities to reduce the burden of stroke through the provision of better preventative, acute and community care. National audits and the 2014 RQIA report into stroke services have made several recommendations for improving stroke care in Northern Ireland many of which are included in this Plan. It will also be the intention of the HSCB to consult on a regional modernisation plan for stroke services in 2018/19.

Service Challenges in 2018/19

In Northern Ireland stroke patients continue to experience significant delays in admission to stroke units which is strongly rated to broader unscheduled care bed pressures. This is very likely to be having a detrimental effect on outcomes such as mortality and level of dependence on discharge. There continues to be significant delays in accessing key interventions, for example weekend swallow assessments which depend on a full seven day multi-disciplinary team. Facilities for the early supported discharge of stroke patients are required. There is an increasing demand on the interventional radiology team as demand increases for the highly effective clot removal intervention.

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Areas of development in 2018/19

During 2018/19 and beyond, the HSCB/PHA working through the existing regional structures will continue to seek to improve the availability, accessibility and patient experience in relation to stroke services.

A number of areas for development have been identified for focused improvement and investment in 2018/19:

- **Development of Early Supported discharge teams** in the WHSCT, SHSCT and NHSCT. This is a vital and evidence based part of the stroke pathway which is known to improve outcomes and reduce length of hospital stay.
- **Ward of First Admission** – Sustained quality improvements around bed utilisation will be undertaken to improvement the number of stroke patients admitted to a Stroke Unit bed within 4 hours of admission.
- **Clot Retrieval Service Expansion** - Capacity building within clot retrieval service in the BHSCT will commence with a step wise approach to expanding the service hours.

Specific issues and opportunities for 2018/19 are as follows:

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to provide appropriate stroke services for younger people as 20% of all stroke occurs in people aged under 65.	Trust responses should demonstrate plans to improve stroke services for younger stroke patients in line with the recommendations of the RQIA inspection report (2014) to include vocational rehabilitation.
2.	Effective arrangements should be in place to ensure that all stroke patients are admitted directly to a stroke unit within 4 hours 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.

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4.	Effective arrangements should be in place to provide thrombolysis as a treatment for 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 those patients who receive thrombolysis do so within 60 minutes of arrival.
5.	Effective arrangements should be in place to provide mechanical thrombectomy for large vessel stroke as an effective intervention for selected stroke patients	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 seven days a week, able to respond within 24 hours of discharge and providing the required levels of therapy.

5.12.2 Diabetes Care

Service Context

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

Around 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 changes to services to meet the needs of pregnant women with diabetes.

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Service Challenges in 2018/19

Year on year increases in prevalence of diabetes creates its own challenges across primary and secondary care. In 2018/19 the following service challenges will be addressed as part of the planned investment in terms of increased demand:

- Improved access to all areas of the feet care spectrum from screening to multi-disciplinary care
- Long term capacity building around structured diabetes education across Northern Ireland and specific investment to address areas of long term unmet need
- Further roll out of community diabetes management building on best practice service models that support primary care and reduce pressure on secondary care
- Further capacity for diabetes in pregnancy clinical services
- Adoption of region wide protocols for best practice inpatient management to reduce medication errors, insulin errors and increase timeliness and appropriateness of treatment

Areas for development in 2018/19

The HSCB/PHA will support the regional implementation of the diabetes feet care pathway as part of the overall implementation of the Diabetes Strategic Framework. In 2018/19 the Diabetes Network will move into more formalised status with the appointment of a clinical leadership team comprising a consultant diabetologist, general practitioner and a representative of people living with diabetes. During 2018/19, the HSCB/PHA and the diabetes network will continue to seek to improve patient experience of diabetes care.

Specific issues and opportunities for 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be put in place to develop services for women with diabetes in pregnancy in Northern Ireland	Trusts responses should demonstrate plans to build capacity in clinical delivery through additional commitment of consultants,

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		midwifery, nursing etc. (or combination of all).
2.	Effective arrangements should be put in place to implement the recommendations arising from the Northern Ireland Inpatient Audit 2016	Trusts responses should demonstrate action plans to address the recommendations of the Inpatient Audit 2016.
3.	Effective arrangements should be put in place to develop a regional Diabetes Prevention Programme (DPP)	Trust responses should demonstrate plans to implement NICE PH38 with a particular focus on supporting behaviour change in high risk groups within community settings.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be put in place to provide education and support for people recently diagnosed with diabetes.	Trust responses should demonstrate plans to expand access to Structured Diabetes Education (SDE) and the associated catch up programme for those requiring it.
5.	Effective arrangements should be put in place to develop patient pathways for insulin pumps and Continuous Glucose Monitoring (CGM).	Trust responses should demonstrate plans to expand access to insulin pumps and CGM in-year.
6.	Effective arrangements should be put in place to ensure appropriate usage of Freestyle Libre.	Trust responses should demonstrate plans to complete the ABCD audit of Freestyle Libre in 2018/19.
7.	Effective arrangements should be put in place to improve transition arrangements for transfer of care from paediatric to adult diabetes services.	Trust responses should demonstrate plans to use ‘Ready Steady Go Hello’ materials in transition planning.
8.	Effective arrangements should be put in place to provide education and support for children with diabetes.	Trust responses should demonstrate plans to ensure all children have updated “annual health plans” and promote the use of the communication booklets among parents for insulin injections and insulin pumps.
9.	Effective arrangements should be put in place to ensure children with diabetes are	Trust responses should demonstrate plans to accommodate children with diabetes up to

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	treated in age appropriate settings	their 16th birthday for in-patients and out services and confirm arrangements are in place for monitoring blood glucose and blood ketones.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
10.	Effective arrangements should be put in place to implement relevant areas of the Northern Ireland Diabetes Foot Care Pathway.	Trust responses should demonstrate plans to develop all areas of the agreed pathway including the vascular surgery interface.
11.	Effective arrangements should be put in place to develop new models of care for people with diabetes.	Trusts responses should demonstrate plans to develop community diabetes capacity and address the needs of vulnerable groups. This will be supported through the 'New Models of Care' work stream which will be launched in 2018/19.

5.12.3 Respiratory

Service Context

Respiratory disease is the most commonly reported physical long term illness in children and young people and the third most commonly reported one in adults, after musculoskeletal and circulatory disorders. Respiratory disease continues to be one of the main causes of death and disability in Northern Ireland, together with cancer, mental ill health, musculoskeletal and circulatory disorders, all of which contribute to multiple disadvantages, high levels of disability and the risk of dying prematurely for people living in socioeconomic deprivation.

Care for people with respiratory diseases is a major contributor to overall expenditure on health and social services. A report on the burden of respiratory disease by the British Thoracic Society stated 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. A more

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recent report by the British Lung Foundation uses a different methodology and is therefore not directly comparable, but increased the overall cost estimate to £11 billion in 2014, thereby almost doubling it in just a decade.

Service Challenges in 2018/19

Exacerbations of respiratory illnesses are the most common factor for unplanned admissions which places unparalleled demands on health and social care providers. Responding to the existing challenges within current resources and service configurations will become unsustainable in the longer term.

In 2015 the Department of Health issued the Revised Strategic Framework for Respiratory Health and Well Being. It remains the long term plan for the implementation of service standards and improvements towards better outcomes for patients. As the Framework is now in its third year it is important to continue to identify effective drivers for change within this service area.

Areas for development in 2018/19

During 2018/19 and beyond, the HSCB/PHA, working with HSC service providers and users through existing and evolving processes, will continue to seek to improve the availability and accessibility of and patient experience with respiratory services.

Specific issues and opportunities for 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to deliver findings from the annual respiratory baseline assessment (subject to some alterations to targets agreed with DoH and limitations of recording mechanisms).	Trust responses should demonstrate that plans are in place to contribute to: • Maintenance of current service standards and, where applicable, meeting minimum standards as outlined in the baseline review undertaken in years 1 and 2 of the revised Respiratory Service Framework. • Development of services in line with Year 3 requirement arising from the baseline

		assessment (where not otherwise explicitly mentioned in this summary)

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to ensure local health economies deliver appropriate integrated pathways for adults and children across community, primary, secondary and tertiary care.	Trust responses should demonstrate that plans are in place to contribute to: • Ongoing implementation of the paediatric asthma pathway in remaining Trusts, including primary care elements • Working with colleagues in HSCB to develop effective counting and coding methodologies to record relevant service and patient level data • Completion of the implementation of recommendations from the RQIA Review of Community Services • Effective arrangements for managing the 'local network' for respiratory care through Integrated Care Partnerships amongst others, including senior level clinical and managerial leadership .
3.	Effective arrangements should be in place to: • promote self-management, self-directed care and other suitable training programmes for patients. • reflect the concepts of co-design and co- production in improving and developing services in line with the *Delivering Together* agenda	Trust responses should demonstrate plans to deliver referral pathways to appropriate self-management programmes.

Transforming Services /Skill Mix and Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be in place to support the development of networked services across Northern	Trust responses should demonstrate plans to: • Develop a network approach for ILD as a conduit for referral, treatment and advice

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	Ireland for the following: • Interstitial Lung Disease (ILD) • Neuromuscular related respiratory disease (NMD) • Non-Invasive Ventilation (NIV) • Obstructive Sleep Apnoea (OSA) • Ambulatory Care Pathways in the Unscheduled Care Reform Programme • Home IV antibiotics service • Difficult asthma guidelines • Implementation of COPD, bronchiectasis and paediatric asthma audit recommendations	across HSCTs and via standardised pathways • Progress one stop shop clinics between neurology and respiratory services to manage patients with specialist needs due to neuromuscular diseases across Northern Ireland including diagnostics in BHSCT and WHSCT. • Facilitate progress of the ongoing regional procurement exercise for Non Invasive Ventilation (NIV) methods • Continue to reduce waiting lists for sleep studies in BHSCT. • Facilitate respiratory teams to develop ambulatory care pathways for patients requiring same day respiratory care, where appropriate • Participate in a regional task and finish group to standardise the Home Intravenous Anti biotic and Anti-Viral service for respiratory patients (OPAT) as required. • Deliver difficult asthma services for children, young people and adults to ensure the implementation of NICE TAs.

5.12.4 Pain Management

Service Context

More than 400,000 people in Northern Ireland suffer from pain persisting beyond the expected period of recovery; it is often the most distressing 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 treated successfully in community, primary and secondary care.

Service Challenges in 2018/19

Enhancement of existing skills and capacity in primary, community and secondary care pain management services and continued support to patients in

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facilitating self-directed care and self-management approaches to support their condition.

Areas for development in 2018/19

During 2018/19 and beyond, the HSCB/PHA working through existing regional structures and processes including the Northern Ireland Pain Forum and PCC will continue to seek to improve pain management service availability, accessibility and patient experience.

Specific issues and opportunities for 2018/19 are as follows:

Strategic Priorities

	ISSUES/OPPORTUNITIES	PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to enhance the skills and capacity of secondary care pain management teams and their scope for integrated working in line with *Core Standards for Pain Management Services in the UK* published by the Faculty of Pain Medicine at the Royal College of Anaesthetists in 2015. This should include capacity for a leadership role in educating and training practitioner colleagues in other secondary, primary and community care services.	Trust responses should demonstrate plans to: • Support staff education and training for improved and integrated bio psychosocial management patients with persistent pain. • Contribute to the development and delivery of pain related public awareness, information and education projects through the Northern Ireland Pain Forum. • Transform services to ensure more patients with complex needs can be seen earlier to prevent or halt irreversible deterioration.
2.	Effective arrangements should be in place to ensure regional and local prescribing guidelines are followed and supported through regular medication reviews in line with NICE recommendations.	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.

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Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Effective arrangements should be in place to ensure patients have timely access to supported self-management options as part of a stepped care model, including those provided with the help of expert patients, peer and lay trainers.	Trust responses should demonstrate plans for a range of supported self-management options in line with a stepped care model. Depending on local service configuration and priorities, this may include: • 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 (CMPs), and • increasing capacity of pain management programmes (PMP) provided by specialist pain management teams.
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 including initial assessment for painful conditions of MSK conditions, fibromyalgia, 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 evidence based services, including interventional techniques like neuromodulation and radiofrequency ablation.	Trust responses should demonstrate plans to optimise patient flows by improving referral pathways for patients with painful conditions. This should include consideration of: • cross speciality triage criteria between primary care, core physiotherapy, ICATS, rheumatology, orthopaedics and pain management • the use of the Clinical Communication Gateway (CCG) and e triage • improved access to evidence base interventional pain management treatments as well as discontinuing treatment modalities that are no longer considered effective

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6.	Effective arrangements need to be put in place to develop a medically led regional diagnostic service for patients with ME and related conditions supported by locally available management support services.	Trust responses should demonstrate a commitment to participate in the development of a sustainable and effective regional service model for diagnosis in partnership with service users and carers.

Skill Mix / Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements need to be put in place to deliver a sustainable regional multidisciplinary persistent pain management service for children and young people with complex needs.	Belfast Trust response should demonstrate plans to reconfigure existing resources, seek additional ones and support delivery of this service on a sustainable basis in line with multidisciplinary models of good practice.

5.12.5 Cardiovascular Disease

Service Context

Cardiovascular disease (CVD) is an umbrella term that describes all diseases of the heart and circulation. It includes everything from conditions that are diagnosed at birth, or inherited, to developed conditions such as coronary heart disease, atrial fibrillation, heart failure, and stroke (described under section 5.12.1).

Coronary heart disease (CHD) is the most common type of cardiovascular disease. It occurs when coronary arteries become narrowed by a build-up of atheroma, a fatty material within their walls. The pain or discomfort felt from such narrowing is called angina and if a blockage occurs it can cause a myocardial infarction (heart attack).
Coronary heart disease (CHD) is one of Northern Ireland's leading causes of death. It is also the leading cause of death worldwide and is responsible for over 1,600 deaths in Northern Ireland each year, an average of around 4 deaths each day. Since the 1960s, CHD death rates in Northern Ireland have fallen by three-quarters but it still kills more than twice as many women as breast cancer in Northern Ireland.

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Around 74,000 people are living with CHD alone in Northern Ireland and over 16,700 have been diagnosed with heart failure. This is causing a substantial burden on health and social services.

Service Challenges in 2018/19

Service challenges in 2018/19 include a focus on streamlining investigations for Transcatheter Aortic Valve Implantation (TAVI) cases and beginning to monitor data on patient numbers and waiting times. The ultimate aim being for inpatients waiting on TAVI to have their procedure completed within 7 working days of being deemed fit for the procedure as is presently the case with inpatients waiting on cardiac surgery.

Other challenges include the need for Trusts to take into account a phased implementation of NICE CG 95 (Chest Pain of recent onset) in NI which will see a move away from exercise stress testing to CT angiography. If Trusts are replacing CT scanners they should take this strategic direction into consideration in deciding on CT scanner specifications.

Areas of development in 2018/19

During 2018/19 and beyond, the HSCB/PHA, working through existing and evolving regional structures, will continue to seek to improve the availability and accessibility of and patient experience with cardiology services.

Specific issues and opportunities in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to further develop services for patients awaiting Transcatheter Aortic Valve Implantation (TAVI) in Northern Ireland.	Belfast Trust should ensure a regular submission of monitoring data on regional patient numbers and waiting times for TAVI. They should also aim for inpatients waiting on TAVI to have their procedure completed within 7 working days of being deemed fit for the procedure. All Trusts should demonstrate plans to

		streamline investigations for patients awaiting TAVI within 28 working days.
2.	Effective arrangements should be in place to scope plans for a phased implementation of NICE CG95 (Chest pain of recent onset) through a regional approach in partnership with cardiology and radiology regional leads.	Trust responses should demonstrate plans that secure a phased implementation of NICE CG 95 (Chest Pain of recent onset) in NI which will see a move away from exercise stress testing to CT angiography.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Effective arrangements should be in place to support the recent implementation of the Clinical Communication Gateways (CCGs) for direct access to Echo, Rapid Access Chest Pain Clinics, holter monitoring and blood pressure monitoring.	Trust responses should demonstrate plans to support direct referrals from GPs for these cardiac investigations and support the timely analysis and follow up of results.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
4.	Effective arrangements should be put in place to develop and test a new model of care within cardiac rehabilitation and heart failure in the Western Trust.	The Western Trust response should demonstrate plans to pilot a new model of care within cardiac rehabilitation and heart failure in the first instance with the potential over time to implement with other patient groups such as people at high risk of heart disease, patients with diabetes and patients with peripheral vascular disease, etc. All Trusts will share in the learning from the pilot outcomes.
5.	Effective arrangements should be put in place to develop new models of care for patients with heart failure in light of the NCEPOD report – Acute Heart Failure and the NICE CG 187.	All Trusts should demonstrate plans to actively participate in a task and finish group to consider the management of heart failure.

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5.13 Sexual Health Services

Service Context

Sexual health is a broad human concept including healthy sexuality along the life course, reproduction, family planning, contraception, prevention, detection and management of sexually transmitted disease (STD) including HIV and illnesses caused by other blood borne viruses like hepatitis in its various forms, as well as human rights aspects of culturally determined behaviours related to sexual practices and identities. It encompasses both the promotion of good sexual health and the provision of sexual health and social services to prevent, manage and improve sexual health impairment. The development and delivery of sexual health services in Northern Ireland are informed by the 2008 Strategy for Sexual Health Improvement and the 2013 RQIA Review of Clinical Specialist Sexual Health Services.

The HSCB/PHA continue to promote equality of opportunity between all section 75 groups. Due regard is taken for the desirability of promoting good relations between persons of different religious belief, political opinion or racial group. In developing the provision of sexual health services the HSCB/PHA recognise the inter dependence of equality and good relations and its effective implementation should improve the quality of life for all of the people of Northern Ireland.

Service Challenges in 2018/19

During 2018/19, work will be required to integrate with mainstream Gynaecology and working alongside ICPs to develop projects such as primary care based erectile dysfunction clinics and to access GP learning using GP ECHO (as recently presented to TIG). The service will also continue to experience staffing pressures.

Areas for development in 2018/19

- Primary care partnership working with ICPs and GP federations for better sexual and reproductive health (SRH) and erectile dysfunction services in SET, BHSCT, NHSCT and SHSCT initially;

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- On-line and postal STI testing (SH:24) accessible from anywhere in Northern Ireland;
- Appointment of clinical consultants with Genito-Urinary Medicine (GUM) and SRH competencies to NHSCT and SHSCT;
- Consider the next steps for Student Sexual Health Clinics within student union facilities.

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure provision of clinical sexual health services in higher education settings, including services such as condom distribution, pregnancy testing, contraception advice and STI testing.	Trust responses should demonstrate actions that continue to refine and develop the Further Education model for delivering sexual health and wellbeing services/initiatives to youths under 25 years of age.
2.	Effective arrangements should be in place for safe and clinically governable SRH and GUM services to respond to patient need within 48 hours.	Trust responses should demonstrate plans to improve patient access times and clinical governance arrangements by appointing the required clinical support staff particularly in the NHSCT and SHSCT areas. Trust responses should demonstrate actions to strengthen sexual health service provision for uncomplicated patients closer to home in collaboration with Primary Care Providers through partnership and collaborative working.
3.	Effective arrangements should be in place for patients to access telephone and online advice for clinical sexual health matters including family planning and sexually transmitted infections.	Trust responses should demonstrate plans to: • Prioritise responses to patients seeking sexual health services and triage these according to need; this requires enough administrative support staff to respond to all telephone calls by patients within a clinically justifiable time frame • Support consolidation of electronic patient management systems across Northern Ireland and exploration of online and

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		postal testing services for uncomplicated sexual health, contraceptive and STI related needs of patients.
4.	Effective arrangements should be in place for evidence-based promotion of sexual health and wellbeing for young people and adults, including HIV awareness, STI prevention, with a particular focus on those most at risk.	Trust responses should demonstrate plans to provide targeted sexual health promotion messages, focusing on those most at risk and explore the potential of social media and other technologies in collaboration with PHA.
5.	Effective arrangements should be in place for Trust Health promotion staff to support the whole schools model of Relationships & Sex Education (RSE) provided by the BHSCT Sexual Health team.	Trust responses should demonstrate plans to continue to provide support through their staff to those schools who receive whole school RSE training in their area as required.
6.	Effective arrangements should be in place to support the sexual health needs of individuals with learning disabilities.	Trust responses should demonstrate plans to ensure uptake of learning disability sexual health training for all relevant staff.

Patient Pathways

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to provide integrated sexual health services to vulnerable parts of the population	Trust responses should demonstrate plans to develop the co-location of GUM and SRH service delivery in geographical areas of need, and to vulnerable populations e.g. in prisons and children's homes.
8.	Effective arrangements should be in place to ensure that HIV prevention clinics are established for high risk groups.	Belfast Trust response should confirm the timescales for implementing the HIV prevention clinics. The Trust response should also confirm that the patient pathway and eligibility criteria for accessing these clinics have been shared with relevant colleagues in other Trusts. The HSCB/PHA will work with the Trust to put in place formal arrangements to monitor and evaluate these clinics.

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Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
9.	Effective arrangements should be in place between local and regional GUM services to support a two year prototype HIV high risk reduction clinic within the defined agreed eligibility criteria for the administration of PrEP as part of a clinically agreed risk reduction package for the assessed patient	Trust responses should demonstrate how they would support and monitor the effectiveness of the two weekly clinics which all Trusts will refer into for those identified as high risk and meeting agreed eligibility criteria including changes in testing behaviours; changes in STI and HIV diagnoses; assessing improved equality/equity of service with other parts of the UK; seeking improvement in the quality and experience of care; building capacity in prevention of HIV and other STIs; supporting and empowering GUM clinic staff

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
10.	Effective arrangements need to be put in place to ensure sustainability of clinical sexual health services	Trust responses should demonstrate actions to identify staff training and replacement needs and communicate these to appropriate regional workforce planning colleagues.
11.	Effective arrangements should be in place to ensure all relevant staff are trained in sexual health issues, including core skills such as awareness, attitudes, information, communication skills, sexuality and relationships.	Trust responses should demonstrate actions to ensure the identification of staff who require training in sexual health promotion and deliver of training as required.

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5.14 Palliative and End of Life Care

Service Context

Palliative care, as it relates to adults, focuses on the provision of care and support to those in the population who have an advanced progressive illness. Palliative Care was historically associated with cancer care, however a palliative care approach is appropriate for all those with a progressive condition such as dementia, other neurological conditions and the increasing numbers of very frail elderly within our population. End of life care, is described as the period of time during which an individual's condition deteriorates to the point where death is either probable or would not be an unexpected event, within the coming 12 months.

One percent of the Northern Ireland population is estimated to benefit from a palliative care approach (approx.' 19,000 people). Of the actual deaths in Northern Ireland each year (approx.' 15,500) it is estimated that 80% of people who died could have benefited from a palliative care approach.

The extant Northern Ireland strategy on Palliative Care - *Living Matters: Dying Matters* and other key strategic drivers form the framework for a regional Palliative Care Programme, *Palliative Care in Partnership* which has joined all partners in a comprehensive rolling work-plan, which aims to improve the quality of care.

Work was progressed with Integrated Care Partnerships to develop a Local Enhanced Service (LES) to improve the identification of patients with palliative care needs in primary care.

Service Challenges in 2018/19

In respect of out of hours care for patients with palliative care needs there remains, across the region, variability in access to rapid response services, particularly in the southern sector of the Western Trust, while access to specialist palliative care advice out of hours can also be problematic.

The HSCB/PHA will continue to seek ways of increasing the service user and carer voice within the Programme structures to ensure that they have a clear input into the design and development of services, both regionally and at locality level.

Areas for development in 2018/19

The Palliative Care Programme will seek to complete the second phase of its needs assessment process. The opportunity to work with the NHS Benchmarking Network on the National Audit of the Care at the End of Life will be an important opportunity, over the next three years, to benchmark care at the end of life in Northern Ireland against GB counterparts and implement changes in the acute sector where appropriate. The Programme has also submitted a set of ambitious transformation proposals under the confidence and supply agenda and this work-stream will be a focus for the programme in 2018/19 and beyond.

Specific areas for development in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure the full implementation of the key worker function.	Trust responses should demonstrate plans to implement the regionally agreed key worker function in line with the roll-out of Delivering Care.
2.	Effective arrangements should be in place to embed Advance Care Planning within operational systems.	Trust responses should demonstrate plans to ensure that those with progressive conditions should be offered the opportunity to access and to record their individual wishes.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
3.	Effective arrangements should be in place to improve the identification of palliative care patients in primary care – identification prototype.	Trust responses should demonstrate plans to ensure that practices taking part in the prototype are supported to hold regular MDT meetings [details of practices taking part in

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		the prototype will be shared with Trusts].
4.	Effective arrangements should be in place to improve the education and training of the professional workforce in palliative care.	Trust responses should demonstrate plans to ensure to support staff to attend relevant courses to strengthen palliative care capacity.
5.	Effective arrangements should be in place to increase the capacity of the out of hours rapid response nursing service across the region to provide full regional coverage of the Marie Curie led service.	Trust responses should demonstrate plans to ensure that current gaps in the service are addressed and that specific proposals are brought forward by the Belfast and South Eastern Trusts/Localities to describe how the service integrates with the generic out of hours district nursing services.
6.	Effective arrangements should be in place to implement a regional specialist palliative care out of hours advisory rota.	Trust responses should demonstrate plans to ensure commitment to working collectively and with voluntary partners to develop a sustainable regional rota for access to specialist palliative care advice out of hours.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to enhance the Specialist palliative care workforce.	Trust responses should demonstrate plans to implement the recommendations of the review of the specialist palliative care workforce and work through their locality board to progress implementation.

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5.15 Prisoner Health Services

Service Context

In 2017/18 there were 3,878 prison committals and the average daily population was 1,448 across the three prison estates; a reduction in the prison population for the third consecutive year. Prisoner Health Services are delivered within the three prison establishments of Maghaberry, Magilligan and Hydebank Wood College and are managed by the South Eastern Trust.

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

Service Challenges in 2018/19

While the overall prison population has fallen for the third year in succession, the profile of prisoners within the three sites continues to change with an overall older age profile. This year, challenges remain in respect of issues associated with the misuse of prescribed medicines and the supply of illicit drugs, ensuring a robust staffing model and implementation of the out working of the Review of Vulnerable Prisoners. The recommendations of the Joint Healthcare and Criminal Justice Strategy, DoH/DoJ, should be launched in 2018 with key recommendations for prison healthcare.

Areas for development in 2018/19

The Prison Health Planning Team has developed a new 10 point plan for the commissioning of prison health services and will be taking this forward in conjunction with the Trust along with the opportunities presented from confirmation of a number of exciting transformational proposals and the

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forthcoming Joint Healthcare and Criminal Justice Strategy action plan. In addition the prison health team will be overseeing the prototyping of a new model, across Northern Ireland, of health care as it relates to custody suites within police stations.

Specific areas for development in 2018/19 are as follows:

Strategic Priorities

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to implement the HSCB/PHA 10 Point Plan to develop Prisoner Health services.	SET should demonstrate plans to take forward the key actions contained within the HSCB/PHA 10 point plan that is inclusive of the HC&CJ Strategy and Review of vulnerable people in Prison group.

Transforming Services

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
2.	Effective arrangements should be in place to enhance and promote the screening of prisoners in respect of TB, Latent BBV and HPV.	SET should demonstrate plans to review its health protection and screening processes across sites and evaluate testing, uptake and bring forward recommendations for future provision.
3.	Effective arrangements should be in place to ensure appropriate use of prescribing information to assist medicines management/optimisation	SET should demonstrate plans to ensure safe use of prescription medications including: • procedures for supervised swallow • medicine management operational systems.
4.	Effective arrangements should be in place to address the significant mental health needs of prisoners.	SET should demonstrate plans to put in place the range of skill mix needed within prison and community workforce to support the recovery of prisoners with mental health needs and to improve their life chances upon release.

Skill Mix/ Workforce

ISSUES/OPPORTUNITIES		PROVIDER REQUIREMENT
5.	Effective arrangements should be in place in regard to workforce and revised skill mix models.	SET should demonstrate steps to strengthen its complement of staff by looking at opportunities to implement new skill mix arrangements to provide a more sustainable staff profile.
6.	Effective arrangements should be put in place to maximise AHPs within the skill mix of the prison healthcare staff to support specific opportunities for service transformation.	SET should demonstrate plans to utilise enhanced AHP support to take forward public health initiatives across prison sites.

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5.16 Northern Ireland Ambulance Service (NIAS)

Service Context

Increasing demand for emergency ambulance services is placing considerable pressure on the Northern Ireland Ambulance Service to deliver against 8-minute response targets despite additional investment in recent years. The Ambulance Service plays an essential role in supporting effective unscheduled pathways, maximising patient flow through hospitals and assisting patients to access elective care. Due to the continued increase in demand for ambulance services, the HSCB has supported NIAS to undertake a capacity-demand review for emergency ambulance services, including Control, which has reported its findings in August 2017. The review has proposed the introduction of a new Clinical Response Model in line with the rest of the UK.

The HSCB/PHA working with NIAS and with the designated charity, Air Ambulance Northern Ireland, has established a dedicated Helicopter Emergency Medical Service (HEMS) for Northern Ireland in the context of the emerging Trauma Network.

Service Challenges in 2018/19

Performance against 8-minute Category A emergency response target has deteriorated further in 2017/18 and it is imperative that NIAS brings to bear various levers to prevent further deterioration. The HSCB recognises that investment will lead to improvements in future years as more paramedics and emergency medical technicians are recruited and trained but nonetheless will work closely with NIAS to ensure performance is maintained at 2017/18 levels as a minimum.

RQIA inspections of emergency ambulances and ambulance stations during 2017/18 identified significant considerable issues relating to infection control. NIAS is engaged in an extensive improvement programme to address these issues, including improved cleaning regimes; additional infection control staff training; and introduction of rigorous monitoring and audit systems.

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Achievement of Departmental Targets
While NIAS is unlikely to achieve the 8-minute Category A emergency ambulance response target in 2018/19, the HSCB is committed to working with the Trust to ensure performance is maintained at 2017/18 levels as a minimum, i.e. 45%.

Areas for development in 2018/19
During 2018/19 and beyond, the HSCB/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 2018/19 are as follows:

Strategic Priorities

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
1.	Effective arrangements should be in place to ensure that available capacity within NIAS is maximised in the context of increasing demand for services.	NIAS's response should: • demonstrate plans to improve emergency response times across NI • outline how the capacity-demand review will ensure alignment of NIAS resources with predicted demand.
2.	Effective arrangements should be in place to introduce a new clinical response model which prioritises the sickest and deploys the most appropriate resources based on improved triage. The HSCB accepts there is a shortfall in ambulance capacity to fully realise this model in coming years.	NIAS's response should outline plans to introduce the Clinical Response Model, including required public consultation.
3.	Effective arrangements should be in place to address the issues raised by RQIA following infection control inspections.	NIAS should provide details on the response to RQIA inspections and recommendations, including details of improvement planned.
4.	Effective arrangements should be in	NIAS's response should outline how it will work

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	place to manage the increasing demand for non-emergency transport.	with the HSCB to introduce eligibility criteria for non-emergency transport which prioritise patients with mobility difficulties.
5.	Effective arrangements should be in place to better coordinate Hospital-related non-emergency transport and to maximise benefits of procuring independent providers on a regional basis.	NIAS's response should outline progress in relation to the pilot with Belfast and Southern Trusts which is coordinating hospital-related non-emergency transport and efforts to realise this to cover the whole region long-term.
6.	Effective arrangements should be in place to appropriately manage the increasing demand on emergency ambulance services in the winter period.	NIAS's response should bring forward a winter plan which outlines how it will manage increased demand in winter 2018/19.

Patient Pathways

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
7.	Effective arrangements should be in place to improve ambulance turnaround times in hospitals.	NIAS's response should describe how it will significantly improve the handover time for patients, with at least 70% of handovers being completed in less than 30 minutes from April 2018.
8.	Effective, integrated arrangements, organised around the needs of individual patients, should be in place in community settings to provide care for people at home, avoiding the need for hospital attendance and admission.	NIAS's response should demonstrate how it is embedding the range of alternative care pathways across all localities in NI during 2018/19, including the paramedic-led clinical decision desk.
9.	Effective arrangements should be in place to fully utilise the Helicopter Emergency Medical Service (HEMS) to support the existing road-based emergency service.	NIAS's response should demonstrate how it will monitor the performance of HEMS during 2018/19 in line with the Commissioning Specification and agreed key performance indicators.
10.	Effective arrangements should be in place to facilitate and promote collaboration, coordination,	NIAS's response should demonstrate how it will work with existing providers of community resuscitation and ensure a smooth transition to

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	communication, learning, sharing of information between different agencies providing resuscitation training.	the new model of community resuscitation that reflects the recommendations of the 2014 Northern Ireland Community Resuscitation Strategy
11.	Effective arrangements should be in place to deliver appropriate CPR and BLS training programmes.	NIAS should provide plans to increase access to CPR training across NI and Basic Life Support (BLS) training in community and educational settings via: • Engagement with CPR training providers • Engagement with Voluntary and Community organisations • Further development of Community and first responder schemes
12.	Effective arrangements include the development of public information / guidance about Automatic External Defibrillators (AEDs) covering purchasing, maintenance, location, access and signage	NIAS should provide plans to develop website literature and guidance information materials on AEDs.

Transforming Services

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
13.	Effective arrangements should be in place to realise the workforce requirements outlined in the NIAS Capacity-Demand Exercise (July 2017), specifically reform in Field Ops, building on reform already underway in Control.	NIAS's response should outline how it will take forward workforce reform, including recruitment and training requirements.

Skill Mix/Workforce

ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
14.	Effective arrangements should be in place to provide training programmes for paramedics which address accreditation difficulties with existing programmes.	NIAS's response should outline how it will work with the HSCB and DoH to develop proposals to support the training of new paramedics which may include a university degree route, building on the foundation level training commencing in 2018/19.

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6.0 LOCAL COMMISSIONING

Local Commissioning Groups (LCGs) have responsibility for assessing the needs of their populations using a wide range of data as well as local intelligence gathered from engagement with service users and carers, local communities and service providers. This engagement means that LCGs are sensitive to needs and priorities which enable them to influence regional commissioning plans. The combination of a regional and local approach to commissioning means that service improvements can be sensitive to local population need while being rolled out across the region at pace and scale for the benefit of all.

LCGs also have a lead role at local level for planning and commissioning services, including securing local implementation of regional plans. They ensure that plans are developed through co-production with their local populations and service providers. Local service providers, including Trusts, GPs, Community Pharmacists, Community and Voluntary Organisations and Service Users and Carers are all represented on Integrated Care Partnerships (ICPs). LCGs are working with ICPs to establish formal Locality Networks in which they can co-design service change that reflect the needs of the LCG population and is also adapted to the health and wellbeing circumstances in local communities.

LCGs are represented on Community Planning Partnerships where they are able to work with a wide range of partners to develop population plans which focus on outcomes and secure the contribution of education, housing, transport and other providers with a significant influence on health and wellbeing. An outcomes-based approach enables an evaluation of the impact of improvements on people's lives as a whole.

6.1 Belfast Local Commissioning Plan

Local needs assessment

The total population of the LCG is expected to increase by 4000 people (1.2%) by 2022. The fastest growing cohort is aged 60-84. The number aged over 85 is also increasing but other age groups are expected to change little or decline over the next few years.

Areas of deprivation cover 29% of the LCG area. GP registers show that these areas have the highest prevalence of respiratory and cardiovascular disease and some cancers, which are the main causes of premature death. Deaths from suicide and alcohol and drugs, see Figure 12, also explain the difference in life expectancy between the less deprived and more deprived areas of Belfast. The higher prevalence of long term health conditions also leads to the significant difference in Healthy Life Expectancy, a measure of the quality of life, in more deprived areas. Poor health and wellbeing in more deprived areas is associated with low performance across a wide range of other outcomes, see Appendix 3. GPs, local communities and the Belfast Strategic Partnership have highlighted the fundamental importance of emotional health and wellbeing to physical health, the prevalence of common mental health conditions such as depression and anxiety

The poor health and wellbeing outcomes in more deprived areas is reflected in the pattern of demand for urgent and emergency care which shows higher rates of attendance and admission from those areas. Demand for primary mental health care also reflects patterns of deprivation as does the rates of prescribing of prescription drugs for depression, anxiety and pain relief. Most of the more deprived areas are within North and West Belfast. South Belfast has fewer of such areas but has a larger number of people suffering from severe mental illness who require inpatient and community support. East Belfast has the oldest population profile which creates additional demand for services supporting those with dementia and frailty, as well as other age-related conditions.

Partnership working
The complex influences on health and wellbeing outcomes and their inequalities in Belfast requires a strong partnership approach with local communities, service users and carers, Community Planning partners and ICPs. The LCG is a member of the Belfast Strategic Partnership and the Belfast Community Planning Partnership.

The LCG area covers all of the Belfast LGD and part of the Lisburn and Castlereagh City LGD. Priorities in the Belfast Agenda community plan include the aim by 2021 to reduce the gap in Life Expectancy between the most and least deprived areas by 33% and to provide integrated support for early years and families. The LCG is also leading the development of the Age Friendly Belfast Plan 2018-21. The Community Action Plan for Lisburn and Castlereagh City Council includes improvements in mental health, physical activity, ageing well and a community of life-savers. The LCG is also working closely with the Council to develop a health hub at the Dundonald Ice Bowl.

Key local issues and opportunities
The LCG will complete a Commissioning Direction for North Belfast as the basis for the development of primary and community care infrastructure in the Ardoyne/Ballysillan and Lower Crumlin Road areas. The LCG is also supporting the community organisations in the Whiterock to develop a local community wellbeing plan. The LCG will also work with the Belfast Trust to re-configure the location of community services to match local need.

The LCG has established, with the Trust and ICPs, a Locality Network to develop population-wide approaches to outcomes. Priorities for 2018/19 are urgent and emergency (unscheduled) care, palliative and end of life care and diabetes. The LCG will support the Locality Network in developing a Winter Resilience Population Plan which will coordinate actions by all stakeholders across the city who can make a contribution to supporting those at risk over the winter period to remain at home.

The LCG will work with the Trust and ICPs to develop ambulatory care, avoiding the need for emergency admission where appropriate. The recent investment in the Surgical Ambulatory Service will be evaluated and arrangements will be agreed for direct access for GPs to the Clinical Assessment Unit at the Mater Hospital.

The Northern Ireland Intermediate Care Audit showed that in Belfast patients with complex needs could be discharged home more quickly to have their needs assessed there if enhanced community rehabilitation and domiciliary care were available.

The LCG will work with ICPs and Trust staff to review demand and capacity for the Primary Care Talking Therapies which secures therapeutic programmes for common mental health conditions from the community and voluntary sector for patients referred by GPs. The service shows good outcomes for those who are able to access it but many are failing to engage and waiting times are growing as demand exceeds supply.

Specific local issues / opportunities in 2018/19 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
B1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	Belfast Trust should state the volumes by service which it will deliver in addition to the 2017/18 Service and Budget Agreement which reflect the Full Year Effect of investments in 2017/18 and additional funding provided within this Commissioning Plan
B2	Effective arrangements should be in place to ensure unscheduled care services in the Belfast LCG/Trust area are safe, sustainable and accessible.	Belfast Trust should work with its ICP partners to expand ambulatory care and secure direct access for GPs. The Trust should contribute to the production and implementation of a comprehensive Winter Resilience Population Plan.

B3	Effective arrangements should be in place to ensure that maternity services are arranged to meet the needs of all pregnant women.	Belfast Trust should provide a plan for the development of midwifery services which includes the development of community midwifery hubs, and midwifery-led care in the new Maternity Hospital.
B4	Effective arrangements should be in place to ensure patients who can be discharged to their own home should be supported to do so as soon as appropriate.	Belfast Trust should implement the recommendations of the Northern Ireland Intermediate Care Audit and provide more home-based community rehabilitation.
B5	Effective arrangements should be in place to ensure patients referred by GPs for Talking Therapies should be able to access the service to meet their needs as soon as possible.	Belfast Trust should work with its ICP partners to ensure that patients who are referred can access the service in a timely way.
B7	Effective arrangements should be in place to ensure patients with specialist rehabilitation needs should be able to access these as soon as they need them in an appropriate environment as close to home as possible.	Belfast Trust should submit an improvement plan for a seamless and timely pathway from specialist surgical services to appropriate rehabilitation.
B8	Effective arrangements should be in place to plan appropriate care for people at risk of hospital admission in the Belfast LCG/Trust area.	Belfast Trust should work with its ICP partners to extend access to the Falls service which provides support for patients to remain at home.
B9	Effective arrangements and infrastructure should be in place to support an integrated model of care across the Belfast LCG/Trust area.	Belfast Trust should demonstrate how it will re-configure its community services and estate to support multi-disciplinary working embedded with general practice, including co-location.
B10	Effective arrangements should be in place to ensure people at risk of Type 2 Diabetes should be offered self - management support	Belfast Trust should work with its ICP partners to develop a prevention programme for Type 2 diabetes.
B11	Effective arrangements should be in place to ensure people who require palliative care are identified and an appropriate care plan developed with them and their carers.	Belfast Trust should work with its ICP partners to ensure that people who require urgent or emergency care and are terminally-ill are identified and have a care plan developed.

6.2 Northern Local Commissioning Plan

Local Needs assessment

According to the Mid-Year Estimates for 2017, there are 474,773 people resident in the Northern LCG (NLCG) area. The total population of the LCG is expected to increase by approximately 7000 people (1.6%) by 2022. The NLCG has one of the fastest growing older populations with those in the 85 and over category anticipated to grow by 17.1% from 9,800 in 2017 to 11,500 in 2022. Similarly, the growth in the over 65 population is also significant with increases of 9,500 people (11.7%) expected in the same timeframe.

With many people now living longer as a consequence of the advances in health and social care over recent years, it is not without its challenges in terms of meeting the needs of older people who are living longer with a range of co-morbidities many of whom do not have family or support networks to assist. At the same time, the number of people in the working population (16-64 year olds) is expected to continue to decline and with this in the mix the challenges around workforce and skills are compelling.

The recent Northern Ireland Multiple Measures of Deprivation (NIMMD 2017) indicate that the Northern LCG fares relatively well in terms of overall levels of deprivation. There are however pockets of deprivation in each of our localities across each of the seven domains (Income; Employment; Health Deprivation and Disability; Education, Skills and Training; Access to Services; Living Environment; Crime and Disorder). Most notably for the Northern area, the biggest inequality is in terms of Access to services. Clustered around a number of towns, the NLCG has a largely rural hinterland with a road network and public transport system that does not lend itself to easy or convenient access to statutory services.

Ambulance response times for category “A” calls are below the target response times for all of the NLCG and there are particular issues for response times in more rural areas. Work continues with Dalriada Urgent Care to maximise the

efforts of a network of First Responder Schemes and this has been given added impetus by community planning in a number of areas, particularly Mid Ulster.

According to the GP QOF Registers, as at 1st April 2018, 67,532 people in the Northern area are registered with a GP as suffering from hypertension, whilst 28,587 people are registered as having asthma. Nearly 25,000 people (aged 17+) are on GP registers as having diabetes and nearly 19,000 are registered as having heart disease. Many will be registered as having more than one condition, the likelihood of which increases with an ageing population. In terms of mental health 3,954 people were on registers in the Northern area GP practices as having a mental health condition.

Partnership working

Partnership working has been enhanced by the advent of Community Planning. The NLCG is a member of four Community Planning Partnerships: Antrim and Newtownabbey, Mid and East Antrim, Causeway Coast and Glens, and Mid Ulster. The Community Plans are a long term vision and blueprint for local communities spanning 10 to 15 years. The ongoing involvement of the LCG ensures Plans are aligned to strategic direction as well as addressing the health and wellbeing needs of the local population.

One of those strategic aims that will benefit from collaborative action is around reducing childhood obesity. In the Northern area, year 8 obesity figures are notably worse than the rest of Northern Ireland (Health Inequalities Annual Report 2018) with Mid and East Antrim and Antrim and Newtownabbey areas being particular outliers. Through Community Planning, there is a renewed focus on increasing opportunities for physical activity and addressing obesity. Working with Sport NI, efforts are being made to encourage uptake of sport and leisure opportunities among all age groups. Linked to this is the development of strategies to promote the use of natural assets such as community allotments and greenways to help improve levels of physical activity more generally and enhance mental wellbeing.

Community Planning partners are also facilitating the roll out of *Take 5* steps to wellbeing with a particular focus on schools, local businesses and the community.

Across all of the Partnerships, there is recognition of the need to support older people to live independent and active lives and to help them stay connected with their community. Age Friendly and Ageing Well initiatives are being developed using a co-production approach involving partners, older people and the voluntary and community sector. A framework for Ageing Well has been developed and agreed in a number of Council areas and the NLCG continues to work with the PHA, Trusts and local Councils to implement the Ageing Well agenda across our local council areas. These low level interventions such as Good Morning schemes, handyvan services, luncheon clubs etc., are pivotal to keeping older people safe and well in their own homes for as long as possible and help reduce the damaging risk of social isolation.

With the growing numbers of people with dementia, there is also a focus on the need to have dementia friendly communities and all partners are committed to contributing to this agenda. Good progress has already been made across the Northern area and as a specific issue in the Causeway Coast and Glens Community Plan, there will be a concerted effort to roll out the training across the borough in schools, shops, statutory organisations and other workplaces to promote recognition of the condition and an awareness of how to treat people.

In line with the Programme for Government, an outcomes based accountability (OBA) approach will be used to measure the effectiveness of the community planning actions.

Key Local Issues and Opportunities

With a growing number of older people and increasing demand for unscheduled care services, the LCG will continue to work as part of the Local Area Network to help plan unscheduled care services for the local health economy. An Acute Care at Home scheme is planned which aims to deliver acute services for older

people in their own home, where appropriate. Ambulatory services will be enhanced to try to manage more people on an outpatient basis and closer to their homes where this is possible. Work continues through the Local Network to establish a GP Proactive Ward round in nursing homes to help minimise avoidable ED attendances from nursing homes.

The NLCG continues to collaborate with regional and other colleagues to develop a network of health and care centres to improve access to integrated services. Mindful that one size does not fit all, the LCG is looking at opportunities to improve the service offering in different localities according to local need. The need to develop a more joined up approach to local service delivery was highlighted in a number of the Community Plans. While it is important that this joined up approach considers buildings- based solutions, it is also critical that services are integrated with communities as far as possible.

The damaging impact of loneliness and social isolation has been well documented and the LCG is involved in a number of projects to help improve social connectedness. The LCG leads on the Dalriada Pathfinder Partnership in the Ballycastle area which has taken forward one such project - Living Well Moyle. This is an approach to help support people with long term conditions who have become isolated and who need help to reconnect with their local community.

There are opportunities to develop this Partnership further to consider the wider needs of the local population and the best use of local assets. The LCG is also closely involved with the IMPACT project in Mid and East Antrim which aims to reconnect older people in the locality with the voluntary and community sector to help improve their health and wellbeing. Both projects will be robustly evaluated using an OBA approach.

Specific local issues / opportunities in 2018/19 include:

LOCAL PRIORITY		PROVIDER REQUIREMENT
N1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	Northern Trust should state the volumes by service which it will deliver in addition to the 2017/18 Service and Budget Agreement which reflect the Full Year Effect of investments in 2017/18 and additional funding provided within this Commissioning Plan.
N2	Effective arrangements should be in place to ensure patients who can be discharged to their own home should be supported to do so as soon as appropriate.	Northern Trust should implement the recommendations of the NI Intermediate Care Audit and provide more home-based community rehabilitation.
N3	Effective arrangements should be in place to ensure Maternity & Child Health services are appropriate for the Northern LCG area.	Northern Trust's response should demonstrate how the change in population need and demand for Maternity & Child Health services will be managed in 2018/19. This should include arrangements to address perinatal mental health issues and to develop a bereavement midwife post.
N4	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 response should demonstrate the continued support of appropriate links between health improvement, Falls Prevention Team and LCG/ICP to reduce the number of falls in the community.
N5	Effective arrangements should be in place to accommodate the increase in demand for mental health services in the Northern LCG area.	Northern Trust's response should demonstrate plans to remodel the Emotional Wellbeing Hub service to ensure population needs are addressed as far as possible.
N6	Effective arrangements should be in place to deal with the fragility fractures which are associated with increased morbidity and mortality.	Northern Trust's response demonstrate plans to: • support the development of the Fracture Liaison Osteoporosis Service in the NHSCT area. • screen patients for the detection of osteoporosis and what treatment will be initiated to prevent further fragility fractures. • provide a comprehensive nurse led assessment at a one stop clinic at the

		Health and Care Centre in Ballymena to take place either one session per week or one full day per fortnight. The service should provide Dexa scanning using the current resource which is in place, blood testing and risk factor analysis, consultant-led management decisions and a consultant-led clinic once a month.
N7	Effective arrangements should be in place to ensure that people with a learning disability (who traditionally experience poorer oral health than the general population), have equal access to oral healthcare services and equitable oral health outcomes.	Northern Trust's response should include plans to: • deliver additional capacity within the service to meet patient dental needs; • better manage existing demand through different pathways and/or skill mix; • deliver a dedicated oral hygiene maintenance clinic to patients with identified as in greater need. • ensure that early intervention minimises disease and operative interventions (since extraction and surgical procedures often produce major management problems for the patient).
N8	Effective arrangements should be in place to improve the health of the local population.	Northern Trust's response should demonstrate how it will progress the agreed Commissioning intentions for 2018/19 in relation to: • Early years • Sexual health • Older people • Mental health & suicide prevention • Tobacco control • Obesity, nutrition & physical activity • Alcohol & drugs
N9	Effective arrangements should be in place to develop a Local Enhanced Service (LES) for people with dementia that will allow the release of sufficient Psycho-geriatrician time to allow for interventions in Primary Care complex cases.	Northern Trust's response should demonstrate integrated plans with the Northern ICP in supporting the Dementia Shared Care Local Enhanced Service.

6.3 South Eastern Local Commissioning Plan

Local Needs assessment

The South Eastern LCG area has a population of almost 360,000 covering the areas of Ards and North Down, Lisburn and South Down. The area is predominantly rural with a number of sizable conurbations. As the south east is close to greater Belfast, a significant proportion of the working population commute, on a daily basis in and out of Belfast.

The total population of the south east is expected to increase by almost 9000 people (2.5%) before 2022, the second highest increase in Northern Ireland. Most of this increase in population will be in the over 65 and over 85 year olds groups which will rise by 12.8% and 16.3% respectively. The population under 65 years of age will only marginally increase by 0.2%.

The south east population is generally above the Northern Ireland average in most aspects of health and wellbeing. Residents can expect to enjoy the highest life expectancy in Northern Ireland. Males on average currently have a life span of 79.5 years, while the female average is 83.1 years. This positive picture masks the issue of inequalities between communities in the south east which means that life expectancy differs for those who are residents in the locality's 20% most deprived areas. Males in the most deprived areas can expect to live 3.6 years less than the south east average, while females will live 2.5 years less. While the longevity of our population is to be celebrated, it does also signpost major challenges in respect of planning to care for an older population that may be living with more complex conditions such as dementia and advanced frailty. This is particularly relevant to the south east given that it has the oldest age profile in Northern Ireland.

In respect of some of the causes of premature mortality from conditions such as circulatory, respiratory and cancer the south east has some of the lowest death rates.

Pregnancy and early years information demonstrates that the south east continues to have higher rates of teenage pregnancy at the under 20 and under 17 categories, while the number of mothers breast feeding on discharge from hospital is the highest in Northern Ireland at 48.9%.

The percentage of adults classed as overweight or obese is 64% which is 2% above the Northern Ireland average. This reflects a more sedentary lifestyle prevalent in first world countries and which is a major factor in the development of a range of complex conditions in later years, most significantly diabetes.

When looking at mental health in regard to self-harm, suicide and prescribing of mood related medication, the south east sits below the Northern Ireland average vis-a-vis these rates. The south east is also generally below the Northern Ireland average in most of the key indicators associated with alcohol/drug misuse and smoking, however the prevalence of adults drinking in the south east in the highest in Northern Ireland.

Despite the overall positive position of the health and wellbeing of the south east population the LCG recognises the disparity across communities associated with these indicators and the levels of inequality which are often linked to levels of income and social deprivation. Analysis of health inequalities in 2018 demonstrate that in respect of the Northern Ireland average, across the 45 indicator areas of inequality, there were in the south east no indicators worse than the Northern Ireland average, with 15 indicators remaining unchanged and 30 areas now better than the Northern Ireland average.

Partnership working

Addressing the future needs of the south eastern population requires an integrated and partnership approach. The LCG continues to support the strong partnership culture established in the localities and the work of the Integrated Care Partnerships in the design and co-production of new services to transform health and social care. The LCG is also participating in the emerging service networks in areas such as elective, unscheduled care, diabetes and palliative care which support the local implementation of regionally driven initiatives.

Of specific interest to the LCG is our participation in the new community planning process across the south east. The LCG is working with Ards and North Down, Lisburn City and Castlereagh and Newry, Mourne and Down Councils at a strategic level to drive, in particular, the health and wellbeing agenda, the true impact of which is reliant on agencies outside of health and social care like education, housing and council services.

The contribution from the voluntary and community sector continues to grow and the SE LCG is supportive of plans to expand community development approaches across Northern Ireland in the future.

Key local issues and opportunities

To address the key issues in the south east the LCG will develop new working arrangements with the Integrated Care Partnership to pursue key joint priorities in the locality. The LCG welcomes the development of emerging Locality Network arrangements to tackle areas of continuing concern in regard to unscheduled care, elective performance and palliative and end of life care provision. Pathway approaches, for example in relation to unscheduled care, will require enhancing community services; ensuring admission avoidance [where appropriate for the patient], maintaining good flows within hospital and focusing on timely discharge from hospital to an appropriate community setting, primarily the individual's home.

Improving access to mental health and therapy services in the south east, both in regard to community and acute provision will remain a key issue in the coming planning period. The LCG will work with colleagues in the South Eastern Trust and the DoH to pursue an urgent solution to the acute mental health needs of the population.

The LCG understands the importance of strong primary and community care services to underpin the health and social care system. The finalisation of the Business Care for the Lisburn Primary and Community Care Centre was very welcome in addition to the opportunity to enhance some of the GP practices in the greater Lisburn area. Completing the primary and community care model in

the south east with the transformation of the infrastructure in the Ards and North Down area will be important in the next planning period.

The LCG will be working with a range of partners in the coming two year planning period on the transformation agenda for HSC. This opportunity should see significant changes in the way services are provided and improve the quality of care.

Success in implementing change in the coming planning period will be reliant on the availability of staff across many professional areas. Steps to enhance the workforce through skill mix and retention opportunities will be important to ensure the delivery of the transformation agenda.

Specific local issues/opportunities in 2018/19 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
SE1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	SE Trust should state the volumes by service which it will deliver in addition to the 2017/18 Service and Budget Agreement which reflect the Full Year Effect of investments in 2017/18 and additional funding provided within this Commissioning Plan.
SE2	Effective arrangements should be in place to ensure unscheduled care services in the SELCG area are safe, sustainable and accessible.	SE Trust should work with its ICP partners to expand ambulatory care and secure direct access for GPs. In addition comprehensive arrangements should be put in place for winter 2018/19 in agreement with the USC locality board.
SE3	Effective arrangements should be in place to ensure patients who can be discharged to their own home are supported to do so as soon as appropriate.	SE Trust should implement the recommendations of the NI Intermediate Care Audit and provide more home-based community rehabilitation.
SE4	Effective arrangements should be in place to ensure patients referred by GPs for	SE Trust should work with its ICP partners to ensure that patients who are referred can

	Talking Therapies are able to access the service to meet their needs as soon as possible.	access the service in a timely way.
SE5	Effective arrangements should be in place to plan appropriate care for people at risk of hospital admission in the SE LCG area.	SE Trust should demonstrate plans to enhance the EC@H service to transform the service to respond to the acuity for patients who need ED attendance or hospital admission.
SE6	Effective arrangements and infrastructure should be in place to support an integrated model of care across the SELCG area.	SE Trust should demonstrate plans to re-configure its community services and estate to support multi-disciplinary working embedded with general practice, including co-location.
SE7	Effective arrangements should be in place to ensure the provision of Enhanced Pain Management Services	SE Trust should work with partners to ensure access to pain management services in the community and additional psychological support for those with chronic long term conditions.
SE8	Effective arrangements should be in place to ensure the provision of Family and Reproductive Health Services	SE Trust should progress the provision of family planning services in the south east and bring forward plans for the implementation of better integrated family planning and sexual health services beyond 2018/19.
SE9	Effective arrangements should be in place to ensure people requiring end of life care are supported to remain at home where that is their wish.	SE Trust should work with voluntary sector partners to implement new rapid response opportunities with a particular focus on nursing homes and hospital/ED in-reach.

6.4 Southern Local Commissioning Plan

Local Needs assessment

According to the Mid-Year Estimates for 2017, there are 358,708 people resident in the Southern LCG area, accounting for over 20% of the total Northern Ireland population. Almost a quarter of those living in the Southern area are children aged 0-15 years and just under 15% are people aged 65 and over. Population projections suggest that within the next five years, the total number of people living in the Southern area will increase by over 4% (17,882 persons) to 398,194. Within this period, the highest growth rate will be seen in the older age groups. By 2022, the 65+ population will have increased by 13.1%, including 20.3% growth in the population aged 85 and over. This equates to an additional 7,229 people aged 65 and over. The number of children aged 0-15 will continue to grow, with a projected increase of 4.4% (3,841 children) in this age group over the next five years. Furthermore, if current trends continue, projections indicate that by 2032, the Southern area will have the highest child population.

In terms of the 2017 Multiple Deprivation measures for Northern Ireland, 15 of the 100 super output areas (SOAs) ranked as most deprived in the multiple deprivation domain are in the Southern area. 11 of the 100 most deprived SOAs in the health and disability domain are in the Southern area.

Over 52,000 people in the Southern area are on a GP register of people suffering from hypertension, whilst 22,574 people are registered as having asthma. Over 17,000 people (aged 17+) are on GP registers as having diabetes and over 14,000 are registered as having heart disease[7]. Many will be registered as having more than one condition, the likelihood of which increases with an ageing population. In terms of mental health, 3,186 people were on registers in Southern area GP practices as having a mental health condition.

[7] Qualities and Outcomes Framework Data Southern Area 2017

Partnership working
The Southern LCG participates in three community planning partnerships across the Southern area – Armagh, Banbridge & Craigavon; Newry Mourne & Down and Mid-Ulster. Using key indicators of need such as lifestyle data, life expectancy rates and numbers of preventable deaths, partnerships, through extensive engagement have identified a number of priorities which have been translated into action plans.

The LCG works closely with local Integrated Care Partnerships to address priority areas such as management of demand for scheduled care and the development of a range of innovative primary and community care services to provide care closer to home.

Key local issues and opportunities
A Local Network Group for Unscheduled Care was established in 2017/18 comprising a range of representatives including Southern Trust, NIAS, service users, general practice, HSCB/PHA. The LCG will support the Locality Network in developing a 2018/19 Winter Resilience Plan which will include actions to both manage demand for services within community and primary care settings and address pressures in the unscheduled and urgent care systems.

The LCG will continue to work with the Trust, Primary Care, ICPs and a range of other stakeholders to further develop the range of ambulatory care services available in the Southern area, avoiding the need for emergency admission where appropriate.

The LCG will work with the Southern Trust and other stakeholders to support the recommendations of the Daisy Hill Hospital Pathfinder Group in delivering a model of care which will meet the unscheduled care needs of the people of Newry and Mourne.

Specific local issues/opportunities in 2018/19 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
S1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	Southern Trust should state the volumes by service which it will deliver in addition to the 2017/18 Service and Budget Agreement which reflect the Full Year Effect of investments in 2017/18 and additional funding provided within this Commissioning Plan.
S2	Effective arrangements should be in place to ensure the full implementation of the key worker function.	Southern Trust should demonstrate plans to implement the regionally agreed key worker function in line with the roll-out of Delivering Care.
S3	Effective arrangements should be in place to ensure unscheduled care services in the Southern LCG/Trust area are safe, sustainable and accessible.	Southern Trust should demonstrate plans to maintain safe, sustainable, accessible unscheduled care services across the SLCG/Trust area with a particular focus on Daisy Hill Hospital. The Trust should work with the ICP to agree a plan to address the issues around access to include telephone advice The Trust, working with key stakeholders, should continue to develop the range of ambulatory care services that are available across the Southern area. Services should where possible offer direct access to advice and support for GPs.
S4	Effective arrangements should be in place to deliver safe and sustainable breast care services.	Southern Trust should demonstrate plans to address current service pressures within the breast care service and the longer term plans to deliver safe and sustainable breast care services.
S5	Effective arrangements should be in place to ensure that an IPT is submitted to secure the further enhancement of the Trauma and Orthopaedic Team, recognising the significant growth in fracture demand	Southern Trust should demonstrate plans to ensure there is sufficient access to theatre capacity for the enhanced team together with a realistic timeline for implementation of the enhanced service

S6	Effective arrangements should be in place to ensure that diagnostics /imaging services are appropriate.	Southern Trust should demonstrate plans to: 1. Optimise utilisation of the available equipment base 2. Ensure capital priority is given to timely replacement of existing equipment and that plans are in place for additional equipment where indicated. 3. Optimise productivity through available sessions 4. Optimise and continued development of skill mix within imaging teams 5. Ensure value for money and productivity from outsourced work where necessary Trust responses should include detailed plans, implementation timelines, slippage assumptions and any potential savings impact. Plans should detail the level of investment, stating the source and the expected volumes to be delivered in 2018/19.
S7	Effective arrangements should be in place to ensure that the population of the Southern Area has access to Sexual Health Services	Southern Trust should demonstrate plans to address current service pressures within the local sexual health service, in line with the regional plan
S8	Effective arrangements should be in place to minimise the need for patients to be referred by GPs to hospital consultants for specialist assessment	Southern Trust should demonstrate plans 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 specialties including: • Neurology • Gynaecology • ENT • Urology • Gastroenterology • General Surgery

		• Dermatology
S9	Effective arrangements should be in place to ensure provision of a sustainable midwifery service.	Southern Trust should demonstrate plans to monitor workforce pressures, projected midwifery retirements and raise workforce issues through appropriate commissioning structures and regional maternity workforce review bodies.
S10	Effective arrangements should be in place to ensure patients who can be discharged to their own home are supported to do so as soon as appropriate.	Southern Trust should demonstrate plans to participate fully in the National Audit of Intermediate Care for the year ending March 2018 and work with the commissioner and ICPs to develop plans to implement recommendations from the 2016/17 audit.
S11	Effective arrangements should be in place to meet the acute care needs of older people.	Southern Trust should demonstrate plans to maximise capacity in the acute care at home team, ensuring full geographical coverage and work towards implementation of a single point of access for the range of services for older people. The Trust should work with its ICP partners to review current arrangements for Direct Admission, community support to maintain patients at home including use of Step-up beds and review of additional plans to address the current conversion rate.
S12	Effective arrangements and infrastructure should be in place to support an integrated model of care.	Southern Trust, working with their local LCG should demonstrate plans to re-configure its community services and estate to support multi-disciplinary working embedded with general practice working, including a Frailty Index, Diabetes Non-Contact Specialist Assessment with community support infrastructure wrapped around the practice.
S13	Effective arrangements should be in place to meet the growing demand for mental health services.	Southern Trust should demonstrate plans to work with primary care services and across local community and voluntary sector organisations to further develop the range of psychological therapy services available in the

		southern area.
S14	People at risk of Type 2 Diabetes should be offered self -management support	Southern Trust should demonstrate plans to work with its ICP partners to take forward a pro-active approach to ensure the Type 2 prevention programme is established and a pro-active approach to staged referrals in the first year.
S15	People who require palliative care should be identified and an appropriate care plan developed with them and their carers.	Southern Trust should demonstrate plans to work with its ICP partners to progress a work plan through the Local Palliative Care Project Board

6.5 Western Local Commissioning Plan

Local Needs Assessment

According to the Mid-Year Estimates for 2017, there are 301,448 people resident in the Western LCG area. The total population of the LCG is expected to increase by approximately 3000 people (0.9%) by 2022. The fastest growing population in the LCG area are those in the 85 and over category which is anticipated to grow by 16.8% in 2022. Similarly, the growth in the over 65 population is also significant with increases of 6,000 people (12.9%) expected in the same timeframe.

One in four people (25.3%) residing within the Western area in 2013 were living within the most deprived of the Northern Ireland deprivation quintiles. Across Northern Ireland, 18.8% of the population live in the most deprived quintile.

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

Partnership working

The LCG is represented on both Derry City & Strabane District and Fermanagh and Omagh Community Planning Partnerships. Work to put in place action plans is underway in both partnerships and opportunities exist to take forward HSC priorities with partners as well as inputting to work which will benefit HSC. Key developments with statutory partners include a pilot of the Derry Crisis Intervention Service and collaborative working on the council masterplan for the Strabane Canal Basin.

The LCG continues to work in partnership with the five local community networks covering the Western area. In recent years this partnership has

enabled a focus on service user experience of HSC services, including unscheduled care initiatives undertaken in 2017 which reached over 1,000 people. In the coming year, the networks have agreed to present an overview of how the HSC service is planned and works to at least 500 people through a series of community-based presentations based on information provided by the LCG. It is hoped that this approach will increase understanding of the issues and challenges facing Health and Social Care.

The LCG is closely involved in projects being rolled out by CAWT with funding from EU Interreg V programme. The project offers opportunities to develop significant new approaches to delivering services in an acute hospital, for children in need, older people and people with mental health problems and significant developments are planned in the Western area.

Key local issues and opportunities

The LCG will continue to work closely with the Western Integrated Care Partnerships on their continued work on outpatient reform. Key developments include:

- Development and implementation of new patient pathways for Inflammatory Bowel Disease, Irritable Bowel Syndrome and Coeliac Disease. This includes the provision of the Faecal Calprotection test to GPs and specialist dietician-led medical reviews of patients with diagnosed Coeliac Disease (part-funded by the LCG).
- Development and implementation of guidelines for the Assessment and Management of Fibromyalgia in Primary Care.
- Undertaking Clinical validation exercises leading to 459 patients being discharged from waiting lists, i.e. 12% of the total patients reviewed.
- Working closely with the Trust to improve the process for referrals into CAMHS and Acute Adult Mental Health services.

The LCG and ICPs are also pleased that the social prescribing service developed and LCG-funded in the Western area has now been rolled out across Northern Ireland and parts of Scotland with funding from the Big Lottery Fund.

Specific local issues / opportunities in 2018/19 include:

LOCAL ISSUE/OPPORTUNITY		PROVIDER REQUIREMENT
W1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	Western Trust should state the volumes by service which it will deliver in addition to the 2017/18 Service and Budget Agreement which reflect the Full Year Effect of investments in 2017/18 and additional funding provided within this Commissioning Plan
W2	Effective arrangements should be in place to ensure unscheduled care services in the Western area are safe, sustainable and accessible.	Western Trust should provide an overview of plans to development unscheduled care, including ambulatory and acute care at home. The Trust should contribute to the production and implementation of a Winter Resilience Plan.
W3	Effective arrangements should be in place to support the need to develop modern, appropriate accommodation for emergency department, theatres and related services on the Altnagelvin site.	Western Trust's response should outline progress in relation to the business case for Altnagelvin Phase 5.2 which the LCG anticipates will be completed during 2018.
W4	Effective arrangements should be in place to ensure appropriate daycase operating capacity.	Western Trust's response should provide an update on the progress of commissioning the two new Daycase Theatres at Altnagelvin which are due to open in August 2018 and give an indication of daycase capacity which will be realised through the investment. It is anticipated that the new theatres will deliver much-needed daycase operating capacity.
W5	The LCG recognises considerable pressure experienced in gastroenterology services in recent years due to medical vacancies. The LCG has invested in specialist nurse training which has gone someway to	Western Trust's response should outline progress in relation to introducing a specialist dietician to undertake reviews of patients with Coeliac Disease, including plans to extend the service to the Southern Sector in due course.

	shoring up capacity shortfall. The LCG is further committed to invest in specialist dietetics to undertake review of patients with Coeliac Disease, thereby allowing consultant gastroenterologists to focus on more chronic gastroenterology conditions.	
W6	The LCG has identified a considerable shortfall in capacity in Trauma and Orthopaedics services in the West. The LCG and HSCB plan three investments in 2018/19: establishment of fracture triage clinics; investment in allied health professionals to support consultants; and funding for two additional orthopaedic consultants leading to considerable additional capacity in orthopaedics and trauma care.	Western Trust's response should outline progress in relation to putting these investments on the ground and an indication of the additional capacity which will be realised.
W7	The LCG notes plans to invest in diagnostics for cardiology ECHO and for audiology which will increase capacity within these services.	Western Trust's response should indicate progress in relation to putting this additional capacity in place and anticipated additional capacity which will be realised.
W8	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.	Western 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.
W9	The LCG introduced out-of-hours palliative care nursing support in the Northern Sector two years ago and there is evidence of its benefit to patients and other HSC services. The LCG, with Transformation Funds, is in the position to roll-out the service in	Western Trust's response should consider how the service provided, with the support of Marie Curie and Western Urgent Care, can be rolled-out in the Southern Sector in line with plans to reorganise community nursing services.

	the Southern Sector.	
W 10	Primary care talking therapies has proven a popular service among GPs and patients. Its successful roll out in the Northern Sector has exceeded initial expectations of patient numbers. Its delayed introduction in the Southern Sector has led to an inequity of service.	Western Trust's response should provide an update on plans to introduce talking therapies in the Southern Sector and an indication of shortfall in capacity in terms of triage and counselling which will be addressed with resources available within Transformation Funds.
W 11	Monitoring of patients prescribed anti-psychotic drugs is undertaken inconsistently in the West. While initial monitoring is undertaken by the prescriber, ongoing monitoring is not rigorously undertaken either in primary or secondary care.	Western Trust's response should consider how it will collaborate with General Practice in ensuring blood monitoring required in line with guidance is undertaken.
W 12	The introduction of Primary Care multi-disciplinary teams offers a significant opportunity to extend capacity within General Practice through access to AHP, mental health and social work resources in General Practice and to address patient issues earlier than at present.	Western Trust's response should demonstrate how it works closely with GP Federations in the Western area to ensure the successful implementation of teams.
W 13	The LCG notes ICPs' plans to continue work on outpatient reform with a focus on: fatty liver pathway, Haemochromatosis Venesection, DMARD monitoring, and NI roll out of primary care Joint injections service. ICPs are also planning a pilot of remote control of Atrial Fibrillation and focused work on development of portfolio opportunities for GPs in the West.	Western Trust's response should confirm its continued support for ICP plans and outline how the Trust will contribute to the work planed in 2018/19.
W 14	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	Western 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.

	registered with Western GP practices than live in the Western LCG area, some of whom may live in ROI.	
W 15	The LCG remains committed to promoting the development of Primary Care Hubs in the Western area. The Enniskillen hub will open during 2018 with additional Trust services being provided adjacent to GP services. Efforts to progress the business case for Lisnaskea hub continue and the LCG is also working closely with Derry City and Strabane District Council to realise a hub in Strabane as part of the Council masterplan project.	Western Trust's response should provide an update on progress on each of the hubs, including Enniskillen, Derry Cityside, Lisnaskea and Strabane. Notably the Trust is asked to confirm its continued support for the council-led masterplan for Strabane Canal Basin which may include the Primary Care hub for the town.

Appendix 1: Delivering on Key Policies and Strategies

While the majority of these strategies are specifically referenced within the Plan, the HSCB/PHA remain committed to the delivery of all existing policies, frameworks, guidance and strategies highlighted below. It should be noted that it is not an exhaustive list.

- Draft Programme for Government (2016-2021)
- Delivering Together
- Quality 2020
- Rural Needs Act
- Institute of Healthcare Improvement Liaison
- Service Frameworks
- Workforce Planning and Development
- Sexual Health Strategy
- Domestic Violence and Sexual Violence Strategy
- A Strategy For The Development Of Psychological Therapy Services
- Adult Safeguarding: Prevention and Protection in Partnership
- Making Life Better
- Maternity Strategy
- Physical and Sensory Disability Strategy
- Delivering Care: Nurse Staffing in Northern Ireland
- Primary and Community Care Infrastructure
- eHealth and Care strategy
- Living Matters Dying Matters
- RQIA Reports
- Northern Ireland Rare Disease Implementation Plan
- NICE guidance

Appendix 2: Commissioning Plan Direction Outcomes Framework

COMMISSIONING PLAN DIRECTION OUTCOME		SECTION
Aim: To improve the health of the population		
Outcome 1: Reduction of health inequalities		
Population Health		
1.1	By March 2020, in line with the Department's ten year "*Tobacco Control Strategy*", to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.	4.1.1
1.2	By March 2019 to have expanded the "*Weigh to a Healthy Pregnancy*" to now include women with a BMI over 38. This programme is one element of the Departmental strategy "*A Fitter Future for All*", which aims by March 2020, to reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.	4.1.1
1.3	By March 2019, through continued promotion of breastfeeding to increase in the percentage of infants breastfed, (i) from birth, and (ii) at 6 months. This is an important element in the delivery of the "*Breastfeeding Strategy*" objectives for achievement by March 2025.	4.1.1
1.4	By March 2019, establish a minimum of 2 "Healthy Places" demonstration programmes working with General Practice and partners across community, voluntary and statutory organisations.	4.1.1
1.5	By March 2019, to ensure appropriate representation and input to the PHA/HSCB led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach.	5.9.1
1.6	By March 2019, to establish a baseline of the number of teeth extracted in children aged 3-5 years - as phase 1 of the work to improve the oral health of young children in Northern Ireland over the next 3 years and seek a reduction in extractions of 5%, against that baseline, by March 2021.	4.1.1
Supporting Children and Young People		
1.7	By March 2019, to have further developed, and implemented the "*Healthier Pregnancy*" approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation.	4.1.1

1.8	By March 2019, ensure the full delivery of the universal child health promotion programme for Northern Ireland, "*Healthy Child Healthy Future*". By that date: • The antenatal contact will be delivered to all first time mothers. • 95% of two year old reviews must be delivered. These activities include the delivery of core contacts by Health Visitors and School Nurses which will enable and support children & young adults to become successful, healthy adults through the promotion of health and wellbeing.	4.1.1
1.9	By March 2019, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 "We give our children and young people the best start in life".	4.1.1
1.10	By March 2019, the proportion of children in care for 12 months or longer with no placement change is at least 85%; and 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer them greater stability while in care.	5.4
Improving Mental Health		
1.11	By March 2019, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a "street triage" pilot and a "Crisis De-escalation Service" pilot. This work builds on previous investments in community mental health crisis teams and is an important element of the work to reduce the suicide rate by 10% by 2022 in line with the draft "*Protect Life 2 Strategy*".	5.6
1.12	By September 2018, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol and drug related harm and to reduce drug related deaths.	5.6
Supporting those with Long Term Conditions		
1.13	By July 2018, to provide detailed plans (to include financial profiling) for the regional implementation of the diabetes feet care pathway. Consolidation of preparations for regional deployment of the care pathway will be an important milestone in the delivery of the "*Diabetes Strategic Framework*".	5.12.2
Aim: To improve the quality and experience of health and social care		
Outcome 2: People using health and social care services are safe from avoidable harm		
Safe in all Settings		

2.1	By March 2019 all HSC Trusts should have fully implemented phases 2, 3 and 4 of *Delivering Care*, to ensure safe and sustainable nurse staffing levels across all emergency departments, health visiting and district nursing services.	4.4
2.2	By 31 March 2019: • Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by 2% from the 2017/18 level of prescribing and: • Taking 2017/18 as the baseline figures, secure in secondary care: ○ a reduction in total antibiotic use of 1%, measured in DDD per 1000 admissions; ○ a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions; ○ a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions, and ○ EITHER ▪ that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category, OR ▪ an increase of 3% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use. With the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 10% by 31 March 2021. **For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.*	5.9.4
Safe in Hospital Settings		
Reducing Gram-negative bloodstream infections 2.3	By 31 March 2019 By 31 March 2019 secure an aggregate reduction of 11% of Escherichia coli, Klebsiella spp. and Pseudomonas aeruginosa bloodstream infections acquired after two days of hospital admission, compared to 2017/18.	4.1.3
2.4	In the year to March 2019 the Public Health Agency and the Trusts should secure a reduction of 7.5% in the total number of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over, and in-patient episodes of Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection compared to 2017/18.	4.1.3
2.5	In the year to March 2019 the Public Health Agency and the Trusts should secure a reduction of 7.5% in the total number of in-patient episodes of Clostridium difficile infection in patients aged 2 years and over, and in-patient episodes of Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infection compared to 2017/18.	4.1.3
2.6	Throughout 2018/19 the clinical condition of all patients must be regularly and appropriately monitored in line with the NEWS KPI audit guidance, and timely action taken to respond to any signs of deterioration.	4.2.1

2.6	By March 2019, review and regionally agree standardised operational definitions and reporting schedules for falls and pressure ulcers.	4.2.1
2.7	By March 2019, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group.	3.0 & 5.9.4
Safe in Community Settings		
2.8	During 2018/19 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.	5.5
Outcome 3: Improve the quality of the healthcare experience		
3.1	By March 2019, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment.	4.2.2
3.2	During 2018/19 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.	5.4 & 5.8
3.3	By March 2019, patients in all Trusts should have access to the Dementia portal.	5.5
3.4	By March 2019, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.	
3.5	By March 2019 the HSC should ensure that the Co-production model is adopted when designing and delivering transformational change. This will include integrating PPI, co-production, patient experience into a single organisational plan.	4.2.2
Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them		
Primary Care Setting		
4.1	By March 2019, to increase the number of available appointments in GP practices compared to 2017/18	5.9.1
4.2	By March 2019, to have 95% of acute/ urgent calls to GP OOH triaged within 20 minutes.	

4.3	From April 2018, 72.5% of Category A (life threatening) calls responded to within 8 minutes, 67.5% in each LCG area.	5.16
Hospital Care Setting – Acute Care		
4.4	By March 2019, 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 2019, at least 80% of patients to have commenced treatment, following triage, within 2 hours.	5.1
4.6	By March 2019, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	5.2
4.7	By March 2019, ensure that at least 15% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.	5.12.1
4.8	By March 2019, all urgent diagnostic tests should be reported on within two days.	5.2
4.9	During 2018/19, 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
Hospital Care Setting – Elective Care		
4.10	By March 2019, 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
4.11	By March 2019, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.	5.2
4.12	By March 2019, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.	5.2
4.13	By March 2019, 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
Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them		

Increased Choice		
5.1	By March 2019, secure a 10% increase in the number of direct payments to all service users.	4.2.4
5.2	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.	4.2.4
Access to Services		
5.3	By March 2019, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.	4.4
5.4	By March 2019, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.	4.4
5.5	By March 2019, Direct Access Physiotherapy service will be rolled out across all Health and Social Care Trusts.	4.4
5.6	By May 2018, to have delivered the Children & Young People's Developmental & Emotional Wellbeing Framework along with a costed implementation plan	5.4
Care in Acute Settings		
5.7	During 2018/19, 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
Outcome 6: Supporting those who care for others		
6.1	By March 2019, secure a 10% increase (based on 2017/18 figures) in the number of carers' assessments offered to carers for all service users.	4.2.5 & 5.5
6.2	By March 2019, secure a 5% increase (based on 2017/18 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.	4.2.5
6.3	By March 2019, to create a baseline for the number of young carers receiving short breaks (i.e. non-residential respite).	4.2.5
Aim: Ensure the sustainability of health and social care services provided		
Outcome 7: Ensure the sustainability of health and social care services		
Primary and Community setting		

7.1	By March 2019, to have commenced implementation of new contractual arrangements for community pharmacy services.	5.9.4
7.2	By March 2019 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users and the baseline activity to measure this.	5.4
Hospital Setting		
7.3	By March 2019, to establish a baseline of the number of hospital cancelled, consultant led, outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment and by March 2020 seek a reduction of 5%.	5.2
7.4	By March 2019, to reduce the percentage of funded activity associated with elective care service that remains undelivered.	5.2
7.5	By March 2019, 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.	5.2
7.6	By March 2019, to have obtained savings of at least £90m through the 2016-19 Regional Medicines Optimisation Efficiency Programme, separate from PPRS receipts.	5.2
Aim: Support and empower staff delivering health and social care services		
Outcome 8: Supporting and transforming the HSC workforce		
Implementing the Workforce Strategy		
8.1	By June 2018, to provide appropriate representation on the programme board overseeing the implementation of the health and social care Workforce Strategy.	1.5 & 4.4
Attracting, recruiting and retaining staff		
8.2	By June 2018, to provide appropriate representation on the project board to establish a health and social care careers service.	4.4
Effective workforce planning		
8.3	By March 2019, to have completed the first phase of the implementation of the domiciliary care workforce review.	4.4

8.4	By June 2018, to provide appropriate representation to the project to produce a health and social care workforce model.	4.4
Build on, consolidate and promote workforce health and wellbeing and staff engagement		
8.5	By March 2019, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10 – 14 of the Workforce Strategy.	4.4
Improving business intelligence		
8.6	By December 2018, to provide the information required to facilitate the proactive use of business intelligence information and provide appropriate personnel to assist with the analysis.	4.4
Supporting our staff		
8.7	By December 2018, to ensure at least 40% of Trust staff (healthcare and social care staff) have received the seasonal flu vaccine.	4.4
8.8	By March 2019, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2017/18 figure.	4.4
8.9	By March 2019, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG.	4.4
8.10	By March 2019 to pilot an OBA approach to strengthen supports for the social work workforce	4.4
Investing in our staff		
8.11	By March 2019, 50% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2 by March 2020.	4.4
8.12	By March 2019, to have developed and commenced implementation of a training plan on suicide awareness and suicide intervention for all HSC staff with a view to achieving 50% staff trained (concentrating initially on frontline staff) by 2022 in line with the draft Protect Life 2 strategy.	4.4
8.13	By March 2019, to have developed and commenced implementation of a training plan on suicide awareness and suicide intervention for all HSC staff with a view to achieving 50% staff trained (concentrating initially on frontline staff) by 2022 in line with the draft Protect Life 2 strategy.	4.4

Appendix 3: Regional and Local Key Population Health Facts

Below are listed the main population health indicators based on the most recent data available. The Regional Northern Ireland and comparative Trust/LCG areas positions are displayed for ease of reference and clearly highlight differentials between Trust/LCG areas across key health indicators.

Indicator Category – Life Expectancy and General Health

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	SE	South	West
Male Life Expectancy at Birth	2014-16	Years	78.5	76.4	79.2	79.5	79.1	78.3
Female Life Expectancy at Birth	2014-16	Years	82.3	81.3	82.9	83.1	82.5	82.2
Male Life Expectancy at 65	2014-16	Years	18.3	17.3	18.4	18.8	18.6	18.4
Female Life Expectancy at 65	2014-16	Years	20.7	20.0	21.0	21.0	20.7	20.3
Male Healthy Life Expectancy	2014-16	Years	59.1					
Female Healthy Life Expectancy	2014-16	Years	60.9					
Male Disability Free Life Expectancy	2014-16	Years	55.3					
Female Disability Free Life Expectancy	2014-16	Years	56.4					
General Health (adults)	2016/17	% Very good/Good	73%	67%	73%	78%	74%	72%
Longstanding Illness (adults)	2016/17	%	42%	51%	44%	43%	37%	36%
Limiting Longstanding Illness (adults)	2016/17	%	30%	39%	30%	28%	27%	28%
General Health (young people: school years 8-12)	2016	% Very good / Good	84%	83%	80%	82%	86%	86%
Longstanding Illness (young people: school years 8-12)	2016	%	24%	25%	26%	28%	21%	23%
Limiting Longstanding Illness (young people: school years 8-12)	2016	%	14%	12%	15%	16%	12%	12%

Indicator Category – Premature Mortality

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	SE	South	West
Potential Years of Life Lost	2014-16	Years lost per 100 persons	8.6	10.6	7.7	7.7	8.4	8.9
Standardised Death Rate Amenable	2012-16	Deaths per 100,000 population	127	164	117	110	120	132
Standardised Death Rate Preventable	2012-16	Deaths per 100,000 population	205	263	188	179	195	216
Standardised Death Rate Avoidable	2012-16	Deaths per 100,000 population	242	313	222	211	228	252
Standardised Death Rate Avoidable: Children & Young People	2012-16	Deaths per 100,000 population	22					
Standardised Death Rate Circulatory U75	2012-16	Deaths per 100,000 population	75	96	68	66	73	76
Standardised Death Rate Respiratory U75	2012-16	Deaths per 100,000 population	34	47	32	26	29	39
Standardised Death Rate Cancer U75	2012-16	Deaths per 100,000 population	151	182	139	137	150	154
Standardised Death Rate All Cause U75	2012-16	Deaths per 100,000 population	369	462	337	329	359	385

Indicator Category – Major Diseases and Conditions

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Standardised Admission Rate Circulatory	14/15 - 16/17	Admissions per 100,000 population	2,170	2,019	2,339	2,080	2,201	2,157
Standardised Admission Rate Circulatory U75	14/15 - 16/17	Admissions per 100,000 population	1,525	1,503	1,566	1,445	1,553	1,557
Standardised Prescription Rate Antihypertensive	2016	Rate per 1,000 population	226	238	223	223	226	221
Standardised Prescription Rate Statin	2016	Rate per 1,000 population	171	173	167	160	177	182
Standardised Admission Rate Respiratory	14/15 - 16/17	Admissions per 100,000 population	2,055	2,249	1,999	1,961	1,959	2,142
Standardised Admission Rate Respiratory U75	14/15 - 16/17	Admissions per 100,000 population	1,506	1,688	1,391	1,397	1,462	1,675
Standardised Incidence Rate Cancer	2009-15	Incidence per 100,000 population	555	599	544	527	558	554

Indicator Category – Mental Health

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Standardised Admission Rate Self-Harm	12/13 - 16/17	Admissions per 100,000 population	173	219	142	169	170	176
Crude Suicide Rate	2014-16	Deaths per 100,000 population	15.9	22.1	12.6	14.8	15.4	15.8
Standardised Prescription Rate Mood & Anxiety	2016	Rate per 1,000 population	213	239	207	204	204	218
12-item General Health Questionnaire (GHQ12)	2016/17	% scoring highly (score of 4 or more)	17%	22%	16%	18%	13%	17%

Indicator Category – Alcohol, Smoking and Drugs

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Standardised Admission Rate Alcohol	14/15 - 16/17	Admissions per 100,000 population	721	1,095	511	636	599	884
Standardised Death Rate Alcohol	2012-16	Deaths per 100,000 population	16.4	24.8	12.8	14.2	12.8	19.5
Standardised Death Rate Smoking	2012-16	Deaths per 100,000 population	157	198	149	136	148	166
Standardised Incidence Rate Lung Cancer	2009-15	Incidence per 100,000 population	80	105	74	67	75	81
Standardised Death Rate Lung Cancer	2012-16	Deaths per 100,000 population	67	89	62	55	63	69
Standardised Admission Rate Drugs	14/15 - 16/17	Admissions per 100,000 population	220	297	186	210	191	226
Standardised Death Rate Drugs	2012-16	Deaths per 100,000 population	6.6	11.9	5.2	5.2	5.7	5.2
Standardised Death Rate Drug Misuse	2012-16	Deaths per 100,000 population	3.7	6.9	2.9	3.1	3.1	2.5
Prevalence of cigarette smoking (adults)	2016/17	% current cigarette smokers	20%	24%	19%	16%	21%	17%
Prevalence of cigarette smoking (young people: school years 8-12)	2016	% current cigarette smokers	4%	7%	4%	5%	4%	4%
E-cigarette use (adults)	2016/17	% current eCigarette users	6%	10%	4%	6%	6%	4%
E-cigarette use (young people: school years 8-12)	2016	% current eCigarette users	5%	8%	4%	6%	5%	2%
Persons accessing smoking cessation services	2016/17	Number of people setting a quit date	18637	4137	3683	2913	4094	3810
Prevalence of drinking alcohol (adults)	2016/17	% adults (18+) who are drinkers	80%	82%	76%	83%	82%	78%
Ever taken an alcoholic drink (young people: school years 8-12)	2016	% young people who have ever taken an alcoholic drink	32%	35%	36%	38%	28%	25%
Prevalence of drinking alcohol (young people: school years 8-12)	2016	% young people who drink at present (from rarely to daily)	23%	21%	29%	27%	21%	15%

Young people getting drunk (school years 8-12)	2016	% young people who report having been drunk	14%	16%	17%	18%	12%	9%
Young people getting drunk (school years 8-12)	2016	% young people that drink that report having been drunk	45%					
Lifetime prevalence of taking drugs (young people: school years 8-12)	2016	% young people who have taken named drugs in their lifetime	4%	5%	3%	6%	3%	2%
Last year prevalence of taking drugs (young people: school years 8-12)	2016	% young people who have taken named drugs in the last year	3%	5%	2%	5%	3%	2%
Last month prevalence of taking drugs (young people: school years 8-12)	2016	% young people who have taken named drugs in the last month	2%	4%	1%	3%	2%	2%
Treatment for alcohol and/or drug misuse (18 and over)	2017	Census - Snapshot - Number in treatment as at 1st March 2017	5256	1176	946	719	1022	1057
Treatment for alcohol and/or drug misuse (Under 18s)	2017	Census - Snapshot - Number in treatment as at 1st March 2017	713	322	77	122	36	151

Indicator Category – Pregnancy and Early Years

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belf	North	South East	South	West
Infant Mortality	2012-16	Deaths per 1,000 live births	4.5	5.0	4.0	4.8	4.4	4.8
Smoking in pregnancy	2016	Proportion of mothers smoking (%)	13.4 %	17.8 %	13.7 %	12.7 %	10.5 %	12.6 %
Teenage Birth Rate U20	2016	Births per 1,000 population	10.0	15.7	8.8	9.1	8.7	8.1
Teenage Birth Rate U17	2016	Births per 1,000 population	1.7	3.4	1.4	1.6	1.5	1.0
Healthy Birth Weight	2016	Proportion of live births (%)	90%	87%	91%	89%	91%	90%
Low Birth Weight	2016	Proportion of live births < 2,500g (%)	6.3%	7.2%	5.9%	6.5%	5.7%	6.2%
Breastfeeding on Discharge	2016	Proportion breastfeeding (%)	46.1 %	45.8 %	45.1 %	48.9 %	48.6 %	41.1 %
Smoking in the home	2016/17	% not allowed in the home	83%	77%	84%	85%	85%	85%
Smoking in family cars	2016/17	% never allowed in any car	86%	88%	86%	87%	84%	86%
Young people having sexual intercourse (school years 8-12)	2016/17	% young people who have ever had sexual intercourse	4%	6%	5%	5%	4%	3%

Indicator Category – Diet and Dental Health

Indicator	Year	Unit of measure	NI	HSC Trust/LCG Area				
				Belfast	North	South East	South	West
P1 Body Mass Index: Obese (Male)	2015/16	Obese (%)	4.5%	4.6%	4.3%	4.5%	5.1%	4.0%
P1 Body Mass Index: Obese (Female)	2015/16	Obese (%)	6.4%	6.0%	6.9%	5.5%	6.7%	7.0%
P1 Body Mass Index: Overweight or obese (Male)	2015/16	Overweight or Obese (%)	18.2%	18.7%	19.6%	17.5%	17.0%	18.1%
P1 Body Mass Index: Overweight or obese (Female)	2015/16	Overweight or Obese (%)	25.9%	24.5%	28.3%	22.9%	24.7%	28.9%
Y8 Body Mass Index: Obese (Male)	2015/16	Obese (%)	6.6%	5.6%	7.8%	4.6%	7.2%	7.6%
Y8 Body Mass Index: Obese (Female)	2015/16	Obese (%)	6.5%	5.4%	7.1%	5.7%	6.1%	8.0%
Y8 Body Mass Index: Overweight or obese (Male)	2015/16	Overweight or Obese (%)	26.7%	25.5%	29.0%	19.5%	29.2%	29.7%
Y8 Body Mass Index: Overweight or obese (Female)	2015/16	Overweight or Obese (%)	27.9%	25.8%	29.4%	22.6%	29.6%	31.9%
Standardised Dental Registrations	2016	Indirectly standardised registration Rate	100	97	102	102	102	95
BMI classifications (adults): Obese	2016/17	Obese (%)	27%	25%	28%	28%	27%	24%
BMI classifications (adults): Overweight or obese	2016/17	Overweight or Obese (%)	62%	61%	62%	64%	61%	63%
BMI classifications (children 2-15): Obese	2016/17	Obese (%) based on IOTF guidelines	8%					
BMI classifications (children 2-15): Overweight or obese	2016/17	Overweight or Obese (%) based on IOTF guidelines	25%					
Meeting 5 a day recommendation (adults)	2016/17	% consuming 5 or more portions of fruit or vegetables each day	43%	39%	42%	40%	50%	45%
Meeting 5 a day recommendation (young people: school years 8-12)	2016	% consuming 5 or more portions of fruit or vegetables each day	17%	18%	17%	19%	18%	16%
Meeting recommended levels of physical activity (adults)	2016/17	% adults aged 19+ meeting CMO's Physical Activity guidelines	55%	53%	55%	60%	56%	49%
Meeting recommended levels (young people: school years 8-12)	2016/17	% meeting CMO's Physical Activity guidelines	13%	15%	12%	12%	13%	12%
Sedentary behaviour weekdays (adults)	2016/17	% adults aged 19+ over 4 hours sedentary time weekday	44%	49%	43%	38%	46%	42%
Sedentary behaviour weekends (adults)	2016/17	% adults aged 19+ over 4 hours sedentary time weekend	54%	55%	56%	49%	59%	47%

Appendix 4: NI Population Statistics

<u>Population Growth 2007- 2017</u> (0-64, 65+ and 85+ population)

0-64 Population by Trust

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belfast	289,660	291,930	293,544	295,068	295,470	295,266	296,289	297,826	299,918	300,655	301,187
Northern	387,235	389,906	391,496	392,001	392,538	392,278	391,778	392,206	392,718	392,998	393,331
South Eastern	288,926	290,273	291,791	292,334	292,396	292,797	291,710	291,324	292,120	292,518	293,216
Southern	298,108	302,968	306,645	309,344	311,881	314,223	315,445	317,835	320,100	323,093	325,095
Western	255,826	256,575	256,490	256,451	256,271	256,251	255,369	255,391	254,941	255,118	255,030
Northern Ireland	**1,519,755**	**1,531,652**	**1,539,966**	**1,545,198**	**1,548,556**	**1,550,815**	**1,550,591**	**1,554,582**	**1,559,797**	**1,564,382**	**1,567,859**

Source: 2017 MYEs

65+ Population by Trust

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belfast	51,816	52,133	52,295	52,547	52,870	52,987	53,329	53,728	53,860	54,051	54,406
Northern	63,866	65,570	67,414	69,298	71,005	73,251	74,946	76,845	78,470	80,078	81,442
South Eastern	48,723	50,201	51,850	53,665	55,316	57,300	59,078	60,977	62,531	64,175	65,492
Southern	42,681	43,818	44,991	46,255	47,540	48,922	50,267	51,556	52,876	54,138	55,217
Western	34,842	35,778	36,817	37,870	39,031	40,359	41,514	42,810	44,087	45,313	46,418
Northern Ireland	**241,928**	**247,500**	**253,367**	**259,635**	**265,762**	**272,819**	**279,134**	**285,916**	**291,824**	**297,755**	**302,975**

Source: 2017 MYEs

85+ Population by Trust

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Belfast	6,561	6,721	6,850	7,037	7,234	7,255	7,318	7,579	7,754	7,901	7,986
Northern	7,118	7,388	7,622	7,937	8,152	8,541	8,725	9,031	9,313	9,631	9,820
South Eastern	6,050	6,187	6,311	6,544	6,731	6,939	7,053	7,300	7,466	7,672	7,838
Southern	4,527	4,793	4,989	5,218	5,386	5,552	5,639	5,811	6,032	6,215	6,357
Western	3,690	3,841	3,960	4,094	4,262	4,426	4,549	4,723	4,895	5,042	5,153
Northern Ireland	**27,946**	**28,930**	**29,732**	**30,830**	**31,765**	**32,713**	**33,284**	**34,444**	**35,460**	**36,461**	**37,154**

Source: 2017 MYEs

Population Projections Trends by Trust (0-15, 16-64, 65+ and 85+ population)

0-15 Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	68,346	71,086	69,543	67,241	66,127	66,215
Northern	96,910	96,929	92,780	88,649	86,082	85,301
South Eastern	72,444	73,255	70,652	68,158	66,894	66,670
Southern	87,359	91,103	90,094	88,683	89,195	90,988
Western	65,180	65,384	62,439	59,099	56,994	56,201
Northern Ireland	**390,239**	**397,757**	**385,508**	**371,830**	**365,292**	**365,375**

Source: NISRA, 2016 Based Population Projections

16-64 Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	232,171	231,526	231,311	229,764	228,667	228,341
Northern	296,306	294,350	291,958	285,395	278,083	274,222
South Eastern	220,658	220,447	220,110	216,812	213,292	212,089
Southern	238,444	244,645	251,331	255,769	258,942	262,272
Western	189,639	186,315	183,533	178,617	172,893	169,373
Northern Ireland	**1,177,218**	**1,177,283**	**1,178,243**	**1,166,357**	**1,151,877**	**1,146,297**

Source: NISRA, 2016 Based Population Projections

65+ Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	54,310	57,135	63,667	71,247	76,734	79,519
Northern	81,651	90,951	102,709	116,055	126,815	131,431
South Eastern	65,622	73,897	84,103	94,693	102,715	106,237
Southern	55,266	62,446	71,944	82,784	92,412	97,972
Western	46,431	52,426	59,570	67,562	73,926	76,566
Northern Ireland	**303,280**	**336,855**	**381,993**	**432,341**	**472,602**	**491,725**

Source: NISRA, 2016 Based Population Projections

85+ Population Projections by Trust

	2017	2022	2027	2032	2037	2041
Belfast	7,968	8,226	8,792	10,233	11,578	12,986
Northern	9,862	11,498	13,803	17,502	20,411	22,623
South Eastern	7,862	9,119	11,042	14,683	17,448	19,190
Southern	6,359	7,647	9,099	11,617	13,858	15,683
Western	5,187	6,020	7,110	9,177	11,052	12,362
Northern Ireland	**37,238**	**42,510**	**49,846**	**63,212**	**74,347**	**82,844**

Source: NISRA, 2016 Based Population Projections

Percentage increase in Population by Trust (0-15, 16-64, 65+,85+ and total population)

0-15 POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	68,618	17.6%	71,086	3.6%
Northern	96,991	24.8%	96,929	-0.1%
South Eastern	72,589	18.6%	73,255	0.9%
Southern	87,262	22.3%	91,103	4.4%
Western	65,224	16.7%	65,384	0.2%
NI	390,684	100.0%	397,757	1.8%

0-64 POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	301,187	19.2%	302,612	0.5%
Northern	393,331	25.1%	391,279	-0.5%
South Eastern	293,216	18.7%	293,702	0.2%
Southern	325,095	20.7%	335,748	3.3%
Western	255,030	16.3%	251,699	-1.3%
NI	1,567,859	100.0%	1,575,040	0.5%

65+ POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	54,406	18.0%	57,135	5.0%
Northern	81,442	26.9%	90,951	11.7%
South Eastern	65,492	21.6%	73,897	12.8%
Southern	55,217	18.2%	62,446	13.1%
Western	46,418	15.3%	52,426	12.9%
NI	302,975	100.0%	336,855	11.2%

85+ POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	7,986	21.5%	8,226	3.0%
Northern	9,820	26.4%	11,498	17.1%
South Eastern	7,838	21.1%	9,119	16.3%
Southern	6,357	17.1%	7,647	20.3%
Western	5,153	13.9%	6,020	16.8%
NI	37,154	100.0%	42,510	14.4%

TOTAL POP.

	2017 MYEs		2016 Based Projections	
	2017	% of NI	2022	% Change
Belfast	355,593	19.0%	359,747	1.2%
Northern	474,773	25.4%	482,230	1.6%
South Eastern	358,708	19.2%	367,599	2.5%
Southern	380,312	20.3%	398,194	4.7%
Western	301,448	16.1%	304,125	0.9%
NI	1,870,834	100.0%	1,911,895	2.2%

Glossary of Terms

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

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

Chronic / long term conditions – illnesses such diabetes or heart disease that can affect people over long periods of their lives and which need regular treatment and medication.

Clinical Guidelines (NICE) - are recommendations on the management of people with specific diseases and conditions – regarded as standards that the HSC is expected to achieve over time.

Commissioning – is the term used to describe all the activities involved in assessing and forecasting the health and social care needs of the population, links investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. Joint commissioning is where these actions are undertaken by two or more agencies working together (in this case the HSCB & PHA), typically health and local government, and often from a pooled or aligned budget.

Commissioning Plan Direction (CPD) – a document published by the Department of Health (DoH) on an annual basis which outlines the key messages, targets and indicators of performance for the year ahead.

Community and Voluntary Sector – the collective name for a range of independent organisations which support the delivery of health and social care but are not 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).

Delivering Care - *Delivering Care* sets out principles for commissioners and providers of Health and Social Care services for planning nursing workforce requirements. It was published in March 2014.

Demography - the study of statistics such as births, deaths, income, or the incidence of disease, which illustrate the changing nature of a country's population.

Evidence Based Commissioning – seeking to provide health and social care services which have proven evidence of their value.

Healthcare Associated Infections (HCAI) - Healthcare-Associated Infections are those infections that develop as a direct result of any contact in a healthcare setting.

Health Inequalities – the differences in health and the rates of illness across different sections of the population and different areas where people live. For instance, we know that in areas of social and economic deprivation, more people tend to suffer from illnesses such as heart disease.

Health and Social Care Board (HSCB) – The HSCB role is to commission services, working in partnership with Trusts to deliver services and manage the annual budget given by the Northern Ireland Executive

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

Integrated Care Partnerships (ICPs) – these evolved from Primary Care Partnerships and join together the full range of health and social care services in

each area including GPs, pharmacists, community health and social care providers, hospital specialists and representatives from the independent, community and voluntary sector as well as service users and carers.

Lesbian, Gay, Bisexual & 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/PHA which provides a strong independent voice for the people of Northern Ireland on health issues.

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

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

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

Public Health Agency (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.

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

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

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