

HEALTH AND SOCIAL CARE BOARD PUBLIC HEALTH AGENCY

COMMISSIONING PLAN 2010/2011



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Foreword

Legislation enacted on 1 April 2009 created a new Commissioning system with the establishment of a region-wide Health and Social Care Board, including 5 Local Commissioning Groups (LCGs), and a Public Health Agency. In line with Departmental direction and guidance the objectives of the new commissioning arrangements were to:

- Approach the future delivery of Health and Social Care from a region-wide perspective focused on outcomes.
- Ensure local sensitivity through the creation of five Local Commissioning Groups reflective of their areas.
- Give appropriate weight to the public health agenda to ensure that commissioning reflects the drive to reduce health inequalities in our society and works in partnership with others to improve health and wellbeing.

In this regard the legislation signalled a new way forward which would first be expressed in a Commissioning Plan for 2010/11 and beyond. This plan outlines how the Health and Social Care Board and the Public Health Agency are approaching that task. It is our aim that this plan is straightforward and written in a manner which will encourage public engagement and understanding. We wish to show clearly how the commissioning task is to be approached and to signal the decisions necessary to ensure the maintenance of a health and social care system in Northern Ireland which responds to the population it serves.

Commissioning is the process which looks at the needs of the population and plans and secures Health and Social Services to respond to that need.

The Commissioning Plan takes full account of the commissioning direction, financial parameters and Priorities for Action set out by the Minister and DHSSPS. Commissioning has been defined as a “... process which looks at the needs of the population, and plans and secures health and social services to respond to that need within given financial parameters with the objective of improving and protecting the health and social wellbeing of the population

and reducing differences in access to good health and quality of life”.

In this regard Commissioning is principally concerned with what is available; it is less concerned with (although not exclusively divorced from) how it is provided. To discharge this responsibility we propose to use the criteria listed below in our planning and decision making to ensure that these processes are linked explicitly to the need for change and for improved clarity of purpose:

- Are decisions rooted in existing policy and targeted to delivering Ministerial objectives and Priorities for Action?
- Do they demonstrate appropriate needs assessment of the population?
- Is there evidence and/or measurement to support these judgements?
- Can we show that the outcomes for the citizen will be improved?
- Is there balance between local provision and the need to ensure safety and sustainability of services to the population?
- Do proposals take account of opportunities for earlier diagnosis and more cost effective intervention?
- Do our proposals ensure an accessible service for the population and address inequalities?
- Do the decisions take account of imminent and future changes in treatment and care?
- Do our proposals contribute to improving health and social wellbeing and reducing health inequalities?
- Are decisions in line with the agreed commissioner quality standards?

The last three years have seen many significant improvements in a wide range of areas, most notably in waiting times for elective

The future shape of Northern Ireland Health and Social Care system needs to change. Maintaining the status quo is not an option.

treatment and for Accident and Emergency services; in childcare services, improved access to specialist drugs, better access to primary care services, the development of enhanced services which have enabled the shift of care from hospital to community, improvements in chronic disease management through the Quality Outcomes Framework and the continuing growth in community services. The improvements – particularly in waiting

times – have been achieved despite a significant growth in demand. This has been achieved by investing in a range of Health and Social Care (HSC) provision and by specific initiatives procured outside that framework.

Over the same period the HSC system has been faced with the need to make an overall 9% reduction in funding through improved efficiency. Simultaneously it has had to absorb significant increases in demand, perhaps up to 2%. That so much has been done in the face of serious financial constraint and increased demand is a tribute to the professionalism and dedication of Health and Social Care. However, if we are to have a prospect of maintaining the quality of our services and indeed making progress on the many challenges still facing us (such as addressing health inequalities) we need to progress three key areas.

First, we need to understand more fully the nature of demand for services and to identify better ways of dealing with the increases in demand that we have experienced. Our experience to date suggests a number of major avenues through which we can take this work forward:

- The development of groups of General Practitioners co-operating together in the delivery of Primary Care;
- The reshaping of existing patterns of hospital services;
- The promotion of “living at home” strategies in dealing with a range of illnesses including many chronic conditions.

Secondly, we must plan for the future in the knowledge that significant new resources are unlikely to be available. This will mean reviewing how existing services can be reshaped to deliver future demand and needs – even where this confronts us with difficult and potentially unpopular choices.

Finally, we need to give a much greater emphasis to health promotion and disease prevention. For example, research suggests up to 70% of all attendances at general practice are directly related to weight, tobacco use, alcohol consumption, poor sleep or stress. Clearly a different approach to lifestyle and targeted interventions can materially change the population's health status and address inequalities in health. The Public Health Agency will have a key role in developing programmes to drive this agenda forward.

We need to give much greater emphasis to health promotion and disease prevention.

The Commissioning Plan was approved by the Boards of the Health and Social Care Board and the Public Health Agency on 27th of May 2010 and submitted to the Department for consideration. The final Commissioning Plan was approved by the Minister on () and arrangements have now been put in place by the Health and Social Care Board, in partnership with the Public Health Agency, to oversee the delivery of the Commissioning Plan. These include:

- The translation of the Commissioning Plan into objectives within corporate and local commissioning plans that will be the subject of scrutiny through established performance review;
- Detailed service and budget agreements with providers, supported by appropriate performance management regimes to ensure delivery of Priority for Action targets and other objectives;
- Project management arrangements to implement and monitor the financial plan for 2010/11 in line with the financial allocation received from the Department;

- Securing the development of detailed proposals from Local Commissioning Groups and Providers to give effect to the commissioning strategy in this Commissioning Plan for consideration, equality screening, consultation and implementation as appropriate.

The future shape of Northern Ireland Health and Social Care system needs to change. Maintaining the status quo is not an option. Commissioning can and will create that change and this Commissioning Plan for 2010/11 reflects that imperative, acknowledging that final decisions fall to the Minister and the Department in the light of resource availability.



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Section One

Summaries and Overviews

1 Strategic Context

This section focuses on some of the environmental factors influencing policy formulation and on the major policy imperatives which define the future direction of travel for service development and redesign.

1.1 Demographic Changes

Northern Ireland is becoming an older society. While the absolute size of our population is estimated to increase over the next ten years, of greater significance to the demand for Health and Social Care is the likelihood that the average age of our population will also continue to increase at a faster rate. Specifically, estimates are that between 2008 and 2020:

- The Northern Ireland population will increase by 142,000 people (8%);
- The number of people over 75 years will increase by 40%.

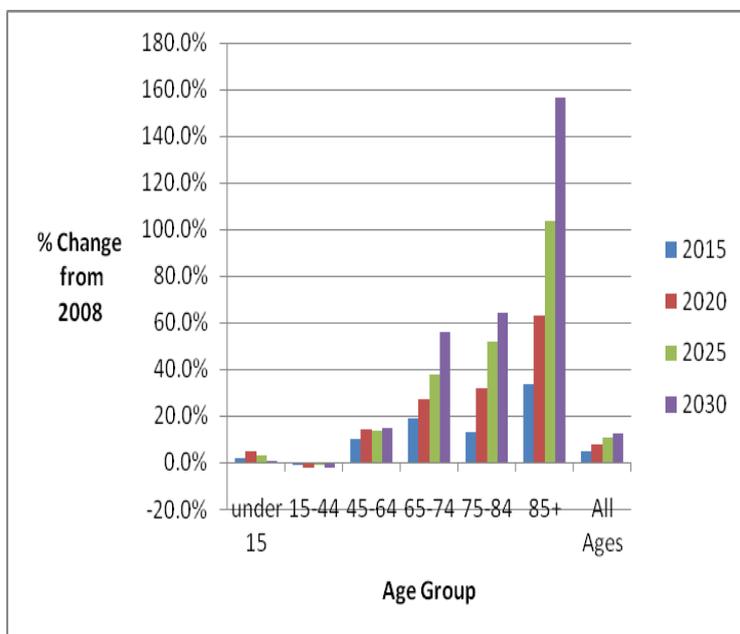


Figure 1: Changing Demography of Northern Ireland - % Change by 2015, 2020 and 2030 by age group.

Older people are major users of our Health and Social Care system. On any given day:

- 800 beds in Northern Ireland are occupied by individuals aged over 70 years;
- Two thirds of acute hospital beds in Northern Ireland are occupied by individuals aged over 65 years;
- 1 in 14 people aged over 65 have a form of dementia, rising to 1 in 6 people over 80 and 1 in 3 over 85 years;
- Of the 21,000 people who receive home help services, 69% are aged 75 years and over;
- 9,485 people aged over 65 are cared for in residential and nursing homes;
- At any given time 1 older person in 8 is very dependent upon health and social services to support them each day.

An important element within this plan is a further shift to supporting people at home.

If systems remain unchanged by 2020 demand placed on our systems by an elderly population mean that hospital admissions will have increased by 17% and beds used by 23%.

Older people tell us that they want care, support and treatment in or close to home (Health & Wellbeing Strategy for Older People 2006-16). Commissioning must therefore continue to reform and modernise the Health and Social Care system, responding to growing demand with an increased emphasis on community based services.

An important element within this plan is to promote older people's health and wellbeing, through a further shift to supporting people at home and giving individuals, their family and local communities' greater control over the range and delivery of services. Major features will be positive health promotion, the active prioritisation of direct payment schemes, the focus on support for carers, the management of people with chronic diseases in their own homes with the help of technology, and the delivery of palliative care in the community.

1.2 Safe and Sustainable Services

The overall aim in commissioning is to ensure that the people of Northern Ireland have timely access to high quality services and equipment, responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively. To maintain and to continue to achieve this standard of service will mean a reprofiling of the current pattern of services. To meet best clinical practice some services may have to be delivered on a national, regional or sub regional basis. This is not a new approach and we have demonstrated in the past – for example by consolidating cancer care into the major acute hospitals with streamlined access to a regional service – that we can provide evidence based practice standards and achieve improved outcomes for people with cancer.

Frequently these changes are simplistically portrayed as centralisation. The Commissioner will wish to secure local services for local people but simultaneously provide safe, sustainable services for the population at large.

The safety of services provided is paramount and we will progress strategies for reducing infection rates, reducing untoward events across all areas of practice, achieving real improvement in hygiene to improve outcomes and the patient/client experience.

To meet best clinical practice some services may have to be delivered on a national, regional or sub regional basis.

Commissioning is about securing good outcomes and providing safe services. We recognise the importance of patient choice and the need for people to have confidence in how our services are provided. Choice will therefore be a major theme in driving commissioning but this must be realistic and consistent with the delivery of safe, effective care.

1.3 Modern Treatments

Since 1948 the nature of Health and Social Care services has been characterised by the need to respond to new demands, treatments and interventions. For example many surgical procedures previously requiring inpatient stays in hospital now

happen safely on a day case basis allowing patients to return home on the same day as their treatment occurs.

In recent years, we have seen the day case rate as a percentage of total elective work increase in certain key service areas. By March 2011, there is a requirement that all Trusts in Northern Ireland achieve a 75% day case rate across a basket of 24 specified procedures which will see the number of day cases rise even further.

Treatment for cancer has been revolutionised over the past decade with survival rates improving across a range of cancers, although we still fall behind European survival rates in a number of cancers, so further work needs to be done.

Improved survival rates have occurred at a time of significant investment in improving access to cancer services including drug regimes. As survival rates continue to increase the nature of caring for people with cancer will change. More people will be living with cancer as a chronic illness and our services must evolve responsively to these needs.

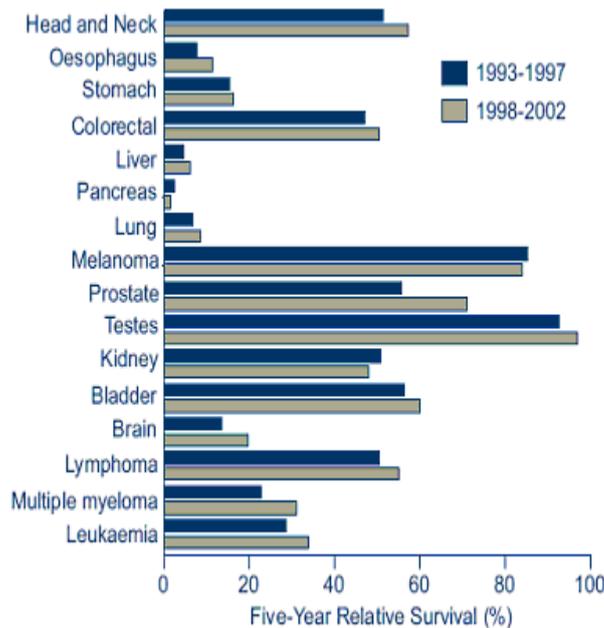


Figure 2: Changes in survival for male patient with cancer by cancer site, 1993 – 2002 (Five year relative survival by sex, cancer site and period of diagnosis. Source NI Cancer registry).

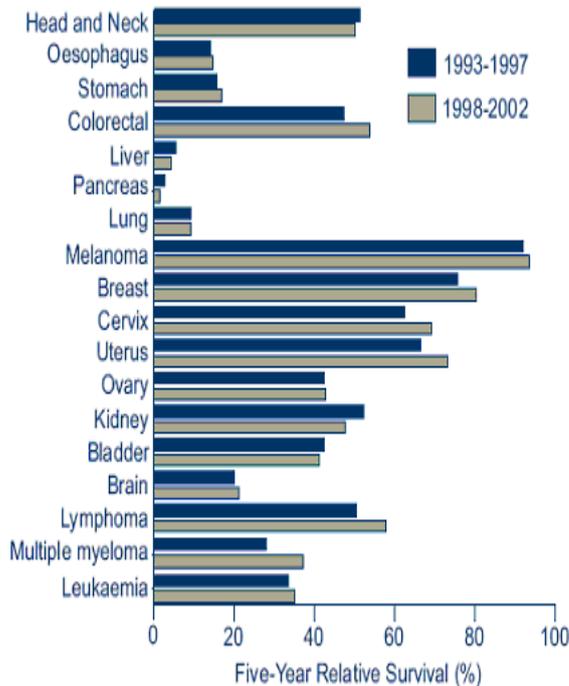


Figure 3: Changes in survival for female patient with cancer by cancer site, 1993 – 2002 (Five year relative survival by sex, cancer site and period of diagnosis. Source NI Cancer registry).

New drugs and treatment techniques for a wide range of healthcare needs are constantly being developed and their efficacy and value assessed by the National Institute for Clinical Excellence.

Traditional support supplied in children’s residential care has been revolutionised by a much expanded and more skilled fostering service.

Home based treatment in mental health services has introduced a recovery model of treatment and led to major changes in how hospital care is provided.

Primary Care has been given the opportunity to provide more care and treatment in the community through locally enhanced services. The decision to introduce and implement these kinds of improvements and innovations is linked to how we use resources. Sometimes this will happen with new funding, or possibly the re-use of funding released by greater efficiency or a decision to change the priority of an existing service.

Our local population of 1.7m cannot support the full range of modern acute services some of which will have to be commissioned outside Northern Ireland to meet the required standards.

The introduction of a service can also depend on the availability within Northern Ireland of staff with the appropriate expertise and skills. For example, with a local population of 1.7m it is difficult to support the full range of modern acute services. Some very specialist services for our population will either be commissioned outside Northern Ireland or will be jointly commissioned with other regions.

It will not always be possible to commission immediately every new service that is available.

It is also essential to recognise that it will not always be possible to commission immediately every new service that is available, even where approved by the National Institute for Clinical Excellence. Commissioning in these areas will inevitably make for difficult choices. For example, we will

shortly complete a pilot on demand for bariatric surgery. There is no certainty that we will be in a position to commission this service locally and we may opt instead for prevention and support services as alternatives for those with obesity problems. Similarly, there are a number of instances where social care patients have been the subject of transfer to high cost facilities outside Northern Ireland. It will be important to scrutinise these and other similar future cases in order to determine whether appropriate alternatives can be supplied locally.

1.4 Resources

Discussion about money is always controversial. In the public perception, proposed changes or debates about money are frequently assumed to be about savings or perceived cuts. **Where any commissioning decisions are primarily taken to make a saving or service reduction, this will be explicitly stated.**

In fact many of the decisions to make change are not driven by money but by a desire to improve quality or effectiveness. Commissioners will not avoid such decisions but will seek to take them in an informed and sensitive manner that reflects the potential implications for individuals and communities.

In the end however there are no neutral decisions. Unnecessary

2010/11 will be the most difficult financial year for Health and Social Care in a generation.

preservation of an existing pattern of service delivery will in all probability mean denial of new developments. Making choices is a reality for any commissioning system. This is vitally important to understand in the financial climate that commissioning is entering. For over a decade Health and Social Care has invested in one year and met the full cost from a growth in funding the following year. The period 2010-13 will not permit such a pattern. It is much more likely that the money currently in the Health and Social Care system is the most that will be available leading to a number of difficult years ahead. Whilst this represents a different climate the Health and Social Care system is likely to continue to spend 38% of the Northern Ireland Block. We will commit nearly £10m¹ every 24 hours to enable the delivery of services to the population of Northern Ireland. Opportunities to develop new services remain but only if there is change and greater efficiency in the current service patterns. It is, however, a fact that 2010/11 will be the most difficult financial year for Health and Social Care in a generation.

*¹Source: DFP
Review of
2010/11
Spending
Plans*

Often when there is a debate in regards to resource the problem is presented in terms of unnecessary bureaucracy. While it is important that administration and management costs are tightly controlled and represent value for money, this does not reflect where the real focus needs to be. Within Health and Social Care today we commit 4.1% of the commissioning resource to management costs. We need a properly managed system that is responsibly resourced. Very significant administrative and management savings have been made in the last 3 years. For example a 20% reduction in the resources available to the Health and Social Care Board has been achieved. The real debate about resource is an understanding of the need for change and decisions about what can and cannot be provided. The Plan will not be distracted from this central issue. However, as Commissioners, we fully appreciate that final decisions require to be endorsed by the Minister and the Department of Health, Social Services and Public Safety (DHSSPS).

1.5 Workforce

Successful commissioning needs to have a keen appreciation of the workforce implications of what it wishes to see provided. This

holds true for all types of grades and staff working in the sector. It also requires the Commissioner to have an appreciation of capacity within the delivery system. This interest spreads across both the statutory and independent sector. In 2009/10 £25m was spent on locum doctors and nurses in Northern Ireland to support the existing hospital system. Such expenditure not only represents poor value for money but also impacts on the continuity and therefore the quality of care provided. Commissioning in 2010 and beyond will seek to reshape the hospital sector in a manner which minimises the need for such expenditure. This change is also required to respond to the implementation of the European Working Time Directive and take account of the actual medical workforce availability.

In 2009/10 £25m was spent on locum doctors and nurses in Northern Ireland to support the existing hospital system.

Such a change is driven principally by quality, and the interplay of quality, volume and value for money is at the core of this decision making process. Although there will be a requirement for rapid change it will be done in such a manner as to reflect the need to respond to capacity. Failure to acknowledge this would simply lead to

unplanned service change or collapse and inappropriate commissioning which does not take account of responsible risk management.

1.6 Demand

Reference has already been made to demographic change and the effect this has on demand for services:

- In 2008/09 demand grew by 12% in the hospital sector and is on target for a further 9% growth in 2009/10;
- Family and child care services saw demand in the children at most risk grow by 20%;
- In one Trust area additional home care services for older people rose by 20% between 2008 and 2009. For the same Trust there was a 55% increase in the number of older people with complex care needs discharged from hospital over the same period.

Understanding these demand patterns is a central issue for the commissioning system and 2010 will see detailed work and analysis undertaken on both demand for services and on our performance in meeting that demand.

For example, if we were able to improve our performance in hospital length of stay to a level equivalent to the better performing hospitals in the rest of the UK this would substantially reduce the requirement for beds. This in turn would allow us to consider re-investment in community based services and prevention/screening programmes whilst maintaining or even raising quality within the hospital sector. This means planned change within the hospital sector.

In 2008/09 demand grew by 12% in the hospital sector and is on target for a further 9% growth in 2009/10.

At the same time, the creation of Local Commissioning Groups provides us with an opportunity to engage with family practitioners, patients, carers and local care providers to examine both the nature of demand and the potential for local alternatives for appropriate assessment and treatment.

Local Commissioning Groups, in partnership with primary care, will have a key role in the analysis of demand for services and in developing, where appropriate, safe, effective alternative models of care. For example in 2010/11 Local Commissioning Groups will, through partnerships with local stakeholders, explore solutions within primary and community care as alternatives to acute assessment and treatment in a range of acute specialities.

1.7 Developing Better Services

We propose to accelerate the implementation of the final stages of this strategy so that the transition to this model will be substantially completed by 2013.

Written in 2002, this DHSSPS strategy addresses the future shape of hospital provision for Northern Ireland. Although time has moved on its core principles remain. Changes have occurred at Downpatrick, Lagan Valley, Enniskillen, Omagh, South Tyrone and most recently Magherafelt and Whiteabbey. In 2010/11 we propose to accelerate the implementation of the final stages of this strategy so that transition

to this model will be substantially completed by 2013. In addition we will need to address the outcome of the recently announced Review of Maternity Services and the impact this will have on the future pattern of provision later in 2010/11.

The principal driver remains the maintenance of quality of intervention and whilst local services and central delivery will be balanced in the commissioning process, safety, sustainability and outcome will be the key determinants.

The next steps in terms of detailed implementation will follow but it will lead to new roles for local hospitals and the concentration of acute inpatient services on fewer sites. This approach will require change to facilities located in both urban and rural settings. Additionally it will signal new commissioning partnerships with the Republic of Ireland and other facilities in the UK. This will reflect the fact that a population of 1.7m is simply too small to safely sustain some highly specialised services.

1.8 The Bamford Report

The Bamford Report and the 'Protect Life' Strategy set out the vision for the reform and modernisation of Mental Health, Learning Disability and Child and Adolescent Mental Health Services over a fifteen year horizon. Since the publication of the individual reports,

A core theme (of Bamford) will be the need to strengthen community services to promote a recovery based model of care provided predominantly in or

further evidence based models of service delivery have emerged and these will be integrated during the implementation of the Bamford recommendations. The Health and Social Care Board and the Public Health Agency have established a number of core task groups to take this work forward and this will be monitored by the Bamford

Implementation Taskforce, led by the Health and Social Care Board's Chief Executive. A core theme will be the need to promote mental health and wellbeing and to strengthen community services to promote a recovery based model of care provided predominantly in or close to people's homes. As outlined in "Delivering the Bamford Vision" (DHSSPS, 2009), key themes include:

- Promoting positive health, wellbeing and early intervention;
- Supporting people to lead independent lives;
- Supporting carers;
- Providing better public services to meet people’s needs;
- Providing structures and a legislative base to deliver the Bamford Vision.

1.9 Older People

The strategic direction for services for older people has been guided by Priorities for Action in recent years, with the focus being on a continuum of integrated primary and community care services, supporting independence and reducing inappropriate reliance on hospitals and other institutional care. The anticipated Service Framework for Older People’s Health and Wellbeing and the NI Dementia Strategy will form the future strategic direction for commissioning, with the agreement of evidence based standards, targets and measurable outcomes. Using this strategic base, commissioning will aim to ensure a balance of provision between disease prevention, health promotion and healthy ageing, and the required network of care and treatment services for those most at risk.

Our focus is on supporting independence and reducing inappropriate reliance on hospitals and other institutional care.

1.10 Children

The theme of improving children’s health and wellbeing resonates with the six high level outcomes identified in the Office of the First Minister and Deputy First Minister Strategy “Our Children and Young People – Our Pledge”, which refers to actions which demonstrate and evidence to show that children and young people are:

It is important that children are valued, protected and cherished as they are the foundation stone for future generations.

- Healthy;
- Enjoying, learning and achieving;
- Living in safety and with stability;
- Experiencing economic and environmental wellbeing;
- Contributing positively to community and society; and
- Living in a society which respects their rights.

This strategy, combined with other overarching strategic documents issued by the DHSSPS, such as “Care Matters” and “Families Matter” provide the context in which services are being commissioned. There is recognition of the need for development and investment across the continuum of children’s services from prevention/early intervention to adoption/leaving and aftercare. There is an extensive body of evidence which demonstrates the cost benefit analysis of an investment in our children. It is important that children are valued, protected and cherished as they are the foundation stone for future generations. “Care Matters” outlines the corporate role of Health and Social Care to assist those children and young people looked after and care leavers whose health and wellbeing requires to be improved.

1.11 Disability

The Regional Strategy for People with Physical Disabilities and Sensory Impairment will be the strategic framework for services for this client group. The focus will continue to be on promoting health and wellbeing, independence and empowerment and improving the quality and responsiveness of Health and Social Care services for people with disabilities and their carers. The Strategy will adopt a life cycle approach covering all age groups and will promote the importance of partnership working across community and independent sectors.

1.12 Reducing Inequalities and Promoting Health and Social Wellbeing

Relative deprivation in Northern Ireland is assessed by looking at income, employment, education, health, including disability and

early death, local environment, crime and proximity of an area to services such as GP surgeries, hospitals or shops. Individual areas are ranked across Northern Ireland based on these. The 20% of most deprived areas represent nearly 340,000 people.

Populations from deprived areas in Northern Ireland experience:-

- Lower life expectancy than the Northern Ireland average;
- 23% higher rates of emergency admission to hospital;
- 66% higher rates of respiratory mortality;
- 65% higher rates of lung cancer;
- 73% higher rates of suicide;
- Self harm admissions at twice the Northern Ireland average;
- 50% higher rates of smoking related deaths;
- 120% higher rates of alcohol related deaths.

It is clear therefore that we need to do more to narrow the gap in health inequalities and improve the health and wellbeing of our population. This means working to address the determinants of ill health and reduce risk factors, including those associated with poverty and social exclusion. This Commissioning Plan contains specific measures to address this challenging agenda, but it is equally important that health prevention and improvement is actively considered as an integral part of all of our commissioning strategies.

The focus will be on the wider public health agenda, addressing the determinants of health that contribute to and sustain health and social wellbeing inequalities. Inequalities in health arise because of inequalities in society. Addressing inequality therefore requires co-ordinated action across many different sectors and government. The reform and modernisation of the commissioning process can greatly assist this goal. Firstly, by taking a leadership role championing the issue and working collaboratively with other sectors to address the challenge; secondly, by shifting resources and commissioning 'upstream' interventions; and thirdly

developing exemplar roles in creating healthy workplaces and by ensuring that the entire health and social care workforce use every interaction with the public to promote health and wellbeing.

We will therefore aim to identify and encourage new models of care that facilitate the transfer of resources to this end. We will also consider the potential value of changes to relevant legislation where this may be a vehicle for promoting change. The aim will be to:

- Make tangible difference to health and wellbeing outcomes;
- Decrease incidence of major causes of ill health;
- Maximise independent living;
- Improve mental health scores of population;
- Reduce health inequalities gap;
- Build sustainable communities and increase social capital and community engagement;
- Impact on the full pathway from community to service.

1.13 Performance Management

The ability to positively impact on health and social inequalities cannot be exclusively addressed by the Health and Social Care Board. Meaningful partnerships and a common agenda need to be developed with our Trusts, our colleagues in local government, housing, education and the environment, and our communities if we are to effectively deliver on improving the health of our population. The Public Health Agency will have a key role in developing programmes to drive this agenda forward in the context of the review of the Investing for Health Strategy and the work that will be developed on a new Investing for Health Strategy for beyond 2012

Strong performance management will be key to achieving an outcome which is positive and publicly understood, and ensures compliance with standards, statutory obligations and Priorities for Action targets set annually by the DHSSPS. In 2010/11 we will

Our first obligation is to ensure safe, sustainable services which respond effectively to the population's needs.

continue to develop the use and publication of a range of high level commissioning milestones as a benchmark of performance. While performance management of our care providers such as Trusts, General Practitioners and other primary care providers will

be conducted in a supportive manner, we will be clear our first obligation is to ensure safe, sustainable services which respond effectively to the population's needs and represent value for money.

1.14 Evidence Based Commissioning

Commissioning needs to be carried out within a framework of formal evidenced based guidance about the standards and outcomes we need to achieve. There are two key drivers in developing this approach:

Managed Clinical Networks

Managed Clinical Networks are a way of supporting the provision of high quality, sustainable, safe and effective services to our population. Integration and partnerships with clinical colleagues, either regionally, nationally or with the Republic of Ireland means that in Northern Ireland, despite our small population, we can be assured that our services are delivered to the highest possible standards. We already have some networks in place for paediatric cardiac surgery, adult intensive care, cancer and pathology services, and we will continue to develop these arrangements as appropriate.

Service Frameworks

Service Frameworks are sets of guidance on the highest quality of care and good practice spanning specific conditions or service areas. This guidance encompasses nationally supported evidence based standards, as well as the input of local clinical experts, in the development of recommendations applicable to our local services. Work is currently underway on the implementation of the Service Frameworks for Cardiovascular and Respiratory Services. Other Service Frameworks for Cancer, Mental Health and

Wellbeing, Learning Disability, the Health and Wellbeing of Children and Young People and the Wellbeing of Older People are at various stages of development.

Commissioning will make progress with the implementation of these recommendations. However, there will be a need to balance how and when the recommendations can be fully implemented with affordability, workforce skills and capital investment.

Approaches in the near future are therefore likely to focus on standardisation of good practice and reprofiling of care systems in the first instance, rather than assuming that significant additional resources will be available for service development.

2. Ensuring Financial Stability and Effective Use of Resources

The key objective of the Commissioning Plan is to use all available resources to ensure the overall investment in services secures as broad a range as is practicable along with the best possible outcomes for local populations. In developing the Commissioning Plan the Health and Social Care Board, supported by the Public Health Agency, recognises that significant resources are available to support its successful delivery. In 2010/11 this will include access to almost £3,559.4m of the commissioning revenue resources.

To deliver a successful Commissioning Plan requires us to be sensitive to the financial parameters within which commissioning operates. It is vitally important that we provide as much clarity as we can to the public in relation to the financial climate within which commissioning will operate in 2010-13. It is unlikely that the level of growth funds that has characterised the last decade will be available in the period 2010-13.

Opportunities to develop new services remain but will require transformational change in the current service patterns. Absolute growth in resources will be very limited.

Decisions about how we make the best use of the resources at our disposal will be complex, challenging and at times controversial. Such decisions will need to take account of rising demand, existing shortfalls, the financial challenges and quality and service outcomes. Change is therefore an integral part of commissioning. The direction of travel set out in the Commissioning Plan will involve a greater focus on value for money, efficiency and improved outcomes in respect of the health and wellbeing of our local populations. Ensuring value for money will be driven forward through new models and pathways of care with greater use of benchmarking of standards for existing services across Health and Social Care. New accountability arrangements between providers and the Health and Social Care Board will underpin this process. This chapter covers:

- An overview of the existing investment of Health and Social Care Board and Public Health Agency resources;

- An overview of the financial plan for 2010/11 and key financial targets.

2.1 Existing Investment

In 2009/10 the DHSSPS received an overall budget of recurrent resources, £4.3bn. Of this, the Health and Social Care Board and Public Health Agency received £3.1bn for commissioning Health and Social Care on behalf of the 1.7m people resident in Northern Ireland. The balance was used by the DHSSPS to directly fund a range of areas such as prescription drugs costs, general practice costs as well as dentistry and optician services. (During 2010 the responsibility for these services will transfer to the Health and Social Care Board).

Figure 4

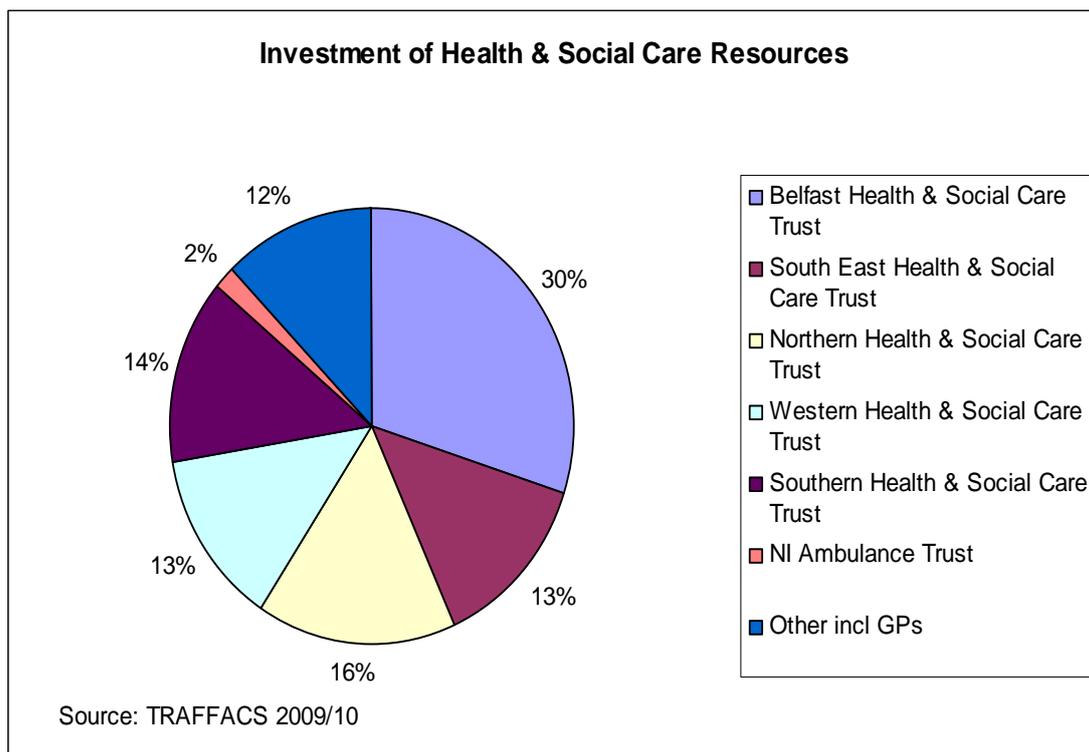
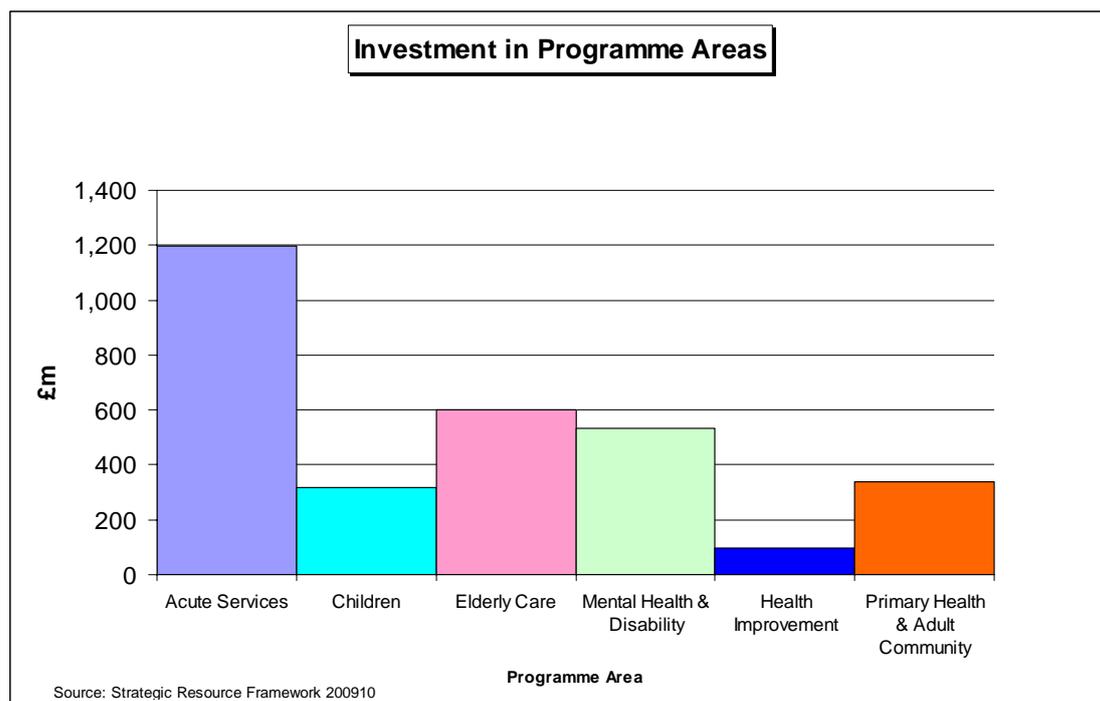


Figure 4 illustrates how commissioning resources are currently allocated across the six Provider Trusts and various other providers of care such as voluntary organisations and General Practitioners.

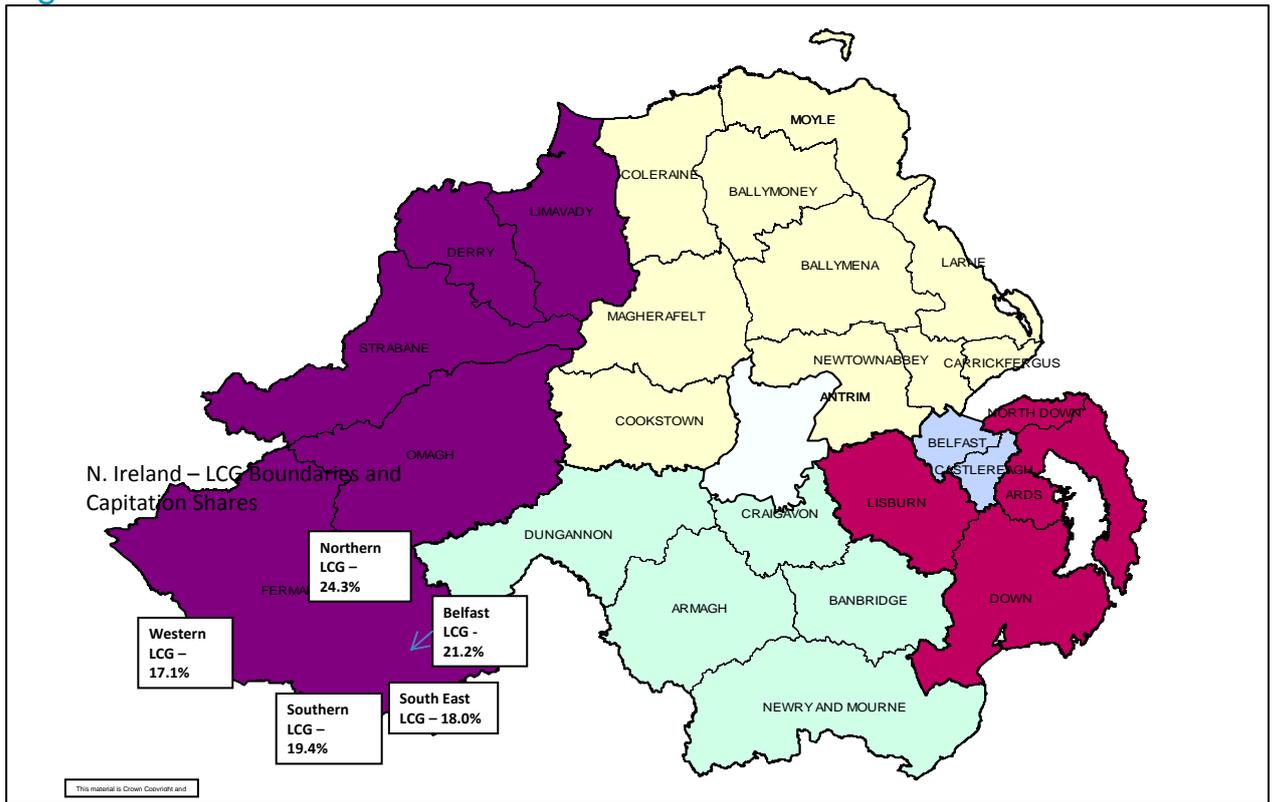
Historically these resources have been invested and managed across Programme of Care areas. These have been broadly mapped in Figure 5 (below) to the Priority for Action areas around which the 2010/11 Commissioning Plan has been developed.

Figure 5



Ensuring these resources are fairly distributed across local populations is a core objective of the commissioning process. Taking account of the diverse needs of local populations is also key. Different population profiles in localities result in the requirement to target resources to reflect the different levels of need; for example, where there are particularly high levels of the very elderly or very young as they are the primary users of health care. It is also the case that where there are high levels of deprivation within population areas this will result in a higher than average need for investment in areas such as social care and health improvement. The Health and Social Care Board uses a validated statistical resource allocation formula to inform its investment decisions made for the population in their localities. This is known as the "capitation formula". It reflects the different levels of needs across the population for Health and Social Care resources. Figure 6 shows the relevant capitation shares mapped to localities.

Figure 6



Capitation shares based on 2007 Mid Year Estimates

Figure 7

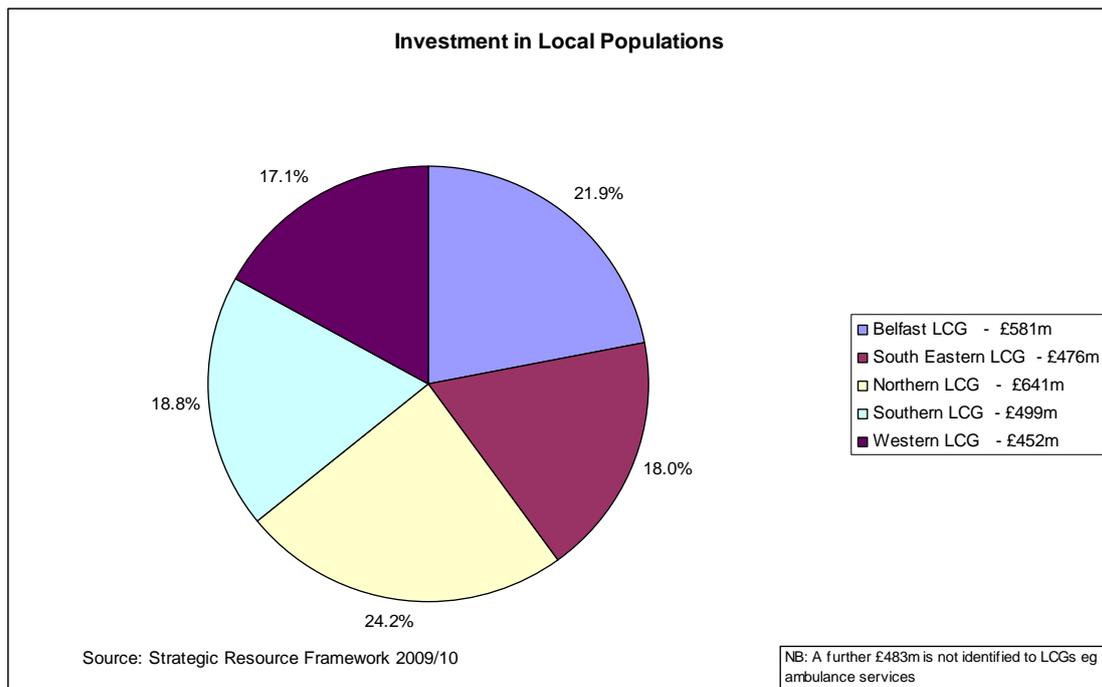


Figure 7 illustrates how existing resources are invested in local populations.

It is important to appreciate that services provided to a population may not always occur in the local geography. Whilst the Health and Social Care Board is committed to local services for local people, it must also ensure that the population has a safe and sustainable service. For example, specialist residential care for children or cardiac surgery will be provided on a province wide basis.

2.2 Overview of Financial Plan 2010/11

The DHSSPS previously published three year resource plans for Health and Social Care spanning 2008/09-2010/11. These were fully approved by the Northern Ireland Executive. These indicated baseline recurrent allocations at the end of the 2009/10 financial year to the Health and Social Care Board and Public Health Agency with plans to allocate around £107m for priority service improvements and developments in 2010/11.

However, the financial climate for 2010/11 has changed since the publication of these original plans. The changes were confirmed when the Northern Ireland budget was ratified by the Executive in April 2010. The key facts for Health and Social Care planning assumptions in 2010 are now threefold:

- Pressures identified at Northern Ireland Block level impacting on all government Departments leading to £105m less for Health and Social Care than was planned within the original three-year 2008/09-2010/11 Comprehensive Spending Review settlement;
- New and emerging inescapable pressures across Health and Social Care which were not included in the original resource plan must be met. For example the cost of continuing to meet waiting time targets;
- Provider Trusts are facing unprecedented challenges in maintaining financial stability and meeting efficiency targets e.g. two Provider Trusts needing temporary financial support

to manage deficits in 2009/10 and enable a recovery plan to be implemented in 2010/11.

The key financial targets for 2010/11 remain financial breakeven and delivery of efficiency savings, therefore the commissioning system will expect all organisations to live within the resources allocated. To achieve this objective the financial aspects of the Commissioning Plan have robustly focused on ensuring there is a source of funds for all expenditure and prioritisation of inescapable funding requirements.

At times there can be a debate about bureaucracy and inefficiency in the Health and Social Care system and the Health and Social Care Board will wish to drive down costs and add to productivity. However, the notion that the financial constraints can be exclusively addressed as a consequence of these issues is not accurate and diverts from the real public debate that will be required on resources and its utilisation.

In order to address the impact of the above and to plan for potential further inescapable pressures emerging across Health and Social Care, the DHSSPS and the Health and Social Care Board/Public Health Agency have undertaken in-depth reviews of the financial position in 2010-11 using the following approach. The outcome of the work is central in shaping the commissioning finance plan for 2010/11.

1. A detailed assessment was undertaken to quantify the scale of funding required to address both the emerging financial pressures and the planning assumptions identified above.
2. Potential sources to address the funding gap were identified, focusing on those sources which will have the least impact on the health and wellbeing of our population.
3. Priority areas for service investment in 2010/11 were identified and resourced in the financial plan.

2.3 Quantification of Funding Pressures

A review of the impact of the emerging 2010/11 HSC financial environment identified total pressures of £275m to £300m

including the third year of the Comprehensive Spending Review. The consequences for the Commissioner are therefore substantial.

Recent pressures at the Northern Ireland Block Level have resulted in the Northern Ireland Assembly advising of further reductions to Departments' 2010/11 baselines. However, notwithstanding this, almost £10m will be spent every 24 hours on our health system.

The Commissioning Plan must also reflect the reality of the financial operating position of the Trusts. Rising demand, for example in hospital care, providing care at home or in child care are demonstrable. Inflation and changing cost patterns in such areas as water charges have added to the pressure. Notwithstanding this, as a Commissioner we will want to audit such pressures to ensure that all is being done to manage efficiently in a difficult financial climate.

2.4 Existing Efficiency Savings Targets 2010/11

Within the context of the original financial plan, covering the three-year period 2008/09 to 2010/11, the Health and Social Care system was required to achieve some £260m of recurrent Cash-Releasing Efficiency Savings by the conclusion of 2010/11, as detailed in Table 1.

Table 1

Organisation	Cumulative Cash Release Targets 2008/09 - 2010/11			In-year 2010/11 Requirement
	2008/09	2009/10	2010/11	
	2.50%	5.50%	9%	3.50%
	£m	£m	£m	£m
BELFAST	-24.67	-55.62	-91.73	-36.11
NORTHERN	-11.73	-26.46	-43.64	-17.18
SOUTHERN	-9.69	-21.86	-36.05	-14.19
SOUTH EASTERN	-9.95	-22.40	-36.90	-14.50
WESTERN	-9.68	-21.83	-36.01	-14.18
NIAS	-1.24	-2.72	-4.45	-1.73
Total Trusts	-66.97	-150.89	-248.78	-97.89
Health and Social Care Board and Public Health Agency RPA	-0.84	-3.88	-10.90	-7.03
Total per allocation letter	-67.80	-157.77	-259.68	-104.91

Based on these earlier Comprehensive Spending Review plans, the Health and Social Care Board and Trusts are currently required to achieve £104.9m of recurrent cash efficiency savings in 2010/11, before consideration of the additional cash releasing requirements of £105m in 2010/11 arising from the recently announced budget change from the Northern Ireland Executive.

2.5 Trusts' Financial Positions

Trusts have experienced increasing financial difficulties during the course of 2009/10. Indeed, in 2009/10, Trusts found it necessary to initiate in-year Trust Contingency Plans, in order to fulfil their statutory duty to financially break even. In the context of 2010/11, the Health and Social Care system anticipates that it will need to invest in maintaining existing services as well as developing new provision.

2.6 Planned Investments in 2010/11

As with any year, there are a large number of new service proposals to be considered. However, we balance the maintenance and reshape of existing services in parallel with the development of new services as the correct way forward. Consequently the speed of new investment will be carefully controlled.

2.7 Sources to Address Identified Funding Gap

Health and Social Care is being asked to deliver savings of £284m in 2010/11 arising from:

- The third year of the Comprehensive Spending Review efficiency savings as agreed in 2008;
- The additional reductions decided by the Northern Ireland Executive in 2010; and
- The need to cover elective care costs consistent with the Minister's decisions as set out in Priorities for Action.

The consequences of the total final position is that the DHSSPS's commissioning direction of the Health and Social Care Board means that it has to plan for savings of £204m. The sources of funds identified are summarised in Table 2.

Table 2 Proposed Sources of Funds

Description	£m
Comprehensive Spending Review Year 3:	
• Trust Payroll;	40
• Strategic Service Redesign and efficiency	15
• Additional Income	3
Deferral of funds associated with Maintaining Existing Services	42
Deferral of originally planned Service Developments	58
Family Health Services Pharmacy Control	46
Total	204

2.7(i) Comprehensive Spending Review – Year 3

This covers the period 2008-2011 and to deliver these targets a series of actions over 2010/11 (Year 3) will be required, specifically;

- Payroll expenditure control which includes the use of agency, locum and overtime alongside containing recruitment within normal turnover parameters;
- The redesign of services focuses on improved outcomes and efficiency. Despite the complexity of the financial environment these changes are principally driven by the need to respond to organising services to achieve efficient, sustainable quality; whilst
- Additional income will come from regularising such issues as staff meal charges across the province.

2.7(ii) Family Health Services Pharmacy Control

It is anticipated that improved procurement procedures and monitoring mechanisms together with other efficiencies such as working with prescribing pharmacists will allow these savings to be delivered from the Family Health Services budget.

2.7(iii) Maintaining Existing Services and Service Developments

The changing financial scenario has required us to look again at the additional funding we proposed to make available for the maintenance of existing services and to curtail some elements of the new service developments originally planned for 2010/11. This will impact across all service areas. The following describes the broad deferral areas.

In **Mental Health** investment of £9.6m will be deferred. This will impact on plans to increase advocacy services and the number of dementia respite places.

In **Learning Disability** of the £8m in service developments originally identified we will not be able to invest £5m. The majority of respite and autism services as originally planned will now be deferred.

In **Children's Services** we are not investing £1.7m into family and child care services.

In **Physical Disability** the figure is £3.8m. Consequently we will not provide the increased level of respite provision originally planned.

In **Cardiovascular, Stroke Services and Long Term Conditions** we will not be able to progress the scale of community based rehabilitation services, monitoring and specialist support for long term conditions as anticipated. We will also have to defer implementation of some of the recommendations in the Cardiovascular and Respiratory Service Frameworks. All this means a deferral in the order of £12.6m.

In **Acute Services** the deferral figure is £16m. Consequently we will need to defer some additional planned intensive care capacity,

consultant appointments and extra radiotherapy capacity and be prudent about the rate of the expanded use of specialist drugs.

In **Elective Care** £10m less will be invested. We will not therefore be able to ensure that all patients receive surgery as quickly as we would wish. The majority of patients will still benefit from 9 weeks for outpatient waits, 9 weeks for diagnostics and 13 weeks for inpatient treatment. However some inpatients may wait up to 36 weeks in a small number of specialities.

In **Public Health** we are not able to invest in planned developments in interventional services, screening and community infection control initiatives.

The Health and Social Care Board recognises that the deferral of new services is disappointing but it is considered better to focus on the consolidation of existing services. If the financial climate permits the deferral decisions will be reviewed.

2.8 Planned Service Investments in 2010/11

There are major and complex management challenges involved in meeting financial pressures of £204m and these will be carried forward by a Programme Board chaired by the Commissioner. Nonetheless, there will be a range of planned service investments of £117.8m in 2010/11. These are summarised in Table 3.

Table 3

Description	£m
Hospital Drugs	13.85
Long term conditions	0.1
Demographics/Elderly	15.1
Mental Health	2.8
Learning Disability	3.09
Physical Disability	1.22
Acute Services and Complex Needs	2.03
Children's Services	2.36
Public Health Public Health Agency (*inc Tele-health £2.1m)	4.8
* Managing Reform	2.4
* Elective Access	40
* Maintaining Services	30
Total	117.8

* Non-recurrent funding in 2010/11

Hospital Drugs - £13.85m

These funds will be used to provide drug therapy for a range of conditions including rheumatoid arthritis, psoriasis, Crohn's disease, HIV, multiple sclerosis, age related macular degeneration, cancer, orphan enzyme conditions, cystic fibrosis, new National Institute for Clinical Excellence approved treatments and high cost blood products.

Long Term Conditions - £0.1m

These funds will be used to fund a British Heart Foundation nurse and a post with Macmillan Cancer regarding palliative care which is match funded.

Elderly and Other Specialist Homecare Services - £15.1m

This funding will meet the growing needs of an ageing population for community care and adult protection. It will provide up to 3,000 additional packages of care to enable older people to remain living at home or to return to home following a stay in hospital.

Mental Health - £2.8m

To fund Mental Health resettlements from hospital, psychological therapies, community infrastructure, personality disorders and substance misuse liaison nurse.

Learning Disability - £3.09m

To fund Learning Disability resettlements from long stay hospital, respite and autism.

Physical Disability - £1.22m

These funds will support wheelchairs and prosthetics services and cover the costs of a process to provide essential replacement of prosthetic equipment.

Acute Services and Complex Needs - £2.03m

This will be used to support renal services, obstetrics, statutory care assessments for autistic children, and stroke services.

Children's Services - £2.36m

This will provide for Family Support Interventions/Packages in the voluntary and community sector, together with funding for Gateway Services and Post Adoption Support.

Public Health Public Health Agency – £4.8m

To support bowel and “Triple A” screening, vaccinations and tele – health, pandemic flu and swine flu immunisation for pregnant women.

Managing Reform - £2.4m

These funds are to fund preserved rights cases, cleaning pressure and activity in the Mater Hospital.

Managing Elective Care - £40m

These funds, in combination with an additional £25m in 2009/10, have been identified to continue to support the maintenance of Elective Access Standards.

Maintaining Existing Services - £30m

This funding is intended to support Trusts in addressing cost pressures arising from areas such as increased utilities costs.

In total therefore, £117.8m will be spent in the year 2010/11 to help maintain existing service delivery and to allow for the development of new services.

It is evident that 2010 and beyond is a very challenging year. It may be that revisions will need to be made in light of the new government's budget. However, it is clear that any further requirements levied would be very challenging with the potential to fundamentally change the current pattern of Health and Social Care provision.

3. Personal and Public Involvement

Personal and Public Involvement is about people and communities influencing the planning, commissioning and delivery of health and social care services. It means actively engaging with those who use our services and the public to discuss: their ideas, our plans; their experiences, our experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services.

Whilst the concept of Personal and Public Involvement is not new, we have made considerable efforts in 2009/10 to further embed Personal and Public Involvement in our everyday work.

For example, under the Health and Social Care Reform Act (NI) 2009, Health and Social Care Organisations were required to have in place Draft Consultation Schemes on Personal and Public Involvement in accordance with Articles 19 and 20 of the legislation. A workshop was held in November 2009 with voluntary and community sector representatives to develop the Draft Consultation Schemes and to collect opinions on how to move Personal and Public Involvement forward. The Draft Consultations Schemes, influenced heavily by the outcome of the workshop, were submitted to the DHSSPS by 31st December 2009 for approval.

Further advice from this workshop was that Health and Social Care Organisations should, in relation to Personal and Public Involvement, find ways to work in a more co-ordinated way. In response to this advice a meeting with the relevant organisations was held in January 2010.

As a result, it was agreed that the Public Health Agency would take a lead role in establishing a regional Personal and Public Involvement Forum and develop a clear work plan for Personal and Public Involvement activities of Health and Social Care Organisations. This Forum will work to promote a whole system approach and reduce unnecessary duplication.

The specific roles for the DHSSPS, Health and Social Care Board, the Public Health Agency and Trusts at a strategic level will be complemented by the unique role of the newly formed Local Commissioning Groups. In preparing their input to this

Commissioning Plan, Local Commissioning Groups engaged with their local populations, including community and voluntary networks, to assist them in the development of their local priorities. The Local Commissioning Groups intend to build on this process throughout 2010/11 and beyond. The Health and Social Care Board, including its Local Commissioning Groups, and the Public Health Agency are committed to working in partnership with the Patient and Client Council, other Health and Social Care Organisations and statutory bodies such as Local Councils, to promote Personal and Public Involvement and identify joint Public Involvement opportunities and reduce duplication.

The Patient and Client Council undertook a major consultation exercise from August to November 2009 to inform the development of the DHSSPS's Priorities for Action 2010/11. As an example of our commitment to work with the Patient and Client Council, we ensured that the recommendations from this consultation exercise have also informed the development of this Commissioning Plan.

We recognise Personal and Public Involvement as an integral process linking human rights and equality, patient and client experience, user involvement and community development. Section 75 of the Northern Ireland Act 1998 provides a legislative framework for the promotion of equality of opportunity and good relations.

² Covers: religious belief, political opinion, racial group, age or marital status or sexual orientation, gender, disability, dependants

³ Covers: religious belief, political opinion and racial group.

The Commissioning Plan, in both its developmental stage and implementation stages, has the potential to impact on Section 75 categories² and the categories³ under Good Relations. It also impacts on the human rights of individuals. In this context, substantial work has been undertaken to ensure that the development of our Personal and Public Involvement consultation schemes were in compliance with the requirements of Section 75 of the Northern Ireland Act (1998), the Human Rights Act (1988) and the Disability Discrimination Act (1995).

Once the Commissioning Plan has been approved by the DHSSPS, consideration will be given to screening/equality impact assessment by the DHSSPS, Health and Social Care Board or Trusts as appropriate and where screening indicates a need for more thorough examination, an equality impact assessment will be considered.

4 Local Commissioning Groups

4.1 Background

Legislation enacted on 1 April 2009 created a new commissioning system with the establishment of a region-wide Health & Social Care Board, including 5 Local Commissioning Groups, and a Public Health Agency. The objectives of the new commissioning arrangements will support local sensitivity with the creation of 5 Local Commissioning Groups reflective of their geography. Local Commissioning Groups are made up of local political representatives and professionals and have a strong role in shaping local services and contributing to the formulation of Board policies.

Local Commissioning Groups are charged with providing local leadership in commissioning health and social care. They are responsible for assessing the needs of the local population, planning to meet those needs and securing delivery of Health and Social Care in line with the Plan. They will do this through wide ranging engagement with local communities, users and carers, and voluntary and statutory partners.

Local Commissioning Group Chairs



Dr G O Neill
Belfast



Dr N Campbell
South Eastern



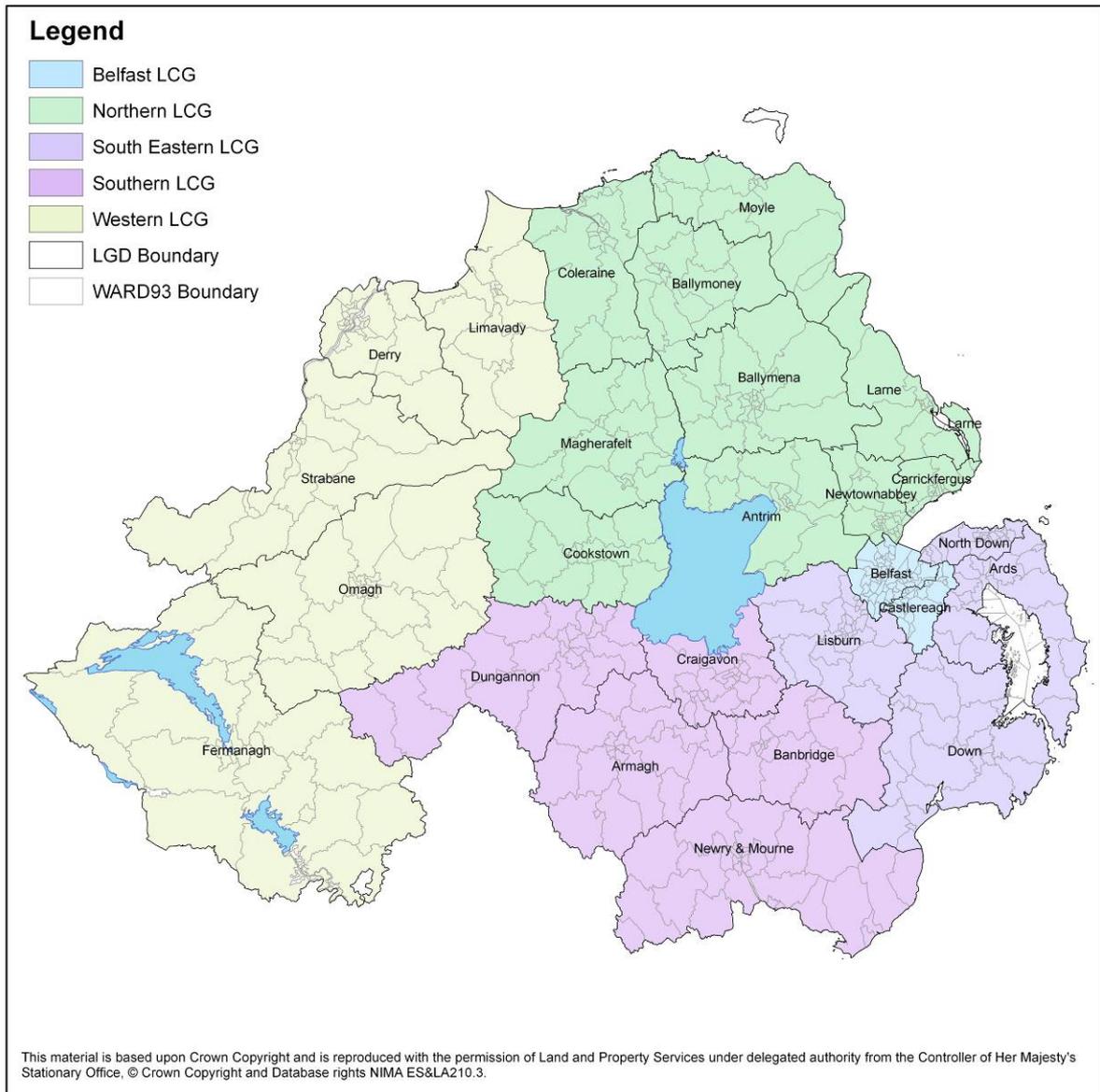
Dr B O Hare
Western



Mr S McKeagney
Southern



Dr B Hunter,
Northern



Local Commissioning Area

Belfast
 South Eastern
 Southern
 Western
 Northern

Population

335,000
 340,000
 348,700
 300,000
 450,000

Funding

£581m
 £476m
 £499m
 £452m
 £641m

4.2 Local Commissioning Group key responsibilities in 2010/11

All Local Commissioning Groups will specifically have the obligation to ensure resources invested in caring for older people and the primary care component of elective care are properly expended. In addition there is an expectation that they will have a central role in the development of Primary Care Partnerships. As part of this process they will be required to contribute to a greater understanding of demand management. Finally, they will be required, as part of the Health and Social Care Board, to contribute to the full range of decisions it is required to take.

Local Commissioning Groups will, in the course of 2010/11, produce a Local Commissioning Plan providing a profile of their local population, needs assessment and commissioning priorities over the next 12 months.

5 Overarching Themes

5.1 Introduction

This section summarises the key commissioning themes for the future and highlights the main changes which will need to take place if we are to secure safe, sustainable and high quality services for people of Northern Ireland. There are powerful arguments about why we need to make changes in how we commission services and we will need strong processes to drive these forward over the next three years. However, it is essential that these begin to take effect in 2010.

We are faced with the need to generate efficiency savings of 9% while simultaneously addressing the potential impact of financial pressures from the wider environment on the Northern Ireland Block. The net effect of this will be less resources for health and social care. The need to deliver savings and respond to pressures generated by the current financial environment will be challenging. However, it is important that these are seen against the scale of our spending on Health and Social Care services. We will still continue to spend £11m per day on Health and Social Care in Northern Ireland.

5.2 Tackling Health Inequalities

Historically, much of our attention has been focused on specific targets and goals however the Public Health agenda has the potential to make a huge impact on the overall health and wellbeing of the population. The main elements of this agenda are:

Tackling Health Inequalities

Challenging health and social inequalities cannot be exclusively addressed by Health and Social Care organizations but requires meaningful partnerships and a common agenda to be developed with our Trusts, our colleagues in local government, housing, education and the environment and our communities if we are to effectively deliver on improving the health of our population.

Public Health Agency is committed to ensuring the IFH strategy is fully implemented and will use the opportunity for developing new

ways of working in collaboration with our partners in local Government to drive this agenda forward. PHA is also committed to exploring new partnership working with other agencies in terms of the wider inequalities agenda in terms of how we share intelligence, agree joint objectives and seek new opportunities for engagement and collaboration

Health Improvement

We also need to give a much greater emphasis to health promotion and disease prevention. For example, research suggests that up to 70% of all attendances at general practice are directly related to weight, tobacco use, alcohol consumption, poor sleep or stress. Clearly a different approach to lifestyle and targeted interventions can materially change the population's health status and address inequalities in health.

Public Health Agency will work across both regional and local domains to promote greater lifestyle choices and addressing the wider determinants of health. This will include directly influencing the joint commissioning plan, the trust delivery plans and the work the Public Health Agency is taking forward with the community and other key stakeholders through Investing For Health Partnerships and joint working arrangements.

Screening Programmes

Population screening is an important public health activity that focuses on the early detection of disease. This allows for earlier interventions contributing to improved outcomes.

5.3 Primary Care Partnerships

In order to support necessary changes in the way in which acute services are provided across Northern Ireland, the Health and Social Care Board will explore the feasibility of Primary Care Partnerships in 2010/11. Demand is an indicator of expressed need and this approach will support the understanding of demand and, as a consequence, enable the redesign of local services through the active involvement of clinical and care professionals, the voluntary sector and service users. The Health and Social Care Board's five Local Commissioning Groups will engage with and support partnerships so that primary and community care

practitioners and staff receive the information and resources required to manage demand through more accessible local services.

Partnerships will be built around local communities numbering around 100,000 and will include GP practices, pharmacists and other providers of health and care based in their area. They will have a key and central relationship with the Local Commissioning Groups and be in a position to provide more local expression of need into the commissioning process. Through assigning indicative budgets covering areas such as prescribing, outpatient care, diagnostics and community services, Partnerships will be afforded the opportunity to reinvest a proportion of savings in local services. They will be clinically led to ensure strong clinical governance and decision making.

Local Commissioning Groups will ensure that, in their formative phase, Primary Care Partnerships are supported with information on referral activity, budget and expenditure reports, quality outcomes and user experience. Partnerships will be ideally placed to exploit the benefits of the GP contracts' Quality and Outcomes Framework in terms of assessing the level of chronic disease in their local communities, with Practitioners overseeing the analysis of this important public health information. By focusing resources on patients with long term conditions and those most at risk of acute complications leading to hospital admission, Primary Care Partnerships will be in a position to improve quality of life through early intervention and a reduced dependence on specialist care. As the budget to support the prescribing of drugs by GPs transfers to the Health and Social Care Board in 2010/11, it will be important to ensure that prescribing activity accurately reflects need and is of the highest quality. Primary Care Partnerships will support local prescribers through the expertise of pharmacists working within the Health and Social Care Board's Medicines Management Team. Efficient and effective prescribing will help to maximise the quality of care provided to patients, particularly those suffering from chronic disease, and reduce the potential impact of budgetary pressures, within prescribing on other essential services. Under the leadership of Local Commissioning Groups, Primary Care Partnerships will be in a position to reinvest savings in developing improved services for local communities including prevention alongside treatment.

In developing this local model it will be important to take account of a wide range of views and the Health and Social Care Board will, through its Local Commissioning Groups, consult with stakeholders. Partnerships will seek approval for investment plans through their 'parent' Local Commissioning Group and their success in delivering change will be subject to evaluation in 2011/12.

5.4 Reshaping Acute Hospital Services

The overall aim in commissioning is to ensure that the people of Northern Ireland have timely access to high quality services and equipment responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively.

To maintain and to continue to achieve this standard of service for our comparatively small population of 1.7m won't be possible unless we change the ways in which we deliver care to people.

Hospital acute services are changing. Commissioning hospital care in a different way does create anxiety but the primary driving force in this is about securing safe, high quality, sustainable services.

As standards for training increase our Medical, Nursing and Allied Health Professions staff are working in an increasingly complex clinical environment. Senior clinical staff need to work in a different way, with access to a significant clinical infrastructure, sub speciality expertise and larger teams of senior colleagues to discuss and to make decisions about the best treatment and care for patients. There are also issues about needing to work in a different way to ensure that staff in training can gain the necessary experience which will best qualify them to provide the highest quality of medical and nursing care. A critical issue in terms of how hospital services are commissioned in the future will be to have a much closer relationship with the training bodies. In this way we can work together to develop approaches about training in systems or networks rather than in institutions to make training better for staff and the patients they care for.

For many years Health and Social Care has tried its best to secure the right clinical staffing profile to maintain acute services but this is becoming increasingly difficult. Many of our services – and not

just those provided in smaller units – are becoming more dependent on the use of locum cover which by its nature must impact on the continuity of care because we cannot attract or retain permanent specialist staff. The drive for change in how we commission and provide acute care is not about money, it is about making sure that all of our population, irrespective of where they live, has access to the same standard of high quality, safe clinical care.

Some of the changes in how we commission hospital care have already happened. Over the last 10 years Northern Ireland has streamlined its care for cancer patients by consolidating services into the major acute hospitals with streamlined access to the regional cancer centre as needed and we are seeing better outcomes for patients as a result. Progress with the 2002 DHSSPS Strategy “Developing Better Services” has also resulted in changes to acute hospital care in Downpatrick, Lisburn, Enniskillen and Omagh.

These approaches will ensure ... timely access to the best possible configuration of clinical expertise to meet health needs and improve outcomes consistently across the whole population.

Around 80% of hospital care is made up of diagnostics, outpatients, day care and ambulatory services. Therefore it becomes clear that, irrespective of some of the changes that will have to happen in inpatient care, there remains a very important and key role for smaller local hospitals where much of this activity takes place. We want to maintain, where it is safe, sustainable and appropriate to do so, as much local access for local people as possible. The local hospital has a key role in refining the diagnosis for patients and referring them through the system as appropriate. We want Local Commissioning Groups to work closely with local hospitals to shape the service care pathways so that they are responsive to local need and connect seamlessly to the rest of the hospital network.

The next steps in terms of a detailed programme will follow, but we want to signal in this Commissioning Plan specifically what the changes and developments are likely to involve:

- Investments in the order of £13.85m to offer access to a range of specialist drug therapies;

- Recurrent investment of £25m in local infrastructure to support waiting time targets to reduce the use of the Independent Sector;
- Further developing the role and function of the local hospital network in providing access to diagnostics, outpatients, day and ambulatory care and establishing care pathways through the rest of the hospital system;
- Supporting the changes which have occurred in 2010/11 in Magherafelt and at Whiteabbey by developing their outpatient, diagnostics, rehabilitation and minor injuries capacity and putting in place new services such as bowel screening;
- Redesign the system of Accident and Emergency provision so that people have access to safe and sustainable services in line with their treatment needs;
- Review the current profile of inpatient emergency surgical services to support emerging sub specialisation and appropriate staffing and expertise;
- Avoiding inappropriate duplication of inpatient specialities in each of the Trust sites;
- Ensure that the current profile of paediatric inpatient services provides appropriate staffing and expertise in line with best clinical practice;
- Commission services in line with the recommendations of the Review of Maternity Services;
- “Right Sizing” the number of acute medical inpatient beds for our population in line with national standards to release resources for reinvestment in front line services;
- More rigorous adherence to the effective use of resources;

Enabling people to live at home is a key objective in this Commissioning Plan.

- Developing new clinical partnerships with larger acute providers in the Republic of Ireland and other facilities in the UK as well as continuing with the programme for establishing local Clinical Networks to ensure our services are delivered to the highest possible standards;
- We will work closely with individuals and their families when there is a change to services, being sensitive to their concerns.*
- Acknowledging that a population of 1.7m may be too small to sustain some highly specialised services, but securing new arrangements which make sure our population gets timely access to these services when they are needed;
 - Specifying and addressing the impact these changes will have on emergency transport services;
 - Ensuring that the acute service developments arising from the investment of £51m in 2009/10 are fully in place in this financial year.

Making these changes won't be easy. It will require dialogue with the population and involve fundamental strategic shifts in the current pattern of care, but we need to do this to secure good outcomes and provide safe services. We need to be innovative in how we establish networks of different elements of care and how we connect them to populations and to each other to ensure continuity.

These approaches will ensure that the people of Northern Ireland get timely access to the best possible configuration of clinical expertise to meet their health needs and improve outcomes consistently across the whole population. We recognise the importance of patient choice and need

Local Area Coordination for disabled people in two Trust areas which opens up opportunities in people's communities for access to, and involvement in, work, leisure, training and further education. Supported living schemes for older people, disabled people, those with mental health problems and young people leaving care provide housing and support as alternatives to institutional care.

for people to have confidence in how our services are provided. Choice will therefore be a major theme in driving commissioning. It must however recognise that there are limits to the extent of choices available and they must be consistent with the delivery of safe, effective care.

5.5 Living at Home

People do better when they live at home. The outcome of people's care is better when provided as close as practicable to their home. This holds true for older people, children, those with disabilities and those with mental health issues.

Enabling people to live at home is a key objective in this Commissioning Plan. Health and Social Care services need to be designed to promote independence, recovery and rehabilitation and to support individuals to live fulfilling lives.

Strong and effective partnerships with service users, families and carers and communities will be essential in order to provide person centred support to meet people's needs; that is support based on an individual's express wishes. This means looking at the support we give in a different way; based on the concept of recovery rather than long term care and increasing community capacity to create greater opportunities for people to be engaged in employment, education, leisure and social activities.

We will need to re-shape our services in the following ways:

- Promoting self care and self management of long term conditions such as asthma, chronic obstructive pulmonary disease, heart failure and diabetes;
- Providing an agreed support plan for all service users that promotes recovery;
- Involving individuals more in decisions about their care; promoting the use of direct payments and exploring the potential for individual budgets;
- Improving partnerships with the voluntary and community sector to provide community based services;

- Providing more rehabilitation at an earlier stage and reviewing domiciliary care and day care services to support this model;
- Reviewing institutional care and the way in which long term support and care is provided;
- Providing greater support to children and families; supporting parents in their parenting role and helping young people who are leaving care.

There are already many examples of community based services that are promoting the principles outlined above, and most people will agree that such alternatives to institutional care are preferable and that more people should be able to avail of them.

However, there are many challenges in realising this shift in services; not least some people will be concerned that appropriate and adequate support will be available in the community. Local Commissioning Groups, with the Public Health Agency, will have a critical role in working with communities to increase community capacity; help re-design existing community support services and bringing forward plans for their local area.

5.6 Detailed responses to Priorities for Action 2010/11

In the next section, we set out in detail our response to the Priorities for Action for 2010/11 reflecting the Commissioning system's obligation to progress and deliver on the Priorities for Action Targets.

Section Two

Detailed Proposals and Funding

Priorities for Action 2010/11 – Detailed Proposals and Funding

This section sets out in detail the areas identified for action and funding in 2010/11 by the Minister and DHSSPS and the actions the Health and Social Care Board and Public Health Agency propose to take to ensure that targets are met.

The DHSSPS has grouped this year's priorities into a number of broad themes. These are:

- 1 Keeping adults and children well, improving their health and reducing health inequalities;
- 2 Ensuring services are safe, sustainable, accessible and patient centred;
- 3 Integrating primary, community and secondary care services;
- 4 Helping older people to live independently;
- 5 Improving children's health and wellbeing;
- 6 Improving mental health and care for people with disabilities;
- 7 Ensure financial stability and the effective use of resources.

Priority Area 1:

**Improve the Health Status of
the Population and Reduce
Health Inequalities**

6.1.1 Strategic Content

Improving health and wellbeing remains one of the most fundamental ways of improving people's quality of life. The key aim is to maintain and improve the health status of the entire population and to reduce inequalities in health status between population group and geographical areas.

Effective sustained improvements in health and wellbeing can best be achieved by promoting and delivering care at earlier stages in 'life pathway' of people. Shifting the focus 'upstream' towards prevention, health promotion and earlier diagnosis of disease through the provision of appropriate and timely population screening and interventions will positively impact on the health and wellbeing of our population.

In shifting and tailoring this focus, account needs to be taken of differences in the health and wellbeing status in our population. Significant inequalities exist between local geographies and communities and are most often related to levels of deprivation and poverty. Action needs to be taken to improve everyone's health as well as those who are most disadvantaged in order to narrow this gap.

6.1.2 Commissioning Themes

In addition to the Priorities for Action Targets the Health and Social Care Board and the Public Health Agency will progress a number of specific themes related to Keeping Adults and Children Well, Improving Health and Reducing Inequalities:

6.1.2(i) Preventable ill Health

It is estimated that there are some 4,000 premature deaths per annum in Northern Ireland. There are, moreover, unacceptable inequalities in health often associated with socio-economic status and disadvantaged areas. Addressing these issues through the promotion of good health and well being, the prevention of illness and injury, early intervention and good long term care remains a key priority for the Health and Social Care bodies and a major priority as they directly contribute to the process of intelligent

commissioning including needs assessment, engagement and demand management.

Some of the most common characteristics associated with being born into poverty as opposed to more affluent circumstances are:

- You are 40% more likely to die before the age of 75;
- You are 5 times more likely to die of drug or alcohol related diseases;
- You are 3 times more likely to be a parent before you are 20;
- You are twice as likely to die of a smoking related disease or lung cancer;
- You are likely to die 7 years earlier than someone from a less deprived area;
- You are 3 times more likely to take your own life by suicide;
- Poor Mental Health Status – 19% of adults in Northern Ireland have a high GHQ12⁴ Score and a 25% higher incidence of Mental Health problems than England and Scotland⁵;
- In addition, it is recognised that other groups also experience disadvantage eg life expectancy for Travellers if estimated at some ten years less than the most disadvantaged settled communities.

⁴ *Northern Ireland Health and Social Wellbeing Survey 2005/06*

⁵ *Frieddi I, Parsonage M. Mental health promotion: Building an economic case. Belfast: Northern Ireland Association for Mental Health (NIAMH) 2007.*

6.1.2(ii) Health Improvement

The theme of health improvement is also an integral element of other sections of the Commissioning Plan. Delivery must address the up-streaming of interventions designed to tackle inequalities. This will require a broad collaborative approach with other sectors, including local government, education, and local communities.

However in terms of Priorities for Action performance, the primary issues for improving outcomes for adults and children include:

- Implementation of the Investing For Health strategy and the commitment to work in partnership with other partners including local Government on agree priorities targeting life expectancy, wider determinants and lifestyle choices.
- Implementation of the mental health promotion strategy and subsequent review
- Implementation of the Suicide Prevention Strategy (Protect Life) and supporting the review
- Implementation of the Teenage Pregnancy Strategy
- Promotion of good Sexual Health
- Addressing the rise in obesity levels, to include the roll out of the regional review on obesity framework consultation, promotion of breastfeeding, promotion of physical activity and healthy diet and nutrition
- Prevention of accidents in the home, workplace and on the roads
- Implementation of the New Strategic Direction on Alcohol and Drugs, with support services for those with addiction, targeting binge drinking and young people
- Implement the Tobacco Control action plan and development of a new regional strategy – with a focus on manual workers, young people, pregnant women etc
- Promotion of good oral health linked into the wider Health Promotion strategies including obesity, smoking, accident prevention etc.

6.1.2(iii) Service Frameworks

Service frameworks set standards with associated performance indicators, performance levels and timeframes for specific service areas designed to:

- Improve the health and social wellbeing of the population of Northern Ireland;
- Reduce inequalities and promote social inclusion;
- Improve the quality and safety of care;
- Safeguard vulnerable individuals and groups; and

- Improve partnership working with other agencies and sectors.

The Public Health Agency will work with relevant stakeholders to implement the health improvement performance indicators set out in the Cardiovascular and Respiratory Service Frameworks. These are aimed at reducing cardiovascular and respiratory disease. Some apply to both Frameworks and include activity to stop smoking, increase physical activity, encourage healthy eating and reduce consumption of alcohol. Some are Framework specific eg, increasing the percentage of people trained in emergency life support, enhancing social and emotional support to people with chronic respiratory illness and increasing access to maintenance exercise classes.

Implementation will focus on tackling known areas of inequality and link carefully with the emerging joint working arrangements with local councils and existing partnerships. This work will be progressed as part of a planned and coordinated approach with the Health and Social Care Board to framework implementation. A similar approach will be used to implement the health improvement standards in the Cancer Service Framework when it is published.

6.1.2(iv) Population Screening

Population screening is an important public health activity that focuses on the early detection of disease. Screening programmes currently in place in Northern Ireland, and those which are planned for implementation, can be grouped into four categories: cancer, vascular, newborn/child and antenatal, a number of these have already been covered by specific Priorities for Action targets. Quality assurance helps to ensure the benefits of screening are maximised and harm minimised. Structures to support the quality assurance function are well established within the cancer screening programmes. These mirror the arrangements elsewhere in the UK. However, the structures for non-cancer programmes are less well developed. The Public Health Agency will lead on the development of the quality assurance function across Health and Social Care to support these programmes.

6.1.2(v) Health Protection

The Public Health Agency will take the lead in ensuring that a full range of health protection services are provided. This includes the direct provision of services by the Public Health Agency, including its statutory obligations (relating to notifiable diseases etc), working with other organisations such as Environmental Health Departments and Northern Ireland Water and commissioning services in areas such as childhood vaccines, healthcare associated infections and the antenatal infections screening programme. In addition the Public Health Agency together with the Health and Social Care Board, Business Services Organisation and Health and Social Care Trusts will continue to review, test and update emergency plans, taking into account lessons learned from recent incidents and the response to swine flu.

Vaccinations have been cited along with clean water by the World Health Organisation as the biggest contributors to improvement in health over the last 100 years. They are also considered among the most cost-effective health interventions. Northern Ireland now has uptake levels for all vaccinations well above the UK average and the Public Health Agency will seek to build on this position during 2010/11. In particular we will aim to reduce inequalities of MMR vaccine, targeting those in geographic areas with relatively low uptake. We will also aim to further improve uptake of HPV vaccine, improving on the good start that has been established in the first two years of the programme. Any new vaccines will be introduced with the aim of achieving the same high uptake of the established vaccines.

6.1.2(vi) Community and Voluntary Sector

The Public Health Agency is committed to working closely with a wide range of organisations to best enable us to reach out to communities and individuals to improve their health and wellbeing. This will include working with and through the Health and Social Care Trusts, other statutory organisations (and especially developing our partnerships with local government) as well as voluntary and community organisations. The legacy organisations already fund a large number and variety of voluntary and community groups, and the new organisations are committed to building on this expertise. The Public Health Agency and Health and Social Care Board will seek to bring an increased rigor and meaningfulness to managing how we use the budget available to

fund health and wellbeing improvements across the full spectrum of organisations, in order to realise anticipated outcomes.

6.1.2(vii) Primary Care

Family Practitioner Services are a key setting for health promotion. The Public Health Agency is committed to working on existing and future Direct and Local Enhancements opportunities which have long-term health improvement and addressing inequalities at the core. Increased focus will be given to:

- Health Promotion standards in the service frameworks eg smoking cessation , brief intervention on alcohol, and nutrition and physical activity;
- Mental Health promotion and support and referral to other services.

In addition, access to and reducing barriers to services will be encouraged, alongside increasing activity in disadvantaged communities. Practices will also be encouraged to build strong links with access to welfare rights groups as an important means of maximising the income of disadvantaged individuals and communities. The Health and Social Care Board and the Public Health Agency will take the opportunity to review current information systems, their efficacy and ease of using the information captured to chart progress and inform future developments.

There are unique opportunities to develop further partnerships with Community Pharmacies to promote health improvement. The Building Community Pharmacy Partnership initiative has evaluated positively and demonstrated the important role that pharmacists can play in promoting health across a whole range of issues. The Health and Social Care Board and Public Health Agency will wish to build on this progress.

6.1.2(viii) Oral Health and Dental

Despite improvements in the oral health of our population, there remains a strong pattern of inequality in those with good and those with poor oral health.

It is well recognised that many chronic diseases including oral disease share common risk factors such as diet and nutrition, tobacco and alcohol. A collaborative approach needs to be adopted in order to tackle local oral health inequalities.

Dental registration for children under five years are another key indicator of health inequalities. The Public Health Agency and the Health and Social Care Board will work with the Trusts through the Regional Service Level Agreement to encourage families from disadvantaged areas to register with a dentist. This will require working in partnership with other stakeholders such as General Dental Practitioners and Community Groups. In addition, emphasis will be placed on the prevention of disease and promotion of oral health, working with communities, and in particular parents.

6.1.2(ix) Quality Assurance

The Public Health Agency and the Health and Social Care Board are committed to the highest standards of service. Specifically the Public Health Agency has prioritised the need to build effective working links with academic institutions. Research and evaluation are embedded into the development of all programmes. Setting standards for new service areas which can be rigorously evaluated will be essential in order to ensure best use is made of resources. Whenever possible the Public Health Agency will seek to integrate and illuminate knowledge on the nature of inequalities and effective action.

6.1.2(x) Health Intelligence and Communications

Public health priorities across health protection, service development, screening and health and wellbeing improvement all require a wide range of 'health intelligence' and 'health communications' support.

For example, good quality health and social wellbeing intelligence is a fundamental requirement to:

- Enable rapid response to immediate public health risks and demands;

- Inform and influence public health interventions and measure impact and outcomes; and
- Improve understanding and aid decision making.

Similarly health communications play an essential role in informing, influencing and motivating individual, institutional and public audiences about important health matters.

As a learning organisation the Public Health Agency is committed to the critical examination of what is most effective, including testing and developing new and innovative practice and seeking greater understanding about the nature of health inequalities and the impact of action.

In addition to providing bespoke Health Intelligence support the Public Health Agency will explore partnership arrangements with key Health and Social Care partners and academic institutions in order to optimise the use of existing data sources and the commissioning of new research. We will also undertake to develop an effective and efficient knowledge base which enables flexible, shared access to public health knowledge and helps to influence the strategic agenda of other organisations and interests. We will seek to ensure that the optimum mix of communication tools is applied to help realise the targets addressed throughout this Commissioning Plan.

6.1.2(xi) Reducing Demand on Acute Services

As part of the wider reform and modernisation agenda the Health and Social Care Board and Public Health Agency will support Trusts in ensuring that acute services address the wider primary and secondary prevention agenda. It is in the interest of the Trust to ensure that patients make a speedy recovery and avoid re-admission. Acute settings are also important locations in terms of promoting the health improvement agenda both for staff and patients/clients.

The Health and Social Care Board and Public Health Agency will support the development of an integrated approach across primary, secondary, tertiary and community care so as to maximise the opportunities to avoid unnecessary admissions and improve population health and social wellbeing. This will include

addressing issues such as falls prevention, alcohol abuse services, soft tissue injuries, emotional wellbeing, all which have a major impact on A&E services and acute admissions. In relation to specific areas such as sexually transmitted infections, HIV and other sexually transmitted infections are increasingly presenting as an important public health problem in Northern Ireland, as is the case elsewhere in the UK and Europe. The Public Health Agency will work with partners in the Health and Social Care Board, Trusts, primary care and voluntary sector to meet these needs. Health improvement plans for sexual health will also focus on the opportunities for prevention of sexually transmitted infections.

The Health and Social Care Board and Public Health Agency will exploit partnership opportunities to work with the NI Ambulance Service on the preventative agenda and raising awareness on the impact of issues such as road traffic collisions, attacks on emergency staff/services, community based first responders and so forth. Addressing the causes of demands on trauma and orthopaedic services will have benefit on both the wider community and service pressures; this will include targeting information and support at the most vulnerable communities.

The promotion of good lifestyle choices on diet, nutrition, physical activity, sexual health, smoking and so forth will impact on service demands for Stroke Services, chronic diseases such as diabetes and respiratory disease, and the need for specialist treatment such as HIV drugs.

6.1.2(xii) Improving Mental Health Services

The Health and Social Care Board and Public Health Agency are committed to ensuring that key health improvement priorities including early intervention, prevention and tackling inequalities are integral to the redesign and delivery of mental health services. Because of the Bamford vision and the establishment of a Mental Health and Learning Disability Commissioning Taskforce, working groups for Promoting Mental Health/Suicide Prevention and Drugs and Alcohol will be established. These will sit alongside a number of service groups including adults, learning disability, Child and Adolescent Mental Health Services and Eating Disorders. Within the framework structure there will be significant opportunities to ensure the key health improvement priorities are addressed in each of the working groups and at the overarching Commissioning

Team. A major priority will be promoting personal development and early interventions that are effective, accessible and person centred supported with advocacy for the involvement of clients and carers.

Core to this will be working with organisations in the statutory, community and voluntary sectors that can provide evidence based services such as building resilience, family support and counselling for those in crisis and in need of support. The continued roll out of the Lifeline Contract will be a major investment in terms of ensuring that those in crisis and/or their carers have immediate support when they require it.

Other priority areas will include delivery of the Hidden Harm action plan, review of addiction services, taking forward the recommendations from the Health Committee Inquiry into the Prevention of Suicide and Self Harm, and joint working to provide better services to meet people's needs.

6.1.2(xiii) Workforce Development

Workplace health and wellbeing is gathering momentum as an issue for consideration by employers and management teams. The growing evidence base demonstrates clearly the benefits to organisations of adopting an approach that considers the health and wellbeing of employees in their everyday business. Health and Social Care bodies must advocate this approach and recognise the importance of providing support and accurate advice to workplaces on the subject.

The Investing for Health Strategy identified the potential for our Health and Social Care services to play a major part in promoting health and wellbeing and in addressing inequalities in our population. The modernisation agenda acts as a springboard for wider co-operation and new partnerships. The Health and Social Care Board and Public Health Agency would see future developments building bridges between various health care settings and communities ensuring an integrated and effective contribution to health and wellbeing at regional and local level.

6.1.2(xiv) Domestic Violence and Sexual Violence

Health and Social Care has conjoined the two regional groups on Domestic Violence and Sexual Violence to strengthen the work of both areas. Health and Social Care will ensure the implementation of the revised Sexual Violence and Domestic Violence Action Plan for 2010/11.

Each of the five Trusts/Local Commissioning Group areas, have a multi-agency domestic violence partnership which identifies local needs and proposals for programmes and services to those in need.

6.1.3 Challenges and Constraints

In order to maximise impact and target resources in areas of greatest need a number of communities who experience greatest inequalities have been identified as requiring particular attention in commissioning interventions to bring about change. For example, Travellers, whose life expectancy is some ten years less than the settled community, other targeted groups include children and young people, lesbian, gay, bisexual, transgender, ex prisoners and their families etc.

In broad terms action will be required at the level of the individual, the community, statutory and voluntary sector agencies, and with policy makers. The Public Health Agency and the Health and Social Care Board will develop effective evidence based policies and practice. A unique opportunity presents, given the size and scale of the population, to make a meaningful impact with a long term commitment of Government. There is urgency and speed required on this agenda – inequalities and the impact of inequity on individual's health and wellbeing across the lifespan is stark. Equally, there is a need to address the burgeoning costs of health care and the predicted inability of government to meet this burden if nothing is done to arrest, resize and scale the challenge.

However, many of these challenges are a result of cultural or intergenerational issues and will take the development of partnership arrangements and a considerable time to change before sustainable transformation can emerge.

Locally the change in responsibilities of the new Health and Social Care structures also provide an opportunity for focusing on the prevention agenda. Health and Social Care Trusts are now

charged with a duty to improve health and wellbeing and whilst services will be commissioned via the Health and Social Care Board there is also the opportunity of working closely with Trusts to ensure that the efforts of the Health and Social Care ‘family’ as a whole are used to greatest effect to bring about change. Commissioning better outcomes for those experiencing the greatest disadvantage is a strong theme in this Commissioning Plan. Specific attention will also be given to:

- Continuing to build on the progress made with partners in developing effective collaborative approaches which address the determinants of health. In particular, work which will integrate approaches including community regeneration, education, health and wellbeing in partnership with communities experiencing disadvantage through the Investing for Health Strategy;
- Changes to the physical environment which promote mental and physical wellbeing;
- Community development approaches to health and wellbeing and service delivery;
- Securing a strategic approach to Early Years Intervention and family support, including implementation of DHSSPS “Families Matter”. In addition to the roll out of a variety of early years investment, the establishment of internationally successful and evidence based early intervention models including ‘Family Nurse Partnerships’ and ‘Roots of Empathy’ into Northern Ireland will be pursued in 2010/11;
- Improving Breast Feeding support and implementation of co-ordinated action;
- Continuing to build on work in the prison setting to meet the health and wellbeing needs of the prison population;
- Developing and building on integrated planning approaches at local level;
- Strengthen developments with the education sector, in particular using the school as an important setting for health improvement.

6.1.4 Summary of Commissioning Proposals/Responses to Priorities for Action

Priorities for Action Target: Improving Life Expectancy

By March 2011, the Public Health Agency should implement agreed actions contained in its Health Improvement Plan to address inequalities at a regional and local level, including any actions arising from the Investing for Health Review:

Life expectancy is impacted by many factors which include socio-economic status, gender, age, ethnicity, poverty and lifestyle factors. Many are outside the direct remit of health but Health and Social Care will advocate and influence other policy initiatives as well as seek shared goals through inter-sectoral work which will ultimately impact on inequalities. The material and structural barriers which are so important in respect of poverty will also be addressed by Health and Social Care. Health and Social Care are committed to building on social capital as part of the process of addressing root causes through initiatives that tackle issues such as fuel poverty, access to welfare rights and so forth. Health and Social Care will invest in initiatives that build resilience, ensuring that community development programmes empower individuals and groups as well as encouraging their active participation.

Health and Social Care will ensure that the broader range of health improvement strategies, including Investing for Health, Health Promotion Strategies such as Accident Prevention, Suicide Prevention (Protect Life), Mental Health Promotion, Fit Futures, New Strategic Direction and Tobacco control etc will be fully implemented. This approach will be taken in conjunction with the planned brief interventions at primary, community and acute settings and will contribute to improving life expectancy with a particular focus on disadvantaged and vulnerable communities. A key focus must be on early years and ensuring that all children have the best possible start in life and taking forward the strategic drive outlined in the Marmot Review into health inequalities.

In addition the varied individual action plans across the various health improvement agenda will target interventions at a regional,

local and neighbourhood level ensuring cross reference is made with other relevant PfA targets addressed in this plan.

Priorities for Action Target: Smoking

By March 2012, reduce to not more than 22% and 28% respectively the proportion of adults and manual workers who smoke. Consistent with the achievement of these outcomes, by September 2010 the Public Health Agency should take forward its action plan to improve access to smoking cessation services for manual workers. By September 2010, the Public Health Agency should also have in place arrangements for obtaining enforcement activity reports from local government and for analysing and reporting this information (including views on value for money) at least twice yearly to the Department. And by December 2010 the Public Health Agency and Trusts should establish additional support arrangements for pregnant women to help them stop smoking.

Health and Social Care will give a renewed emphasis to reducing levels of smoking, in particular to stopping young people starting smoking and to helping smokers stop. Multi faceted actions including use of media, access to smoking cessation services and working with communities, alongside ensuring robust enforcement of legislation. Health and Social Care bodies will review current interventions and focus on settings which will include enhanced support to women smoking during pregnancy, schools, primary care, ante-natal services, community and voluntary sector partners, employers and working with other statutory agencies to connect with otherwise 'difficult to reach' groups with a particular focus on manual workers and developing innovative approaches to engage with, and support, this target group.

Priorities for Action Target: Reducing the Rise in Obesity

By March 2012, reduce to not more than 9% the proportion of children that are obese. Consistent with the achievement of this outcome, the Public Health Agency should throughout 2010/11 ensure timely and effective arrangements are in place in each Trust area to provide targeted support to children identified through the ongoing BMI monitoring process in schools. By February 2011, the Public Health Agency should

produce an integrated action plan to take forward the obesity prevention strategic framework to address overweight and obesity across the whole life course.

Health and Social Care will have in place effective arrangements for the collection and recording of BMI data through the School Nursing Service. This will include a completed evaluation of the various pilot initiatives undertaken by each Trust area to provide support for those children identified through the monitoring process as being obese or at particular risk. (Health and Social Care will be guided by any revised DHSSPS guidance on changes to the Year of Measurement in 2010/2011. Monitoring arrangements are in place within each Local Commissioning Group area to ensure the collection and recording of this data).

Health and Social Care will develop an evidence based integrated approach at a number of levels to address obesity, including the implementation of the strategic obesity framework currently being developed by DHSSPS. This will require a population approach as well as working within the Health and Social Care system to target 'at risk' individuals and groups with information, advice and referral to appropriate services. In the context of Fitter Future for All Frameworks Health and Social Care will work with key stakeholders to promote increased physical activity, improved diet and nutrition and a general sense of wellbeing. Changes to the environment are crucial and the use of Health Impact Assessment and evidence based interventions will be central to future action.

Priorities for Action Target: Reducing the harm related to Alcohol and Drug Misuse

By March 2012, reduce to 29% the proportion of adults who binge drink, reduce to 27% the proportion of young people who report getting drunk, and reduce to 5.5% the proportion of young people taking illegal drugs. Consistent with the achievement of these outcomes, the Public Health Agency should from April 2010 further develop and evaluate the brief intervention pilot designated to support primary care to undertake screening and brief intervention on alcohol misuse. By December 2010, the Public Health Agency should produce

an effective training methodology and determine the feasibility of rolling this out across GP practices. And, from April 2010 the Public Health Agency in partnership with the Health and Social Care Board should, through the implementation of the joint Hidden Harm Action Plan, increase awareness of relevant services and ensure that more young people affected by parental substance misuse are effectively signposted to existing services.

The Health and Social Care bodies will take forward the implementation of the New Strategic Direction on Alcohol and Drugs and build on existing multi-sectoral work and in particular will give increased focus to the implementation and evaluation of:

- Education, Training and Prevention Programmes for GPs , pharmacies, communities and other settings;
- Enhanced collaborative approaches and joint working with communities and local government at a local level;
- Services for Chronic Street Drinkers and outreach services;
- Family support interventions;
- Arrest Referral schemes;
- Alcohol Liaison Services;
- Collaboration with Community Safety Partnerships on wider determinants and anti social concerns.

Health and Social Care will review the outcome from the pilot brief intervention support in a primary care setting and based on the learning examine the opportunity to develop a broader initiative and training programme that could be rolled out on a programmed basis to all GP practices.

Health and Social Care are fully committed to the implementation of the Regional Hidden Harm Action plan to support those children and young people affected by parental substance misuse so that they can avail of the appropriate support service and intervention.

There is also a need for a programme of wider public awareness. There remain major challenges for Health and Social Care to address the growing impact of alcohol misuse on service pressures and demands.

Priorities for Action Target: Suicide

By March 2012, ensure that the suicide rate is reduced below 14.5 deaths per 100,000. Consistent with the achievement of this outcome, by September 2010 the Public Health Agency should ensure that a Deliberate Self Harm Registry pilot is established in the Belfast HSC Trust, and a first draft report produced by March 2011. By September 2010, the Public Health Agency should produce an action plan to implement recommendations arising from Mental Health Promotion/Suicide Prevention Training in Northern Ireland.

Each locality has established multi sector partnerships which oversee the development and delivery of the “Protect Life” and Promoting Mental Health action plans at local level. These partnerships will continue to ensure that local plans are revised regularly and fully implemented in response to locally identified need. All of the plans will be taken forward within the recently established Bamford Taskforce framework and will also take account of regional initiatives such as Life Line and public information campaigns.

Examples of local action includes:

- Building capacity in communities (geographic and / or community of interest) to address suicide prevention and the wider determinants of suicide and mental ill health.
- Community Support for those bereaved through suicide
- Joint working with the Trusts to improve access to services
- Family support for those who self harm
- Liaison with Coroner’s office and PSNI to improve communication and early identification of suspected suicides in locality.

Regional actions will include:

- Developing regional co ordination and quality standards for training
- Taking forward model of locality 'Suicide Cluster' plan
- Regional Lifeline telephone helpline and wrap around support services
- Self Harm register and mentoring support (Initially in West now extending to include Belfast)
- Public information campaigns and evaluation of same
- Media monitoring

Health and Social Care bodies will establish the All Ireland Deliberate Self Harm Registry within Belfast Trust area by September 2010, building on the work in the Western Trust and have a draft report by 31 March 2011. Health and Social Care bodies will assess the recommendations of the review of mental health promotion/suicide prevention training and have an action plan in place by 30 September 2010 addressing the priority recommendations.

Priorities for Action Target: Mental Wellbeing

By March 2011, the Public Health Agency should produce an action plan to take forward the relevant regional and local elements contained within the Mental Health and Wellbeing Promotion Strategy

Health and Social Care bodies will support the proposed public consultation on the Draft Emotional Wellbeing Strategy with the final strategy being completed by the early autumn. Health and Social Care bodies will ensure that the process builds on important links with early years and the development of interventions to improve mental health and wellbeing. This will explore the evidence base for the strategy targets and begin the consultation process with key stakeholders for an action plan to deliver the targets. The Public Health Agency and Health and Social Care Board will work with all partners including Trusts to finalise a plan by March 2011.

Priorities for Action Target: Early Years Intervention

By March 2011, the Public Health Agency and Trusts should ensure that the updated child health promotion programme is fully implemented. The impact of the programme will be measured through the Child Health System and the introduction of a new schedule of visits to be undertaken by health visitors.

The Public Health Agency will lead the implementation of the revised Child Health Promotion Programme. Arrangements need to be put in place to use the Child Health System to ensure the uptake of the revised Programme. The Programme will be fully implemented by March 2011.

Priorities for Action Target: Births to Teenage Mothers

By March 2012, the Public Health Agency should ensure that the rate of births to teenage mothers under 17 is reduced to not more than 2.7 births per 1,000. Consistent with the achievement of this outcome, by December 2010 the Public Health Agency should complete a review of the latest evidence of effective intervention for reducing teenage pregnancy, take forward agreed actions to secure further reductions in the rates of teenage pregnancy linked to the Sexual Health Promotion Action Plan.

Each of the five Trust/Local Commissioning Group areas has a multiagency group which identifies local needs and proposals for programmes and services to meet those needs. These plans are brought together regionally, common issues and approaches identified, and these form the sexual health commissioning priorities for the Commissioning Plan.

Achievability of this target is particularly dependant on factors outside health and social services as higher rates of teenage pregnancy are, as identified in the regional 'Sexual Health Promotion Strategy & Action Plan 2008-2013', linked with poor educational attainment, poor physical and mental health, social isolation and poverty.

The Public Health Agency is therefore committed to joint approaches with a wide range of partners. Engagement with and commitment from other sectors such as education, the community and voluntary sector are critical for achieving success.

The Health and Social Care will ensure a review of trends and effective interventions and agree actions that will include key areas such as:

- Programmes to support Looked After Children;
- Sexual health services focused on young people;
- Personal development and training programmes;
- Work with the education sector to support Relationships Sexuality Education.

In respect of Sexually Transmitted Infections (STIs) HIV and other STI's are increasingly presenting as an important public health problem in Northern Ireland, as is the case elsewhere in the UK and Europe.

Between 2000 and 2008

- HIV diagnoses increased by 384%.
- Chlamydia diagnoses increased by 102%.
- Syphilis has become re-established.

The PHA will work with partners in the HSCB, Trusts, Primary Care and Voluntary Sector to meet these needs. Health improvement plans for sexual health will also focus on the opportunities for prevention of STI's and a second workshop will be held to examine trends and the evidence base for effective interventions.

Priorities for Action Target: Bowel Cancer Screening

During 2010/2011, the Public Health Agency, Health and Social Care Board and Trusts should establish on a phased basis a bowel screening programme for those aged 60-69 (to include appropriate arrangements for follow-up treatment).

Health and Social Care bodies will introduce a bowel cancer screening programme for people aged 60-69 in April 2010. The Public Health Agency will be establishing the required quality assurance structures to support this programme and working jointly with the Health and Social Care Board, the Business Services Organisation and relevant Trusts, to ensure that diagnostic and treatment services are provided at the required standards.

Priorities for Action Target: Screening for abdominal aortic aneurysm and (“Triple A”)

During 2010/2011, the Public Health Agency should work with the Health and Social Care Board and Trusts to commence preparatory work for the phased introduction of screening arrangements for abdominal aortic aneurysm.

Every effort will be made to support the introduction of this programme.

Priorities for Action Target: Emergency Preparedness

By March 2011, all relevant HSC organisations should review, test and update their emergency plans, including building on the lessons learned from recent incidents, exercises and the response to swine flu together with any regional and national developments for pandemic flu preparedness.

The relevant Health and Social Care organisations will seek to update their emergency preparedness arrangements in line with this target.

Priorities for Action Target: Business Continuity Planning

By March 2011, each HSC organisation should ensure it has a fully tested and operational business continuity plan in place.

The Health and Social Care Board, Public Health Agency and Business Services Organisation will work together to review legacy arrangements for Emergency Preparedness and Response. This review will be the initial step in a process to develop and test new Public Health Agency, Health and Social Care Board, Business Services Organisation Emergency Preparedness and Response

Interim Arrangements which will include the development of joint protocols and reporting arrangements between the various Health and Social Care bodies including Trusts and the DHSSPS. The review will include implementation of the lessons from the response to recent incidents and the swine flu response. It will also build on regional and national developments and good practice in the area of Emergency Preparedness and Response.

In addressing key health and wellbeing inequalities, the Public Health Agency will refocus £1.25m of programme funds in 2010/2011 as follows:-

Area	Part Year Effect	Full Year Effect
Interventions with local government partners (other core programme funding also supports this work)	£0.250m	£0.500m
Early Years Intervention Nursing (£100,000 set up and £300,000 for team of 4 in 1 Trust; additional team is £300,00)	£0.100m	£0.400m
Parent Support Officers (to help mainstream initial work in this area)	£0.075m	£0.100m
Roots of Empathy (for phase1)	£0.075m	£0.250m
Non recurrent funding for evidence based campaigns (tobacco / mental health / suicide)	£0.750m	

Priority Area 2:

**Ensuring Services are Safe,
Sustainable, Accessible and
Patient Centred**

6.2.1 Strategic Context

The overall aim is to ensure that the people of Northern Ireland have timely access to high quality services responsive to their needs and delivered locally where this can be done safely, sustainably and cost effectively.

This aim will provide a strategic and operational approach to how we secure consistency of proven clinical, quality and safety standards across the region to improve outcomes and reduce health inequalities.

There will be challenges to progress. Some of the changes will be controversial and some of our goals will be financially unaffordable in the current environment. Key to the Commissioning role however is to challenge the standards by which we deliver care and make a positive difference to the health and experience of our patients and clients.

The last three years have seen some significant improvements in waiting times for elective treatment and for A & E services, albeit many of our A & E Departments have experienced considerable pressures during 2009/10. These improvements have been achieved despite a growth in demand. We will continue to focus on meeting these needs but at the same time seek to gain a better understanding of the nature of what is driving the demand and how it might be better and more efficiently managed. We recognise the importance of patient choice and engagement and need for people to have confidence in how our services are provided. Choice will be a major theme in driving commissioning though it must be balanced with our commitment to deliver safe, effective and sustainable services.

The approach to commissioning must also address inequalities, ensure equitable access to services and deliver patient treatment in the most appropriate setting.

6.2.2 Commissioning Themes, Challenges and Constraints

6.2.2(i) Evidence Based Commissioning

Consistency of standards across the service by using evidenced based approaches with recognised good practice and proven outcome measures will be driven forward. Service Frameworks and nationally accepted guidance available from the National Institute for Clinical Excellence and NHS Evidence will underpin our approach.

Northern Ireland has a formal relationship with the National Institute for Clinical Excellence in endorsing clinical guidance and appraisals for introduction locally. Whilst we are committed to introducing new technologies and therapies in a timely manner, this will be constrained by the financial environment. We will be more active in using the evidence from the National Institute for Clinical Excellence and NHS Evidence sources to guide us on treatments that are proven not to be effective so that we can reinvest more effectively. We also need to better understand the uptake levels of therapies and the resultant differences in outcomes for our population compared with other regions in the UK. There is some evidence to suggest that we are higher users of some of the high cost drugs and this needs further review. Over the last number of years a number of Service Frameworks for the region have been developed which set out recognised standards for good practice and care to be adopted across the spectrum of provision. Where there is good evidence of proven outcomes we must take steps to ensure these are put in place. Affordability in fully implementing the Service Frameworks will be an issue given the constraints on funding. However, we recognise that Health and Social Care has received substantial funds over the last 2 years for cardiovascular services, respiratory services, cancer and stroke care and not all of these developments have been fully consolidated. In implementing Frameworks, we will give appropriate attention to all elements of the Framework and not just 'new leading edge' type developments. The impact on health which can be progressed through management of chronic disease is hugely valuable.

At a broader level, there will be a formal focus identifying evidence of improving clinical outcomes such as mortality and survival rates. Data from Trusts in these areas will be monitored and benchmarked against peer comparators locally and nationally.

6.2.2(ii) Quality and Safety

Our services need to be delivered in an environment which is safe for patients and improves the quality of their experience. It will be essential to focus on minimising risk through robust infection control, high standards of hygiene, reducing adverse incidents, early detection of preventable illness and taking better care of our most vulnerable patients.

In the coming year, the Public Health Agency, in partnership with the Health and Social Care Board, will establish arrangements to ensure that lessons learnt from adverse events are taken forward by Trusts, primary care and other providers.

During this time period, Trusts will have a lead role in implementing quality improvement plans with specific targets for ventilator associated pneumonia, surgical site infection, central line infection, crash call rate, prevention of venous thromboembolism and mental health inpatient care. Trusts will also prepare quality improvement plans to implement World Health Organisation surgical checklists in 80% of cases by March 2011 and promote initiatives in collaboration with the HSC Safety Forum aimed at reducing the incidence of falls and medication errors.

Considerable progress has been made over the last 24 months to ensure a reduction in both the number and rates of Healthcare Associated Infections occurring across Health and Social Care. To date, Healthcare Associated Infections improvement work has focused mainly on secondary care settings. 'Changing the Culture 2010' aims to eliminate the occurrence of preventable Healthcare Associated Infections in all Health and Social Care settings. The Public Health Agency will continue its regional leadership role to ensure ongoing Healthcare Associated Infections reduction during 2010/11. In particular, the Public Health Agency will work to maintain and build on reductions already achieved across secondary care and to address Healthcare Associated Infections associated with and/or occurring in community and primary care settings.

During 2010/11 the Public Health Agency will work in partnership with Trusts, supporting work to deliver clean safe healthcare including work to achieve performance targets for MRSA (Methicillin – resistant *Staphylococcus aureus*) and *Clostridium difficile* infections, and full implementation of quality improvement plans. The Public Health Agency will extend the 'cleanyourhands'

hand-washing campaign to include primary, community and independent care settings. The Public Health Agency will establish robust systems for surveillance of surgical site infections in neurosurgery and cardiac surgery. The Public Health Agency will develop a rolling educational programme in respect of Healthcare Associated Infections, including a regional annual symposium to facilitate learning across Health and Social Care. The Health and Social Care Board will lead performance management in respect of Healthcare Associated Infections, supported by the Public Health Agency.

6.2.2(iii) Accessibility

In 2005 the DHSSPS initiated an Elective Care Reform Programme designed to reduce the access times in Northern Ireland for assessment, diagnostics and elective treatment to a level similar to that in the rest of the United Kingdom. The longer term intent is that this should be achieved and maintained through more efficient waiting list management allied to additional investment in Health and Social Care services. It was accepted that, until this investment was fully in place, treatment might also have to be paid for in Independent Sector treatment centres.

The elective access standards applying in 2009/10 were that patients should wait no longer than 9 weeks for assessment, 9 weeks for diagnostics and 13 weeks for treatment. These standards were substantially (though not universally) achieved by March 2010. However, reduced waiting times have triggered substantial increases in demand in many areas. Consequently, we will focus attention on ensuring that waiting times for assessment remain at 9 weeks and that waiting times for treatment are kept as short as resources allow.

6.2.2(iv) Modernising and Reconfiguring Services

Ensuring services are delivered in ways which continue to be of high quality and are safe and effective will be an increasing challenge over the next few years and will result in a reconfiguration of services. To maintain and to continue to achieve this standard of service for our comparatively small population of 1.7m will not be possible unless we change the ways in which we deliver care to people.

As standards for training increase our Medical, Nursing and Allied Health Professions staff are working in an increasingly complex clinical environment. Senior clinical staff need to work in a different way, with access to a significant clinical infrastructure, sub speciality expertise and larger teams of senior colleagues to discuss and to make decisions about the best treatment and care for patients. For staff in training there are also issues about needing to work in a different way to ensure they can gain the necessary experience which will best qualify them to provide the highest quality of medical and nursing care. A critical issue in terms of how hospital services are commissioned in the future will be to have a much closer relationship with the training bodies. In this way we can work together to develop approaches about training in systems or networks rather than in institutions to make training better for staff and the patients they care for.

For many years the Health and Social Care has tried its best to secure the right clinical staffing profile to maintain acute services but this is becoming increasingly difficult. Many of our services – and not just those provided in smaller units – are becoming more dependent on the use of locum cover (which by its nature must impact on the continuity of care) because we cannot attract or retain permanent specialist staff. The drive for change in how we commission and provide acute care is not about money, it is about making sure that all of our population, irrespective of where they live, has access to the same standard of high quality, safe, clinical care.

There has been progress in networking of clinical teams across Northern Ireland and beyond and increasing use of new medical technologies in diagnostics and telemedicine which have helped support safe and effective practice across the country. However, it has to be recognised that even with such innovations and other initiatives, Northern Ireland is a small country with a small population and it simply won't be possible to sustain the current pattern safely for much longer.

For more specialist services, the need for access to expert teams in centres of excellence is a key quality driver for securing the best outcomes for what are often small numbers of complex patients – even within much larger populations than ours. Strategies need to be developed within Northern Ireland as to how we can best secure equality of access to specialist care, taking into account

that it may well not be possible or desirable to try to provide all of this care locally. Different models need to be developed involving formal clinical networks and other innovative relationships with UK services and within the Republic of Ireland.

Some of these changes in how we are commissioning hospital care have already happened. Over the last 10 years Northern Ireland has streamlined its care for cancer patients by consolidating services into the major acute hospitals with streamlined access to the regional cancer centre as needed and we are seeing better outcomes for patients as a result. Progress with the 2002 DHSSPS Strategy 'Developing Better Services' has also resulted in changes to acute hospital care in Downpatrick, Lisburn, Enniskillen and Omagh.

Around 80% of hospital care is made up of diagnostics, outpatients, day care and ambulatory services. Therefore it becomes clear that irrespective of some of the changes what will have to happen in inpatient care, there remains a very important and key role for smaller local hospitals where much of this activity takes place. We want to maintain, where it is safe, sustainable and appropriate to do so, as much local access for local people as possible. The local hospital has a key role in refining the diagnosis for patients and referring them through the system as appropriate. We want Local Commissioning Groups to work closely with local hospitals to shape the service care pathways responsively to local need and to seamlessly connect this to the rest of the hospital network.

The next steps in terms of a detailed programme will follow but we want to signal in this Commissioning Plan specifically what the changes are likely to involve:

- Optimise the role and function of the local hospital network in providing access to diagnostics, outpatients, day and ambulatory care and establishing care pathways through the rest of the hospital system;
- Supporting the changes which have occurred in 2010/11 in Magherafelt and at Whiteabbey by developing their outpatient, diagnostics, rehabilitation and minor injuries capacity and putting in place new services such as bowel screening;

- The concentration of acute inpatient services on fewer sites with the necessary clinical infrastructure to provide safe high quality services with improved patient outcome;
- Changes to the current provision of 24/7 Accident and Emergency Services will improve performance and deliver consistency of care across the region;
- Changes to the current profile of inpatient emergency surgical services to provide for sub-specialisation and appropriate staffing and expertise;
- Avoiding inappropriate duplication of inpatient specialities in each of the Trust sites;
- Changes to the current profile of paediatric inpatient services to provide for appropriate staffing and expertise in line with best clinical practice;
- Changes to maternity services to provide for appropriate staffing and expertise in line with best clinical practice;
- 'Right Sizing' the number of acute medical inpatient beds for our population in line with national standards to release resources for reinvestment in front line services;
- More rigorous adherence to the effective use of resources (demand management);
- Specifying and addressing the impact these changes will have on emergency transport services;
- Taking account of the impact of developments in new technologies and therapies will have on both our capital and staffing infrastructures needs and planning flexible options to accommodate these;
- We also have a substantial agenda in progressing service developments which commenced in 2009/10 but have yet to be consolidated fully.

Making these changes won't be easy. It will require dialogue with the population and involve fundamental strategic shifts in the current pattern of care but we need to do this to secure good outcomes and to provide safe services. We need to be innovative in how we establish networks of different elements of care and how we connect them to populations and each other to ensure continuity.

6.2.2(v) Personal and Public Involvement

Personal and Public Involvement is about people and communities influencing the planning, commissioning and delivery of health and social care services. It means actively engaging with those who use our services and the public to discuss; their ideas, our plans; their experiences, our experiences; why services need to change; what people want from services; how to make the best use of resources; and how to improve the quality and safety of services.

Whilst the concept of Personal and Public Involvement is not new, we have made considerable efforts in 2009/10 to further embed Personal and Public Involvement in our everyday work and a draft Consulting Schemes document has been submitted to the DHSSPS. The Health and Social Care Board and Public Health Agency are committed to working in partnership with the Patient and Client Council, other Health and Social Care Organisations and statutory bodies such as Local Councils, to promote Personal and Public Involvement and identify joint Public Involvement opportunities and reduce duplication.

6.2.3 PFA Targets

PFA Target: Specialist Drug Therapies for Arthritis

From April 2010, the HSC Board and Trusts should ensure no patient waits longer than nine months to commence specialist drug therapies for the treatment of severe arthritis.

It is anticipated that around 290 additional patients will need to be commenced on treatment during 2010/11. Funding up to a level of £3.150m will be made available to Trusts to support the drug and infrastructure costs to allow these additional patients to commence treatment and maintain the maximum waiting time at nine months. During 2009/10, the number of patients on treatment increased by approximately 500 which was in excess of the estimated growth. Should the recurrent annual costs of this patient group exceed the monies available from 2009/10, it may not be possible to commit the totality of the new monies for additional patients. If this transpires it may not be possible to meet the target.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The service profile will need to support opportunities for patients to be treated locally and funds allocated to Trusts will reflect the usage patterns from each of the Local Commissioning Group areas.

The Regional Medical Services Group has concerns with regard to a differential uptake in usage of these drugs both across Local Commissioning Group areas and in comparison with national peers. During 2010/11 work will be undertaken to confirm this position and the rationale, if any, for same.

PFA Target: Elective Care (Consultant-led)

By March 2011, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks for a first outpatient appointment and 9 weeks for a diagnostic test, the majority of inpatients and daycases treated within 13 weeks and no patient waits longer than 36 weeks for treatment. During 2010/11, Trusts should take steps to ensure review patients

are seen in a more timely fashion; from March 2010, all reviews should be completed within the clinically indicated time.

PFA Target: Diagnostic Reporting

From April 2010, the HSC Board and Trusts should ensure all urgent diagnostic tests are reported on within two days of the test being undertaken, with 75% of all routine tests being reported on within two weeks and all routine tests within four weeks.

It is expected that full implementation of the Northern Ireland Picture Archive and Communication System across all Trusts during 2010/11 will contribute to improved performance in this area and the Health and Social Care Board's Performance Management and Service Improvement Directorate will continue to support Trusts to identify and implement the necessary service reforms.

PFA Target: Elective Care (AHP)

From April 2010, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks from referral to commencement of AHP treatment.

The DHSSPS has identified a total of £40m (£25m recurrent; £15m non recurrent) in funding to assist in the delivery of these targets. It is anticipated that this, allied to £25m in elective investment already allocated to Trusts in 2009/10, should be sufficient to allow these targets to be substantially met, although resource constraints will still present real obstacles to delivery. It is proposed that:

- The levels of demand experienced in 2009/10 will be used as an indicator of where resources should be allocated;
- Providers will be encouraged to implement approved service developments as quickly as possible;
- Short term funding will be prioritised for those providers able to deliver additional assessment and treatment capacity within Health and Social Care;
- Trusts will only be allowed to use the Independent Sector in exceptional circumstances;

- Greater emphasis will be placed on Effective Use of Resources policies to ensure that resources are targeted to service areas with the greatest clinical need.

PFA Target: Fractures

From April 2010, the HSC Board and Trusts should ensure 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient fracture treatment.

The ability to achieve this standard is impacted upon by the flows and fluctuations in the number of patients presenting at the fracture units across Northern Ireland on a daily and weekly basis. This has resulted in all Trusts experiencing difficulties in meeting the standard on an ongoing basis. The Health and Social Care Board is working with Trusts to ensure that during periods of pressure arrangements are in place to ensure that the maximum number of patients are treated within 48 hours with priority given to procedures with evidenced based outcomes and a focus on ensuring that no patient waits longer than 7 days.

PFA Target: Cancer

From April 2010, the HSC Board and Trusts should ensure all urgent breast cancer referrals are seen within 14 days, 98% of cancer patients commence treatment within 31 days of the decision to treat, and 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62 days.

This target requires additional capacity in oncology and radiotherapy services. Investments already agreed in 2009/10 are expected to be implemented during 2010. These will include an increase in the number of consultant oncologists.

Where investment in cancer drugs is made this will include the appropriate level of infrastructure to provide timely treatment.

Investment in Elective Access Standards will also contribute to the achievement of this target. Investments agreed in 2009/10 include additional radiography and medical physics staff to provide an increase in radiotherapy in BCH Cancer Centre. Every effort will

be made during 2010/11 to optimise the capacity by using extended operating days on the current equipment.

PFA Target: A & E

From April 2010, HSC Board and Trusts should ensure 95% of patients attending any A & E DHSSPS are either treated and discharged home, or admitted within four hours of their arrival in the DHSSPS. No patient should wait longer than 12 hours.

Trusts have indicated difficulties in achieving and maintaining the required level of performance across the current configuration of A&E Departments. This has been reflected in the commissioning statements earlier in this document which recognises the need to review A&E provision across the region. The Health and Social Care Board will continue to engage with Trusts to ensure that the best possible standard of performance is delivered through the implementation of agreed good practice.

PFA Target: Stroke Services

By March 2011, the HSC Board and Trusts should ensure 24/7 access to thrombolysis and that high risk transient ischaemic attacks are assessed and treated within 24 hours. Trusts should also work towards a door to needle time of 60 minutes for thrombolysis by March 2011.

The Health and Social Care Board and the Public Health Agency will work closely with the Trusts to develop these services during 2010/11. Allocations made in 2009/10 will also be consolidated or reprofiled as appropriate to support the service further.

The additional funding of £1.75m will be used to achieve the PFA targets for 24/7 thrombolysis and assessment within 24 hours of high risk TIA's. In view of the reduced funding available in 2010/11, the number of thrombolysis sites in Belfast will be reviewed to take account of this.

PFA Target: Renal Services

From April 2010, the HSC Board and Trusts should ensure all patients should continue to have timely access to dialysis services. From April 2010, at least 60% of patients should receive dialysis via a fistula. By March 2011 the Belfast HSC Trust should deliver a minimum of 50 live donor transplants.

The number of patients needing treatment for end – stage kidney disease grows each year by about 40 cases. These patients are largely treated by hospital haemodialysis (HD), with some patients undertaking home peritoneal dialysis (PD) or home haemodialysis (HHD) and some receiving kidney transplants.

Transplantation is the best treatment in terms of offering increased survival and improved quality of life. It is also cost effective, particularly after the first year.

During 2009 the process to assess patients and their relatives for live kidney donation was strengthened and streamlined. This has resulted in a significant number of potential pairs coming forward as suitable for transplantation. This is very positive for both the individuals and the service. The increased activity will be challenging due to both operational and resource issues.

In order to address the need generated by this approach an increased number of cases will need to be delivered over the next 12-18 months through a specific, time limited arrangement.

By March 2011, it is expected that the PFA Target of 50 live donor transplants could be met by using a combination of enhanced local provision, a level of inreach to the Belfast Trust from a UK NHS Trust and a smaller number of patients being offered transplantation in an NHS Trust in England. Every effort will be made to deliver this target but it presents a significant financial challenge. Early discussions and agreements will need to take place at Commissioner, Trust and Departmental level on the resource issue if we are to achieve the target within the necessary timescale.

All available recurrent and non-recurrent resources for this programme in 2010/11 will be targeted at increasing the transplantation numbers.

It is expected that approximately 35 live donor kidney transplants would be needed each year thereafter in Northern Ireland to meet demand. This would almost balance out the need for growth in hospital haemodialysis places, offer substantially better outcomes for patients and has the potential to reduce future costs in the longer term.

There is already sufficient funded hospital haemodialysis capacity in Northern Ireland to meet the 2010/11 growth in this demand. However the pattern of capacity may not always be in the unit closest to the patient's home. Trusts will be expected to take measures to minimise the need for patient travel in such cases by making available other dialysis treatments such as supported peritoneal dialysis or home haemodialysis as alternative options where clinically suitable, which will be cost neutral. The demand on haemodialysis capacity will be monitored throughout the year. Where there is opportunity to release substantial goods and services resource these will be re-directed to support the in-year costs of additional live donor transplant programme.

The provision of dialysis via fistula will continue to be developed and opportunities to support the achievement of this target via vascular as well as transplant surgical skills will be pursued and developed in a managed way.

PFA Target: Ambulance Services

From April 2010, the HSC Board and Northern Ireland Ambulance Service (NIAS) should ensure an average of 72.5% of Category A (life-threatening) calls are responded to within eight minutes, increasing to an average of 75% by March 2011 (and not less than 67.5% in any LCG area).

Every effort will be made to ensure that this target continues to be delivered.

PFA Target: Healthcare Associated Infections

In the year to March 2011, the Public Health Agency and Trusts should secure a further reduction of 20% in MRSA and C. difficile infections compared to the position in 2009/10.

The target reductions for each Trust in 2010/11 are based on benchmarking against peer organisations in England. The Public Health Agency will work with Trusts to ensure a further reduction in MRSA and C difficile infections compared to the 2009/10 baseline within the context of the funding available.

PFA Target: Hygiene and Cleanliness

From September 2010, each of the five HSC Trusts should put in place arrangements to routinely review compliance with updated and consolidated regional standards of hygiene and cleanliness. Trust review arrangements should include consideration at Trust Board.

This target will be addressed by Trusts.

PFA Target: Mortality

From September 2010, each of the 5 HSC Trusts should put in place arrangements to routinely review the Trust's standardisation mortality rates, both over time and against comparator organisations in NI and GB. Trust review arrangements should include consideration at Trust Board.

This target will be addressed by Trusts.

PFA Target: Trust Quality Initiatives

From April 2010, the Public Health Public Health Agency and Trusts should continue to ensure satisfactory progress is made towards the full implementation of approved quality improvement plans and the achievement of Trust – specific targets for ventilator associated pneumonia, surgical site infection, central line infection, the crash call rate, the prevention of venous thromboembolism and mental health inpatient care. By July 2010, Trusts should submit to the Public Health Agency, for approval and monitoring, quality improvement plans to implement WHO Surgical Checklists in 80% of cases by March 2011, and in collaboration with the HSC Safety Forum promote initiatives aimed at reducing the incidence of falls and medication errors.

The Public Health Agency and the Trusts will work towards full implementation of approved quality improvement plans and achievement of targets as specified.

PFA Target: Patient Experience

Following the adoption of the Patient and Client Experience standards in 2009, Trusts should extend the clinical care areas monitored and increase the range of monitoring tools and ensure appropriate reporting and follow – up, consistent with direction from the Public Health Agency.

This target needs to be addressed by Trusts consistent with the direction of the Public Health Agency.

PFA Target: Patient Involvement

By March 2011, the Public Health Agency in partnership with the HSC Board should: establish a regional Health and Social Care forum, with appropriate Patient Client Council and Public representation, to drive the PPI agenda; develop and implement a regional Health and Social Care Action Plan for PPI including arrangements to promote and evidence active PPI; arrange for the publication of an annual summary of PPI activity across Health and Social Care Organisations.

The Public Health Agency, in partnership with the Health and Social Care Board, will take forward this target as outlined by March 2011.

PFA Target: Service Frameworks

By March 2011, Commissioners and Trusts should have action plans in place to ensure the implementation of agreed standards from the Cancer Framework in accordance with guidance to be issued by the DHSSPS in October 2010.

The Health and Social Care Board and Public Health Agency will seek to have an action plan in place by March 2011.

6.2.4 Summary of Commissioning Proposals in 2010/2011

6.2.4(i) Specialist Drugs (£13.85m)

A total of £13.85m has been allocated regionally in 2010/11 to support the continued introduction of specialist drugs.

Allocation by Local Commissioning Group (LCG) for specialist drugs (FYE)

Belfast	Northern	South Eastern	Southern	Western
£2.943m	£3.363m	£2.492m	£2.681m	£2.371m

The Health and Social Care Board proposes the following use of the funds available. Local Commissioning Groups will be expected to commit their share of resources based on the pattern of usage by their populations by Trust.

6.2.4(ii) High Cost Drugs Inflationary Uplift (£3m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.638m	£0.728m	£0.540m	£0.580m	£0.514m

A total of £3m is required across the region to meet the baseline price uplift associated with the current usage of high cost drugs. Funding will need to be provided to Trusts in a pattern reflective of the Local Commissioning Group service usage.

6.2.4(iii) Treatment of Severe Rheumatoid Arthritis (£3.150m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.669m	£0.765m	£0.567m	£0.610m	£0.539m

PFA Target – By March 2011, the HSC Board and Trusts should ensure no patient waits longer than nine months to commence specialist drug therapies for the treatment of severe arthritis.

It is anticipated that around 290 additional patients will need to start treatment during 2010/11. Funding up to a level of £3.150m will be made available to Trusts to support the drug and infrastructure costs to allow these additional patients to commence treatment and maintain the maximum waiting time at nine months. During 2009/10, the number of patients on treatment increased by approximately 500 which was in excess of the estimated growth. Should the recurrent annual costs of this patient group exceed the monies available from 2009/10, it may not be possible to commit all of the new monies for additional patients. If this transpires it may not be possible to meet the target.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The service profile will need to support opportunities for patients to be treated locally and funds allocated to Trusts will reflect the usage patterns from each of the Local Commissioning Group areas.

The Regional Medical Services Group has concerns with regard to a differential uptake in usage of these drugs both across Local Commissioning Group areas and in comparison with national peers. During 2010/11 work will be undertaken to confirm this position and the rationale, if any, for differences.

6.2.4(iv) Age Related Macular Degeneration (£2.200m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.467m	£0.534m	£0.396m	£0.426m	£0.377m

Services have been established in both the Western and Belfast Trusts to provide treatment for age related macular degeneration for the population of Northern Ireland. Resources have been made available to both Trusts to ensure that timely treatment is provided to preserve the sight of people affected by this condition, in accordance with therapies and regimes approved by the National Institute for Clinical Excellence. The additional funding being made available in 2010/11 will ensure that new patients continue to access this treatment.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The funds allocated to the Western and Belfast Trusts will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(v) Immunoglobulins and Haemophilia Blood Products (£1m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.213m	£0.242m	£0.180m	£0.194m	£0.171m

The Regional Medical Services Group will continue to work with Trusts in order to profile the increased usage of these products by Trust and speciality.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The funds allocated will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(vi) Disease Modifying Therapies for Multiple Sclerosis (£0.100m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.022m	£0.024m	£0.018m	£0.019m	£0.017m

This treatment is provided by the Belfast and Western Trusts for the population of Northern Ireland. The amounts above are required to support the continued maintenance of the 13 week maximum waiting time for these specialist drugs.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with each of the Trusts to agree business cases for development of this service. The funds allocated to the Belfast and Western Trusts will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(vii) Tobramycin for Cystic Fibrosis (£0.088m)

Allocation by LCG (FYE)

Belfast	Northern	South	Southern	Western
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		Eastern		
£0.019m	£0.021m	£0.016m	£0.017m	£0.015m

Northern Ireland has significantly higher survival rates for patients with cystic fibrosis. This service is provided from the Belfast Trust and the funding earmarked for 2010/11 will support the increasing number of patients receiving this drug.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process with the Belfast Trust to agree a business case for development of this service. The funds allocated to the Belfast Trust will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(viii) HIV and GUM Drugs (£1.500m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.319m	£0.364m	£0.270m	£0.290m	£0.257m

Over the past two to three years there has been a significant increase in the notifications of patients with HIV in Northern Ireland. Around two thirds of these patients have required the introduction of early treatment for their condition.

The funding earmarked for 2010/11 will fund the full year effect of patients commenced on treatment during 2009/10 and the projected increase in patient numbers during 2010/11.

The Health and Social Care Board and Public Health Agency will seek to direct some of the total funding available to early detection and preventative programmes given the very significant potential health gain that can be achieved.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process to agree business cases for development of this service. The service profile will need to support opportunities for patients to be treated locally. The funds allocated will need to

reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(ix) Orphan Enzyme Therapies (£0.650m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.138m	£0.158m	£0.117m	£0.126m	£0.111m

These funds are to support patients with enzyme deficiencies – estimated at 2 to 3 additional patients per year.

Over the coming months the Health and Social Care Board and Public Health Agency via the Regional Medical Services Group will engage in a process to agree the patient profile for these resources. Funding to support this will be provided on a capitation basis from each of the Local Commissioning Group areas on a risk sharing basis, irrespective of the area of residence of the patient.

6.2.4(x) Cancer Drugs and Infrastructure (£1m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.212m	£0.243m	£0.180m	£0.194m	£0.171m

A process is in place between the Regional Medical Services Group and the Northern Ireland Cancer Network Haematology and Oncology Drug and Therapeutics Committee to guide the introduction of new cancer drugs.

The Northern Ireland Cancer Network Haematology and Oncology Drug and Therapeutics Committee assesses formal business cases and cross references against the National Institute for Clinical Excellence and Scottish Medicines Consortium guidance before providing a prioritised shortlist of potential drugs for introduction. The current list being reviewed includes a number of drugs which were identified by the Committee in previous years but have not yet been funded recurrently and drugs which have been approved by the National Institute for Clinical Excellence but

for which the Committee has not yet had the opportunity to consider business cases.

In 2010/11 there is £1m available regionally for new cancer drugs. The introduction of new drugs will need to be prioritised within this funding.

The Northern Ireland Cancer Network Haematology and Oncology Drugs and Therapeutics Committee has recently submitted a number of potential proposals for new developments in 2010/11, which are under consideration by the Regional Medical Services Group. The majority have already been approved by the National Institute for Clinical Excellence while a number of the remainder are expected to be approved during 2010. Previously, the Regional Medical Services Group has committed funding to introduce new drug regimes pending an indication that the National Institute for Clinical Excellence approval was expected shortly, only for this approval to be delayed or, on occasion, rescinded. This has meant that these ring fenced resources have not been fully utilised as planned whilst at the same time, other drug pressures have not been supported.

There is balance to be struck between ensuring there is sufficient funding to introduce new drug therapies in accordance with the National Institute for Clinical Excellence whilst trying to ensure a degree of flexibility to allow funding to be reprofiled if a significant delay in approval occurs.

Final decisions have yet to be made on the distribution of funding for cancer drugs and infrastructure in 2010/11.

Over the coming months the Health and Social Care Board and Public Health Agency, via the Regional Medical Services Group, will engage in a process with each of the Trusts to agree business cases for the introduction of the cancer drugs which will be supported in 2010/11 in the cancer centre and the cancer units. The service profile will need to support opportunities for patients to be treated locally where clinically appropriate. The funds allocated will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(xi) Other uses of Anti TNF Drugs (£0.500m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.106m	£0.121m	£0.090m	£0.097m	£0.086m

The use of Anti-TNF therapies has been approved by the National Institute for Clinical Excellence for the treatment of Psoriasis. These therapies have also been approved as short term induction regimes for the treatment of Crohn's disease and for acute exacerbations of ulcerative colitis. A National Institute for Clinical Excellence Multiple Technology Appraisal for infliximab and adalimumab in Crohn's disease was expected to be published in May 2010. This is expected to give approval for maintenance use. The funding earmarked for 2010/11 will allow an increased number of patients to have timely access to these drugs.

Over the coming months the Health and Social Care Board and Public Health Agency, via the Regional Medical Services Group, will engage in a process with each of the Trusts to agree business cases for development of this service. The service profile will need to support opportunities for patients to be treated locally. The funds allocated will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(xii) Introduction of other National Institute for Clinical Excellence approved therapies (£0.663m)

Allocation by LCG (FYE)

Belfast	Northern	South Eastern	Southern	Western
£0.142m	£0.161m	£0.119m	£0.128m	£0.113m

This funding has been earmarked to fund drug regimes likely to be approved by the National Institute for Clinical Excellence during 2010/11. However, due to the pressures to fund cancer treatments that have already been approved by the National Institute for Clinical Excellence, this resource may instead have to be reprofiled to support the latter. This may delay the implementation of future National Institute for Clinical Excellence recommendations/Technical Appraisals in 2010/11.

Over the coming months the Health and Social Care Board and Public Health Agency, via the Regional Medical Services Group will engage in a process to agree the profile of new drugs to be introduced and business cases to support these. The service profile will need to support opportunities for patients to be treated locally. The funds allocated will need to reflect the usage patterns from each of the Local Commissioning Group areas.

6.2.4(xiii) Renal Services (£0.130m)

Discussions will take place with renal services providers in respect of these funds in the context of reduced demand for dialysis.

6.2.4(xiv) Stroke Services (£1.7m)

Discussions will take place with providers in respect of how services will be developed in line with objectives set out in the Priorities for Action Target.

6.2.4(xv) Support for Ward Sisters/Charge Nurses

The sum of £1.2m will be invested across the five Trusts to allow ward sisters/charge nurses to spend an additional 20% of their time on improving safety, quality and the patient experience.

Priority Area 3:

Integrating Primary, Community and Secondary Care Services

6.3.1 Strategic Context

- 6.3.1(i) Integrating care services involves removing organisational and professional boundaries, promoting coordination and cooperation, in order to provide 'person-centred' health and social care. The right care, by the right person, in the right place, at the right time: evidence-based care, which is timely and cost-effective.
- 6.3.1(ii) The Health and Social Care Board and Public Health Agency will continue to develop and support initiatives to build a continuum of responsive, integrated health and social care; balancing health promotion and illness prevention with effective interventions to diagnose and treat illness in the most appropriate setting. Providers will be encouraged to continue to focus on supporting individuals to live independent lives and reduce unnecessary and inappropriate reliance on hospitals or other institutional care. Local Commissioning Groups will play a vital role in consultation with Councils, Trusts, Local Area Partnerships and Voluntary Organisations, to review health and wellbeing needs across their respective localities, working with local communities to seek ways of looking beyond the traditional organisational construct for the delivery of local care.
- 6.3.1(iii) Commissioners will seek to ensure continued progress in aligning investment with need. The aim of increasing the proportion of care delivered in a community setting will necessitate some redistribution of funding, investment being closely aligned with demand and provision, at the most appropriate point of delivery. Investment in new services will also be linked to rigorous evaluation of delivery and outcomes. In the context of a difficult economic environment, it will be essential to focus on efficiency, value for money and outcome measurement, in order to maximise the benefits for all.
- 6.3.1(iv) For effective commissioning it is essential that reliable information is available upon which to base commissioning decisions. Integration of care will place an increasing onus upon providers to cooperate in the

collation of reliable information, measuring activity and outcomes, to support the delivery of effective quality care.

6.3.2 Commissioning Themes

Through the vertical integration of Health and Social Care services, Commissioners will seek to enable the removal of traditional primary / secondary care boundaries. The aim is to assist a shift in emphasis through the enhanced local provision of services within the primary care setting, while supporting secondary care providers to focus on specialist secondary care interventions. Supporting the diagnosis, treatment and holistic care of the majority within a local setting ensures that only those who genuinely require secondary care intervention are managed within that domain: improving access and decreasing the unsustainable growth in demand. This will deliver an improvement in the quality of the patient experience, while driving greater overall efficiency in health and social care provision. The Health and Social Care Board and Public Health Agency will require enhanced access to diagnostic services in primary care, supported by clinical decision support tools, so that General Practitioners can efficiently and effectively diagnose more complex conditions, offering a greater range of services to manage increased case complexity, and improving the quality of referrals, with a higher proportion being referred appropriately (requiring intervention that is only available in secondary care).

A significant proportion of secondary care outpatient activity (up to 70%) involves reviewing patients who have already been treated in secondary care. There is evidence that a substantial proportion of these patients could be reviewed and managed in primary care; increasing efficiency and convenience for patients. New models of review are required, to ensure that patients are not required to attend secondary care providers needlessly. Trusts will be encouraged to engage in the development of a new approach to reviewing patients in partnership with primary care.

Delayed discharge of individuals requiring complex support in the community setting causes significant inefficiency. The Health and Social Care Board will seek to engage in partnership, with the Local Commissioning Groups and Trusts, to improve the efficiency of discharge planning. There will also be a requirement for Trusts to improve communication of information into primary and

community care, to accompany patients, ensuring the safe transfer of responsibility of care. This will build upon work undertaken by the Registration and Quality Improvement Authority in this area.

General Practitioners and primary care teams, acting as gatekeepers to health and social care services, are a major determinant of health care utilisation in terms of the care that a patient/client receives and how patient choice is exercised. Linking gatekeeper clinical and financial responsibility has the potential to reconfigure commissioner investment in a way which develops more integrated care whilst raising the standard of care, improving provider efficiency and making services more responsive to patients and clients. The Health and Social Care Board will work with Local Commissioning Groups and healthcare professionals to develop a supportive structure to promote the federation of GP practices to deliver this aim.

Local Commissioning Groups are exploring new and innovative approaches to integrating healthcare and will deliver this on the ground through local partnerships. 'Primary Care Partnerships' will be built around local communities of circa 100k population and will include GP practices, pharmacists and other providers of health and social care based in their area. Through assigning indicative budgets covering areas such as prescribing, outpatient care, diagnostics and community services, partnerships will be afforded the opportunity to reinvest a proportion of savings in local services. They will be clinically led to ensure strong clinical governance and decision-making.

Through Regional Clinical Networks we have seen significant engagement between the range of health care professionals, and organisations, across health and social care, for the benefit of patients. Such cooperation is essential, and should be routine professional activity, across the spectrum of health and social care. Key to improving the quality of care is the agreement of clinical pathways and implementation of agreed standards. Trusts will be encouraged to build on the achievements to date, with increased support to clinicians and practitioners to engage across interfaces, delivering continuing improvement. By encouraging healthy lifestyle choices, health improvement can contribute to reducing demands on primary and community services. With demographic changes and increased life expectancy, the Public Health Agency is keen to ensure that people living longer enjoy

healthier and happier lives. Through targeted health improvement measures, partnership with Local Commissioning Groups and community support, the Public Health Agency will ensure that older people will remain active longer and have less requirements for health and social care interventions; promoting increased independence and improved self management of long-term conditions through healthier choices.

Support will be given in private care settings, such as residential and nursing homes, to ensure the development of a health promotion ethos. Carers providing support to individuals in their own homes will not be overlooked, being considered as a thematic community, prioritised for targeted intervention.

Horizontal integration of health and social care services will be an important development, redefining professional responsibilities, and improving the utilization of all health and social care professionals within the primary care setting. Commissioners envisage a redistribution of the responsibility of elements of care provision, with improved communication and coordination of care. The aim is to provide a genuinely multidisciplinary team approach, with 'person-centred' care, and not care which is organisationally or professionally focused.

6.3.2(i) Demand for services

Trusts have experienced continuing pressure to respond to an ever increasing demand for services. Whilst in the context of delivering significantly improved access to secondary care services, the average growth in demand is estimated at 10% to 12%. This level of growth in demand would be unsustainable in the longer term. To maintain the quality of care, and further improve access to services, it is envisaged that a significant proportion of services will be delivered more appropriately, in primary care and community settings.

6.3.2(ii) General Medical (GP) Services

General Medical Services are a key location to target health improvement initiatives from promotion of immunisation initiatives, targeting emotional wellbeing through to more general health and wellbeing initiatives on diet, exercise, alcohol and smoking. In 2009/10 £43.9m was invested by the Health and Social Care

Board in the General Medical Services Quality and Outcomes Framework (QOF), supporting professionals in General Practice to deliver a range of health promotion and disease prevention activity. £27.3m was invested in Enhanced Services*. The total investment in General Medical Services, for the region in 2009/10 was £236.1m.

** Services for patients, delivered to a higher specified standard than, and not routinely delivered though the essential/core contract for General Medical Services (GP Services).*

General Medical Services Expenditure 2009/10 (Draft)				
Global Sum/MPIG			£116.1m	
Health and Social Care Board Admin			£9.4m	
QOF			£43.9m	
OOH			£21.7m	
Enhanced Services			£27.3m	
IT Revenue			£3.2m	
Premises			£14.5m	
Total	General	Medical	Services	£236.1m

Projected General Medical Services Expenditure 2010/11				
Global Sum/MPIG			£114.6m	
Health and Social Care Board Admin			£9.4m	
QOF			£43.8m	
OOH			£21.0m	
Enhanced Services			£25.2m	
IT Revenue			£4.5m	
Premises			£15.7m	
Total	General	Medical	Services	£234.0m

N.B.: General Medical Services Allocations for 2010/11 not yet finalised

The Health and Social Care Board is committed to working with the Public Health Agency and Local Commissioning Groups to improve existing services and develop new Enhanced Services promoting long-term health improvement and addressing inequalities. The Health and Social Care Board is currently engaged in a review, and regional harmonisation, of Enhanced Services to ensure effectiveness, equality of access, and value for

money. Engagement with professionals, across health and social care is ongoing, to deliver the aims of the Service Frameworks. Integrated primary, community and secondary care services, and the provision of effective Enhanced Services, will be essential for delivery.

A re-focus of existing investment and bids for additional funding are being considered by the Health and Social Care Board, to complement the work undertaken in General Practice in managing chronic illness, through improved integration of care in the delivery of Service Frameworks. For example, in implementation of the Respiratory Framework, the intention is to implement a chronic disease management model, using a self-management approach, and basing services within primary care supported by specialist community input. The focus will be on the avoidance of unnecessary admissions and facilitation of early discharge; with services operating across acute and community interface, to increase effectiveness and efficiency.

The implementation plan has identified investment priorities for Trusts, to establish community multi-disciplinary teams, with a range of professionals such as Nurse Specialists, Physiotherapists and Clinical Psychologists; supported by General Practitioners. Such teams will facilitate a range of activities, including early supported discharge, admissions avoidance, support and training to GP practices, nebuliser and long term oxygen therapy assessments, case management of moderate to severe cases, pulmonary rehabilitation and palliative care. These developments are aimed at an improvement in the quality of life of patients and a reduction in mortality, in an evidence-based and cost effective re-organisation of the delivery of care. "The right care, by the right person, in the right place, at the right time: evidence-based care, which is timely and cost-effective".

6.3.2(iii) Dental Services

The Health and Social Care Board will continue to work with both independent contractors and Trusts to prevent dental disease. The Health and Social Care Board has a central coordinating role in the Northern Ireland Caries Prevention in Practice trial, the largest primary care based research study into the prevention of tooth decay ever undertaken in the UK. The trial began in November 2009 and recruitment of practices commenced in May

2010. The Health and Social Care Board will also continue to work collaboratively with the Public Health Agency and the Trusts to reduce oral health inequalities through the five Investing for Health funded toothpaste schemes. An evaluation of the schemes undertaken by the Health and Social Care Board in May 2009 found them to be effective and recurrent funding has now been secured.

Registrations with Dental Services for children under-5 are a key indicator for health inequalities and the Public Health Agency will work with communities to encourage more parents to be aware of their own and their children's dental hygiene. The Health and Social Care Board is keen to improve access to dental services across the region, and improve the quality of care provided. The Health and Social Care Board will seek to improve access by new approaches to contracting services, where traditional models of provision have not delivered. To that end, the Health and Social Care Board has invested £17.1m in enhancing access through partnership with the private sector. The Health and Social Care Board entered into a contract with Oasis Dental Care Limited in September 2009 to provide dental services in the areas of Northern Ireland where access was considered problematic. The contract requires that by September 2010, Oasis will have 38 new dentists, working out of 15 practices, in the areas perceived to have the greatest requirement for improved access. To date, two practices have opened in the Western area, and plans remain on the schedule for the remaining 13 practices. To ensure appropriate levels of dental access in the long term, the Health and Social Care Board is working collaboratively with DHSSPS and the British Dental Association on the piloting arrangements for three new dental contracts: one for General Dental Services, one for Orthodontic Services and one for Oral Surgery. In contracting for General Dental Services, there is an aim to shift the emphasis to holistic quality of care, rather than the traditional model, based on 'item of service' payments.

The Health and Social Care Board is committed to improving outcomes and securing best value from the services it commissions. There are currently three centralised out-of-hours dental services in Northern Ireland Health and Social Care, each of which operate in different ways. In 2010-2011 the Health and Social Care Board plans to review these services to ensure that across Northern Ireland out-of-hours dental care is provided in the

most equitable, effective and efficient manner. Specialist Oral Surgery services in Northern Ireland are provided in both the primary and secondary care setting. To maximise efficiency and access to care, it is important that the most complex cases are seen in the most specialised centres and, where possible, that less complicated conditions are treated locally. The Health and Social Care Board will review the provision of Oral Surgery and Maxillofacial Surgery to ensure that the twin goals of efficiency and access are met.

6.3.2(iv) Pharmacy and Medicines Management

There are unique opportunities to develop further partnerships with Community Pharmacies to promote health improvement messages and campaigns. The Building Community Pharmacy Partnership initiative provides one opportunity but other approaches include tackling sexual health, obesity prevention and oral health.

Medicines are an important intervention in healthcare. With over 30 million prescription items being dispensed annually costing over £400m, it is important that we optimise the use of medicines to ensure maximum benefits to patients.

The use of medicines can inadvertently lead to adverse incidents with between 5% and 10% of acute admissions to hospitals linked to the use of a medicine. It is important that there are good processes in place to monitor and review medicines and provide support to patients so that their safety is assured.

The cost of medicines used is an important factor to consider. In Northern Ireland we spend £224 per head of population, the next highest administration being Wales at £194 per head of population. The Regional Twenty Year Strategy for Health and Wellbeing “A Healthier Future” recognised that medicines matter and identified the need to “... embrace appropriate Medicines Management services to improve the way medicines are used both by individual patients and by the Health and Social Care”. Much work has been done by practitioners and by legacy HSS Boards, Trusts and DHSSPS in providing direction and support under a range of initiatives. The Pharmaceutical Clinical Effectiveness Programme, led by DHSSPS, has provided a focus on safety and quality to drive efficiency and effectiveness and in so doing has supported the delivery of higher attainment of generic prescribing and dispensing; the implementation of repeat dispensing; adoption of a

methodology to assist in the appropriate selection of therapeutic choices; and the commissioning of Integrated Medicines Management within Health and Social Care Trusts.

In 2010/11, the Health and Social Care Board will implement a programme of medicines governance in primary care. This will build upon the project carried out in the legacy SHSSB and encourage practitioners to report prescribing, dispensing and administration incidents so that lessons can be learned on how to make the management of medicines safer.

6.3.2(v) GP Out-of-Hours Service

The need for integration of health and social care is not confined to normal working hours. The Health and Social Care Board will focus attention on improved integration of unscheduled care and regionalisation of the GP Out-of-Hours Service. The GP Out-of-Hours Service has provided a quality service to patients since its inception. With increasing demand on services, the ability to continue delivering a quality service, within budget, is limited without reorganisation. Regionalisation of the service will deliver efficiencies in service provision, to sustain the delivery of a quality service, and maintain access. In partnership with Local Commissioning Groups, the Health and Social Care Board will seek to improve integration of the service with other forms of community and unscheduled care, building on progress that has already been made, and ensuring equality of access across the region. This will include access to a range of services, for example nursing, dental, pharmacy, mental health and social care. It will also include voluntary and charitable providers. The key is to ensure that GP Out-of-Hours services and unscheduled care are linked with daytime care with significant benefits for essential service such as palliative and 'end-of-life' care.

Underpinning this requirement for greater integration of services, development of new care pathways, integration and extension of professional roles, is the need for professional development. The Health and Social Care Board will, in partnership with educational and training agencies, seek to facilitate professional development to support the changing health and social care environment. It is important to ensure that Appraisal, Governance and developments in service delivery are more robustly linked to educational provision.

6.3.3 PFA Targets

PFA Target: Pathway Management

By March 2011, the Health and Social Care Board should establish pilot programmes to evaluate: (i) models of integrated care in community settings which incorporate integration along clinical care pathways and address the wider determinants of health; and (ii) models of unscheduled care in hospital settings which integrate primary care out-of-hours services with ambulance and A&E services.

The Health and Social Care Board will, through Local Commissioning Groups and the development of 'Primary Care Partnerships', establish pilot programmes to evaluate new models of integrated care in community settings. This will build on existing work in developing clinical care pathways, placing a focus on the patient-centred integration of services. The Health and Social Care Board/Local Commissioning Groups and Public Health Agency will work in partnership to address the wider determinants of health, helping a shift in emphasis to prevention. Trusts will be supported to develop improved models of unscheduled care delivery, integrating primary care Out-of-Hours and community unscheduled care services with A&E services, and acute hospital care provision.

PFA Target: Hospital Discharges

From April 2010, the Health and Social Care Board and Trusts should ensure that 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days. All other patients should be discharged within six hours of being declared medically fit.

Timely discharge promotes better patient outcomes and reduces demand on the acute sector, even when the coordination of care and support services is complex. Moreover, timely discharge is frequently the expressed preference of the patients. It requires a discharge ethos to be well embedded across the community-acute interface, in the use of Estimated Dates of Discharge, proactive discharge planning (including the use of existing discharge coordinators) and the focus of all professionals on rehabilitation potential.

At the point of discharge, there must still be the appropriate use of Enhanced Intermediate Care, with the Care Management of patients taking place outside of the ward setting, enabling all involved to make informed and coordinated post-discharge care decisions, eliminating unnecessary delay. The Health and Social Care Board will continue to promote the development and implementation of discharge protocols which are consistent with timely discharge, while facilitating patient choice and the need for carers to be integral to the discharge planning process.

The majority of the necessary elements cited above are established, or are in development, but this activity in development and implementation will need to be sustained. Complementary to this, will be a drive towards greater integration of statutory, independent and voluntary services in the community; stronger partnership with local government, housing, rural development etc. The Health and Social Care Board, through Local Commissioning Groups, will seek to extend the continuum of support, or care services, in place in the local community, facilitating optimal discharge planning and delivery. Such 'whole-systems' working and continuing improvement is at the heart of integrating care, delivering the best outcomes for individuals, and for Health and Social Care across the region.

It is the aim of the Health and Social Care Board to work with Trusts, in order to ensure that 90% of complex discharges take place within 48 hours, with no discharge taking longer than seven days. It is also intended that all other patients will be discharged within six hours of being declared medically fit.

PFA Target: Unplanned admissions

By March 2011, the Health and Social Care Board and Trusts should further develop early intervention approaches to support identified patients with severe chronic diseases (e.g. heart disease and respiratory conditions) so that exacerbations of their disease which would otherwise lead to unplanned hospital admissions are reduced by 50%.

In seeking to reduce exacerbations of chronic disease leading to unplanned admissions the Health and Social Care Board will progress parallel approaches to deliver a holistic solution.

In the first instance the Health and Social Care Board will work with general practitioners, through the General Medical Services Contract, seeking to ensure optimal care of all patients through the Quality and Outcomes Framework and Enhanced Services for the management of chronic disease. The Health and Social Care Board will engage general practitioners to review variation in referral rates and unscheduled admissions, in order to optimise effectiveness in the community – based management of such patients.

To ensure an integrated approach across primary and secondary care, the Health and Social Care Board will continue to progress the implementation of current and future Service Frameworks standards in order to optimise the management of chronic illness within the population. Communication at the Primary/Secondary care interface will be examined to ensure effective and timely communication underpinning referral, outpatient attendance and discharge; with an emphasis on ensuring sufficient information and care planning is provided to support patients in the community, and prevent avoidable readmissions.

In order to ensure that resource is focused to provide maximum benefit, the Health and Social Care Board will support clinicians in primary and secondary care in the identification of those patients most likely to benefit from more intensive care management. Research conducted in Northern Ireland, and in England has shown the potential to identify patients with chronic diseases at risk of hospitalisation, at an early stage. PARR (Patient At Risk of Re Hospitalisation) tools have been developed to model risk, and identify patients for intervention in order to prevent hospitalisation rather than react to it. The Health and Social Care Board is exploring approaches taken elsewhere, including those undertaken by the Nuffield Trust in the development of risk modelling for patients in Northern Ireland.

Once patients at risk have been identified evidence is lacking to determine the most effective form of intervention. The Health and Social Care Board/Public Health Agency will seek to evaluate models of intervention across each Health and Social Care Trust in

order to determine effectiveness. The intention will be to monitor delivery of the PfA Target in relation to predicted risk while measuring the relative effectiveness of interventions, in order to optimise care across the region. Work will be undertaken with Local Commissioning Groups / Primary Care Partnerships to develop integrated and coherent interventions across the Primary/Secondary Care interface. Part of this work will involve focus on improved health promotion and outcome focused management of long term conditions, evaluated through measuring the rate of unscheduled admissions to hospital, in absolute terms and relative to the predicted risk. The Health and Social Care Board will expect to see a downturn in rates as a measure of effective care.

PFA Target: Direct Payments

By March 2011, the Health and Social Care Board and Trusts should increase the number of direct payment cases to 1,750.

Considerable progress has been made by Trusts in response to the target for achieving an additional 1,750 clients on Direct Payments between 2008 and March 2011. Commissioners expect Trusts to continue to promote the take up of Direct Payments across all client groups in 2010/11 as a means of ensuring responsive services and value for money.

Trusts are expected, through their Carer Coordinators, to increase the number of carers' assessments offered and the number of completed carers' assessments recorded. In addition the Health and Social Care Board will work with Trusts and relevant independent sector agencies, to ensure that information for carers is up to date and appropriate. Through General Medical Services Quality and Outcomes Framework investment, General Practitioners are encouraged to identify carers and put in place a mechanism for the referral of carers for social services assessment.

PFA Target: Palliative Care

By March 2011, Trusts should establish multi-disciplinary palliative care teams and supporting service improvement programmes to provide appropriate palliative care in the community to adult patients requiring such services.

Trusts are tasked to progress the development of palliative care teams to provide support and care to palliative and end-of-life patients in the community on a 24/7 basis, with the aim of decreasing the number of inappropriate admissions to hospital. Trusts have been required to put in place service improvement programmes to support these teams; delivered in the context of the Gold Standards Framework, Care Pathway for the Dying and the best standards of multi-professional education. The Health and Social Care Board will seek to facilitate engagement and integration of these services with Family Practitioner Services, both in-hours and Out-of-Hours.

PFA Target: Primary Care Access

From April 2010, the Health and Social Care Board should ensure 70% of patients receive an appointment within two working days with a GP or appropriate practice based primary care practitioner, increasing to 80% from April 2011.

The Health and Social Care Board is committed to ensuring good access to General Practitioner services. The Health and Social Care Board will continue to promote this through implementation of nationally agreed Quality and Outcomes Framework measures of the 'Patient experience of access', and the current Regional Directed Enhanced Service for access.

PFA Target: Medicines Management

By March 2011, the Health and Social Care Board should introduce a Northern Ireland Medicines Formulary.

The Health and Social Care Board will give due consideration to the capacity to achieve this target and in particular build on the excellent work that has been led by the DHSSPS through the pharmaceutical clinical effectiveness programme. In support of this target the Health and Social Care Board will convene a Medicines Management Forum to advise on the safe, effective and efficient use of medicines within Health and Social Care. A key output of this group will be to advise on the development and application of a formulary for Northern Ireland by March 2011

Supplementary Information on PfA Medicines Management Target

A number of products have been identified to develop a formulary in 2010/11:

1/ The Medicines Management Forum will support the corporate governance controls in respect of development and implementation of a formulary. Therefore the establishment of the MMF will be a key output.

2/ A process for developing, reviewing and authorising the content of the formulary. This includes linkage into secondary care to ensure consistency of approach.

3/ Formulary sections - the following will be developed and produced by year end: Gastro-intestinal; Cardiovascular; Central Nervous System; Antimicrobials; Wound Dressings. The delivery of these sections constitutes 60% of products in primary care

4/ Preparatory work to establish the remaining elements of the formulary (respiratory (which will link to the Respiratory Services Framework); endocrine; NSAIDs; dermatology; nutrition).

5/ Implementation plan to include the development of IT infrastructure to support the use of the formulary; and the process for update, review and control of entry onto the formulary.

PFA Target: Greater use of generic drugs

The Health and Social Care Board should ensure the level of dispensing of generic drugs increases to at least 64% by March 2011.

On prescribing, in England and Wales there has been a focus on Better Care, Better Value. These indicators are based upon National Institute for Clinical Excellence guidance and are supported by a clear evidence base. Within the context of a Medicines Management Programme, the Health and Social Care Board will pay due regard to the following targets by March 2011:

- Generic dispensing to increase to 64%;
- Repeat dispensing to increase to 5%.

The Health and Social Care Board will also encourage the alignment of prescribing to Better Care, Better Value, for the following indicators, by March 2011:

- Increase low cost lipid lowering therapy to 60% of total;
- Increase low cost proton pump inhibitors to 80% of total;
- Increase the proportion of low cost Angiotensin Converting Enzyme inhibitors, as a percentage of total use of drugs affecting the rennin-angiotensin system, to 72% of total.

Through the application of these initiatives, it is envisaged that the cost of prescribed medicines will be reduced by some £7m.

Priority Area 4:

Helping Older People to Live Independently

6.4.1 Strategic Context

To date Northern Ireland has not had the advantage of a Regional Strategy for Services for Older People, rather each legacy Board developed their own local strategic statements of intent. Priorities for Action has continued to set the direction of travel for the programme of care, towards the building of a continuum of integrated primary and community care services that focus on people at greatest risk, supporting independence and reducing inappropriate reliance on hospitals and other institutional care. The launch of the plan to develop a Service Framework for Older People's Health and Wellbeing in January 2010 established a regional process to agree evidence based standards, targets and measurable outcomes for the individual's journey from prevention to ongoing support and care, including where necessary, palliative care.

The strategic direction for commissioners in respect of the needs of people with dementia will be set by the forthcoming NI Dementia Strategy which is expected to be published in mid 2010. The Strategy will reflect the recommendations about dementia included in the Bamford Review report with specific reference to the identification, treatment and care of people with dementia and the provision of better support for carers. A key priority will be improvements in integrated working across primary, secondary and community care.

Commissioning must aim to strike the balance between the need to shift resources towards disease prevention, health promotion and active ageing while also ensuring the delivery of a network of care and treatment services for those at the dependent end of the scale.

6.4.2 Commissioning Themes

Section 1.1 of this Commissioning Plan, 'Demographic Changes', has highlighted already the challenges for Health and Social Care arising from an ageing population. However, it is important to acknowledge the fact that increasing numbers of older people are enjoying active and independent lives for longer. Commissioning needs to build on this positive trend by pursuing a healthy ageing agenda through "Investing for Health" partnerships to address key issues such as isolation, abuse, fuel poverty and the need for improved transport services.

6.4.2(i) Demand for services

Population ageing is a key driver for policy. It is well recognised that the conditions that account for most diseases in the UK are primarily related to old age. Older people are proportionately the main users of acute hospitals and community health and social care services. The greatest concentration of health care costs occurs in the last year of a person's life, whatever the age at death. The DHSSPS Capitation Formula Review Group work shows that the cost per person by age group across all programmes of care rises steeply from an average annual cost of £1,800 in the 60-64 age band to over £11,000 in the 85+ band. An increasing pressure for resources is resulting from the growth in the number of people with dementia. The cost is high in terms of both public and private resources. In Northern Ireland 16,000 people are understood to be living with dementia, 400 of these with early onset dementia. The ageing of the population means that by 2017 the figure is likely to rise to over 20,000 people. Research estimates that the annual average cost of care for someone with dementia ranges from £14,540 for a person with mild dementia living in the community, to £28,527 for someone with severe dementia in the community. The average cost for someone in supported accommodation was estimated to be £31,300. This demonstrates both the human and financial challenge to the commissioning system.

6.4.3 Priorities for Action

The specific standards and targets to be achieved in 2010/11 are:

PFA Target: PSA 4.1: Supporting People at home

From April 2010, the Health and Social Care Board and Trusts should ensure at least 45% of people in care management have their assessed care needs met in a domiciliary setting.

PFA Target: Assessment and treatment of older people

From April 2010, the Health and Social Care Boards and Trusts should ensure older people with continuing care needs wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.

PFA Target: Individualised Care Plans

From December 2010, the Health and Social Care Board and Trusts should ensure any patient receiving a new care package at home is provided with a copy of their individual care plan to enable them to understand the level of care to be

provided and who to contact if difficulties arise with care package arrangements.

In respect of the Priorities for Action targets for 2010/11, the Health and Social Care Board will continue to monitor performance specifically in respect of waiting times for assessment/treatment and hospital discharges. Trust performance against the unplanned admissions target for people with severe chronic diseases will continue to be monitored closely.

Work will be undertaken through the development of the Service Framework for Older People's Health and Wellbeing to identify standards which are evidence-based, and to describe the key performance indicators and benchmarks. As with all Service Frameworks, the process of audit and measurement of the standards will be built in from the start. Likewise, the Northern Ireland Dementia Strategy will represent the main future monitoring framework for dementia provision.

6.4.4 Challenges and Constraints

In 2010/11 the priority for the programme of care for older people will be to continue to reform services to achieve an integrated system which responds flexibly to demand and addresses capacity issues more effectively. The current Health and Social Care Board community care demand/capacity work will analyse variations in charging, costs, demand and application of eligibility criteria. The lessons from best practice elsewhere will be considered for application across NI, particularly the Care Services Efficiency Development programme, or reablement initiative, being implemented in GB and piloting in Southern and Northern Trusts. The emphasis on prevention, detection and early intervention will grow and the role of General Medical Services and the independent sector will be at the forefront of the outcome driven modernisation process. New models of care reflecting innovative practice and the active promotion of Direct Payments and personalised budgets will be significant elements of future commissioning for the care and treatment of older people, as will the provision of support for carers, including formal assessment of their needs. The Carer's Support and Needs Assessment component of Northern Ireland Single Assessment Tool provides an effective, consistent framework for this.

The Trusts, in partnership with primary care, and the independent sector, will be expected to continue to strengthen and streamline discharge planning arrangements and to consolidate the capacity for post-acute rehabilitation in a range of intermediate care settings. The restructuring of existing facilities, resources and

workforce will be crucial to the achievement of the strategic shift away from traditional forms of provision. Individualised care plans for people receiving care at home will be introduced in 2010/11, as an important element in the promotion of self-management. In previous years the growing needs of an ageing population have been met by a growth in funding. Trusts have already had to increase their spending to meet demand into 2010/11 and an additional £15m is being made available to meet this. The Local Commissioning Groups will have a critical role in how this resource is commissioned within each of their areas.

The Health and Social Care Board will look to the Local Commissioning Groups to adopt a more consistent approach to charging where there are existing variations, aiming for greater equity between different localities. Trusts will also be expected to seek greater value for money in their use of service providers. The Local Commissioning Groups will also have a role in bringing greater consistency to the procurement of community care. Beyond 2010/11 the main drivers for the strategic development of services for older people will be the forthcoming service framework and the NI Dementia Strategy. The outcome of the demand/capacity work will also influence strongly the priorities for commissioning, as will feedback from effective performance management.

6.4.5 Summary of Commissioning Proposals in 2010/11

The Health and Social Care Board Response/Intent for 2010/11 Based on Funding Intentions or Other Factors (e.g. Restructuring). The Health and Social Care Board will deploy £15.1m across 5 Trusts to meet the anticipated growth in demand for 2010/11 so that waiting time targets are maintained and to support adult protection.

The Health and Social Care Board expects Trusts to continue to move away from providing care in institutional settings, in particular traditional forms of residential care, and to work with housing agencies and others to develop accommodation which offers a home-based care setting with more flexible and responsive care and support.

The Health and Social Care Board will expect Trusts to plan hospital discharge from the day of admission and to work with carers and other providers to ensure that patients are discharged from hospital as soon as is clinically safe, to appropriate settings, for assessment of their future care requirement.

Priority Area 5:

Improve Children's Health and Wellbeing

6.5.1 Strategic Context

The theme of improving children’s health and wellbeing resonates with the six high level outcomes identified in the Office of the First and Deputy First Minister Strategy – ‘Our Children and Young People – Our Pledge’. Achieving the outcomes from this strategy is the underpinning aim for all services to support children and young people in being:

- Healthy;
- Enjoying, learning and achieving;
- Living in safety and with stability;
- Experiencing economic and environmental wellbeing;
- Contributing positively to community and society; and
- Living in society which respects their rights.

This strategy combined with other overarching strategic documents issued by the DHSSPS, namely ‘Care Matters’ and ‘Families Matter’ provide the context in which services are being commissioned. The planned Children’s Services Framework will also influence future commissioning. There is recognition of the need for development and investment across the continuum of children’s services from prevention / early intervention to adoption /leaving and aftercare. There is an extensive body of evidence which demonstrates the cost benefit analysis of an investment in our children. It is important that children are valued, protected and cherished as they are the foundation stone for future generations. “Care Matters” outlines the corporate role of the state to assist those children and young people looked after and care leavers whose health and wellbeing requires to be improved.

6.5.2 Commissioning Themes

6.5.2(i) Demand for Services

In Northern Ireland over 7000 children and young people are referred each year to specialist Child and Adolescent Mental Health Services. The Health and Social Care Board under the auspices of the Bamford Implementation Taskforce has established a Child and Adolescent Mental Health Services task group to take forward service improvement in line with the specific actions outlined in the Bamford Implementation Plan. Birth rates across Northern Ireland as a whole have fluctuated in recent years but show a general upward trend particularly over the past five years. This is illustrated in the following table:

Birth Rate per 1,000 population by Trust for 2000 - 2009

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
BHSCT	12.0	11.9	11.5	12.0	12.4	12.0	12.5	13.4	14.2	14.0
NHSCT	12.5	12.6	12.6	12.3	13.1	12.8	13.0	13.4	14.0	13.1
SEHSCT	12.2	12.4	11.5	12.1	12.4	12.0	12.6	13.4	13.7	13.3
SHSCT	13.7	14.6	14.0	14.0	14.6	14.7	15.0	15.6	16.0	15.9
WHSCT	13.9	13.9	13.6	13.4	12.9	13.4	13.9	13.8	14.4	14.2
NI	12.8	13.0	12.6	12.7	13.0	12.9	13.4	13.9	14.4	14.0

Source: NISRA

Notes: Population used is mid-year estimates for each year (2009 figures are provisional – 2009 rate is calculated using the 2008 mid-year estimated population).

6.5.2(ii) Partnership Working

The Health and Social Care Board/Public Health Agency remains committed to working in partnership with service users and a range of stakeholders across the statutory, voluntary, community and independent sectors. These partnerships, which are integral to commissioning include:

- Children and Young People’s Committees;

- Hidden Harm Quality Assurance Group;
- Regional Child Protection Committee;
- Child Care Partnerships;
- Investing For Health Partnerships;
- Think Child, Think Parent, Think Family.

There is commitment to bring forward and consolidate work on outcomes based planning and measuring how effective service interventions are with children and their families. There is a need to strengthen the arrangements for children and young people's participation in planning processes and ensure that there are mechanisms in place for feedback on the services available to these children.

6.5.2(iii) Reform and Modernisation

The need to commission services which are fit for purpose has been high on the agenda of the Health and Social Care Board/Public Health Agency which is why there has been and will continue to be in 2010/2011 a focus on reform and modernisation. The Performance Management and Service Improvement Directorate within the Health and Social Care Board has a specific responsibility to take this agenda forward and within children's services the Children's Service Improvement Programme and the Reform Implementation Team have been the vehicles through which prioritisation, demand and capacity, modernisation and productivity have been pursued. This has resulted in multiagency engagement/involvement and the promotion of greater consistency across the Health and Social Care sector. This process will be ongoing in the forthcoming year to consolidate the need for collaborative working and the recognition that more can be achieved for the population.

6.5.2(iv) Family Support

The Children's Services Planning process has effectively brought stakeholders together to plan and provide both local and regional services in line with the strategic direction as spelt out in 'Families Matter'. These services are monitored and require to report on the progress measured against the Children's Strategy High Level Outcomes.

This is the third year of Comprehensive Spending Review funding to a wide range of family support projects and the bulk of the reduced funding available to children's services for 2010/2011 will require to be used to adhere to these contractual arrangements. In the event that some of this funding is mainstreamed in future years the Health and Social Care Board will need to consider the balance of investment between family support and statutory services.

The Childcare Partnerships operating as multiagency partnerships are financed by Department of Education but led by the Health and Social Care Board and this will continue at least for the next year. The primary focus is on early years and family support services in the most deprived areas and the agenda can only be effectively delivered if the partnership arrangements are maintained, if communities continue to contribute and if quality remains as integral to service provision.

It will be important that Local Commissioning Groups are kept apprised of developments commissioned through these multiagency processes but which operate at a local level and will impact on the work of the Local Commissioning Groups.

6.5.2(v) Early Intervention Strategy

The foundations for physical, intellectual and emotional development are primarily established in early childhood. To have an impact on health inequalities ensuring the optimum focus on early interventions is therefore critical. In addition to the roll out of

a variety of early years investment the establishment of internationally successful and evidence based early intervention models including 'Family Nurse Partnerships' and 'Roots of Empathy/Seeds of Empathy' into Northern Ireland in 2010/2011 will be pursued.

6.5.2(vi) Healthy Child, Healthy Future

The Healthy Child, Healthy Future programme is a universal public health service offered to all children and young people aged 0-19 years. This programme requires a set number of contacts to be made to each family in Northern Ireland to identify the health need(s) through a holistic assessment which includes screening and surveillance, where necessary provide early intervention to ameliorate the potential early negative impact of any physical, social or emotional factors on a child or young person's health and wellbeing. The Commissioner and Trusts will fully implement the revised Child Health Promotion Programme by 31st March 2011.

We will take into account the Marmot Review of Health Inequalities 2010 which said that reducing health inequalities is a matter of fairness and social justice and the fair distribution of health, wellbeing and sustainability are important social goals.

6.5.2(vii) Long Term Conditions In Childhood

Partnership with parents and children and young people is central to the planning and delivery of children's services. Parents of children and children with long term conditions e.g diabetes, epilepsy and childhood disability should be supported to manage their child's condition and help the child self manage whenever possible. A three year Northern Ireland wide project for children and adolescents with diabetes, funded through Inter-Reg IV, is piloting the introduction of Structured Patient Education for all children with diabetes and their families in Northern Ireland.

This will support families and children with diabetes to optimize diabetes control in childhood and prevent or delay the development of complications of diabetes in adulthood. There is a need to ensure children have access to effective interventions in managing their condition.

6.5.2(viii) Pre-pregnancy Care

Evidence is increasing of the importance to pre-pregnancy care for the health of children, particularly for women of child bearing age with long term conditions such as diabetes and epilepsy. A three year Northern Ireland wide project, funded through Inter Reg IV, is piloting pre-pregnancy care for diabetic women of child bearing age in Northern Ireland. This aims to reduce the increased perinatal mortality and congenital malformation rates observed in diabetic pregnancies.

6.5.2(ix) Pregnancy Care

Births have increased in Northern Ireland since 2004. We have endorsed the National Institute for Clinical Excellence guidelines for ante-natal, post –natal and intra-partum care. Trusts need to ensure targeted interventions are available for high risk pregnancies.

6.5.2(x) Child and Adolescent Mental Health Services (Child and Adolescent Mental Health Services)

In response to the growing demand for specialist intervention, legacy Health and Social Care Boards invested over £1.6m over the last two years. This investment was largely focused on developing capacity within existing specialist Child and Adolescent Mental Health Services teams, and in establishing eating disorder and crisis assessment teams. Whilst there has also been some modest investment in the development of wraparound/therapeutic care services for looked after children, there remains a significant gap in earlier intervention services and in the range of available

psychological therapies across the Child and Adolescent Mental Health Services tiers. The Health and Social Care Board has promoted and will continue to apply the Choice and Partnership Approach model in taking forward the modernisation and commissioning agenda.

Currently in Northern Ireland there is a total of 27 regional beds, of which 12 are for adolescents (aged over 14) and 15 for children. This level of provision has historically led to higher levels of admissions of young people to adult mental health wards and Extra Contractual Referrals for those young people with intensive psychiatric/complex care needs. As a result of capital investment from April 2010 the number of beds will rise by 6 to 33 beds regionally, (16 adolescent, 2 Intensive psychiatric care and 15 children's beds). These additional beds should reduce reliance on adult mental health beds and assist in the preventing some Extra Contractual Referrals for intensive psychiatric care. However in order to avoid unnecessary admission and to support earlier discharge there will be a need to develop the scope and range of community child and adolescent mental health services. The Health and Social Care Board in partnership with the Trusts will review the range and scope of tier 4 Child and Adolescent Mental Health Services provision.

6.5.2(xi) Children with Disabilities

Trusts should ensure progress is achieved against the regional Autism and Acquired Brain Injury Action Plans. This necessitates that Trusts develop service capacity across the Children's Mental Health and Disability services and encompasses the child, adolescent and adult age range. A key requirement is to ensure that existing infrastructure and practitioners across the wider range of Children's Mental Health and Disability Services are better able to meet the needs of both children and adults with Autism and Acquired Brain Injury. Trusts must evidence that individuals with Autistic Spectrum Disorder and Acquired Brain Injury are considered within a person centred framework and not restricted

by specific criteria which risk excluding individuals from access to services.

The Health and Social Care Board/Public Health Agency will seek to engage with Trusts in scoping current access criteria to establish regional consistency in the application of such criteria.

Trusts should also ensure that appropriate Transitions services for young people with a disability and their carers are in place and the relevant information around transitions between Children and Adults services is available to service users and their carers including information in relation to carer's assessments and direct payments.

6.5.2(xii) Prevention and Community Engagement

An important theme in community engagement is to avoid crises arising where possible through preventative approaches. Solutions to challenging structural problems require strong service user, carer and community engagement in planning services and new initiatives. Some communities, individuals and families experience multiple social problems. For example they may lack employment, skills and qualifications, are living in poor accommodation, live on a low income, have addiction and substance problems or may be at risk. Health and Social Care services work with some of the most excluded and vulnerable members of society and in working with people with limited capacity must be imaginative in promoting participation, user involvement and person centred approaches. This kind of intervention promotes real empowerment and self help in the community and enables service users and carers to speak for themselves, advocate for service improvements and fully engage with Health and Social Care Board/Public Health Agency in planning new services. User involvement and community based development supports confident active and sustainable communities, capable of meeting their own needs in partnership with Health and Social Care services and others. The Health and Social Care Board/Public Health Agency will continue to employ community development principles in involving service users and carers in planning and developing services.

6.5.3 PFA Targets

The range of targets posed particular challenges as they also reflect the continuum of care covering family support, child protection, looked after children, care leavers and family group conferencing.

In view of the numbers of unallocated cases it has been necessary to put in place robust monitoring processes to be assured that cases of a child protection nature are responded to immediately and that cases are being screened and assessments completed along the pathway in a timely fashion.

The Health and Social Care Board has made recurrent and non recurrent investment in the past year to assist Trusts to respond to an increased number of referrals and will continue to see this as a priority area in the forthcoming year.

It will be important to retain the commitment to the targets as far as this is practically possible as these assist in promoting the outcomes relating to children living with safety and stability and young people experiencing economic and environmental wellbeing.

PFA Target: Children In Care

From April 2010, the Health and Social Care Health and Social Care Board and Trusts should ensure children admitted to residential care have prior to their admission: (i) been the subject of a formal assessment to determine the need for residential care, and (ii) had their placement matched through the Children's Resource Panel process. For every child taken into care, a plan for permanence and associated timescale should be developed within six months and formally agreed at the first six-monthly Local Advisory Committee review.

PFA Target: Family Support Interventions

By March 2011, the Health and Social Care Health and Social Care Board and Trusts should provide family support interventions to 3000 children and vulnerable families each year. By this date, Trusts should also have updated the Regional Information System with details of family support services which they provide.

PFA Target: Care leavers in education, training or employment

From April 2010, the Health and Social Care Health and Social Care Board and Trusts should ensure that at least 70% of all care leavers aged 19 are in education, training or employment.

PFA Target: Care leavers living with former foster carers or supported families

By March 2011, the Health and Social Care Health and Social Care Board and Trusts should ensure that at least 200 care leavers aged 18+ are living with their former foster carers or supported family.

PFA Target: Looked-after children on the child protection register

By March 2011, the Health and Social Care Health and Social Care Board and Trusts should ensure that the child protection status of all looked-after children on the current register is reviewed in line with Departmental guidance issued in April 2010.

PFA Target: Family group conferencing

During 2010/11, the Health and Social Care Health and Social Care Board and Trusts should ensure that at least 500

children and young people participate in a family group conference.

As regards the targets referring to Family Group Conferencing and Education, Training and Employment opportunities for Care Leavers, some Trusts have stipulated that achievability is dependent on the young person's willingness to be involved and that the economic climate will impact on the careleavers target. The Board will continue to work closely with the Trusts to monitor progress and ensure that the standards are met within the required timescale."

PFA Target: Assessment of children at risk and in need

- **From April 2010, the Health and Social Care Health and Social Care Board and Trusts should ensure the following:**
- **Child protection (allocation of referrals) – all child protection referrals are allocated within 24 hours of receipt of the referral.**
- **Child protection (initial assessment) – all child protection referrals are investigated and an initial assessment completed within 10 working days from the date of the original referral being received.**
- **Child protection (pathway assessment) – following the completion of the initial assessment, a child protection case conference is held within 15 working days of the original referral being received.**
- **Looked-after children (initial assessment) – an initial assessment is completed within 10 working days from the date of the child becoming looked after.**
- **Family support (family support referral) – 90% of family support referrals are allocated to a social worker within 20 working days for initial assessment.**
- **Family support (initial assessment) – all family support referrals are investigated and an initial assessment**

completed within 10 working days from the date the original referral was allocated to the social worker.

- **Family support (pathway assessment) – on completion of the initial assessment, 90% of cases deemed to require a family support pathway assessment should be allocated within a further 20 working days.**

6.5.4 Challenges and Constraints

Within Child and Family Care Services there is a requirement on Trusts to effectively discharge a range of statutory functions and to provide assurances that this is the case. The Health and Social Care Board will wish to strengthen Gateway and Family Intervention Teams to meet demand.

The significant increase in children's names placed on the child protection register reflects the national perspective and the response to high profile situations where children are exposed to serious harm or even death. The Health and Social Care Board/Public Health Agency expect, as will service providers, that there is adherence to procedural requirements and that responses are timely, proportionate and robust.

The needs of looked after children are diverse and complex. They must be informed by meaningful engagement of the children and young people as well as assessment processes which are multi disciplinary and recognise the role to be played by various partners if these children are to recover from previous traumatic experiences, or to form meaningful attachments to appropriate adults and go on to make a positive contribution to the community and society.

The Health and Social Care Board will wish to ensure that previous investment in the development and maintenance of therapeutic fostercare schemes and therapeutic inputs for children in residential care have been utilised and consider which aspects can be regionalised to produce better outcomes. There is a need to consolidate the position and for Trusts regionally to utilise investment in finalising structures. The need for post adoption support services is also recognised and the Health and Social Care Board will work with potential providers to further develop these services in the forthcoming year. Care leavers must

continue to receive support; practical, financial and therapeutic if their needs are to be met. This will allow statutory functions to be discharged whilst also beginning to break the cycle where a significant proportion of care leavers will continue to experience various forms of disadvantage into adulthood which is a further call on public resources.

The former foster care (Go the Extra Mile) scheme has been a positive example of promoting stability for care leavers and leaves Northern Ireland as a forerunner in this regard. The Health and Social Care Board would wish to see this further expanded.

The Health and Social Care Board has established processes for Trusts to report all placements of 16/17 year olds in unregulated accommodation. It is understood standards are to be issued via DHSSPS in relation to such accommodation and Trusts should seek assurance that appropriate safeguarding arrangements are in place and that placements can meet the needs of the young people concerned.

Multi-sectoral discussions have also been ongoing in relation to young homeless and there is a potential for this area to be a significant call on social care services resource if this cohort were to require to be seen as looked after children.

Residential child care is the preferred and necessary placement choice for some young people; there have been some occasions where Trusts have considered their needs can only be met in specialist placements outside Northern Ireland. These have been identified as high cost cases and the Health and Social Care Board has identified recurrent funds to the Trusts for these cases in the expectation that this process and the available funds will be used appropriately with Trusts seeking to remain in budget. It is also the case that the number of young people who experience this level of disruption should be minimised and the Health and Social Care Board will still therefore require to be advised where this is being considered to offer a view on the appropriateness of young people being placed outside the jurisdiction.

Trusts now have a stock of residential care and all Trusts have access to the regional secure unit. The Health and Social Care Board will retain its commitment to the places provided within the regional voluntary children's home during 2010/11 whilst a

decision is reached in relation to regional provision. It is felt that there is a need for additional differentiation and specialisation in this sector. The Health and Social Care Board would wish to engage further with providers in this regard to determine the specific needs and the potential to work across Trust boundaries to create a more receptive portfolio of provision.

6.5.5 Summary of Commissioning Proposals

2010/11 Investment	
Family Support Interventions / Packages	£1.04
Gateway Services	£1.17m
Adoption Support Services	£0.15m
Children's Services Total	£2.36m
2010/11 Investment	
Statutory Carers Assessments for Autistic Children	£0.10m
Out of Hours Cover re Obstetrics	£0.05m
Children with Complex Needs Total	£0.15m

Priority Area 6:

Improve Mental Health Services and Services for People with Disabilities

6.6.1 Strategic Direction

The Bamford Report and the 'Protect Life' Strategy set out the vision for the reform and modernisation of Mental Health, Learning Disability and Child and Adolescent Mental Health Services over a fifteen year horizon. Since the publication of the individual report, further evidence based models of service delivery have emerged and these will be integrated during the implementation of the Bamford recommendations. The Health and Social Care Board has established a number of core task groups to take this work forward and this will be monitored by the Bamford Implementation Taskforce, led by the Health and Social Care Board's Chief Executive. A core theme will be the need to strengthen community services to promote a recovery based model of care provided predominately in or close to people's homes. As outlined in 'Delivering the Bamford Vision' (DHSSPS, 2009), key themes include:

1. Promoting positive health, wellbeing and early intervention;
2. Supporting people to lead independent lives;
3. Supporting carers;
4. Providing better public services to meet people's needs;
5. Providing structures and a legislative base to deliver the Bamford Vision.

Additional strategic drivers include the regional 'Protect Life', Suicide Prevention and Promoting Mental Health and Wellbeing strategies and the new Strategic direction for Drugs and Alcohol, which aim to promote mental health and wellbeing and foster resilience within communities.

The strategic direction for Learning Disability service developments and service improvement is set out in the "Equal Lives" report of the Bamford Review. This envisages a similar model of community based care so that no-one remains in hospital unnecessarily and the people with a learning disability can enjoy the maximum quality of life possible, consistent with their needs.

In the absence to date of a regional strategy for Physical Disability/Sensory Impairment, legacy Boards developed local strategies which reflected the aims of promoting independence and empowerment and improving the quality and responsiveness of health and social services for people with disabilities and their carers. Late in 2009, DHSSPS launched the process for developing a Regional Strategy for People with Physical Disabilities and Sensory Impairment and it is anticipated that this will be completed by early Autumn 2010. The Strategy will adopt a life cycle approach covering all age groups and will promote the importance of partnership working across statutory, community and independent sectors.

The focus of Priorities for Action 2009/10 for this programme of care was the continued development of person-centred, seamless community-based services, informed by the views of users and carers. Key priorities were, and continue to be, the avoidance of inappropriate hospital admission, facilitation of early discharge, improved respite and carer support, and the enhancement of provision for those with acquired brain injury and for those who require Wheelchair services.

The latter two areas have recently been the subject of regional review and implementation processes are currently progressing. The targets associated with the action plans for each review are being monitored through the performance management process.

The emphasis now must be upon the reform and modernisation of our existing services. New investment may occur in strategically critical areas (i.e. to deliver Priorities for Action and drive efficiency and effectiveness). The Health and Social Care Board will seek evidence that any new investment is linked to significant reform and service improvement as a condition of approving any new service developments.

The Bamford Implementation Taskforce commenced in January 2009 and is jointly led by the Health and Social Care Board and the Public Health Agency in partnership with Trusts and other stakeholders. At a local level, this process will be led by Local Commissioning Groups.

The Taskforce will be the principal source of advice and guidance regarding service development priorities and will facilitate greater consistency and standardisation of service provision across NI.

The Taskforce will also ensure that service users and carers become partners in the planning and delivery of services regionally.

6.6.1(i) Drivers for Change

There will be a continuing focus on delivering existing, and any new, Priority for Action Targets. Service improvement activity will be focused on those areas where performance is weak or where there is a consensus about the need for whole system reform and modernisation. In particular, attention will concentrate on;

- Consolidation of the stepped care model across all mental health services, in particular Tier 2 and the use of funding provided for the Depression Directly Enhanced Service within primary care;
- A 9 week maximum wait time for all mental health services including within Child and Adolescent Mental Health Services (13 weeks for psychological therapies);
- Continue the process to eliminate hospital delayed discharges;
- Community follow-up within seven days of discharge from hospital
- Resettlement of the long-stay hospital population;
- Growth in the development of alternatives to hospital admission;
- Promoting the quality of the in-patient experience through the 'Releasing Time to Care' initiative;

- Full and consistent implementation of the ‘Card Before You Leave’ scheme;
- Promoting cooperation between Trusts on specific topics of common interest, for example the coordination of access to in-patient resources;
- Maximising the utilisation of existing capacity within community services;
- Support the regional process to scope out the development of peri-natal mental health services;
- Supporting the roll-out of the Beating the Blues project;
- Overseeing the regional Life Line contract;
- Delivery of local Protect Life Action Plans with priority focus on community support;
- Extension of Deliberate Self Harm registry to Belfast Trust;
- Coordination and quality assurance of training under ‘Protect Life’ & Promoting Mental Health;
- Evaluation of “One Stop Shops”;
- Continued implementation of New Strategy Direction for Drugs and Alcohol and substitute schemes;
- Increased awareness of, and signposting to, services for children and young people affected by Hidden Harm;
- Development and evaluation of the brief intervention pilot designed to support primary care to undertake screening and brief intervention on alcohol misuse. Production of an effective methodology for training.
- Continue to develop the range of psychological therapies in line with the 2010 strategy and the stepped care approach;

- Begin to develop a Personality Disorder Service in each Trust to be built on as further funding is available;
- Continue to develop Autistic Spectrum Disorder Services to meet the targets for timely diagnosis and intervention and the Autistic Spectrum Disorder Network Action Plan.

6.6.2 General Context including Indicators of Need/Demand

A considerable proportion of the NI population experience problems associated with mental ill-health, learning and/or physical disability. The direct/in-direct costs associated with mental ill health are estimated to be circa £3 billion in NI.

At any one time, 1-in-6 adults will experience a diagnosable mental health problem and a quarter of all primary care consultations will be associated with mental ill health. The Health and Social Care Board will wish to support the efforts of Local Commissioning Groups in developing services embedded within the primary care and at the interface with secondary care.

Around 2-3% of the population have a significant learning disability. In comparison to elsewhere levels of mental ill health and disability are relatively high in NI. For example, the NI Survey of People with Activity Limitations and Disabilities (NISRA July 2007: Bulletin 1) indicates that 18% of all people living in private households in Northern Ireland have some degree of disability. The prevalence rate for adults is 21% and 6% for children.

6.6.3 Commissioning Priorities

6.6.3(i) Mental Health

The promotion of mental health/wellbeing across wider society is a central priority within the Health and Social Care Board/Public Health Agency commissioning intentions. The Health and Social Care Board/Public Health Agency are committed to ensuring that key health and wellbeing priorities including early intervention,

prevention and tackling inequalities are integral to the re-design and delivery of mental health services. There will be significant opportunities to ensure that improving health and wellbeing is addressed in each of the Bamford Implementation Taskforce working groups.

A major priority will be promoting personal development and early interventions that are effective, accessible and person centred, supported with advocacy for the involvement of clients and carers. Core to this will be working with organisations in the statutory, community and voluntary sectors that can provide evidence based services such as building resilience, family support and counselling for those in crisis and in need of support. The continued roll out of the Lifeline Contract will be a major investment in terms of ensuring that those in crisis and/or their carers have immediate support when they require it. Other priority areas will include developing regional co-ordination and quality standards for training, taking forward the recommendations from the Health Committee Inquiry into the Prevention of Suicide and Self Harm, and joint working to provide better services to meet people's needs.

Therefore, local 'Protect Life' and Mental Health Promotion Strategy Action Plans will continue to be supported with existing investment levels during 2010/11. Mental Health promotion, prevention and earlier identification must be better reflected within front line mental health services. Trusts should therefore ensure these themes are fully incorporated as key objectives within all service development proposals.

The continuing increase in Extra Contractual Referrals to specialist services outside Northern Ireland is not sustainable from a financial perspective. A more robust regional approach will be established to assist in the reduction of Extra Contractual Referrals. Clinicians, professionals and managers within Trusts should work collectively together in the context of this regional approach to deliver a significant reduction in Extra Contractual Referrals costs during 2010/2011. Failure to achieve this objective will curtail the release of funding to Trusts for planned new mental health services outlined within this Commissioning Plan. In the first instance an agreed regional process involving Health and Social Care Board and Public Health Agency staff will be identified to oversee all proposed Extra Contractual Referrals. The Health

and Social Care Board/Public Health Agency will take this forward in partnership with Trusts with a view to introducing a new regionally agreed process to be in place by end September 2010. The Health and Social Care Board expects Trusts to work in partnership with their respective Local Commissioning Groups and the wider range of primary care stakeholders, to develop the Stepped Care model. Models should better reflect the provision of specific primary care mental health services (ie. Level 1/2 service provision as per the Stepped Care Model).

The Health and Social Care Board/Public Health Agency will support Trusts to develop and standardise the provision of Crisis Response/Home Treatment services in order to reduce variation between the models and reduce the need for inpatient care. This work will take into consideration the regional principles (published January 2010) which are intended to guide the provision of services to people at risk of suicide or serious self harm.

Efforts will be made to strengthen specialist services. New 'Regional Networks' will be established to oversee the development of Personality Disorder and Forensic Services. These will be established as an integral part of the Bamford Implementation Taskforce. The development of Eating Disorders services should continue in accordance with the regional specification agreed in 2009.

Through the existing regional Child and Adolescent Mental Health Services group efforts will continue to reform and modernise services in each Trust area during 2010/11. Local Drug and Alcohol Co-ordination Teams action plans for the new Strategic Direction for Alcohol and Drugs, the Addressing Young People's Drinking Action Plan and the Hidden Harm Action Plan will be rolled forward. Trusts should continue to implement and support the delivery of specialist substance misuse services including partnership working with key service providers in the independent / voluntary sectors.

Trusts should maintain progress towards existing 'resettlement' plans ie. from 2008/09 & 2009/10 baselines, in terms of the resettlement of mental health clients from long stay hospital based facilities. The Health and Social Care Board will also lead a review of acute psychiatric inpatient services to determine how these

services should be configured to most effectively meet the needs of users across the region.

6.6.3(ii) Learning Disability

The main focus for service delivery and modernisation in 2010-2011 will be to continue to promote inclusion and independence for people with Learning Disability in line with “Equal Lives”.

This will be done by further development and improvement of services to people with a Learning Disability. The services must better support people with a Learning Disability to be able to enjoy housing, training, further education and employment opportunities which all citizens benefit from.

Key to succeeding in this aim is adequate support for parents and carers which recognises that the majority of people in N.I. with a Learning Disability live with family members.

All service plans and improvements must be underpinned by a greater focus during 2010/2011 on recognising and meeting the physical and mental health care needs of people with a Learning Disability. In this regard the full implementation by Trusts of the Directed Enhanced Service for Learning Disability during 2010/2011 is necessary.

Equally as important as specific health screening activity through the Directed Enhanced Service will be the involvement of people with a Learning Disability in all of the other physical and mental health promotion activities of Trusts aimed at improving the health and wellbeing of the general population. New in-patient assessment and treatment services for children and young people from Belfast, South Eastern, Northern and Southern Trusts will be operational during 2010/11 at the Iveagh Unit in Belfast.

Both the long term resettlement and the delayed discharge populations will be reduced in line with the target for 2010/2011 and help progress towards the 2013 target that no one with a Learning Disability should remain unnecessarily in hospital.

The continued growth in the numbers of children with complex needs alongside their Learning Disability will need to be met by

improvements in the transition experienced by young people moving to adult services.

Key to this will be renewed efforts by Trusts to review day support services both in day care settings and in integrated community activities. Additional improvements in services for children and young people with a Learning Disability who have communication difficulties should be delivered by Trusts.

Trusts should ensure progress is achieved against the priorities identified in the Regional Autism Spectrum Disorder Action Plan and Priorities for Action. This necessitates that Trusts should develop service capacity across Child health, Mental Health and Disability Services and encompasses the child, adolescent and adult age range. A key requirement is to standardise the care pathway for children and adults across Child Health, Mental Health and Disability services. Trusts must evidence that individuals with Autistic Spectrum Disorder are considered within a person centred framework and not restricted by specific criteria which risk excluding individuals from access to services. The Health and Social Care Board and Public Health Agency will continue to lead reform and modernisation through the Autism Taskforce.

6.6.3(iii) Physical Disability/Sensory Impairment

In 2010/2011 the priority for the Physical Disability/Sensory Impairment Programme will be to continue to address specific Priorities for Action 2010/2011 targets, to implement the Regional Review Implementation Plans for Acquired Brain Injury and for Wheelchair Services and to seek to address a number of other key areas of need. These include the requirement to consolidate the baseline resource position of the Regional Prosthetics service and the Wheelchair service. Critical to ensuring the appropriate placement of people with severe brain injury following treatment and rehabilitation is the development of suitable long term care options and reduction in the need for Extra Contractual Referrals. This will also improve the operation of the existing care pathway for this client group, releasing treatment and rehabilitation placement currently affected by prolonged discharge delays.

Sensory impairment services will benefit from the intention to complete the implementation of the Challenge and Change inspection report recommendations, to implement the NI

contribution to the UK Vision Strategy 2009-2012 and to procure a regional communication support service for people who are deaf/hard of hearing to ensure equity of provision across NI.

The Trusts will be expected to take forward these priorities whilst also addressing the need to promote strongly the take up of Direct Payments, to take account of, and respond to the needs of carers, and to engage effectively with service users throughout.

Thalidomide: Commissioners and Trusts should also take forward the provision of any assessment required in allocating the additional support for Thalidomide survivors generated by the provision of an extra £1.1m, to be made available by the DHSSPS to the Thalidomide Trust over the next three years.

6.6.4 Priorities for Action – Standards and Targets 2010

The limited availability of Comprehensive Spending Review year 3 funding allocation will constrain the scale and momentum of service developments and limit the ability to deliver the Priorities for Action targets.

The specific standards and targets for Mental Health, Learning Disability and Physical/Sensory Impairment programmes are:

- **Reducing the harm related to Alcohol and Drug Misuse (linked to PSA 1.4, 1.5, 1.6 and 1.7): by March 2012, reduce to 29% the proportion of adults who binge drink, reduce to 27% the proportion of young people who report getting drunk, and reduce to 5.5% the proportion of young people taking illegal drugs. Consistent with the achievement of these outcomes, the Public Health Agency should from April 2010 further develop and evaluate the brief intervention pilot designed to support primary care to undertake screening and brief intervention on alcohol misuse. By December 2010, the Public Health Agency should produce an effective training methodology and determine the feasibility of rolling this out across GP practices. And, from April 2010 the Public Health Agency in partnership with the Health and Social Care Board should, through the**

implementation of the joint Hidden Harm Action Plan, increase awareness of relevant services and ensure that more young people affected by parental substance misuse are effectively signposted to existing services.

- **Suicide (linked to PSA 1.8): by March 2012, ensure that the suicide rate is reduced below 14.5 deaths per 100,000. Consistent with the achievement of this outcome, by September 2010 the Public Health Public Health Agency should ensure that a Deliberate Self Harm Registry pilot is established in the Belfast HSC Trust, and a first draft report produced by March 2011. By September 2010, the Public Health Agency should produce an action plan to implement recommendations arising from Mental Health Promotion / Suicide Prevention Training in Northern Ireland.**

- **Mental Wellbeing (linked to PSA 1.8): by March 2011, the Public Health Public Health Agency should produce an action plan to take forward the relevant regional and local elements contained within the Mental Health and Wellbeing Promotion Strategy.**

- **Unplanned admissions (PSA 6.1): by March 2011, the HSC Health and Social Care Board and Trusts should take steps to reduce the number of admissions to acute mental health hospitals by 10%**

- **Assessment and treatment (PSA 6.3): from April 2010, the HSC Health and Social Care Board and Trust should ensure no patient waits longer than 9 weeks from referral to assessment and commencement of treatment for mental health issues with the exception of psychological therapies for which no patient should wait longer than 13 weeks.**

- **Card before you leave: from April 2010, the HSC Health and Social Care Board and Trusts should ensure that all adults and children who self harm and present for assessment at A&E are offered a follow-up appointment with appropriate mental health services within 24 hours.**

- **Resettlement of Learning Disability patients (PSA 6.4):** by March 2011, the HSC Health and Social Care Board and Trusts should resettle 120 long stay patients from Learning Disability hospitals to appropriate places in the community compared to the March 2006 total. (Note: PSA target 6.2 for the resettlement of mental health patients has already been achieved.)
- **Discharge (both mental health and those with a learning or physical/sensory disability):** from April 2010, the HSC Health and Social Care Board and Trusts should ensure that 75% of patients admitted for assessment and treatment are discharged within seven days of the decision to discharge, with all other patients being discharged within a maximum of 90 days. All mental health patients discharged from hospital who are to receive a continuing care plan in the community should receive a follow-up visit within seven days of discharge.
- **Eating Disorders:** further enhancement of a regional approach to eating disorder services recognising the need for specialist provision, and at least a 10% reduction in extra contractual referrals
- **Respite – Learning Disability (PSA 6.7):** during 2010/11, the HSC Health and Social Care Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 125 additional dementia respite packages by March 2011 compared to the March 2008 total.

Learning disability respite services will be commissioned across Trusts to achieve the target of an additional 125 packages by 31st March 2011 when compared to the 31st March 2008 baseline. These services will be composed of residential, domiciliary and host family schemes.

- **Respite – dementia:** during 2010/11 the HSC Health and Social Care Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 1,200 additional dementia

respite places by March 2011 compared to the March 2008 total.

The PFA 2010/11 target remains at the level set in PFA 2009/10 . The Health and Social Board is currently working with Trusts to finalise agreed definitions of respite and refine performance reporting to ensure achievement of this target in 2010/11. Trusts invested the additional allocation for this purpose in 2009/10 to progress towards the required level of provision by March 2010 and work will continue in 2010/11 to maximise the delivery of dementia respite within the resources available, and in the context of the forthcoming Regional Dementia Strategy.

- **Respite – physical/sensory disability (PSA 6.5): during 2010/11, the HSC Health and Social Care Board and Trusts should improve access to respite care through innovative approaches and service redesign, providing at least 110 additional respite packages by March 2011 compared to the March 2008 total.**

The PFA 2010/11 target was uplifted by 10 packages over and above the PFA 2009/10 level. The Board is currently working with Trusts to finalise agreed definitions of respite and refine performance reporting to ensure achievement of this target in 2010/11 . Trusts invested the additional allocation for this purpose in 2009/10 to progress towards the required level of provision by March 2010 and work will continue in 2010/11 to maximise the delivery of physical disability respite within the resources available through a range of approaches including partnership with the independent sector and the promotion of Direct Payments .

- **Wheelchairs (PSA 6.6): by March 2011, the HSC Health and Social Care Board and Trusts should ensure a 13-week maximum waiting time for of all wheelchairs, including specialised wheelchairs.**
- **Housing adaptations: from April 2010, the HSC Health and Social Care Board and Trusts should ensure all lifts and ceiling track hoists are installed within 22 weeks of**

the OT assessment and option appraisal as appropriate, and all urgent minor housing adaptations to be completed within 10 working days.

The Health and Social Care Board continue to monitor Trust performance against this target. The Health and Social Care Board the Public Health Agency are currently working closely with Trusts and DHSSPS on a regional group to review provision of housing adaptations in Northern Ireland. This work represents the Health and Social Care element of the wider Inter-Departmental Review of Housing Adaptations. The timescales for reporting recommendations is Autumn 2010. The outcome of this work will have implications for the future response to the PfA target.

- **Autism: from April 2010, the PHA, HSC Health and Social Care Board and Trusts should continue to progress the ASD action plan, ensuring that all children wait no longer than 13 weeks for assessment following referral and a further 13 weeks for commencement of specialised intervention.**
- **Acquired Brain Injury: from April 2010, the HSC Health and Social Care Board and Trusts should ensure a 13 week maximum waiting time from referral to assessment and commencement of specialised treatment.**
- **Domestic violence: during 2010/11, each Trust should ensure that appropriate social services staff has participated in at least 95% for the Multi-Public Health Agency Risk Assessment Conferences (MARAC) held in their area during the year.**

6.6.5 Outcome Measures and /or Other Indicators of Success

While performance will be monitored in respect of the key Priorities for Action target areas, the Bamford Mental Health/Learning Disability Implementation Taskforce will develop a range of key indicators to determine wider progress towards achieving the Bamford vision. This will include not only indicators of service provision but also health and wellbeing focused targets and

benchmarks. The Health and Social Care Board will maximise the potential of the Mental Health and Learning Disability Minimum Dataset to better inform all partners in a benchmarking and activity monitoring process.

In respect of the Physical Disability/Sensory Impairment Priorities for Action targets for 2010/11, the Health and Social Care Board will continue to monitor performance specifically in respect of waiting time for wheelchairs, housing adaptations, respite and acquired brain injury.

In addition, the implementation plans associated with the regional reviews of wheelchair services and acquired brain injury have clear outcomes and milestones and work will continue throughout 2010/11, in partnership with Trusts, service users and relevant independent sector agencies to achieve progress against these.

It is expected that the forthcoming Regional Strategy for People with Physical Disabilities and Sensory Impairment will identify clear indicators of success across a broad range of areas of need, which will be incorporated into future commissioning intentions.

6.6.6 Commissioning Intentions and Associated Funds

The 2010/11 proposed service investments are summarised in the tables below:

2010/11 Proposed Service Development Investments in Mental Health Programme of Care

	Total Investment 2010/11	BHSCT	SEHSCT	NHSCT	SHSCT	WHSCT	Total
	£m	£m	£m	£m	£m	£m	£m
Mental Health							
SHSCT: Resettlement of 12 patients from St Lukes which were due to be resettled in 2009/10 in advance of 2010/11 funding.	0.274				0.200		0.200
BHSCT : Costs of resettling MH patients from hospital that took place in 08/09 & 09/10 (£147k FYE) in advance of 2010/11 funding.	0.147	0.147					0.147
SEHSCT : Additional funding to enable the resettling of 16 patients from Downshire hospital. Plans for these resettlements are at an advanced stage.	0.244		0.122				0.122
NHSCT: Substance Misuse Liaison Nurse	0.077			0.077			0.077
BHSCT: Agreed funding to top up Trust contract rate with a Voluntary Provider	0.006	0.006					0.006
Further investment in Psychological therapies.	1.000	0.213	0.180	0.243	0.194	0.171	1.000
Enhanced Community Services	0.560	0.119	0.101	0.136	0.108	0.096	0.560
Personality Disorders	0.500	0.106	0.090	0.121	0.097	0.086	0.500
LCG indicative adj for JCP (In Year only)	0.000	0.042	0.035	0.048	0.038	0.034	0.196
Total Mental Health	2.808	0.632	0.528	0.625	0.637	0.386	2.808

2010/11 Proposed Service Development Investments in Physical Disability Programme of Care

	Total Investment	BHSCT	SEHSCT	NHSCT	SHSCT	WHSCT	Slippage
£m	£m	£m	£m	£m	£m	£m	£m
Specialised Wheelchairs	1.143	0.243	0.205	0.278	0.222	0.195	
Prosthetic service	0.075	0.016	0.013	0.018	0.015	0.013	
Total Physical Disability	1.218	0.259	0.218	0.296	0.237	0.208	

2010/11 Proposed Service Development Investments in Learning Disability Programme of Care

	Total Investment 2010/11	BHSCT	SEHSCT	NHSCT	SHSCT	WHSCT	Total
	£m	£m	£m	£m	£m	£m	£m
Learning Disability							
BHSCT Costs of Resettlements which occurred in 09/10 which contribute to 2010/11 resettlement target.	0.327	0.327					0.327
SEHSCT Costs of Resettlements which occurred in 09/10 which contribute to 2010/11 resettlement target.	0.369		0.369				0.369
WHSCT Costs of resettlements in 2 new ISU's to open, 28th March 2010 and 1st July 2010.	0.934					0.934	0.934
SHSCT : flexible respite packages to build on 08/09 developments to ensure Trust meets Pfa target for respite.	0.065				0.065		0.065
12 new resettlements for 2010/11	0.650	0.217	0.054	0.325	0.054	0.000	0.650
Respite Care	0.600	0.128	0.108	0.146	0.116	0.103	0.600
Autism	0.140	0.030	0.025	0.034	0.027	0.024	0.140
Total Learning Disability	3.085	0.701	0.556	0.505	0.262	1.061	3.085

6.6.6(i) Constraints

The limited availability Comprehensive Spending Review Year 3 funding allocation will constrain the scale and momentum of service developments and limit the ability to deliver the Priorities for Action targets. However, as already noted, the emphasis for at least the short-to-medium term must be upon the reform/modernisation of existing service infrastructure. While arguments may be placed regarding the relative under-resourcing of mental health/disability services compared to elsewhere, it is incumbent upon all stakeholders to pro-actively evidence added productivity and service improvement within existing resources.

The Health and Social Care Board expects Trusts to continue the process of reform and modernisation of services to achieve efficiencies in process and streamline systems, for example, the LEAN methodology work on wheelchair services. There will also be a continued focus on improving care pathways for specific conditions to enhance the quality of care for patients and clients, for example, within Child and Adolescent Mental Health Service and psychological therapies. The use of personalised budgets and Direct Payments will also be a priority.

In addition to financial constraints, the availability of highly skilled practitioners, in particular, to work within relatively more complex areas of service provision is an ongoing challenge. Workforce plans will need to be developed for services, taking into account the recommendations of the Workforce Report commissioned by the DHSSPS.

Priority Area 7:

Effective Use of Resources

6.7.1 Commissioning Themes

6.7.1(i) Productivity and Efficiency

The current financial context will require all organisations to transform their services, embedding a culture of prevention, earlier intervention and service reform and improvement to meet increasing population needs and demands and the expectations of local communities.

Service users and their carers are increasingly well informed and expect modern, fit for purpose and evidence based care. They have a growing expectation that the services commissioned will result in maximum health gain for the resources deployed. Increasing throughput, streamlining patient and client care pathways, minimising delay and focusing on safety are some of the ways to improve quality of care and a more efficient and productive health and care service.

Value for money and improved outcomes are not competing alternatives – they are one and the same thing. The improvements in outcome measurement and the associated ability to measure productivity are vital instruments for improving performance in Health and Social Care, expressed by better preventative measures and the provision of improved quality of care. Services should be assessed in terms of the outcomes they achieve from the resources available. The achievement of better outcomes is the dominant consideration in assessing effectiveness and efficiency.

While steady improvements in efficiency and productivity have been made by Trusts in recent years, there still remains significant scope to secure further gains. For example, audits carried out across Unscheduled Care during 2007/08 have shown that of the 4362 patients audited, 42% of unscheduled admissions did not require an acute hospital bed on the post admission day, and of the 58% of patients who were appropriately placed, a proportion of these could have had a reduced length of stay. Further implementation of the Unscheduled Care/Elective Reform Programme and the recommendations from the Rolling Audit and Improvement Programme will help to address these and other issues. Similarly, full implementation of the Integrated Elective Access Protocol and the recommendations from Elective Pathway

Review visits will assist Trusts to secure further efficiencies in the elective pathway and deliver improved services for patients. The continuing development of home treatment services will enable Trusts to reduce their reliance on hospital based treatment options, and the application of the service principles contained in the Choice and Partnership Approach will further enhance the capacity of community mental health services. The 'Releasing Time to Care' project will improve patient experience by increasing the availability of therapeutic interventions by trained nursing staff.

6.7.1(ii) Measuring Outcomes

In order to demonstrate improved outcomes, the Health and Social Care Board will require service providers to develop, collect and report on outcome measures for all services. For example:

- agreed elective surgery procedures;
- mortality data;
- cancer 5 year survival;
- readmission rates to acute psychiatric care;
- child protection and family support services;
- waiting times for all services;
- patient and client satisfaction with the care received.

The Health and Social Care Board will work with Trusts to develop a better understanding of the relative costs and benefits of local and regional services to help target expenditure most effectively, reduce unnecessary costs and drive improvements in productivity.

6.7.1(iii) Agreeing a Framework for Delivery

The Health and Social Care Board will work in partnership with Trusts to develop and agree accurate Service and Budget Agreement service volumes across all service areas and these will be closely monitored to ensure agreed productivity is delivered and

to identify early deviation from these to enable appropriate corrective action.

The Health and Social Care Board will support Trusts to improve the productivity and quality gains in care outside hospital by reviewing and rationalising the estate and effectively harnessing technology.

6.7.1(iv) Information and Communications Technology (ICT)

Information and Communications Technology has a major role to play in supporting service delivery and improving productivity and efficiency. The regional Information and Communications Technology strategy aspires to having a person centred electronic care record for every citizen and to ensure that Information and Communications Technology is effectively used to facilitate communication between care professionals. If information is to be communicated and shared electronically, it must be recorded electronically. There is a range of new Information and Communications Technology systems at implementation stage and others at the planning stage. Existing systems such as Patient Administrative System and SOS CARE could be more effectively used and the Health and Social Care Board will assist Trusts in identifying areas where improved use of such systems could improve effectiveness. Data quality and the timelessness of recording data on Information and Communications Technology systems must be improved. The Health and Social Care Board will support initiatives that improve the use of Information and Communications Technology systems and the quality of data recorded in them.

The Health and Social Care Board fully supports additional investment in Information and Communications Technology, however the scope for future increases in the level of investment is limited so new investment must be carefully targeted. This will require an increased focus on benefits identification and benefits realisation. The major areas currently targeted for investment over the next few years are:-

- New integrated Information and Communications Technology systems supporting Social Care, Mental Health, Children's and Community Services;

- Improved systems in the Primary Care area, particularly in those areas that improve communication across the interface between Primary Care and Secondary Care;
- Information and Communications Technology improvements in specific areas of Acute Care;
- A Health and Social Care wide Electronic Care Record system;
- Information and Communications Technology support to improve general administration and support activities;
- Trust Information and Communications Technology infrastructure modernisation.

6.7.1(v) Management Information and Analysis

It is vital that there is a regular flow of rich, timely and quality management information and analysis to support the drive for greater productivity and efficiency. To date much work has been carried out between the Health and Social Care Board and the Business Services Organisation on developing a greater and more timely flow of data from core Health and Social Care information systems such as Patient Administrative System, SOS CARE, Mental Health and Learning Disability systems, and latterly the Theatre Management System. This data is accessed via the regional data warehouse and is the primary source for much of the required productivity and efficiency analysis. However in parallel with these developments, there needs to be an equal focus on data quality improvement, covering:

- A much greater focus on administrative and clerical processes to produce higher quality and more timely data inputs into these core operational systems;
- Richer and more timely coding; and
- Greater standardisation of how these systems are used across the Health and Social Care e.g. Patient Administrative System Technical Guidance.

This work is vital in order to produce better quality source data and needs to be driven by the information and service improvement elements within the Health and Social Care Board working together with Trust colleagues.

6.7.2 PFA Targets

PFA Target: Hospital productivity

Each Trust should achieve a 3% improvement in hospital productivity, from its 2006-07 base year, for each year over the CSR period.

PFA Target: Daycase rate

Each Trust should secure improvements in daycase rates for a defined range of procedures in accordance with Departmental targets for March 2011.

PFA Target: Pre-operative length of stay

Each Trust should secure reductions in average pre-operative length of stay in accordance with Departmental targets for March 2011.

PFA Target: Cancelled operations

From April 2010, all surgical patients should have appropriate pre-operative assessment, and no more than 2% of operations should be cancelled for non-clinical reasons.

Service redesign, based on a more sophisticated understanding of capacity is a key component of the reform and modernisation agenda and the Health and Social Care Board will continue to work closely with local Trusts, to progress this work in 2010/11. In particular Trusts will be expected to focus on the following key areas:

- Reduced length of stay – Trusts should review and improve admission and discharge processes, and be able to evidence a reduction in the average number of bed days patients spend in hospital settings;

- Pathways of Care – Trusts should deliver effective integrated pathways of care that reduce unnecessary steps in the process, improve the patient and client experience and lead to better outcomes;
- Care in the right place – Trusts should demonstrate a commitment to intervening earlier in the patient and client pathway that reduces inappropriate demand for beds and other care packages. This should include a focus on delayed discharges, early and safe discharge to community care and a more focused approach to the management of specialist services including referrals to services outside Northern Ireland;
- Implementing evidence – There is evidence from local audits that further efficiencies can be gained through streamlining the patient pathway. Trusts have been asked to produce Unscheduled Care Action Plans to identify how they will implement recommendations following recent audits, and monitoring and support to Trusts will be embedded in the Health and Social Care Board’s work plan for emergency care during 2010/11;
- Clinical decision-making and engagement – Trusts should demonstrate that they have systems in place to provide effective access to appropriate clinical opinions to facilitate good patient flows and that Clinicians are fully involved in service improvement processes;
- New to review ratios – Trusts should benchmark ratios with high performing services elsewhere and should ensure that all review appointments are clinically appropriate. Consideration should be given to developing new ways of working and alternative models of service delivery;
- Day surgery, treatment and care – Trusts should work, in partnership with primary care and others, to increase the range and volume of procedures and services that are carried out without the need for unnecessary overnight stays;
- Short stay surgery and early discharge – Trusts should work to reduce post operative length of stay by improving discharge processes and identifying suitable short stay beds

(i.e. 24hrs stay beds) for elective procedures. They should also seek to better integrate community services that can in-reach to hospital care and promote earlier discharge;

- Day of admission surgery – Trusts should put in place protocols to ensure that admission on the day of surgery is the default position for all clinically appropriate patients;
- Cancelled Operations: Trusts will put in place protocols to ensure that all patients will have appropriate pre operative assessment and ensure that no more than 2% of operations will be cancelled for non clinical reasons;
- Theatre utilisation – Trusts should produce consultant level data detailing theatre utilisation rates and use this data to benchmark against peer groups;
- Did Not Attends – Trusts should continue to monitor Did Not Attends across all services and establish the causes for the non-attendance, and develop plans to address these;
- Can Not Attends – Trusts should monitor the level of both clinical and non-clinical cancellations across all services. Trusts should ensure that their booking process complies with IEAP guidance;
- Service Provision – Trusts will need to be cognisant of the Effective Use of Resources Review and the potential impact on service provision. Consideration should be given to reviewing the clinical benefit and rationale for undertaking certain surgical procedures.

These should not be regarded as separate projects but as means to work with clinical teams to modernise and review the complete care pathway. It is important that Clinicians see and understand the benefits of measuring outcomes in their day to day work, and this should be linked to the principles of good clinical practice. The Health and Social Care Board will adopt a whole systems approach and will work with Trusts to ensure that proposed productivity and demand management changes are balanced across the region.

Underpinning all these processes is the need for organisations to engage with their staff and their representatives to inspire, motivate and engage them in taking forward these service improvements.

PFA Target: Absenteeism

Each Trust should reduce its level of absenteeism to no more than 5.2% in the year to March 2011.

The need to ensure an effective productive workforce within a changing healthcare environment will require a clear workforce strategy which will include the use of more effective workforce planning techniques. In the past workforce planning has tended to be based around a centralised model focusing on the development of the commissioning of training places in the education sector. There has been recent investment in Human Resources, Nursing and Allied Health Professions capacity to undertake Strategic Workforce Planning using the “Six Step Model” developed by Skills for Health and the National Workforce Project.

This model can be effectively used in both local service delivery planning but also at a Commissioning level. The forthcoming financial challenges provide a stimulus for greater levels of cooperation and collaboration between workforce planners both at Trust and Commissioning level to identify the workforce implications of the changes that are required of the workforce not only on dealing with commissioning intentions but also the productivity agenda. An important tool in ensuring more effective planning is access to meaningful performance information.

The engagement of the Trust workforce planning network in a prioritised plan of work will be an important step in developing workforce plans in a manner which will enable the development of a workforce that can be deployed both numerically and with appropriate skills to provide safe and effective healthcare.

PFA Target: Staff health and wellbeing

All HSC organisations should put in place organisational health and wellbeing strategies including being pro-active in improving the quality of and speeding up access to occupational health services, and strengthen Health and

Social Care Board accountability for the management of sickness and absence.

Work is underway not only in some Trusts but also in Review of Public Administration Phase 2 organisations to ensure the development of a strategic approach to improving the health and wellbeing of the workforce. The importance of ensuring the health and wellbeing through the optimum use of people and other resources is an important human resource approach at a time when the workforce is being asked to improve productivity and potential responding to an increasing patient and client safety agenda. This will have to address the issues of the effective deployment of resources, skill mix reviews and the need to ensure access targets are achieved.

SCHEDULES

Health and Social Care Board Commissioning Plan

FP1

PLANNED INCOME AND EXPENDITURE COMMITMENTS 2010/11

Income/Expenditure	HSCB		PHA		TOTALS	
	IYE £K	FYE £K	IYE £K	FYE £K	IYE £K	FYE £K
RECURRING INCOME						
1.0 Recurring departmental allocation	3,582,829	3,559,392	70,418	68,097	3,653,247	3,627,489
2.0 Other Income					0	0
TOTAL INCOME	3,582,829	3,559,392	70,418	68,097	3,653,247	3,627,489
RECURRING COMMITMENTS						
3.0 Direct commissioning by Board & Agency Local Commissioning Group analysis:	34,942	34,440	11425	11424	46,367	45,864
4.1 Belfast	609,657	599,747	9230	8784	618,887	608,531
4.2 Northern	667,365	657,191	10621	10111	677,986	667,302
4.3 Southern	532,640	525,108	7635	7228	540,275	532,336
4.4 South Eastern	493,874	485,646	7115	6737	500,989	492,383
4.5 Western	468,513	462,185	8304	7945	476,817	470,130
Management & administration:						
5.1 Board / PHA	26,872	27,345	14179	13959	41,051	41,304
5.2 BSO	19,271	19,271	294	294	19,565	19,565
5.3 LCGs					0	0
5.4 other					0	0
6.0 Patient & Client Council					0	0
7.0 FHS	655,390	655,390	1615	1615	657,005	657,005
Reserves: (specify)						0
8.1 Central Pressures	8,196	11,960			8,196	11,960
8.2 Elective Care	48,450	33,450			48,450	33,450
8.3 DIS - IT revenue/licences	17,659	17,659			17,659	17,659
Other expenditure: (specify)						0
9.1 CSR bridging		30,000			0	30,000
9.2 AFC/Incremental drift					0	0
TOTAL RECURRING COMMITMENTS	3,582,829	3,559,392	70,418	68,097	3,653,247	3,627,489

Commissioning Plan

RECURRING EXPENDITURE COMMITMENTS BY LCG AND TRUST- HSCB

FP2

	Belfast IYE £k	Northern IYE £k	Southern IYE £k	South Eastern IYE £k	Western IYE £k	NIAS IYE £k	other IYE £k	Total IYE £k		
Belfast LCG	538334	941	156	41513	100	10946	17667	609657	778617	-250
Northern LCG	132429	494871	3191	5770	6652	13390	11062	667365	858877	-250
Southern LCG	73493	1487	426816	9627	3108	9464	8645	532640	684231	0
South Eastern LCG	123119	730	1058	350499	82	8649	9737	493874	637024	0
Western LCG	40616	1282	1143	2018	401079	11160	11215	468513	614379	0
Direct Commissioning				7356				7356		
Totals	907991	499311	432364	416783	411021	53609	58326	2779405		

Totals for Board and each LCG must reconcile to lines 3 and 4.1 to 4.5 of FP1

Commissioning Plan

RECURRING EXPENDITURE COMMITMENTS BY LCG AND TRUST- HSCB

FP2

	Belfast FYE £k	Northern FYE £k	Southern FYE £k	South Eastern FYE £k	Western FYE £k	NIAS FYE £k	other FYE £k	Total FYE £k	
Belfast LCG	528586	941	156	41408	100	10946	17610	599747	773669
Northern LCG	129842	487361	3191	5754	6499	13390	11154	657191	852858
Southern LCG	68055	471	426167	9152	3108	9464	8691	525108	680139
South Eastern LCG	121768	730	1058	343668	82	8649	9691	485646	632738
Western LCG	39111	1282	1143	2013	396231	11160	11245	462185	610789
Direct				7356					
Totals	887362	490785	431715	409351	406020	53609	58391	2729877	

Totals for Board and each LCG must reconcile to lines 3 and 4.1 to 4.5 of FP1

Commissioning Plan

RECURRING EXPENDITURE COMMITMENTS BY LCG AND TRUST- PHA

FP2

	Belfast IYE £k	Northern IYE £k	Southern IYE £k	South Eastern IYE £k	Western IYE £k	NIAS IYE £k	other IYE £k	Total IYE £k
Belfast LCG	1670	33	0	0	0	0	7527	9230
Northern LCG	210	3145	892	0	0	0	6374	10621
Southern LCG	156	36	2437	0	0	0	5006	7635
South Eastern LCG	782	34	0	477	0	0	5822	7115
Western LCG	148	32	626	0	2178	0	5320	8304
Direct Commissioning	5457	563	315	591	469		4025	11420
Totals	8423	3843	4270	1068	2647	0	34074	54325

Totals for Board and each LCG must reconcile to lines 3 and 4.1 to 4.5 of FP1

Commissioning Plan

RECURRING EXPENDITURE COMMITMENTS BY LCG AND TRUST- PHA

FP2

	Belfast FYE £k	Northern FYE £k	Southern FYE £k	South Eastern FYE £k	Western FYE £k	NIAS FYE £k	other FYE £k	Total FYE £k
Belfast LCG	1670	33	0	0	0	0	7081	8784
Northern LCG	210	3145	892	0	0	0	5864	10111
Southern LCG	156	36	2437	0	0	0	4599	7228
South Eastern LCG	782	34	0	477	0	0	5444	6737
Western LCG	148	32	626	0	2178	0	4961	7945
Direct	5457	563	315	591	469		4025	11420
Totals	8423	3843	4270	1068	2647	0	31974	52225

Totals for Board and each LCG must reconcile to lines 3 and 4.1 to 4.5 of FP1

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG:

All LCGS

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	17921	9523	8278	7867	7887	1038	9632	62146
Non-pay (line 233)	5033	2774	2449	2277	2301	309	950	16093
SCAPE (line 241)	10971	5833	4885	4415	4733	751	629	32217
Children & Young People (line 242)	2940	3987	3063	2998	2610	0	0	15598
TOTAL	36865	22117	18675	17557	17531	2098	11211	126054

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG:

Belfast LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	10690	19	3	833	2	214	2154	13915
Non-pay (line 233)	2990	5	1	239	1	63	230	3529
SCAPE (line 241)	6623	13	3	481	3	160	133	7416
Children & Young People (line 242)	2940							2940
TOTAL	23243	37	7	1553	6	437	2517	27800

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG:

South Eastern LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	2464	16	26	6697	1	172	1704	11080
Non-pay (line 233)	695	4	6	1940	0	50	165	2860
SCAPE (line 241)	1491	14	26	3747	0	135	114	5527
Children & Young People (line 242)				2998				2998
TOTAL	4650	34	58	15382	1	357	1983	22465

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG:

Northern LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	2618	9452	62	113	125	257	2220	14847
Non-pay (line 233)	741	2755	18	33	38	77	192	3854
SCAPE (line 241)	1564	5781	37	61	65	182	153	7843
Children & Young People (line 242)		3987						3987
TOTAL	4923	21975	117	207	228	516	2565	30531

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG:

Southern LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	1375	9	8162	184	63	187	1754	11734
Non-pay (line 233)	386	3	2417	53	18	54	146	3077
SCAPE (line 241)	844	5	4798	104	42	145	123	6061
Children & Young People (line 242)			3063					3063
TOTAL	2605	17	18440	341	123	386	2023	23935

ALLOCATION OF FUNDING FOR PAY AND OTHER COSTS (FYE)

FP3 (a)

Name of LCG:

Western LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Pay pressures (line 229)	774	27	25	40	7696	208	1800	10570
Non-pay (line 233)	221	7	7	12	2244	65	217	2773
SCAPE (line 241)	449	20	21	22	4623	129	107	5371
Children & Young People (line 242)					2610			2610
TOTAL	1444	54	53	74	17173	402	2124	21324

ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG:

All LCGS

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health	590	577	599	615	352	0	74	2807
Learning Disability	701	505	262	556	1061	0	0	3085
Stroke	0	0	0	0	0	0	1751	1751
Acute (incl renal)	130	0	0	0	0	0	0	130
Children with complex needs	21	24	70	18	17	0	0	150
Children	272	65	52	168	46	0	666	1269
Physical Disability	259	296	236	219	209	0	0	1219
Long-term Conditions - palliative care	0	0	0	0	50	0	0	50
Long-term Conditions - chronic disease	0	0	45	0	0	0	0	45
Demographics	3188	3642	2904	2698	2568	0	0	15000
Hospital & Specialist Drugs	5976	551	372	312	327	0	6318	13856
Child Protection Gateway Teams	234	267	213	198	188	0	0	1100
Adult protection arrangements	47	2	2	47	2	0	0	100
IT services reduction to revenue	0	0	0	0	0	0	-201	-201
Managing Reform	0	0	0	0	0	0	0	0
TOTAL	11418	5929	4755	4831	4820	0	8608	40361

ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG:

Belfast LCG

	£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health		590						16	606
Learning Disability		701							701
Stroke								372	372
Acute (incl renal)		28							28
Children with complex needs		21							21
Children		272							272
Physical Disability		259							259
Long-term Conditions - palliative care									0
Long-term Conditions - chronic disease									0
Demographics		3188							3188
Hospital & Specialist Drugs		1518			76			1343	2937
Child Protection Gateway Teams		234							234
Adult protection arrangements		47							47
IT services reduction to revenue								-43	-43
Managing Reform									0
TOTAL		6858	0	0	76	0	0	1688	8622

ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG:

South Eastern LCG

	£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health					615			13	628
Learning Disability					556				556
Stroke								315	315
Acute (incl renal)		23							23
Children with complex needs					18				18
Children					168				168
Physical Disability					219				219
Long-term Conditions - palliative care									0
Long-term Conditions - chronic disease									0
Demographics					2698				2698
Hospital & Specialist Drugs		1262			236			1136	2634
Child Protection Gateway Teams					198				198
Adult protection arrangements					47				47
IT services reduction to revenue								-36	-36
Managing Reform									0
TOTAL		1285	0	0	4755	0	0	1428	7468

ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG:

Northern LCG

	£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health			577					18	595
Learning Disability			505						505
Stroke								425	425
Acute (incl renal)		32							32
Children with complex needs			24						24
Children			65					370	435
Physical Disability			296						296
Long-term Conditions - palliative care									0
Long-term Conditions - chronic disease									0
Demographics			3642						3642
Hospital & Specialist Drugs		1345	547			2		1534	3428
Child Protection Gateway Teams			267						267
Adult protection arrangements			2						2
IT services reduction to revenue								-49	-49
Managing Reform									0
TOTAL		1377	5925	0	0	2	0	2298	9602

ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG:

Southern LCG

	£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health				599				14	613
Learning Disability				262					262
Stroke								339	339
Acute (incl renal)		25							25
Children with complex needs				70					70
Children				52				142	194
Physical Disability				236					236
Long-term Conditions - palliative care									0
Long-term Conditions - chronic disease				45					45
Demographics				2904					2904
Hospital & Specialist Drugs		1107		372				1224	2703
Child Protection Gateway Teams				213					213
Adult protection arrangements				2					2
IT services reduction to revenue								-39	-39
Managing Reform									0
TOTAL		1132	0	4755	0	0	0	1680	7567

ALLOCATION OF FUNDING FOR SERVICE IMPROVEMENTS AND SERVICE DEVELOPMENTS (FYE)

FP3(b)

Name of LCG:

Western LCG

£'000	Belfast	Northern	Southern	South Eastern	Western	NIAS	Other	TOTAL
Mental Health					352		13	365
Learning Disability					1061			1061
Stroke							300	300
Acute (incl renal)	22							22
Children with complex needs					17			17
Children					46		154	200
Physical Disability					209			209
Long-term Conditions - palliative care					50			50
Long-term Conditions - chronic disease								0
Demographics					2568			2568
Hospital & Specialist Drugs	744	4			325		1081	2154
Child Protection Gateway Teams					188			188
Adult protection arrangements					2			2
IT services reduction to revenue							-34	-34
Managing Reform								0
TOTAL	766	4	0	0	4818	0	1514	7102

GLOSSARY

8 Glossary of Terms

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

Quality Outcomes Framework – a system under which the effectiveness of schemes and measures to improve health is measured against a set of agreed targets.

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

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

Palliative Care – services for people who are terminally ill and who suffer from conditions such as advanced cancer.

National Institute for Clinical Excellence – an expert organisation based in London that guides health care organisations across the UK on the effectiveness of new treatments, new drugs and other innovations.

Bariatric Surgery – a new type of hospital operation that enables some chronically obese people to reduce their weight by extensive surgery on their abdomen and digestive organs.

Northern Ireland Block – the total amount of financial support given to Northern Ireland by the Treasury in London.

Locum doctors – doctors whose work is based upon short term or temporary contracts.

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

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

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

Evidence Based Commissioning – the provision of health and social care services based upon proven evidence of their value.

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

Board Membership

Health and Social Care Board Membership

Dr Ian Clements – Chair
Mr John Compton – Chief Executive

Non Executive Directors

Mr Robert Gilmore
Mrs Elizabeth Kerr
Mr Stephen Leach
Dr Melissa McCullough
Mr Brendan McKeever
Mr John Mone
Dr Robert Thompson

Executive Directors

Ms Fionnuala McAndrew, Director of Social Services
Mr Paul Cummings, Director of Finance
Mr Dean Sullivan, Director of Commissioning
Mr Michael Bloomfield, Acting Director, Performance Management and Service Improvement

Public Health Agency Board Membership

Ms Mary McMahon – Chair
Dr Eddie Rooney – Chief Executive

Non Executive Directors

Ms Julie Erskine
Dr Jeremy Harbinson
Ms Miriam Karp
Mr Thomas Mahaffy
Councillor Cathal Mullaghan
Councillor Stephen Nicholl
Mr Ronnie Orr

Executive Directors

Dr Carolyn Harper, Executive Medical Director/Director of Public Health
Mr Ed McClean, Director of Operations
Mrs Mary Hinds, Director of Nursing and Allied Health Professions

Local Commissioning Groups

Belfast Local Commissioning Group

Dr George O'Neill (Chair)
Mr Iain Deboys, Commissioning Lead
Cllr. Tim Attwood
Ms Gerry Bleakney
Dr Grainne Bonner
Mr Gerry Burns
Ms Pat Cullen
Dr Jenny Gingles
Alderman Michael Henderson
Cllr. Mervyn Jones
Dr Terry Maguire
Ms Joyce McKee
Mr Danni Power
Alderman Gerry Rice
Ms Catriona Rooney
Mrs Irene Sloan
Dr Alan Stout
Mr Mike Townsend

Western Local Commissioning Group

Dr Brendan O'Hare (Chair)
Mr Paul Cavanagh, Commissioning Lead
Dr Kieran Deeny
Dr Eugene Deeny
Cllr. Mark H Durkan
Mrs Jenny Irvine
Cllr. Robert Irvine
Dr Jackie McCall
Dr Martin McCloskey
Mr Seamus McErlean
Mrs Clare McGartland
Ms Loretto McManus
Mr Eamon O'Kane
Mr Martin Quinn
Mr Graham Robinson
Cllr. Bernice Swift

Northern Local Commissioning Group

Dr Brian Hunter (Chair)
Mrs Bride Harkin, Commissioning Lead
Cllr. David Barbour
Dr Iain Buchanan
Mrs Linda Clements
Cllr. Adrian Cochrane-Watson
Mr Brendan Ford
Mrs Molly Kane
Mr Kevin Keenan
Dr Fiona Kennedy
Dr Una Lernihan
Mr Laurence O’Kane
Dr Terry McGowan
Cllr. Louise Marsden
Cllr. Thomas Nicholl
Ms Sharon Sinclair
Dr Turlough Tracey

South Eastern Local Commissioning Group

Dr Nigel Campbell (Chair)
Mr Paul Turley, Commissioning Lead
Cllr. Dermot Curran
Dr Paul Darragh
Mr John Duffy
Cllr. Andrew Ewing
Dr Colin Fitzpatrick
Mr David Herron
Dr Garth Logan
Ms Louise McCormick
Ms Joyce McKee
Dr Paul McGarrity
Ms Heather Tennyson
Cllr. William Ward
Ms Deirdre Webb

Southern Local Commissioning Group

Mr Sheelin McKeagney (Chair)
Mrs Lyn Donnelly, Commissioning Lead
Mrs Beverly Allen
Dr Walter Boyd
Cllr. Vincent Currie
Dr Sean Digney
Dr Brid Farrell
Mr Gerry Maguire
Mr Paul Maguire
Dr Keith MCollum
Mr Miceal McCoy
Mrs Claire McGartland
Cllr. Sean McGuigan
Cllr. Sylvia McRoberts
Mr Kieran McShane
Dr Tom O'Leary
Cllr. Dr Philip Weir