

**Belfast Local Commissioning Plan
2011-12**

CONFIDENTIAL

Foreword

I am pleased to be able to present this Local Commissioning Plan which comes at the end of the Belfast Local Commissioning Group's first full year in operation. The first year has required the establishment of relationships with stakeholders and the coordination of work with other parts of the Health and Social Care Board and Public Health Agency. I am particularly pleased that we have been able to remain focused on the needs of patients, clients, the public and the communities they live in and provided many opportunities for them to get involved in re-designing services to suit their specific needs.

At the beginning of 2010 the LCG made clear its commitment to integrated care which would break down organisational boundaries and develop much more coordination between secondary and primary care within the health and social care sector, the very valuable services delivered by community and voluntary organisations, and the important contribution of other agencies. The Primary Care Partnerships which we have established will deliver integrated care to support the life pathways and care needs of service users.

Too often health and social care professionals feel that we must take the lead in developing new services to meet every need. However, this can lead to dependence on statutory services which actually undermines the patient or client's own capabilities. It also ignores the huge capacity of communities to support people in their own neighbourhoods to take control of their own health and well being, taking account of their own values and the way they lead their lives. Seeing the glass of communities as half full rather than half empty will help us develop a new partnership approach to some of our most intractable problems. It is this view of health and social care professionals, working with partners to support people in reducing their own risks, recovering their personal capabilities and exercising choice in how the services they need are delivered, which has informed this plan.

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Chairman
Belfast Local Commissioning Group
April 2011

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Section 1: Commissioning Process

Belfast Local Commissioning Group (LCG)

The Local Commissioning Group (LCG) is a Committee of the Health and Social Care Board and is comprised of 17 members: 4 General Practitioners (including the Chairman); 4 Local Councillors; two representatives from the community and voluntary sectors; a General Dental Practitioner; a Community Pharmacist; a Nurse; an Allied Health Professional; a Consultant in Public Health and two Social Workers.

It has a statutory responsibility to assess the health and care needs of its local population (covering Belfast and Castlereagh Local Government Districts), to plan to meet those needs and to secure delivery of services. This is done in partnership with users and carers, local Councils and communities, health and social care professionals and other service providers and agencies. The LCG is supported by regular information on finance, quality and performance and a Local Executive Team comprised of officers from within the Board and Public Health Agency. A range of Regional Service Teams provide advice and guidance to ensure regional consistency of approach within which the LCG designs services to meet local needs.

Each year the Board and Public Health Agency prepare a Commissioning Plan which sets a framework of policy within which the Local Commissioning Plans are developed. The Commissioning Plan must aim to deliver the Government priorities and be developed within the budget available from the Department of Health, Social Services and Public Safety. It must also take account of the various strategies, policies and Service Frameworks issued by the Department, following consultation, as well as the recommendations of regulatory bodies, best practice and new technologies. Local plans must align with the Commissioning Plan so that major initiatives are taken forward in concert across the region and the population right across Northern Ireland can expect the same standard of care no matter where they live.

Needs and circumstances vary considerably across relatively short distances and each community has a different history and set of values which must also be taken into account. Local Commissioning Plans must therefore connect the regional framework with the needs of individuals and communities in local settings. The LCG regularly reviews the needs of its population and communities to inform its planning. This is carried out by scrutinising research carried out by many different agencies, voluntary organisations and community groups into local needs, assessing the demands on services and their performance, and engagement and discussion of the data with providers and users of services.

Engagement

The LCG has developed modes of engagement which fully involve a very wide range of stakeholders at all stages of its commissioning process. This approach involves the design of integrated care pathways taking a “user’s eye view” involving professionals and service providers in direct engagement with users, carers and advocate organisations in shaping services together during the first year. The re-design of services for stroke, Type 2 diabetes and mental health have all involved voluntary organisations, local community groups, users and carers, GPs, Pharmacists, Allied Health Professionals, Nurses and Consultants working together to discuss and agree actions and investments which would have the greatest impact on the lives of patients and carers. The LCG works closely with the Patient and Client Council in ensuring that users and carers have a voice within its decision-making processes.

The LCG leads the multi stakeholder Healthy Ageing Partnership (HASP). This Partnership has helped bring together the major voluntary sector providers of services for older people into a new collaborative relationship which is taking a lead role in supporting older people, particularly those who are socially isolated, to remain at home. HASP is also supporting the six Older Peoples’ Forums across the city to come together to provide a concerted voice for older people, the Greater Belfast Seniors’ Forum which will be involved in future planning of services.

The LCG is also involved in the work of Belfast Healthy Cities and the programme for Integrated Services for Children and Young People and is a full and active member of the Belfast Strategic Partnership (focusing on life inequalities), working alongside statutory, voluntary and community organisations.

A “Life Pathways” Approach

The LCG views the delivery of health and social services as one means of supporting people to maintain their health and well being, to reduce their risk of ill health, to address their specific care needs as these arise and to promote and support the self management of their own health and recovery and their lives and those of their carers beyond treatment. The LCG is developing networks of support, including signposting to community and voluntary and other statutory resources when help is sought, developing partnerships between providers centred on the service user appropriate to their needs, and ensuring that support is available from a wide range of community resources for life after treatment or care. This approach puts the person at the centre of the support available as a key decision-maker.

Developing Integrated Care

The LCG has developed four Primary Care Partnerships (PCPs), North, South, East and West. Each has a population of broadly 100,000 and involves a network of all GP and Pharmacy practices and other independent contractors, the Belfast Trust, voluntary providers, other agencies and community-based organisations in the area. The PCPs are supported by the LCG to re-shape specific services from a user's perspective.

East Belfast PCP - Demand Management: a design group involving primary and secondary care professionals and the local community is developing enhanced local expertise within primary care. This service will provide advice and support to local practices to ensure consistency in the management of patients, access to the most appropriate and improved service in a timely manner with assessment and diagnosis as locally as possible, promote health within the community to avoid the need for specialist treatment, and provide a local clinic where up to 50% of patients can be assessed without having to travel to hospital. Initially this will cover ENT services but will be extended in 2011-12 to cover other specialties, such as Dermatology and Neurology.

West Belfast PCP - Mental Health services: a design group has been established, involving voluntary and community providers as well as care professionals and local practitioners. This aims to reduce avoidable referrals to specialist services by up to 6000 per year by developing alternative referral and "signposting" pathways to the very wide range of community-based provision already available. This will not only reduce the demand on secondary care but also reduce the very large numbers of patients who do not respond to appointments or attend the clinics to which they are referred. These developments will more effectively support the recovery of good mental health and patient self management. The PCP approach will also enable locality-based primary and secondary care advice and education together with improved coordination and communication.

South Belfast PCP – Chronic Disease Management: a design group has been established involving a very wide range of stakeholders focusing initially on Type 2 Diabetes. Type 2 Diabetes is a largely preventable disease associated with ageing and obesity. Some communities are at significantly more risk, including people of South Asian origin and more deprived neighbourhoods. It is also a disease which can in the main be managed by patients themselves with support from primary care.

The aim is to work with local communities and primary care to reduce the risk of developing Type 2 diabetes, reduce the impact of the disease on the life pathway of patients, support practices in managing the disease within primary care and promote

self management through structured patient education. This will aim to reduce the numbers of people developing the disease, reduce the risk of avoidable blindness due to retinopathy, reduce referrals to secondary care and reduce incidences of limb amputations.

North Belfast PCP – Avoiding unnecessary admissions to hospital: The PCP will aim to reduce avoidable admissions to hospital by ensuring cooperative working between GP Practices and Community Pharmacists, community based providers and the Belfast Trust. The PCP will also work with local hospital clinicians, local providers and communities to develop alternative alternatives to A&E attendance and emergency admissions

A design group will focus on reducing hospital admissions for end of life care, taking forward the recently published DHSS&PS Palliative and End of Life Care Strategy which recommends greater choice of setting for patients who are at the end of their lives. This requires much greater coordination and communication between GP practices, community based providers and nursing services in local areas.

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Section 2: Commissioning Intentions

Improvements in health and well being and reducing inequalities

The LCG area includes the Local Government Districts of Belfast and Castlereagh. In 2009 the NI Statistics and Research Agency (NISRA) estimated there were 335,150 residents in the LCG area and this was projected to increase to 339,000 by 2015. The population is slightly older than in other LCGs, particularly in Castlereagh, and the numbers of older people will increase by 1400 over the next four years. It is important to note that this increase will be almost wholly in people aged over 85, as people in this age group tend to need much more support from health and social care services than younger seniors. There were almost 4700 births in 2009, a birth rate close to the Northern Ireland average.

Multiple Deprivation affects 46% of the Belfast population though this is mainly concentrated in the most deprived wards. The NISRA Multiple Deprivation Measure (MDM) is made up of a weighted combination of seven domains including income and employment which together comprise 50% of the MDM index; crime and disorder; health and disability; education, skills and training; proximity to services and living environment. 16 Belfast wards are in the top 20 deprived wards (ranked by MDM) in Northern Ireland.

The most significant aspect of health and well being in Belfast is the much lower life expectancy among a significant proportion of the city's population. Life expectancy for men in Ardoyne is under 70 years, compared to a regional average of over 76 years. This gap is strongly correlated with deprivation. People living in the least deprived areas can expect on average to live 7-10 years longer than those in the most deprived.

There have been increases in life expectancy across all areas in the main disease groups of cardiovascular and respiratory diseases and cancer but in deprived areas the reductions in deaths from the main disease groups has been offset by premature death from suicide and accidents. Suicide and self harm are much more prevalent in the most deprived wards and so tend to offset improvements due to reductions in cardiovascular disease. There were 72 suicides in Belfast LCG in 2009, of which 56 were men. The rate for the most deprived areas is 73% higher than the regional rate.

Cardiovascular disease remains the main cause of premature death. However, reductions in premature death from stroke and coronary heart disease which have led to increased life expectancy elsewhere have not been as marked in areas of deprivation. Smoking and obesity remain significant risk factors for cancer and cardiovascular diseases and are associated with deprivation. Smoking related

deaths remain 50% higher in deprived areas (189/100,000) than for the region as a whole.

There are a range of ethnic minority communities in Belfast who tend to have poorer health outcomes than the wider population and are more likely to experience social barriers in accessing health care. Travellers have a significantly lower life expectancy and South Asians are up to six times more likely to develop Type 2 diabetes. Health risks are also higher for recent immigrants such as asylum seekers, compounded by language and other cultural barriers which mean they tend to make less use of primary care services.

However, direct action by health and social care organisations to reduce life inequalities is limited as only 20% of the gap in outcomes between the most and least deprived wards is amenable to health care intervention as it is caused by a complex relationship between other determinants of health and wellbeing such as social and personal circumstances and environmental factors. These wider determinants of health and well being require a concerted approach by many organisations, led by local communities.

Action Proposed in 2011-12:

1. Agree one specific joint programme with each Belfast Area Partnership within each PCP area.
2. Develop a programme in West Belfast PCP to coordinate the efforts of GPs, community pharmacists, statutory services and local communities to reduce cardiovascular risk factors.
3. Map assets and resources in community, voluntary and statutory services and create a network for early identification and referral to appropriate services which can help people with mental health problems and those at risk of suicide or self harm towards recovery and self-directed care.
4. Involve ethnic minority communities, and other groups which experience life inequalities, in the design of care pathways to ensure that services are accessible to individuals from these communities and that barriers of language, custom, culture and prejudice are removed as far as possible.

Primary Care

Primary care provides the majority of care on a day to day basis for the population. The many individual decisions taken every day by primary care practitioners to advise, assess, treat or refer patients onwards for specialist advice is critical to not only the welfare of patients but also the operation of the whole health and care system. Small changes in these decisions can have very significant consequences for the whole system. The development of PCPs will support the enhancement of skills in primary care which facilitate a greater consistency of clinical management by practices, greater awareness by practitioners of the impact of their decisions, and their awareness and connectivity with community-based providers, voluntary groups within their areas so that they have a greater range of alternatives to offer patients.

Action Proposed:

1. Work through PCPs to develop and implement agreed care pathways which reduce variation in referral rates and prescribing between GP practices
2. Review and develop local enhanced services which increase the capacity of primary care to meet patient needs more effectively and reduce the need for referral to secondary care
3. Develop a Prescribing Plan which coordinates actions across all GP practices, community pharmacists and secondary care to improve the quality and reduce the costs of prescribing.
4. Provide systematic information to GPs about the range and quality of community and voluntary resources in their area which can provide an alternative to prescribing or secondary referral

Emergency and Urgent Acute Care

People in Belfast use their local Emergency Departments much more than any other population in Northern Ireland. In 2009-10 the rate in Belfast was 563 per 1000 compared with the regional average of 402 per 1000 (DHSSPS: NI Hospital Statistics: Emergency Care (2009/10)). Most of those attending had done so directly through self referral rather than being referred by their GP or coming by ambulance. A survey of users at the Royal Victoria Hospital showed that many of these people said they had not sought advice from their GP before attending A&E. There is therefore scope for a significant number of patients to be dealt with by their GP or benefit from advice in the first instance as an alternative to direct self referral.

An analysis of those attending the Royal Belfast Hospital for Sick Children showed that a large proportion of children were discharged home from the Emergency Department, without needing further follow up care. Most of these families lived within a short distance of the hospital, perhaps preferring to have their children seen by a specialist for reassurance. The Patient and Client Council will speak to some of these families to find out more about why they chose to attend the hospital. People in Belfast also make much greater use of Ambulance Services than elsewhere with 102 per 1000 dialling 999 compared with a regional average of 73 per 1000. The number of calls across the region increased by 31% over a four year period to 2009-10. Although only around 10-15% are referred to A&E by their GP, there is a wide variation in the rate of referral by GPs. The high volume of attendance at A&E in Belfast means that those who actually need to be seen by a specialist doctor must wait longer.

The key performance indicator used to measure the quality of emergency and urgent care is the waiting time within Emergency Departments, either waiting to be discharged or admitted as an inpatient or immediately referred to other services. The waiting time has been increasing in Belfast Hospitals indicating that the care pathway for patients needs to be improved to make sure patients get the right care from the right practitioner in the right setting. Clearly this is not happening at present and is causing delays and a waste of precious resources.

Improvements also need to be made to the admission pathway within the hospital, and in the utilisation of beds and discharge pathways including greater use of intermediate or "step down" beds and rehabilitation. In recent years the Belfast Trust has been able to reduce the number of beds required as a result of improved efficiency in the way patients are managed during their stay and in the preparations for discharge. This improved efficiency requires clinical leadership and decision-making at all stages along the care pathway if it is not to lead to waiting times within the Emergency Department. It is essential that the hospital system works in concert and has a sufficient cadre of senior doctors working closely together to ensure that there are no delays. This in turn requires a degree of specialisation among the hospitals so that senior doctors and high quality nursing and other support staff are able to work closely in teams. The Belfast Trust set out such a plan in New Directions and this is firmly supported by the LCG which will work closely with the Trust's hospital teams to shape care pathways so that they are responsive to local need and connect seamlessly to the rest of the hospital network.

Many admissions could also be avoided with closer working between primary and secondary care, enhanced primary care improved access to diagnostics and supported patient self management especially for patients with long term conditions.

This work will involve all four Primary Care Partnerships and will have three key aims:

- to encourage appropriate use of existing services and self management supported by primary care as the default for minor conditions. This will be focused on the communities who live closest to the Emergency Departments.
- to ensure patients have ready access to primary care as an alternative to using A&E for minor conditions and have rapid access to specialist care when they need it
- to streamline pathways for admission and discharge, especially aiming to reduce avoidable admissions and reduce length of stay for those patients who require only a short in patient admission.

This work has initially been focused on the RBHSC where a network of partners has been established to develop an overall pathway and progress has already been made with the strengthening of clinical leadership and the creation of a separate stream for patients with minor conditions. The work will now be extended to all three acute hospitals in Belfast.

Actions Proposed:

1. Work closely with the Belfast Trust and other key stakeholders in taking forward the modernisation of emergency and urgent care in Belfast, working with the clinical teams at each hospital and with community service teams to ensure that these are coordinated with the hospital system.
2. Review and improve accessibility to primary care so that as far as possible and appropriate families and individuals see these services as the first point of contact for urgent care
3. Identify those neighbourhoods where most use is being made of A&E Departments and hold discussions with local people on their reasons for using A&E and what alternatives could be offered.
4. Identify reasons repeated attendances of A&E, for example due to abuse of alcohol, falls or self harm and work with health improvement services, local communities and other partners to offer preventative services and primary care alternatives.

5. Work with primary care and hospital teams, patients and carers, local communities, the Out of Hours service, the NI Ambulance Service and the Belfast Trust to develop agreed care pathways for common conditions, such as Acute Chest Pain, so that these patients can get the right service more quickly and more efficiently than having to be referred to A&E. This will also focus on reducing the variation in the rate of referral to A&E by GPs.

Long Term Conditions

The relative prevalence of Coronary Heart Disease, COPD, Diabetes and Stroke, recorded in primary care, is higher in Belfast than in the rest of Northern Ireland. A key determinant of this pattern of ill health is deprivation. For example, heart disease, with the exception of its inborn forms, affects people from disadvantaged backgrounds more commonly and more severely than others. Most urgent admissions to hospital are for patients with heart disease and respiratory conditions and many of these patients have long standing illness which could be managed more effectively in the community. Whilst a relatively small number of these patients with long term illness are re-admitted to hospital several times each year and use up to half of all hospital beds. Therefore, small improvements in their clinical and self management can have a significant impact.

Primary care practices play a very important role in the clinical management of patients with long term conditions. However, there is some variation in the performance of practices across the LCG which is not related to the effects of deprivation. This inevitably leads to use of more expensive outpatient and inpatient resources, which might otherwise be avoided. The LCG will support a regional programme which will enhance primary care management of cardiovascular risk factors, focusing on areas of deprivation.

Self management by patients of their own conditions is an important factor in their quality of life for these patients. Patients need to be made aware of these programmes and encouraged to participate and maintain motivation to manage their conditions. There is considerable variation in the uptake of self management programmes. Remote telemonitoring can also support a partnership approach between patients and clinicians in the management of some diseases.

Psychological and therapeutic support must be readily available for those who require it. Physical activity programmes are an important means of maintaining health and addressing the risk of depression which can accompany these conditions. Community groups and local Councils are important providers of these programmes and should be integrated within a network which supports patients and their carers in living with the conditions for the rest of their lives.

In addressing these issues the LCG is taking a Life Pathway approach to the management of long term conditions, by looking at all aspects from prevention through to life-long self management and support. Users and carers have told us that when their course of treatment is completed they need to be able to access support within the community as their lives with the disease continue. They have said that it is just as important to have information about how to manage their disease, to be signposted to appropriate community support for example Local Council-run leisure centres, and to have confidence that those service providers will have an awareness of their disease. This requires a broader view of the lives of patients and carers so that services and care pathways are seen as support structures rather than a system which patients go through.

The LCG has focused on Diabetes as its incidence is growing with the increase in obesity. In South Belfast the LCG is working with community groups and ethnic community leaders to raise awareness of the risks of developing Type 2 diabetes, promoting physical activity, good nutrition and foot health, increased uptake of retinopathy screening, improving referral to structured patient education, and developing support materials and a standard care pathway for practices to reduce variation clinical management of the disease within primary care. A community development approach to prevention has been adopted, as recommended by NICE, aiming to identify and reduce the cultural barriers to good health among those communities most at risk such as South Asians.

The LCG has made a major investment in acute and community stroke services over the past year. This investment plan was informed by ongoing engagement with the Stroke Survivors Forum working closely with Belfast Trust, voluntary organisations and the patients and carers to improve the Life Pathway for stroke. The Stroke Survivors Forum produced their own view of a good pathway entitled "Our Stories in Our Words" which has been used as a guide for prioritising investment and action. A recent workshop led by the LCG with all parties identified key actions across the whole pathway which will now be taken forward.

COPD is one of the most common reasons for emergency admission to hospital. The relative prevalence of COPD (Chronic Obstructive Pulmonary Disease) is 19% higher in Belfast and is 61% higher in North Belfast than in N Ireland as a whole. It has been shown that the risk of patients having an emergency episode requiring admission can be predicted to an extent and staff resources and monitoring deployed according to these risks, so reducing avoidable admissions.

Action Proposed

1. Support a regional programme to enhance primary care management of cardio-vascular risk factors, focused on areas of deprivation.
2. Work with Belfast Health Development Unit to improve the quality of advice and support for patients and carers in their lives beyond treatment.
3. Take forward the action plans agreed for Diabetes and Stroke.

Seniors and those with a physical disability or sensory impairment

Belfast has an older population than Northern Ireland as a whole. 12% of people aged between 16 and 64 are receiving multiple disability benefit. 5,500 people use wheelchairs. 11,000 carers in the LCG area provide care for more than 50 hours per week and are essential partners in providing support at home. Almost 8000 people receive homecare support from the Belfast Trust, with a further 2900 living in nursing and residential homes.

The LCG is working with users, carers, voluntary organisations, local communities and partner organisations to promote and support health ageing and independent living. It is working in partnership, through its leadership role in the Healthy Ageing Strategic Partnership, to develop referral pathways and sign-posting for people with low to moderate needs, particularly those who have become socially isolated. This work is being taken forward in partnership with the voluntary age sector providers and will closely involve the Greater Belfast Seniors' Forum, comprising the six older people's forums from across the city.

This work will be an important contribution to the development of a Re-ablement approach. In this model of care, an initial contact with statutory services will trigger support for self-directed care and sign-posting to local community and voluntary provision. This will be supported by practical therapeutic support where necessary, with assessment for long term care being considered only after the abilities of the client have been assessed. The LCG will work with its partners to ensure that the client's abilities are enhanced by a wider range of housing options, transport, assistive technologies, information and flexible support.

Residential care is largely outmoded as most people living in these homes can be offered higher quality options within supported housing. The LCG has given its support to the development of a scheme to replace Shankill House and will consider options for the future of residential care which can offer a superior quality of life for people who can live independently.

Care in nursing homes is the only viable option for some very dependent patients and it is important to ensure that this continues to be of high quality. However, the use of this option needs to be considered carefully following an assessment of all other alternatives. The LCG will work with the Trust and patients and families to ensure that all options for supported independent living have been considered before a decision is made on Nursing Home care as the most appropriate option.

Actions Proposed:

1. Lead the Health Ageing Strategic Partnership, working closely with voluntary sector providers and the Greater Belfast Senior's Forum to deliver a shared agenda, and in particular, to address the issues of fuel poverty, social isolation, falls prevention and improving the pathway for discharge from hospital.
2. Work with Belfast Trust and other partners to introduce a Re-ablement model of care which puts the individual needs of clients first.
3. Secure the development of further Supported Housing Schemes and intermediate care as alternatives to residential care

Children and Families

The higher rates of suicide and self harm, teenage pregnancy, low birth weight, lower registration of children with dentists, obesity, abuse of alcohol and drugs and accidents within Belfast are closely related to the extent of deprivation across the city. Deprivation is also closely associated with low levels of educational attainment which in turn affects employment opportunities, household incomes, mental health and strains on relationships. These in turn affects the start in life experienced by children, which is a key factor in their future health and well being.

Support for families facing these stresses requires an integrated collaborative model, in conjunction with local communities, the voluntary sector and other agencies that have a role in relation to children. Family support services at local level are being commissioned within the remit of the Belfast Outcomes Group which is a sub-committee of the newly established Children and Young People's Strategic Partnership (CYSP). The aim is to strengthen communities and locality networks so children and families can have a wider and more easily accessible range of family support services.

A model of integrated local planning and provision has been developed in West Belfast and Shankill with support from the Office of the First Minister and Deputy First Minister. This provides community based support which promotes early intervention as well as providing additional support for more vulnerable families and children. The CYSP is currently mapping all models of multi-agency integrated planning at local level across the Belfast LCG area and throughout Northern Ireland.

Action Proposed:

1. Support the work of the CYSP in mapping local support services, establishing Locality Planning groups and developing Family Support Hubs.

Maternal and Child Health

The birth rate within Belfast is not expected to rise significantly over the next four years but the number of births delivered within the Belfast Trust will increase as a result of changes to services in the Lagan Valley Hospital. More mothers from the Lisburn and Dunmurry areas are expected to use the Royal Jubilee Maternity Hospital in future and this has been planned for within the hospital. A new hospital is now planned to replace the Royal Jubilee Maternity Hospital on an adjacent site, with the facility for future links to a redevelopment of the Royal Belfast Hospital for Sick Children. This has the potential to significantly improve the quality of care as was envisaged in the original Business Case for an integrated Women's and Children's' Hospital.

The future pattern of maternity services in Belfast will be considered in the context of the Review of Maternity Services being undertaken by the DHSS&PS. Re-design of care pathways for maternity and paediatric care will need to be able to support local access to midwife-led care while also providing access to specialist support of high quality. The involvement of the Maternity Services Liaison Committee will be key to ensuring that pathway design meets the needs of users.

The proportion of children with physical disabilities and sensory impairment in Belfast is higher than for Northern Ireland as a whole. Children with complex disabilities can be socially excluded or suffer life inequalities as a result of their disability,

Action Proposed

1. The LCG will take forward relevant actions in the Review of Maternity Services once it has been issued by the DHSS&PS and review of health visiting.

2. The LCG will work in partnership with the Belfast Trust, schools and the Belfast Education and Library Board to ensure that children with complex physical disabilities have equitable access to appropriate therapeutic support.

Mental Health and Learning Disability

The relative prevalence of mental illness recorded in primary care, where most patients are treated, is 20% higher in Belfast LCG area than in the rest of Northern Ireland. Most mental illness takes the form of mild to moderate depression and anxiety and is managed in primary care. In many cases GPs either prescribe medicines to alleviate the symptoms or make a referral to a statutory or voluntary provider.

In 2008 14% of the Belfast Local Government District population were taking prescription drugs for mood or anxiety disorders (DHSSPS Inequalities Monitoring System). The rate of prescribing of these drugs is much higher than in other LCG areas. However, there is considerable variation between even neighbouring GP practices which is not explained simply by relative deprivation in the population. In addition, long term prescribing of some medicines can lead to addiction and can have harmful effects for both the individuals, their families and wider society.

Around 500 patients per week are referred by GPs to statutory services provided by the Belfast Trust. However, less than half of these patients are dealt with directly by Trust Services. About one third of these patients are immediately returned to GPs or re-referred to community-based organisations and almost another third do not respond to a letter of appointment or do not attend the appointment. This means that many patients are not being assessed or supported appropriately, their recovery is therefore delayed and their condition may deteriorate. Much better coordination and communication between GPs, statutory services and community-based providers of mental health or general health improvement services is required.

The West Belfast PCP, which includes a wide range of community and voluntary organisations as well as GPs and secondary care clinicians, is working to improve this network of support. It has partnered with the Belfast Health Development Unit (which supports the Belfast Strategic Partnership) to commission a map of community assets with a view to developing a network of alternative pathways and reducing the need for medication or referral to secondary care.

The West Belfast PCP has extended its remit beyond the LCG area into the Colin Neighbourhood of Lisburn as many of the patients in this area are on the practice lists of GPs in West Belfast and many of the mental health issues are similar, particularly where these are related to relative deprivation. Suicide and self harm are

more prevalent in deprived areas and a rapid joint response from community groups, statutory services and GPs is essential. The PCP is supporting the development of a joint response through its work.

The PCP is also bringing primary and secondary care clinicians together to re-design care pathways for patients with acute mental illness. The LCG has supported the Trust in developing a model of care in which home treatment services and community based short stay beds provide an alternative to inpatient care. The reduction in inpatient beds will enable investment of savings in community support and the consolidation of acute services on a single site with an associated improvement in the quality of care. The DHSSPS has now given approval in principle to the consolidation of services on a single site located at the Belfast City Hospital.

There are currently 69 patients with learning disabilities originally from the Belfast LCG area living in Muckamore Abbey Hospital. These are people who have traditionally been cared for in the hospital on a long-term basis, some of whom have lived in the hospital for forty or fifty years. There are also 45 patients with mental illnesses living in long stay wards in Knockbraken Health Care Park who could live in community settings with appropriate support, as well as acute inpatients whose discharge has been delayed while community support packages are developed for them. The LCG will work closely with the Belfast Trust and the Housing Executive through the Supporting People Partnership to continue the resettlement programme for these people.

There are 1,271 people registered with GP practices in Belfast LCG area who have a learning disability. These people often need life-long support from carers and as they now live longer, so older carers experience particular difficulties and will require additional support as they age. People with learning disabilities also experience inequalities in health and well being as they have more difficulty accessing primary care as well as housing, training, further education and employment opportunities.

Action Proposed:

1. Work with GP practices to safely reduce long term prescribing of medicines
2. Complete the mapping of the provision of therapeutic services within the community, voluntary and statutory sectors in West Belfast and develop a formal network which supports self-recovery, reduces referrals to statutory services and re-invests in community-based provision
3. Align Primary care services with local Protect Life and Mental Health Promotion resources and service models.

4. Agree an investment plan with Belfast Trust which supports the new model of care for acutely ill patients
5. Facilitate primary and secondary care clinicians in developing agreed care pathways for specific acute conditions and regular feedback and advice on the appropriate management of these conditions in primary care
6. Work with the Belfast Trust and NI Housing Executive to take forward plans for the re-settlement of long stay patients in Knockbracken and Muckamore Abbey.
7. Work with the Greater Belfast Seniors' Forum to improve support for older people who suffer mental health problems.
8. Develop local community support options for people with learning disabilities in partnership with local housing, employment, further education and leisure providers.

Palliative Care

Palliative care is no longer just about caring for people at the end stage of their illness. Good quality palliative support should be part of the ongoing care plan for any person who has been diagnosed with a terminal illness. Many life limiting diseases including many cancers, are now considered as chronic conditions which may progress relatively slowly over a period of years, rather than weeks or months. End of life care more specifically is the care provided in the last few months, weeks or days of life and will involve a multi disciplinary focus on the usually more acute needs of the person, including symptom control and psychological and spiritual support.

There are currently 438 patients registered with GPs in Belfast in receipt of palliative care services. However, the newly published DHSSPS Palliative Care and End of Life Care Strategy suggests that more than 1800 people could benefit from Palliative Care and that this would reduce the number of people who die at hospital. Currently 50% of people in Northern Ireland die at hospital and 14% of these people are admitted in the last hours of their life rather than being provided with support to allow them to choose to die at home.

The key to increasing this choice is to improve awareness, coordination and communication between agencies, to provide 24 hour coverage and to fully involve patients, families and local community and voluntary organisations.

Action Proposed

1. The North Belfast PCP will develop a model for this network approach, building on the work of the Belfast Trust's Palliative Care Steering Group and the LCG's recent investment in District Nursing. This will include:
 - a. Measuring baselines and developing plans for the enhanced provision of a 24hr palliative care support service
 - b. Identifying opportunities for shifting resources from acute care particularly for patients with cancer who are currently admitted within 48 hours of death and for patients with cancer who wish to be discharged to die at home.
 - c. Developing plans to increase choice for patients by providing appropriate input and training to nursing homes working with Trusts and RQIA eg by the further development of PCPs .
 - d. Developing plans to sustain palliative care co-ordinators
 - e. Ensuring advice and support contact points for patients and carers out of hours by improved training, co-ordination and utilisation of existing services.

Cancer services

Premature death from cancer, mainly lung and colorectal tumours, accounts for a large proportion of the lower life expectancy in the most deprived wards. The standardised death rate from cancer in Belfast is significantly higher than in the rest of Northern Ireland, as is the incidence of lung cancer.

Reduction in risk behaviours such as smoking has been addressed already in this plan. Early detection and treatment are key to improved outcomes, particularly in areas of deprivation. Clinical teams in the primary and secondary care need to be able to identify symptoms as early as possible and individuals need to know how and when to seek medical advice.

Increasing numbers of patients with cancer are now surviving. The LCG will help to support these people and their families to live as healthily as possible. This will entail, in many cases, supporting their own self management, encouraging them to engage in moderate physical activity and signposting them to community based resources. For others it will also require primary care based monitoring with specialist support when necessary and a for some it will require continued review by specialists supported by primary and community care resources for information, counselling, befriending and self management.

Action Proposed:

2. Take forward a partnership project involving primary care, local communities and other partners to raise awareness of the risk factors for cancer and to improve early detection, especially among groups who are often slower to address their own health issues or access primary care.
3. Take forward with the Trust, primary care and community based groups the re-design of services for the appropriate follow up of patients who have had treatment for Prostate Cancer

Elective Care

Referrals for outpatient consultations for common conditions have been increasing in recent years though this rate has slowed in the past year. The rate is significantly lower in Belfast than in any other LCG area, except in Cardiology, but could still be reduced with enhanced services in primary care and a focus on health improvement.

The initial focus for action by the LCG has been in the re-organisation of services for ear nose and throat conditions which are the most common conditions referred to outpatients and which evidence shows could be reduced by up to 50% through enhancement of primary care. The East Belfast Primary Care Partnership is designing a new care pathway which will incorporate health promotion within the community and local pharmacies and locally based primary care clinics where patients can be seen and assessed more quickly. Hospital consultants will provide advice to GPs on clinical management and local expertise will be developed within practices which will reduce referrals overall.

Waiting lists for outpatient appointments, inpatient and day case surgery and diagnostic tests have increased over the past year. The Board has invested in a substantial increase in clinical staff and these posts are being filled. This will increase the capacity of Trusts to assess and treat the patients being referred and the Board has been reviewing this capacity to ensure that it is performing at a level comparable with best practice guidelines and levels achieved by the best elsewhere.

The LCG will review its Service and Budget Agreements with Trusts to reflect this expected level of utilisation. However, in some specialties demand may still exceed capacity. The LCG will focus action to work with primary care and local communities to manage demand in these specialties and work with secondary care specialists to

develop assessment and treatment protocols linked to effective use of resources policies developed at regional level.

The Belfast Trust has consulted on a Strategic Review of Acute Services which will relocate some key services creating more efficient linkages and so improve the overall quality including the experience of patients. The patient experience, clinical quality and efficiency of treatment services can be improved through the greater use of day surgery. The LCG will consider proposals to be brought forward by the Belfast Trust to modernise its day surgery provision through the replacement of the Gardner Robb Unit at the Belfast City Hospital.

Patients who require review of their condition following an initial outpatient appointment should have this carried out in the most setting by the most appropriate clinician. Many reviews could potentially be carried out in primary care and Primary Care Partnerships will look for opportunities for this to be done. Some conditions require review on a regular basis so it is even more important for this to be carried out as close to the patient's home as possible.

The numbers of patients waiting for review appointments is longest for eye conditions and a third of these people have Glaucoma. Their conditions mean that it is particularly important that these patients have regular reviews. The LCG led the development of a modernisation plan for Glaucoma services which requires regular review over the lifetime of the patient, following diagnosis. This will enhance the skills of community optometrists and provide satellite clinics, reducing travel time for patients and their carers.

Action Proposed:

1. Commission locally-based ENT, Dermatology and Neurology services within a primary care setting.
2. Implement the regional pathways and referral guidelines arising from the implementation of the Urology Review.
3. Ensure that PCPs coordinate the systematic and regular review of referrals and provide feedback and advice to practices to ensure consistency and develop practice-based review
4. Take forward a programme of pathway re-design coordinated at regional level which ensures that patients receive the right care from the right practitioner in the most appropriate setting, as locally as possible

5. Have a plan in place to ensure that hospital resources are as productive as possible and that action is taken where demand for services exceeds this capacity to ensure that waiting lists do not lengthen
6. Ensure that the plans of Belfast Trust to modernise day surgery facilities meet the needs of population
7. Have a plan in place to ensure that by March 2012 patients requiring clinical review have this carried out in appropriate settings and within the clinically indicated time.

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