HSC Health and Social Care

Northern Local Commissioning Plan 2013/14

14 March 2013

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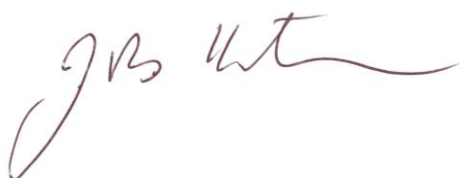
Chairman's Foreword

During the past year, the Northern Local Commissioning Group (Northern LCG) has progressed significant local commissioning initiatives. These have included for example, beginning to explore the development of Integrated Care Partnerships in partnership with our Primary Care colleagues. There have also been notable successes in working with primary and secondary care colleagues to improve patient care pathways and in particular to facilitate direct access for GPs to an increasing number of diagnostic procedures. A significant focus on reablement has strengthened the aim of enabling older people to live independently at home where appropriate.

In the coming year, and following the consultation process, we will build on these successful developments to take forward the recommendations of Transforming Your Care (TYC). The Northern LCG will work closely with the Northern Health and Social Care Trust (NHSCT) to consult the population on changes to local services which will continue to focus on innovation, productivity and integration.

The Northern LCG is also aware of the increasing challenges presented by growing demand and the changes to our demography. The Local Commissioning Plan for this year heralds the start of the process of transformation and the key local actions are clearly built upon the principles of TYC. It will be a challenging time ahead but there are many opportunities as we have already demonstrated arising from local commissioning to ensure more integrated health and social services for our local population.



Dr Brian Hunter
Chair, Northern Local Commissioning Group

1. The Northern LCG Population and Need

The Northern Local Commissioning Group (Northern LCG) covers an area of 1,670 square miles and includes ten Local Government Districts (LGDs) with a total population of 463,000. Despite having some large urban areas, the Northern LCG area has a large rural hinterland which in itself poses particular issues in terms of accessibility to services. The LCG is keen to develop a hub and spoke model for primary and community care infrastructure which will help in the delivery of services as close to the patient and client as possible.

Population Projections

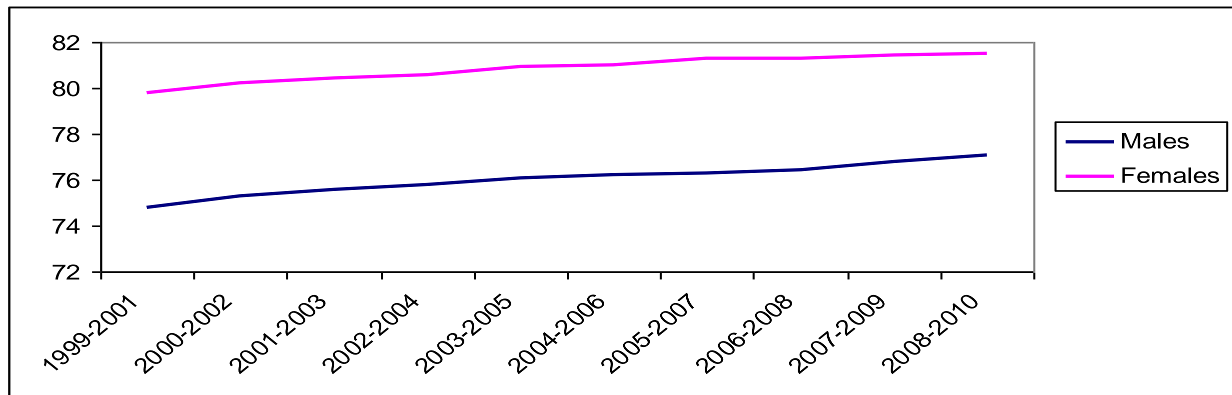
The Northern LCG is calculated to have an overall population growth of 5.9% between 2012 and 2023. This is slightly lower than the Northern Ireland average. Currently the Northern LCG has the highest number of younger people within its population at 96,000 or 20.8% of its population. The number of children under 16 is expected to increase by 1.6% from 2012-23. Not surprisingly, the greatest increase is found in the number of older people (85+) which is expected to rise by 65.1% in that period.

The Northern LCG has the largest population (26% of NI Total) and is the area projected to have the highest number of persons aged 65+ by 2023. It has the second fastest growing population in Northern Ireland with Cookstown, Antrim and Magherafelt projected to increase by approx 11% from 2010-20.

Life Expectancy

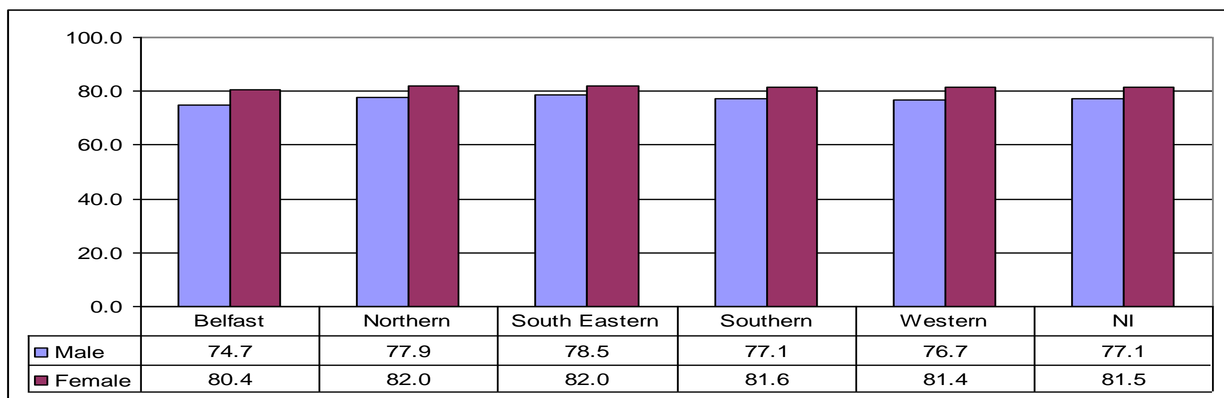
Life expectancy is used internationally as a measure of population health. For the period 2008-2010, life expectancy in NI was lower than in the rest of the UK, with the exception of Scotland (ONS Interim Life Tables). In N Ireland, life expectancy has increased between 1999-2001 and 2008-2010 from 74.8 years to 77.1 years for men and from 79.8 years to 81.5 years for women (Source: Sub-NI Life Expectancy at Birth andAge 65, NISRA).

Figure 1: Life Expectancy by Gender in N Ireland, 1999-2000 to 2008-2010



In tandem with the overall growth in population, there is an improvement in life expectancy. When looking at the Northern LCG as a whole, for people born between 2008 and 2010, life expectancy is higher than the Northern Ireland average.

Figure 2: Life expectancy by Gender for Local Commissioning Groups, 2008-2010.



	Belfast	Northern	South Eastern	Southern	Western	NI
Male	74.7	77.9	78.5	77.1	76.7	77.1
Female	80.4	82.0	82.0	81.6	81.4	81.5

Source: PHA, 2012

While there are some signs of general improvement in life expectancy, not everyone has been able to avail fully of the benefits of this progress. Unfortunately, social inequality has endured to the extent that health outcomes for some groups remain poorer than for others, and smoking, obesity, misuse of drugs and alcohol, teenage conception rates, poor mental health are disproportionally concentrated amongst particular deprived groups (Source: PHA, 2012).

Chronic Illness / Long term conditions

Self assessed health, long term limiting illness and provision of unpaid care (Census, 2011)

The 2011 Northern Ireland Census asked respondents how they perceived their health, whether they had a long term limiting illness and if they provided unpaid care. Approximately one fifth of the Northern Ireland population stated that they had a long term limiting illness. Almost 80% felt they were in good health, and almost 12% said that they provide unpaid care.

Figure 3. Percentage of population with a long term limiting illness, with good or very good general and providing unpaid care, Census 2011

	Long term limiting Illness	General health: Good or Very Good	Providing Unpaid care
Belfast	23.04	76.71	12.33
Northern	19.65	80.43	11.55
South Eastern	19.82	80.84	12.82
Southern	19.64	80.61	11.34
Western	21.85	78.46	11.04
Northern Ireland	20.69	79.51	11.81

Source: Census 2011

When asked about the type of long term condition suffered 6.6% of the Northern Ireland population stated they had a chronic illness and 10% suffered long term pain or discomfort Figure 4).

Figure 4: Type of Long Term Condition as assessed by the NI Census 2011

LCG	Deafness or partial hearing loss (%)	Blindness or partial sight loss (%)	Communication difficulty (%)	A mobility or dexterity difficulty (%)	A learning, intellectual, social or behavioural difficulty (%)	An emotional, psychological or mental health condition (%)	Long-term pain or discomfort (%)	Shortness of breath or difficulty breathing (%)	Frequent periods of confusion or memory loss (%)	A chronic illness (%)	Other condition (%)	No condition (%)
Belfast	5.6	2.0	1.9	13.1	2.6	7.4	11.4	10.3	2.5	7.2	5.6	66.0
Northern	5.2	1.6	1.5	10.7	2.0	5.1	9.7	8.4	1.7	6.6	5.1	69.2
South Eastern	5.6	1.7	1.6	11.1	2.2	5.1	9.9	8.5	1.9	6.7	5.3	68.4
Southern	4.5	1.6	1.6	10.8	2.0	5.3	9.5	7.8	1.8	5.9	4.9	70.8
Western	4.8	1.7	1.8	11.9	2.4	6.6	10.2	8.8	2.0	6.4	5.3	68.2
Northern Ireland	5.1	1.7	1.7	11.4	2.2	5.8	10.1	8.7	2.0	6.6	5.2	68.6

Source: Census 2011

In general at sub Northern Ireland level, Belfast LCG reported above average percentages across all types of long term conditions presented with the Northern area on a par with the region as a whole (Figure 4).

QOF Disease Registers

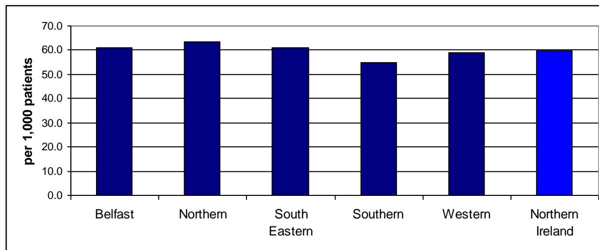
The prevalence of long term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation (PHA, 2011).

Across Northern Ireland the most prevalent LTCs are hypertension (127.38 per 1000 patients), asthma (59.81 per 1000 patients) and diabetes (39.95 per 1000 patients).

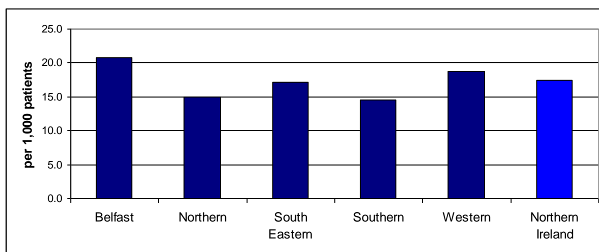
At sub regional level (Figure 5), the Northern LCG has higher than average rates of asthma, diabetes, hypertension and stroke.

Figure 5: Disease prevalence for selected Long Term Conditions (per 1,000 patients) by Local Commissioning Group, 2011/12.

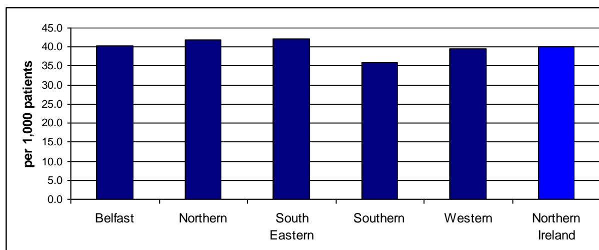
i. Asthma



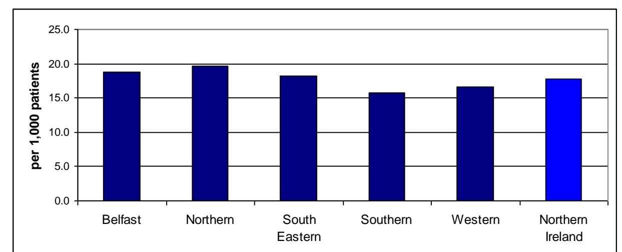
ii. COPD



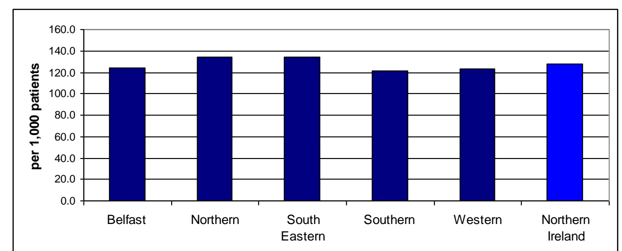
iii. Diabetes



iv. Stroke



v. Hypertension



Source:
QOF data @ DHSSPSNI.gov.uk, 2013.

Emergency Admissions to hospital for LTC

During 2011/12, long term conditions such as asthma, COPD, diabetes, heart failure and stroke accounted for a total of 11, 620 emergency admissions to hospital (where relevant ICD-10 codes were coded as a primary diagnosis or main condition treated on the admission episode). COPD accounted for just over 40% of this total, at a rate of 342 admissions per 100,000 population (aged 18+).

Figure 6: Total number of Emergency Admissions and rate per 100,000 population (aged 18+) to hospitals in N Ireland for selected Long Term Conditions 2011/12.

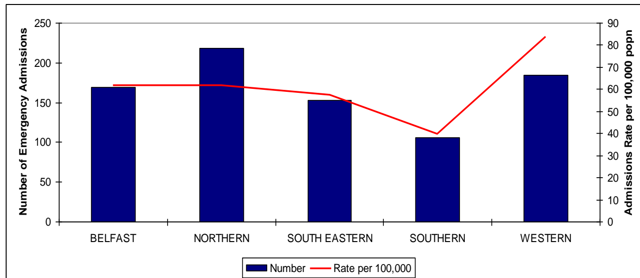
Northern Ireland	Asthma	COPD	Diabetes	Heart Failure	Stroke
Number of Emergency Admissions	835	4,717	1,008	2,363	2,697
Rate per 100,000 popn.	61	342	73	171	195

Source: Hospital Inpatient System, DHSSPS

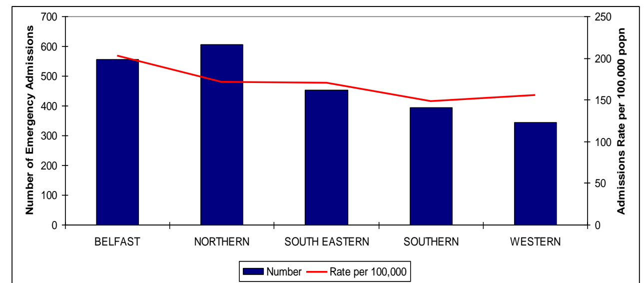
The breakdown of these admissions by LCG of residence is shown in Figure 7. During 2011/12, the Northern LCG had the highest number of emergency admissions to hospital for asthma, diabetes, heart failure and stroke. This is one of the drivers for the management of long term conditions in the community as part of the developing ICP model. The data below clearly shows the potential for reduced admissions for chronic conditions if we can commission services in primary and community care settings to support those patients at home.

Figure 7: Number of Emergency Admissions and rate per 100,000 population (aged 18+) to hospitals for selected Long Term Conditions by Local Commissioning Group of Residence 2011/12.

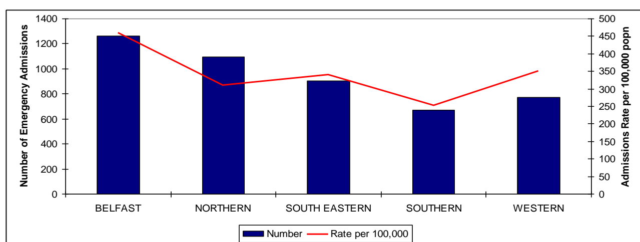
i. Asthma



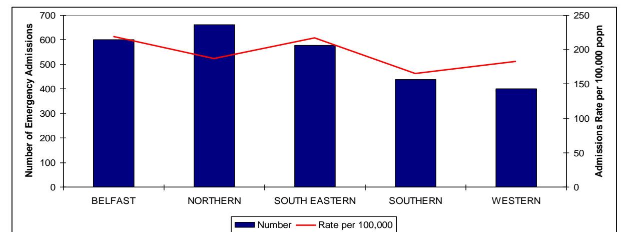
iv. Heart Failure



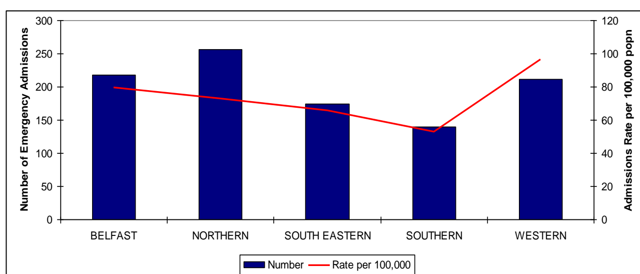
ii. COPD



v. Stroke



iii. Diabetes



Source: Hospital Inpatient System, DHSSPS .

2. Key Successes 2012/13

- Northern LCG has supported a reduction in waiting times across all elective services, including New Outpatients, Review Outpatients, Day Case and In-Patient treatments, diagnostic access times and access to Allied Health Professionals.
- Elective demand and capacity gaps have been identified and agreed with the Northern Trust, this has facilitated local elective commissioning intentions for the Northern LCG together with the identification and development of local Primary Care Partnerships (PCPs).
- The Northern LCG has made a number of investments to manage expected levels of demand across a range of specialities to increase capacity and improve waiting times.
- 9 week access times to all Diagnostics have largely been delivered.
- 13 week access times to Endsocopy (coloscopy, ERCP, gastroscopy and flex sigmoidoscopy) have largely been delivered.
- A new Acute Medical Assessment Area at AAH has been opened facilitating direct access to advice and treatment for GP referred patients.
- A GP unscheduled hub is being developed within AAH to include access to consultant advice and treatment across a range of medical specialties.
- Four Primary Care Partnerships have been established with active input from both primary and secondary care sectors.
- The Northern LCG is also actively piloting a number of PCP initiatives, these include:-

  - Dermatology PCP: up-skilling GPs to manage more routine skin conditions in a primary care setting (across Mid Ulster, Antrim/Ballymena & East Antrim Localities);
  - Dermatology Photo Triage Service (Causeway);
  - Direct Referral Endoscopy (all localities);
  - Tele-Neurology (all localities);
  - Direct Access Echoes (Mid Ulster); and,
  - Direct Access Holter Tape (all localities).

- A Medicines Management Prescribing Initiative has been introduced and has contributed to the delivery of significant prescribing savings. A number of schemes have been implemented as savings have been reinvested in local services.

- Reablement has been introduced in the Northern area with initial positive results in respect of successful rehabilitation of older people.

3. Key Challenges 2013/14

Addressing Inequalities

Approximately 4,000 people die prematurely due to preventable ill health every year in Northern Ireland (1,000 in the Northern LCG area). The health of the population has improved over time but this improvement has not been seen in all groups and the pattern of health inequalities is persistent over time. It is clear that much more needs to be done to narrow this gap. This is a key plank within Transforming Your Care but more needs to be done to mainstream health improvement within core commissioning agenda. Health improvement will be at the core of our work on long term conditions as part of the emerging ICPs.

The Commissioning Plan focuses on those aspects of Trust services where greatest impact can be made in addressing inequalities, creating better outcomes for service users and ensuring a reduction in the prevalence of illness/long term conditions, which pose a major challenge to the health and social care budget. It is essential that all areas of treatment and care identify opportunities for providing appropriate health and wellbeing information, advice and support for service users.

The Health and Social Care Board (HSCB) and the Public Health Agency (PHA) will require the Trust to ensure health improvement is integrated into all programmes and will particularly wish to see progress on the following key themes:

- Giving every child and young person the best start in life - establish Family Nurse Partnership programmes, breast feeding peer support programmes, extend roots of Empathy programme;
- Working with others to ensure a decent standard of living - Support programmes which tackle poverty, programmes that address employability and the needs of long term unemployed people;
- Building sustainable communities – adopting a community development approach to service design and delivery and taking an assets-based approach to promote change within local communities will be key to improving health; and,
- Making healthy choices easier – simple appeals for individual behaviour change will have limited value without also creating a supportive environment through the alignment of policy and action.

A focus on specific health issues such as cancer; circulatory disease; respiratory disease; tobacco; alcohol and drug use; obesity; diabetes, mental health and sexual health all point toward the need for interconnected action across a range of fronts. Health improvement actions will be embedded within the developing ICP models.

Delivering TYC

Commissioning Care Closer to Home

The Northern LCG will be working closely with Primary Care colleagues, the NHSCT, patients, clients and carers and voluntary and community sector to progress the recommendations outlined in Transforming Your Care (TYC). In particular, the Northern LCG will focus on commissioning services that:

- Focus on prevention and enabling individual responsibility for health and wellbeing;
- Provide care as close to home as practical;
- Provide greater choice of service provision, particularly in the use of the independent sector; and
- Enable a shift of resources from the acute sector to community and primary care settings.

The Case for Change

In Transforming Your Care, there are five main reasons outlined as to why change is required in the way health and social services are delivered in Northern Ireland. These apply to the Northern area as follows:

- A growing and ageing population: As outlined above the population aged 85+ is to increase by 64.7% by 2023.
- Increased prevalence of long term conditions: Within the Northern area, hypertension and asthma are the most prevalent LTCs. The Northern area has a higher prevalence rate in the areas of hypertension, asthma, CHD, hyperthyroid, atrial fibrillation, diabetes mellitus and chronic kidney disease compared to NI averages.
- Increased demand and over reliance on hospital beds: Based on DHSSPS 2011/12 figures, Northern Trust had the third highest occupancy rate with 84.2% of beds occupied compared to other Trusts. Overall there was a 0.1decrease in the total number of admissions from 2007/08 to 2011/12.
- Clinical workforce supply difficulties which have put pressure on service resilience: There are ongoing challenges to meet current clinical recommendations on staffing, particularly in the acute settings.

- The need for greater productivity and value for money: Significant cash and productivity savings have to be achieved against a backdrop of increasing demand on services.

Integrated Care Partnerships

The development and implementation of Integrated Care Partnerships is recognised as key to improving integration across the whole of the health and social care system and to enable a refocusing of service delivery outside of hospital settings. ICPs in the Northern area will join up local services including GPs, community pharmacists, community health and social care providers, hospital specialists and the voluntary and community sector to deliver services locally. The alignment of ICPs with the proactive management of long term conditions has been identified as a key goal in the Northern area, to improve patient experience and reduce unplanned hospital admissions. Much of the effort will focus on supporting people within a self-care and personalised care approach.

Primary Care Partnerships (PCPs) have been established in East Antrim, Causeway, Antrim/Ballymena and Mid-Ulster and have worked very successfully on the development of a range of patient pathways under the leadership of GP and Pharmacy Leads. The Northern LCG will continue and develop the PCPs into Integrated Care Partnerships (ICPs). These Partnerships will be established to bring together primary care professionals, community health and social care providers, clinicians from the acute sector and representatives from the independent and voluntary sector. The overall objective will be to provide the optimum care outside the hospital setting and to fully develop the home as the hub concept as outlined in TYC.

Aligned with the proactive management of long term conditions, the initial focus of ICPs will be on the over 75 population. However, the intention is to include patients with a range of long term conditions. Multi-disciplinary teams will form community based support programmes for patients with long term conditions. This will provide them with a named point of contact and direct admission to hospital care when necessary, bypassing A&E as agreed between the GP and the hospital specialist. Dedicated community based clinics will be set up where patients can access a range of health and social care services with inputs from GPs and hospital specialists alongside community pharmacy, allied health professionals, nursing care and social work support. Changing the centre of gravity of healthcare from secondary to primary and community care

will be the key focus.

The developments, as outlined, will have a significant impact on the range of ministerial targets. There will be an emphasis on prevention, health promotion and earlier intervention. This will be developed in partnership with the voluntary and community sector, using evidence based approaches such as self-management.

The focus of the development of the pathways will be to improve the quality of services and outcomes for patients, clients and carers by providing the right care, in the right place, at the right time. The provision of care in the primary and community settings will ensure that only those who require care in the acute setting will be referred for further diagnostics and treatment.
ICPs will have a clear role to develop more innovative, accessible and responsive services; which promote choice and, where appropriate, are available in a community setting. In particular, it is envisaged that pathways relating to the management of long term conditions will make significant use of telemonitoring.

In all of the work to be taken forward by the NLCG and the ICPs, there will be an emphasis on the need to improve productivity in order to ensure that the needs of the local population can be addressed. This is in light of the continuing growth in the numbers of older people and the prevalence of long term conditions, both of which continue to place pressures on the local health care economy.

While the opportunities for change are apparent, there are challenges ahead in terms of accessing pump priming or transitional funding to enable new service models to be implemented with the clear and stated aim of reducing dependence on hospital beds within a defined period. To deliver on all of this, we will need to develop a robust financial model to support the shift left agenda. Communication with our partners in health and social care and the wider community will be critical as we move to transform how care is delivered outside of the hospital setting.

Reform of Community Services for Older People
Within the Northern area it is envisaged that the programme of reform designed to enable older people to maintain independence and to remain in their own homes for as long as possible will continue to be developed. This

will include an increasing focus on reablement, short term, intensive care and support and an increasing role for the voluntary and community sector in supporting people at home. There will also be additional provision of supported living and a move away from traditional residential care homes.

Acute Reform and Hospital Configuration

The Northern Health Economy faces its own particular challenges over the years ahead in terms of maintaining acute hospital services across both Antrim and Causeway sites. It has already been through a significant period of acute hospital reform with changes to the profile of service in Mid Ulster and Whiteabbey in recent years.

Specifically, the focus through the TYC Population planning process has been on obstetrics, emergency surgery, emergency care, anaesthetics/critical care and paediatrics. The issues around all of this have been well documented in the draft Population Plan and we will continue through 2013/14 to work with colleagues in HSCB/PHA, NHSCT and primary care to develop a model that is sustainable into the longer term, acknowledging that there is no immediate risk to services. Our focus will be on networking arrangements across hospital sites and partnerships with primary care to continue to meet the needs of our local population

It is critical that the local Health Economy focuses on improving acute productivity with a view to maximising the investment in both unscheduled and scheduled care. We will seek to maximise the planned development of outpatient and diagnostic activity within primary and community care settings, secure additional productivity from outpatient, inpatient, day case and diagnostic services from existing hospital infrastructure; support the development of Integrated Care Pathways which proactively manage long term conditions within primary and community care settings and develop pathways across the existing acute settings to promote improved access to services. This will also serve to facilitate timely and supported discharge for both planned and unplanned attendances.

Notwithstanding acute hospital configuration, there are challenges ahead in terms of local and community hospitals and the services that they can provide. In 2013/14, we will be working with the Trust and primary care colleagues to develop a strategic vision for those sites and localities, exploring where

appropriate the added value of health and care centres as hubs within local communities delivering a range of primary and community services.

Vulnerable Adults and Children

The NLCG will continue to support the work of the NHSCT in ensuring that the most vulnerable in our society, including children and adults at risk of harm, are looked after across all our services.

HSCB is currently engaged in the development of a new combined Domestic and Sexual Violence and Abuse Strategy by the DHSSPS. The strategy will identify high level outcomes and key priorities to be tackled under a number of specified strands. Work will be progressed by the HSCB in collaboration with other lead agencies to address the key priorities contained within the strategy and associated Action Plan for 12/13 and to contribute to the delivery of high quality, co-ordinated, multi agency responses to domestic and sexual violence. From a Children and Families perspective emphasis will be placed on early intervention and education, safeguarding and addressing the needs of children affected by or who are victims of domestic and sexual violence and abuse. A regional Sub Group chaired by HSCB is currently establishing a combined action plan which will target early intervention and responsive initiatives to include supporting the delivery of a pilot initiative on the Helping Hands Programme to be evaluated with a view to roll out across all primary school settings, capacity building with frontline staff in specific childcare settings to act as social guardians and the roll out of a Domestic Violence assessment model across all five HSC Trusts.

Controlling Prescribing Costs

The Northern LCG encompasses 78 GP practices with an annual prescribing budget of approximately £97m. For a number of years, substantial levels of efficiencies have been required from the prescribing budget. Due to the efforts made in reviewing prescribing practice a prescribing underspend was achieved in 2011/12. In moving forward the main aim continues to be the delivery of improved clinical and cost effective medicines management.

The Northern LCG must also focus on the costs associated with prescribing as outlined above. As GP prescribing patterns are significantly impacted by decisions taken in secondary care, the interface issues between primary and secondary care prescribing will need to be given a particular and sustained focus.

4. Regional Commissioning Objectives & Local Commissioning Intent

Cancer Care

Regional Commissioning Objectives	Local Commissioning Intent 2013/14
Ministerial target: From April 2013, ensure that 95% of patients urgently referred with a suspected cancer, begin their first definitive treatment within 62 days.	
During 2013/14 all Trusts will continue to address longest waits and improve the headline percentage to ensure that 95% of patients receive their first definitive treatment within 62 days to include: maintaining mechanisms for patient tracking; breach analysis; and action planning and follow up with HSCB personnel In addition, Belfast Trust will progress developments to include: improved access to Brachytherapy; provision of enhanced thoracic surgical capacity and the centralisation of upper GI surgery in order to address pathway issues which contribute to delays.	
Trust should implement a risk stratified model of follow up in line with the National Cancer Survivorship Initiative which includes rehabilitation and recovery. • Minimum of 30% of Breast Cancer Patients on self-	NHSCT should work to achieve the regional objectives as specified.

directed aftercare pathway by Jan 2013- rising to 40% from Jan 2014. • All Trusts to maximise skills mix initiatives in implementing risk stratified follow up for prostate cancer patients which reduces demand on hospital OP services. • All Trusts should develop clear project plans and begin to introduce a risk stratified model of follow up across all other cancer groupings, which will clear and prevent review backlog. • Findings of external evaluation to be incorporated into Trust Transforming Follow Up action plans.	
All Trusts should work with HSCB to implement the recommendations of the 2010 NI Chemotherapy Service Review. This should include: • Establishment of an Acute Oncology Service (activity to be monitored as agreed with the HSCB). • All Trusts to work with HSCB to agree regional model that provides appropriate oncology presence across centre and units. • All Trusts to monitor compliance with NICE guidance on neutropenic sepsis and to report to the HSCB on a monthly basis via the performance management	NHSCT should work to achieve the regional objectives as specified.

information returns. • All Trusts to work closely with HSCB to modernise oncology services including staff levels and skills mix. • All Trusts to implement C-PORT. • All Trusts to continue to ensure involvement of relevant personnel / stakeholders in the development of RISOH.	
Effective Multidisciplinary Teams All Trusts should ensure that cancer MDTs undertake the NICaN Peer Review process and develop action improvement plans which will be shared with HSCB. • All Trusts should participate in peer review of, Lung, Gynae, Colorectal, Urology and Haematology. • All Trusts will participate in peer review of Skin, Head and Neck, Upper GI/HPB and Breast, MDTs. • BHSCT to participate in peer review of Sarcoma, Brain& CNS MDT. • All Trusts to participate in national Lung, e.g Bowel, UGI and Head and Neck audits. • All Trusts to share with HSCB on an annual basis findings from national and other relevant audits (including M&M Meetings) and subsequent action plans. • All Trusts will audit the Protocol for Amending the Status	NHSCT should work to achieve the regional objectives as specified.

of a Red Flag Referral including the implementation of the NICE Guidance for Suspected Cancer.	
All Trusts will work with the Regional NICaN TYA postholder to scope out current practice (including pathways and referral patterns) and will encourage staff involvement in education and training on the needs of this cohort of patients. • All Trusts to participate actively in the development of streamlined pathways for teenagers and young adults with cancer. • Trusts to participate in multiprofessional multidisciplinary working e.g virtual MDMs.	NHSCT should work to achieve the regional objectives as specified.
Haematology Services • All Trusts should formally establish & implement virtual clinic arrangements and support the agreed MDM configuration as determined by the HSCB regional working Group. • Trusts working with HSCB should ensure recommendations from NICR Haematological Malignancy Audits are implemented. • All Trusts should ensure maximisation of skills mix initiatives as determined by the HSCB working group.	NHSCT should work to achieve the regional objectives as specified.

• All Trusts should ensure that clinical teams commence work on implementing a risk stratified model of follow up for patients with a haematological cancer. • All Trusts should apply the agreed regional commissioning planning assumptions for Haematology and ensure the delivery of the core volumes in the Haematology SBA, including the agreed Clinical Nurse Specialist Job Planning.	
Ovarian Cancer Trusts should link with Primary Care to raise awareness of the signs and symptoms of cancer, working with GPs within their area to provide Training and Awareness events. An initial focus will be on the introduction of specific referral and diagnostic pathways for suspected ovarian cancer in line with NICE Clinical Guidance.	

Children and Families

Regional Commissioning Objectives	Local Commissioning Intent 2013/14
Ministerial target: From April 2013, increase the number of children in care for 12 months or longer with no placement change to 85%.	
Ministerial target: From April 2013 ensure a 3 year time-frame for 90% of all children to be adopted from care.	
Ministerial target: By March 2014, increase the number of care leavers aged 19 in education, training or employment to 75%	
All Trusts should ensure that a child becomes looked after where that child's long term outcomes will be improved or there is a need for the child to be removed as a safety measure. Trusts should ensure that there is an adequate range of placements available to meet the assessed needs of Looked after Children / Care Leavers.	The Looked After population in the Northern Trust has increased steadily since March 2011 (n=579). At 30 September 2012 the number of Looked After children in NHSCT was 635. The total Looked After population for the region was 2705. Provision of a range of suitable placements that are responsive to meeting emergency and medium to long term care needs of Looked After Children is pressing. In line with the TYC priorities for Family and Child Care NHSCT needs to place an emphasis on expanding community based care to include recruitment and retention of emergency and longer term non-kinship foster care as well as ensuring appropriate support to maintaining and supporting kinship care arrangements. TYC recommends both the promotion of

	foster care and the development of specialist foster care schemes, alongside minimising the need for residential care. Both of these require investment particularly to meet the increasing complex needs of children entering the care system.
Working within the Children and Young Peoples Strategic Partnership NHSCT led Outcomes Group should progress the development of local integrated delivery arrangements with the establishment of more Family Support Hubs. This should ensure that interventions are needs led and strive for the minimum intervention required. It is assumed SureStart Projects, reporting to the Childcare Partnership will provide support in those localities and the focus for greater co-ordination and development will be in those areas which do not have Surestart provision.	The development of Family Support Hubs is progressing in the Northern Trust with six Family Support Hubs being rolled out. Roll out, delivery and maintenance of Family Support Hubs is contingent upon sufficient resources being available to populate and coordinate FSHs across NHSCT area. Engagement with the voluntary/community sectors and delivery of integrated commissioning through the Northern Outcomes Group to provide needs led interventions and effectively support and strengthen families is critical to ensuring that an appropriate range of accessible family support services is in place across NHSCT area. There is a growing evidence base which indicates that effective intervention in early child development will bring significant benefits long into adult life in terms of educational attainment and economic status. The PHA and HSCB will advance investment in and extend evidence based initiatives

	such as the Family Nurse Partnerships, parenting support programmes and infant mental health programmes and thereby progress Family Support and Parenting Programmes in line with TYC recommendation 46. It is proposed that Surestart programmes, funded through DENI and reporting through the Childcare Partnership, will provide support in those areas currently targeted and that the focus for will be on greater coordination across and targeting of those areas that currently do not have Surestart provision. Through the Children and Young People's Strategic Partnership and in recognition of the requirement for and benefits of integrated planning and commissioning an emphasis and focus will remain on early intervention and prevention with a focus on supporting families and children. HSCB is currently investing in Family Support Hubs which will offer coordinated local integrated delivery arrangements.

All Trusts should ensure that a robust needs assessment and a localised service is provided for children with complex healthcare needs and for children with a learning disability and challenging behaviour.	The Northern Trust, based on Corporate Parenting Returns for 30 September 2012 reported the highest number of children with a disability. Of the regional total of 3900, the Northern Trust had 1449 children with a disability. 552 were defined as having a learning disability and 35 were identified as having a chronic illness. In line with regionally agreed targets and priorities the Northern Trust is required to give priority to delivery of: • Integrated health and social care services to best support children with complex health needs • Responsive services to meet the needs of children with learning disability and challenging behaviour • Provision of short breaks and respite services for children with disability and their carers.
All Trusts are required to implement the actions arising from the review of AHP services for children with special needs within Special Schools and mainstream education will be concluded and Trusts will require to progress the Implementation Plan arising.	The Northern Trust should progress the Implementation Plan when it becomes available.
All Trusts to engage in the Review of AHP support for Children with Special Needs within Special Schools and Mainstream	

Education	
All Trusts should fully implement the recommendations of the RQIA CAMHS Review and implement the DHSSPS Stepped Care Model.	The Northern Trust has the highest under 18 population and has seen a year on year growth in referrals to CAMHS (6.1% - 09/10; 10.9% in 10/11; and 5.7% projected for 11/12). Building on conjoint work between Social Care, HSCB and the Northern Trust and an allocation of additional monies aligned to core strategic initiatives and service model requirements immediate priorities for the Northern Trust include the specific development of a CAMHS – Primary Mental Health Team Step 2 Service and the overall delivery of a more comprehensive and flexible CAMHS service. The components of this service are required to: • Target prevention and early intervention thus preventing escalation of mental health problems. • Target children and young people who are experiencing mental health problems and/or emotional crisis.
All Trusts to increase the percentage of women who receive the recommended antenatal visit by a Health Visitor to reach 100% by March 2016	

Community Care and Older People's Services

Regional Commissioning Objectives	Local Commissioning Intent 2013/14
Ministerial target: From April 2013, people with continuing care needs wait no longer than 5 weeks for assessment to be completed, and have the main components of their care needs met within a further 8 weeks.	
Ministerial target: By March 2014, all Trusts should deliver 720,000 telecare Monitored Patient Days (equivalent to approximately 2,100 patients) from the provision of remote telecare service including those provided through the Telemonitoring NI contract.	
Trusts will review existing residential care provision and develop proposals for a phased reduction in capacity which is coordinated with the provision of alternative community based models of care.	NHSCT should continue to promote independent living through the development of supported living, better use of sheltered housing and alternative services that enable people to continue to live at home for as long as possible. NHSCT should proceed with the development of the supported living units currently being planned and should develop proposals for further reduction in capacity of existing residential care against the backdrop of further expansion of community

	based care.
Trusts and HSCB will work with independent sector providers to identify practice, training and contractual implications of preventing unnecessary admissions to acute care from nursing homes.	NHSCT should participate in the roll out of targeted training programmes for independent sector providers.
Trusts will review current intermediate and respite care provision to identify the potential for increased support for carers through service remodelling/re-investment in the independent sector.	NHSCT should continue to explore innovative approaches to providing short breaks for carers, focusing particularly on carers of people with dementia.
Trusts will work collaboratively with HSCB/PHA/LCG's to scope and develop a regional network for Memory Services.	NHSCT will work with primary care colleagues to deliver memory clinics within a reconfigured dementia pathway.
Trusts will progress a comprehensive range of targeted health and wellbeing programmes in all localities to address the changing health and well- being needs of older people. They should ensure that arrangements are in place:- • To improve provision of advice information and signposting on all aspects of health and wellbeing improvement. • Deliver a co-ordinated, multi-faceted falls prevention	NHSCT shall: • Further progress collaborative working to link key health improvement areas to improve information and signposting – prioritising the most vulnerable and isolated older people with the Northern area. • Develop services to include access to exercise based interventions such as the Otago programme and

service • To ensure older people have access to evidence based Falls Prevention Services. • To fully implement the "Promoting Good Nutrition Guidelines for Older people across all settings. • Develop and co-ordinate a shared service model to reduce the risk of social isolation and poor mental well-being amongst vulnerable older people • With relevant partners to reduce the risk of social isolation and poor mental well-being particularly amongst vulnerable older people. • Deliver a co-ordinated range of Targeted Physical Activity and Health programmes to address the CMO Guidelines for Physical Activity.	methods of signposting to existing home safety assessment schemes. • Update, distribute and implement key guidelines to improve nutrition for older people. • Continue to work with NLCG to identify best practice and effective use of resources to reduce risk of social isolation and poor mental well-being amongst vulnerable older people. • Deliver a range of opportunities to encourage active living for older people, including frailer older people, and to develop opportunities for the well-elderly that will maintain activity and inclusion.
Trusts will implement eNISAT, the ICT for the Northern Ireland Single Assessment Tool within older people's services in line with agreed Project Structures, processes and deadlines.	As part of the NISAT Regional Project Team, the NHSCT is receiving central funding (circa £450K) to assist in rolling out and maintaining the electronic Northern Ireland Single Assessment Tool (eNISAT) in Older People's Services. NHSCT is required to implement in line with agreed Project Structures, processes and deadlines. The implementation will start in the first Quarter of the financial year 2013/14 and is scheduled for completion by April 2015.

Trusts will establish single point of entry arrangements; enhance the role of the community and voluntary sector and develop a Re-ablement service which maximises the independence of the service user.	NHSCT will continue to progress the roll out of the Reablement Care Pathway and will establish therapy led teams across NHSCT. Work will commence to establish a Contact Centre and NHSCT should continue to explore with the voluntary and community sector, options for their role in the delivery of the reablement model of care.
Trusts will develop a Gateway Model and single point of referral for the receipt and screening of all referrals to adult safeguarding.	It is vital that NHSCT has adequate arrangements in place to respond to the increase in referrals to adult safeguarding services and to ensure that Care and Protection Plans are implemented and reviewed appropriately, bearing in mind that such plans may be required for lengthy periods of time. In particular the NHSCT should move towards a “Gateway” or single point of entry approach to adult safeguarding. This approach will also support NHSCT more effectively to safeguard the human rights of adults at risk of abuse, neglect or exploitation as highlighted in, for example, Article 3, Right to Security of Person, or Article 5 Freedom from Inhumane Treatment by improving response times and through the quality assurance of those responses. **To support this development, an additional sum of £93,000 has been made available to each HSC Trust on a recurrent basis.**

	It is anticipated that NHSCT will use this funding to support: a) The recruitment of an additional 1.0 (WTE) appropriately trained and experienced Band 7 Social Worker to act as Designated Officer within adult Programmes of Care as required across the HSC Trust; b) The recruitment of an additional 1.0 (WTE) appropriately trained and experienced Band 6 member of staff to assist in complex investigations across the HSC Trust; and c) The recruitment of an additional 0.5 (WTE) Band 3 Minute Taker to support Designated Officers in the recording of Case Conferences and Case Discussions.

Diagnostics

Regional Priority	Local Commissioning Intent
Ministerial Priority: From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should ensure that the RQIA radiology recommendations are fully implemented during 2013/14. As a	NHSCT should work to achieve the regional objectives as specified.

minimum this requires all Trusts to: • Put in place written escalation procedures to reduce the risk of delays in plain X-ray reporting during 2013/14. • Ensure that all images are accounted for on the PACs system from March 2013 and they have processes in place to ensure that all images are reported on within the required target times from March 2014	
All Trusts should provide Ultrasound as part of the neonatal hip screening programme from 2013/14.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should ensure that the requirements for 7 day access to the MRI imaging requirements for Stroke and MSSC are delivered by March 2014. Going forward, all Trusts should ensure that, where additional imaging capacity is commissioned, that this will in the first instance be achieved through a longer working day to improve patient access	NHSCT should work to achieve the regional objectives as specified.
All Trusts should implement NICE CG on Management of Dyspepsia, supported by pre-referral testing as indicated by the Guidance	NHSCT should work to achieve the regional objectives as specified.

All Trusts should have implemented a direct access pathway for ECHO for patients considered for left ventricular failure (LVF) *as defined by NICE Guidance CG for chronic heart failure,* by September 2013 with the aim to have reduced referrals to cardiology outpatients by 10 % by March 2014	NHSCT should work to achieve the regional objectives as specified.

Elective Care

Regional Commissioning Objectives	**Local Commissioning Intent 2013/14**
Ministerial target: From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures	
Ministerial target: From April 2013, at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014 and no patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014.	
Ministerial target: From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.	

Ministerial target: From April 2013, at least 70% of inpatients and daycases are treated within 13 weeks, increasing to 80% by March 2014, and no patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014.	
All Trusts should ensure they have robust and effective booking, scheduling, POA processes to ensure the full utilisation of available elective capacity. The HSCB will expect the following and will monitor these indicators to ensure this objective is achieved. • All Trusts should reduce current rates of Outpatient DNAs for new patients to no more than 5% and for review patients to no more that 8% by March 2014 Trusts should demonstrate a measurable improvement in shift of procedures from day surgery to outpatients with procedure (OPP) by April 2014. (this will be based on the day surgery rates at April 2012) • All Trusts should reduce Theatre DNA/Cancellation rates to 5% by 31 March 2014. • All Trusts should ensure theatre utilisation rates of 83% (as a minimum and in line with Audit Commission recommendations) from March 2014. • All Trusts should work to improve endoscopy throughput per session from an average of 6.2 patients per session in 2012/13 to 6.5 patients per session by December 2013, 6.7	NHSCT should work to achieve the regional objectives as specified.

by March 2014 and 7.1 by March 2015. • Trusts will ensure that they are delivering the recommended day surgery rates for the trolley of procedures identified by The British Association of Day Surgery from March 2015/16. • As a minimum Trusts should ensure that they are delivering the day surgery rate for the basket of 24 procedures identified by the Audit Commission (excluding Termination of Pregnancy). • The commissioner will fund additional activity at the BADS recommended best practice day surgery levels. • In addition, the Trusts should utilise the electronic referral system, to support effective patient pathways and triage processes from March 2013. For example in the use of photo images to support dermatology referrals and other means which will support the implementation of the EUR policy.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should implement an enhanced recovery model across an agreed range of surgical specialties to improve outcomes, reduce lengths of stay and increase productivity by 2014/15.The initial focus should be on the best practice pathways. This may include the pathways associated with the following 8 procedures: colectomy; excision of rectum;	

prostectomy; cystectomy; hysterectomy (vaginal and abdominal); and hip and knee replacement.[1]	
Once established as a regional service, all Trusts will utilise the podiatric surgery service for foot and ankle surgery from 2014/15.	
In line with the NICE guidance for Glaucoma, Trusts will work with primary care in the referral refinement programme for glaucoma during 2013/14. This will reduce the false positives and ensure only those patients who require evaluation, monitoring and treatment are referred to secondary care.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should provide an ultrasound service for infants at risk of or with suspected developmental dysplasia of the hip in line with the standards and guidance of the UK National Screening Committee, the Royal College of Radiologists and the College of Radiographers	
All Trusts will work towards the development of pathways to support: • All Trusts will achieve 90% of vasectomy procedures provided within primary care or as a minimum all moved off main acute hospital sites from April 2014. • All Trusts will move all low risk skin lesions off main acute sites from April 2013 and from April 2014 90% of low	

[1] Requires further discussion between the Commissioner and provider(s) and /or DHSSPS

risk skin lesions are moved to a primary care setting. • All Trusts to work towards the introduction of a regional pathway for varicose veins which is in line with NICE guidance (CG the diagnosis and management of varicose veins) and includes the provision of minimally invasive surgery for 90% of varicose veins from April 2014. • All Trusts should support the implementation of an MSK / Pain pathway. This service will support the delivery of a primary/community care facing service, with MDT pathways developed to include lower back, knee, shoulder etc., by the end of March 2014. All service models should include self-management/education at the core of service design.	
All Trust will support improved outcomes measurements to support service improvement and evidence based commissioning • All Trusts should participate in the national hip fracture database during 2013/14 and ensure 100% compliance from 2014/15. • All Trusts providing elective orthopaedic procedures will participate and provide data into the National Joint register from 2013/14 and ensure 100% compliance from 2014/15.	NHSCT should work to achieve the regional objectives as specified.

• All Trusts providing vascular services should ensure the full participation in the National Vascular Database from 2013/14. • Support the Patient reported outcome measures (PROMS) pilot for varicose veins.	
One Trust to work with the commissioner to undertake a pilot service of self-referral for Musculoskeletal Physiotherapy. Pilot to be evaluated for local learning moving towards implementation in 2014/15	

Health and Well Being Improvement

Regional Commissioning Objectives	**Local Commissioning Intent 2013/14**
Ministerial target: By March 2014, improve long-term outcomes for the children of teenage mothers by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site.	
All Trusts are expected to deliver on the implementation of 'Fitter Futures for All' framework including: • Pilot pregnancy programmes; • Achieving UNICEF Baby Friendly Standards and peer support	NHSCT should work to achieve the regional objectives as specified. • NHSCT should continue to deliver the Carrick BHF pilot and the regional PHA pilot.

initiatives to support breast feeding; • Pilot weight loss programmes for adults and children; • Provision of healthy food choices in all HSC facilities.	• NHSCT should continue to develop peer support programmes in areas with low breastfeeding rates and monitor impact. • NHSCT should deliver weight loss programmes in line wth PHA guidelines and in accordance with emerging ICP direction of travel. • NHSCT should ensure that healthy food choices are available for patients, visitors and staff.
All Trusts will ensure delivery of a range of evidence based early years intervention programmes including: • Roots of Empathy • Family Nurse Partnership • Infant Mental Health Training • Parenting support.	NHSCT should work to achieve the regional objectives as specified.
All Trusts will ensure that they support the implementation of key public health strategies including: • tobacco cessation services and BIT in particular for pregnant women and other vulnerable groups; • work toward smoke free campuses; • services within hospital settings (including emergency departments) which can respond to alcohol and drug	NHSCT should work to achieve the regional objectives as specified.

misuse, self harm and associated mental health issues; • continue to collect data for the Deliberate Self Harm Registry on attendances at ED that are related to self-harm, report on trends and emerging issues and influence the maintenance and/or re-design of appropriate services.	
All Trusts should provide specialist sexual health services in line with the findings of the RQIA Review.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should ensure that existing health and well-being service provision is tailored to meet the needs of vulnerable groups including: • Looked After Children; • Homeless people • LGBT • Travellers • Migrant groups	NHSCT should work to achieve the regional objectives as specified.
All Trusts should support social economy businesses and community skills development through public procurement, expanding capacity incrementally over the following 3 years.	NHSCT should work to achieve the regional objectives as specified.

Health Protection

Regional Commissioning Objectives	Local Commissioning Intent 2013/14
Ministerial Priority: By March 2014, secure a further reduction of X% in MRSA and Clostridium difficile infections compared to 2012/13. [X to be available in March 2013]	
All Trusts should test and review arrangements to maintain the required standard of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption potentially associated with specific major events including the G8 Summit; the World Police & Fire Games 2013 and the All Ireland Fleadh in August as part of the City of Culture in Derry/Londonderry	
All Trusts will ensure that they support the implementation of key health protection initiatives including maintaining Northern Ireland's excellent vaccination rates in respect of influenza and childhood immunisations and the introduction of two new childhood vaccination programmes (Flu and Rotavirus)	
All Trusts will continue to monitor and review the occurrence of Health care Associated Infections (HCAI) and implement appropriate and agreed infection control measures with particular reference to Ministerial targets on Clostridium difficile and MRSA.	

Learning Disability

Regional Commissioning Objectives	**Local Commissioning Intent 2013/14**
Ministerial target: From April 2013, ensure that 99% of all learning and disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.	
Ministerial target: By March 2014, 75 of the remaining long-stay patients in learning disability hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015.	NHSCT should continue the resettlement of the remaining long stay patients from Northern Ireland learning disability hospitals – by resettling a further 12 in the community by March 2014. (6 patients resettled in 12/13)
All Trusts should start to deliver Day Services in line with the Regional Model 2013 currently being developed.	NHSCT should improve post transition from school services to meet the full range of assessed needs for day time opportunities.
All Trusts should develop their specialist community services to respond to the needs of people whose behaviours challenge services and those with offending behaviours including a 24 hour response 7 days per week and high support beds in the community.	NHSCT should develop short-term community based assessment and treatment interventions avoiding specialist hospital admissions.

All Trusts should deliver additional support for Carers through enhanced short break and respite services.	NHSCT should increase the range and volume of short break/respite services for adults with a learning disability which meet their needs and the needs of their families/carers.
All Trusts should work with primary care to further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation.	NHSCT should further develop the Directed Enhanced Service (DES) for learning disability in line with the findings of the current evaluation.
All Trusts should deliver the targets of the Learning Disability Bamford Action Plan 2012-2015 DHSSPS.	NHSCT should work to achieve the regional objectives as specified.
All trusts should develop action plans to promote the health of people with a learning disability, in line with the priorities identified in the Public Health Strategic Framework: Fit and Well Changing Lives 2012-22.	NHSCT should work to achieve the regional objectives as specified.

Long Term Conditions

Regional Commissioning Objectives	Local Commissioning Intent 2013/14
Ministerial target: By March 2014, reduce the number of unplanned admissions to hospital by 10% for adults with specified long term conditions.	
By March 2014, all Trusts should ensure that integrated community teams are available to meet the needs of patients with long term conditions including: • a named nurse for patients on disease registers, with clear arrangements for dealing with multi-morbidity and complex medication regimes • access to specialist medical or nursing advice	The NHSCT will work with other stakeholders within the current ICP structure, to ensure the development and implementation of pathways for the 12 long-term conditions. These must focus on the management of these conditions in primary and community settings and reducing the number of unplanned admissions.
Respiratory • Northern & Western Trusts should ensure that arrangements are in place for all TB patients to be managed by a specialist TB Service (Clinician who is a respiratory physician or appropriately trained infectious disease physician/paediatrician and specialist TB nurse)	NHSCT should work to achieve the regional objectives as specified.

• All Trusts should have in place integrated paediatric respiratory and allergy and anaphylaxis teams, which can outreach to other parts of the hospital including A&E, outpatients and ambulatory care, and to the community, in cases of difficult asthma. • All Trusts should fully implement the COPD integrated Care Pathway. • All Trusts should fully develop Home Oxygen Services Assessment and Review. • All Trusts to participate in a six monthly audit of all COPD patient admissions	
Stroke • Thrombolysis ➢ All Trusts to achieve a door to needle time of 60 minutes on a 24/7 basis ➢ From April 2013,Trusts to ensure that at least 10% of patients with confirmed ischaemic stroke receive thrombolysis (**Ministerial target**) • Urgent assessment of high risk TIAs ($ABCD^2$>4) must be available on a 7 day basis • All Trusts should support early supported discharge (ESD)	Local Commissioners are reviewing the Trust, Primary Care and Out of Hours Providers to ensure that access to thrombolysis is maximised in both acute sites. Work is being done to establish those that access this service and to understand the reasons that some people are "outside the window" with the key objective of ensuring that as much is done to promote this service and the benefits in the most appropriate manner, and to ensure that services are available and aligned to meet this priority. The NHSCT should implement the recommendations of the review. NHSCT should work to achieve the regional objectives as

following an acute stroke. This should support shorter LOS and "shift left" where resources will be freed from hospital beds to develop services in the community.	specified. NHSCT should work to achieve the regional objectives as specified.
Diabetes • All Trusts should expand insulin pumps provision for children and adults with Type 1 diabetes • Subject to satisfactory pilot evaluation, all Trusts should mainstream the CAWT pre pregnancy care and structured patient education program (CHOICE) for children from January 2014 onwards. [2] • All Trusts should complete demand/capacity analysis of hospital based diabetes services in 2013/14.	Building on current progress, the NHSCT should work to achieve this objective. NHSCT should work to achieve the regional objectives as specified. NHSCT should work to achieve the regional objectives as specified.
Cardiac • Implement a Familial Hypercholesterolaemia cascade	

[2] Requires further discussion between the Commissioner and provider(s) and /or DHSSPS

testing service in N. Ireland • All Trusts should implement a model for Emergency Life Support (ELS) training in together with an audit process to monitor agreed outcomes.[3]	The NHSCT shall continue to develop a model for Emergency Life Support (ELS) training.
Prevention • All Trusts should ensure that smoking cessation services are available in all locations where patients with LTCs are seen including hospitals, primary care and community pharmacy • All Trusts should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively **Ministerial target:** By March 2014, all Trusts should deliver 500,000 telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract.	NHSCT should work to achieve the regional objectives as specified. Self -care and self -management are key aspects and 1 identified work strand of the Integrated Care Partnership. Development of a self-care ethos/ culture so that every person is to be given the remit and responsibility to take charge of their own health. This includes the development of preventative educational model across the chronic care continuum. From awareness approaches, through generic expert patients, specific disease management programmes concluding with end of life care programmes. The NHSCT shall work with other key stakeholders. The provision and use of telemonitoring services for suitable

[3] Requires further discussion between the Commissioner and provider(s) and /or DHSSPS.

• Increase the uptake of direct payments by people with neurological conditions.	and appropriate patients is a priority in the management of Long Term Conditions as identified in the Population Plan. Details have been established in terms of how the patients are to be identified as suitable for this service and the numbers and types of patients to be managed through this service. The NHSCT shall work with the LCG to develop such programmes within the context of the ICP model. The NHSCT shall work to achieve the target.

Maternity, Child Health & Sub-fertility

Regional Commissioning Objectives	**Local Commissioning Intent 2013/14**
All Trusts should ensure that the level of resident medical cover for consultant-led obstetric units meets the minimum standard recommended in the DHSSPS Maternity Strategy (ST3 or equivalent for obstetrics, paediatrics, anaesthetics). Those units that do not currently meet this standard must ensure in the interim that the risk profile of women booked to deliver in the unit is clinically appropriate to the level of staffing available.	NHSCT should ensure that resident medical cover is at ST3 or equivalent for obstetrics, anaesthetics and paediatrics in both Antrim and Causeway Hospitals' obstetric units. If the recommended level of resident medical cover cannot be provided, the inclusion/exclusion criteria for the unit must ensure that the risk profile of women attending the unit is clinically appropriate i.e. to ensure the safety of mother and baby only low risk women should be booked for delivery.
All Trusts should ensure implementation of Normalising Birth Action Plans including: • Keeping first pregnancy and birth normal • Increasing vaginal births after previous caesarean section (VBAC) • Benchmarking against comparable units in NI, the rest of the UK and ROI • Implementation of NICE clinical guideline 132.	NHSCT is expected to implement its Normalising Birth Action Plan with a particular focus on keeping first pregnancy and birth normal; and increasing the rate of vaginal birth after previous caesarean section (VBAC). By the end of 2013/14 there should be a reduction in first time caesarean section rates and an increase in VBAC rates.
All Trusts should ensure that where a consultant-led obstetric unit is provided a midwife-led unit will be available on the same site.	NHSCT should bring forward proposals for the future configuration of maternity services for discussion with the commissioner in the wider context of the reconfiguration of hospital and community services in 'Transforming Your Care'.

All Trusts should ensure that all women are provided with balanced information on the available options for place of birth and benefits and risks, including midwife and consultant led units and home births.	NHSCT should confirm that this information is provided to women when they first come in contact with maternity services, including place of birth options available outside the Northern area, such as midwife-led units in other Trusts for women with straightforward pregnancies.
All Trusts should ensure that antenatal booking clinics will be provided in the community by midwives which will offer: • Direct access for women to their community midwife • Confirmation of pregnancy scan • Access to NIMATS • Bookings and risk assessment carried out by 12 weeks and women provided with their maternity hand held record.	NHSCT should confirm the proposed location of antenatal booking clinics in the Northern locality; the dates by which clinics will be provided at these locations; and provide assurance that they will comply with the standards set in the Maternity strategy and the Maternity services specification.
All Trusts should ensure that for women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community and give greater continuity of care.	NHSCT to develop an action plan to increase the level of antenatal care provided in the community and submit this to the local commissioner by 30 June 2013 for approval. The action plan should also demonstrate how continuity of care will be enhanced.
All Trusts should bring forward 3 year plans to develop skill mix in the community midwifery service to include a phased increase in the number of maternity support workers in the community to assist with breastfeeding and early interventions	NHSCT to develop a 3 year plan to develop skill mix in the community midwifery service.

commencing from 2013/14.[4]	
All Trusts should implement the Royal College of Obstetricians & Gynaecologists green top guideline No. 36 "The Prevention of Early-onset Neonatal Group B Streptococcal Disease".	NHSCT to provide commissioner with assurance that RCOG guidelines for Group B Streptococcal Infection are being followed.

Child Health

Regional Commissioning Objectives	**Local Commissioning Intent 2013/14**
All Trusts to ensure that all children and young people admitted to an in-patient paediatric unit are seen by an appropriate level of medical staff within 4 hours and a consultant paediatrician within 24 hours of admission.	NHSCT should ensure that all children admitted to either Antrim or Causeway paediatric inpatient units should have access to resident medical cover. Doctors working on the middle tier paediatric rota should have achieved level 1 competencies of the RCPCH framework (normally ST4 or above). All children admitted as an inpatient should have access within 24 hours to a consultant paediatrician (or equivalent, i.e. specialty or associate specialist grade doctor trained and assessed competent in acute paediatric care). If the most senior resident doctor is at ST3 level – then they should be seen by a consultant paediatrician (or equivalent) within 12 hours.
All Trusts to achieve 16 years as the upper limit for acute paediatric and surgical care. Age appropriate care must be	NHSCT should ensure that all children up to the age of 15 years of age should be cared for within a paediatric setting

[4] Requires further discussion between the Commissioner and provider(s) and /or DHSSPS

provided in all in-patient and out-patient settings.	(in patients and out patients) by 2014/15, moving to all children under age of 16 by 2015/16. Robust internal processes should be put in place to ensure that there is internal transfer of resources (from current care setting) as appropriate.
All units with in-patient paediatric services must have a short stay paediatric assessment unit SSPAU on site.	NHSCT should ensure that plans are in place to provide a short stay paediatric assessment unit in Causeway and Antrim Units opening between 10am – 6pm by end of 2014, extending to 8pm by end of 2015 and 10pm by 2016.
All Trusts should ensure that all parents with a child with a Long Term Condition are given a named contact worker they can liaise with directly to discuss management of their child's condition and who will liaise with education services if required.	The NHSCT should ensure that the identified key worker should have access to the clinical team providing care across the patient pathway and play a central role in facilitating communication between the child, their family/carers and the service as appropriate.
All Trusts to ensure that all children receiving palliative care have an emergency plan agreed with their GP, care team and secondary care services.	Emergency plans should also be available to primary care out of hours services to prevent inappropriate admissions and provide direct access to inpatient care (i.e. bypass A&E) where appropriate. (Who develops?)
All Trusts to ensure that diagnostic imaging services are available on a 7/7 basis to diagnose and manage the acutely ill child including the assessment of acute surgical conditions of childhood.	Where unavailable locally, the NHSCT should ensure that arrangements are in place for timely access to diagnostics as required, particularly in regard to emergency admissions e.g. assessment of acute abdomen.

All Trusts to implement the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units and NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection.	NHSCT to provide commissioner with assurance that the recommendations of the RQIA Independent Review of Pseudomonas in neonatal units have been fully implemented and that NICE guidance on antibiotics for the prevention and treatment of early-onset neonatal infection are being followed.

Sub-Fertility:

Regional Priority	**Local Commissioning Intent 2013/14**
Belfast Trust should introduce oocyte cryopreservation (egg freezing and storage), and a blastocyst service[5].	

[5] Requires further discussion between the Commissioner and the DHSS&PS with regard to funding.

Medicines Management

Regional Commissioning Objectives	Local Commissioning Intent 2013/14
Ministerial target: From April 2013, ensure that 70% compliance with the Northern Ireland Medicines Formulary is achieved within primary care	
All Trusts and primary care to ensure the formulary is embedded within prescribing practice through active dissemination within electronic prescribing platforms.	NHSCT shall implement the NI Medicines Formulary.
All Trusts and primary care will work with the Health & Social Care Board in 2013/2014 to establish the baseline position ensuring 70% compliance by end 13/14 and Trusts attaining target delivery in 2014/2015.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should put in place arrangements to manage regional monthly managed entry recommendations including monitoring, reporting and disinvestment arrangements.	NHSCT shall further develop and implement a process for Managed Entry of medicines.
All Trusts to ensure 100% compliance with local delivery against the Regional Pharmaceutical Clinical Effectiveness Programmes such that all targets are met.	NHSCT shall implement the Regional Pharmaceutical Clinical Effectiveness Programme which provides rational product selection for the HSC, which can be consistently applied across secondary and primary care to increase the

	effectiveness of medicines usage and to gain efficiencies in the pharmaceutical budget.
All Trusts should support development of e-prescribing in hospitals through identification of clinical champions and leads and co-ordination of local Trust implementation teams.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should ensure that all patients with highest risks (complexity; high risk medicines) have their medicines reconciled on admission and at discharge in line with NICE guidance (http://guidance.nice.org.uk/PSG001) – baseline in 13/14; delivery 14/15.	NHSCT should work to achieve the regional objectives as specified.

Mental Health

Regional Commissioning Objectives	Local Commissioning Intent 2013/14
Ministerial target: From April 2013, ensure that 99% of all learning and disability and mental health discharges take place within 7 days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours; with no complex discharge taking more than 7 days; and all non-complex discharges from an acute hospital take place within 6 hours.	
Ministerial target: By March 2014, 23 of the remaining long-stay patients in psychiatric hospitals are resettled to appropriate places in the community, with completion of the resettlement programme by March 2015	NHSCT should continue the resettlement of the remaining long stay patients from Northern Ireland psychiatric hospitals – by resettling a further 7 in the community by March 2014.
Ministerial target: From April 2013, no patient waits longer than 9 weeks to access child and adolescent mental health services; 9 weeks to access adult mental health services; and 13 weeks to access psychological therapies (any age)	
All Trusts should establish integrated care arrangements for the care and treatment of patients with common mental health needs to include arrangements for the provision of a Primary Care Psychological Therapy Service beginning with the appointment of Primary Care Coordinators and training in CBT and/or counselling for a minimum of 5 staff in each Trust.	NSHCT should further develop a range of Integrated Care Pathways utilising a stepped care approach, in partnership with primary care, with an emphasis on early interventions, and a shift on the reliance of medications towards a range of alternative therapeutic interventions.

All Trusts should begin to implement Recovery Approaches and related Integrated Care Pathways by December 2013.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should implement Crisis Response and Home treatment services for CAMHs with associated primary care teams/services including full implementation of the DHSSPSNI strategy for CAMHs.	NHSCT should implement Crisis Response and Home treatment services for CAMHs.
All Trusts should further develop Specialist Community Services to include: • Autism Spectrum Disorder (ASD) services for Adult Services • access to dedicated eating disorder beds in mental health and/or general hospitals (All Trusts should reduce eating disorder extra contractual referrals expenditure by 50% (based on the 01/04/2011 baseline)) • a range of evidence based treatment options for people with a personality disorder in the community and in prison (leading to a 20% reduction in Extra Contractual Referrals based on the 1/4/2012 baseline). • the implementation of the regional Tier 4 Substance Misuse Model including the development of agreed supporting community services and enhanced alcohol liaison services within Emergency Departments • the implementation of services to identify, assess and treat first episode psychosis (age 16+).	NHSCT should develop additional capacity within specialist mental health services (including services for people with Eating Disorders, Forensic Mental Health, Personality Disorders and adults with Autism).

Northern Trust to provide the regional Sexual Assault Referral Centre (SARC) at the Antrim Area Hospital site.	NHSCT to provide the regional Sexual Assault Referral Centre (SARC) at the Antrim Area Hospital site.
All Trusts should achieve the targets of the Mental Health Bamford Action Plan 2012-2015 DHSSPS.	NHSCT should work to achieve the regional objectives as specified.

Palliative Care

Regional Commissioning Objectives	**Local Commissioning Intent 2013/14**
All Trusts and ICPs should ensure that effective arrangements are in place to engage and promote awareness with the general population and professionals regarding issues around palliative care, dying and service delivery around death.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should provide evidence that they are working to increase the quality of life for people in the last year of life by ensuring that palliative care measures run alongside acute intervention for people with cancer, cardiovascular and respiratory disease, dementia, frail elderly and those with a physical disability who are at the end of life. This should include: • implementation of the end of life operational systems model, • identification, holistic assessment and referral for carers assessment • offering people the opportunity to have an advance care plan developed within 3 months of admission to a nursing home, in the last year of life and for those who have an anticipated deterioration in their condition (e.g. on diagnosis dementia)	NHSCT should work to achieve the regional objectives as specified.

• people are supported to die in their preferred place of care • use coordinated care planning in the last few days of life.	
Trusts and ICPs should have processes in place to ensure that care for individuals identified as being on the possible last year of life is coordinated around the patient and across services and organisational boundaries. This should be supported through continuation of the palliative care coordination posts and should include: • Implementation of the regionally agreed key worker function • The use of multidisciplinary records in the home • Effective out of hours hand over arrangements	NHSCT should work to achieve the regional objectives as specified.
Trusts and ICPs should provide evidence of how they are working with the independent and voluntary sector to ensure that there is an increased provision of *general* palliative care services in the community, supporting patients within their own home and nursing homes where that is their choice. This should include: • Access to 24 hour care and support	NHSCT should work to achieve the regional objectives as specified.

• Equipment • Arrangements to support timely hospital discharge • Support to nursing homes to meet the standards being developed in conjunction with RQIA.	
Trusts and ICPs should provide evidence of how they are working with the voluntary sector to ensure that there is an increased provision of *specialist* palliative care services in the community, supporting patients dying within their own home and nursing homes where that is their choice. This should include: • Support to generalist palliative care services • Education and training • Development of community multidisciplinary palliative care teams • Development of new models of palliative care day hospice and outpatient services • Access to face to face specialist advice 7 days a week 9am to 5pm • Trusts & ICPs to work with the commissioners to develop access to telephone advice to professionals 7 days per week until 11pm	NHSCT should work to achieve the regional objectives as specified.

All Trusts should provide education and training in communication and end of life care for all staff (e.g. GPs, hospital doctors, nurses, allied health professionals, ambulance staff, social workers, support workers etc).	NHSCT should work to achieve the regional objectives as specified.

Physical and Sensory Disability

Regional Commissioning Objectives	**Local Commissioning Intent 2013/14**
Trusts and HSCB will collaborate in producing a needs analysis of people who are Deaf blind to improve assessment and access to services.	NHSCT should work to achieve the regional objectives as specified. NHSCT will continue to participate in the roll out of the action plan arising from the Physical and Sensory Disability Strategy.
Trusts will participate in a Regional Review of Communication Services in order to improve service access and consistency.	NHSCT should work to achieve the regional objectives as specified.
Trusts will pilot at least one programme specific Self Directed Support scheme in order to develop a common approach to the use of personalised budgets and promote learning on a cross programme basis.	NHSCT should work to achieve the regional objectives as specified.
Trusts will review their respite capacity by identifying opportunities to reduce reliance on current residential and domiciliary models and developing community-based services offering short break support.	NHSCT should work to achieve the regional objectives as specified.
Trusts will work with the Carers Strategy Implementation Group to address the recommendations of the 2012 Self-Audit Update and RQIA Inspection of NISAT Carers Assessments.	NHSCT should work to achieve the regional objectives as specified.

Screening

Regional Commissioning Objectives	Local Commissioning Intent 2013/14
Ministerial target: The HSC will extend the bowel cancer screening programme to invite in 2013/14 50% of all eligible men and women aged 60-71, with a screening uptake of at least 55% in those invited, and will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from April 2014.	
From April 2014, all Trusts should work with the PHA and the HSCB to increase screening colonoscopy capacity across the region by 25% to facilitate age extension of the bowel cancer screening programme up to 74 years. This should include the provision of at least one more endoscopy unit of JAG standard in Northern Ireland by the end of March 2015 and a further unit by 2015/16	NHSCT should work to achieve the regional objectives as specified.
All Trusts should deliver a bowel screening service in 2014/15 for the eligible population aged from 60 to 74.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should develop and implement action plans to enhance informed choice for the eligible population for bowel, breast and cervical screening. Work to focus particularly on hard to reach groups to reduce inequalities of access and uptake of cancer screening programmes.	NHSCT should work to achieve the regional objectives as specified.

Trusts who deliver the Breast Screening Programme to implement local action plans, for the replacement of analogue breast imaging equipment with digital equipment to ensure the images taken are stored on NIPACS.	NHSCT should work to achieve the regional objectives as specified.
All Trusts to identify all women who are, or have been, under their care and who are at high risk (x8 normal risk) of developing breast cancer. From April 2013, an identified Trust to provide an imaging service for ladies at high risk (x 8) of developing breast cancer in accordance with NHSBSP guidelines.	NHSCT should work to achieve the regional objectives as specified.

Specialist Services

Regional Commissioning Objectives	Local Commissioning Intent 2013/14
Ministerial target: By March 2014, 30% of kidneys retrieved in Northern Ireland through DCD are transplanted in Northern Ireland.	
Ministerial target: From April 2013, no patient should wait longer than 3 months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis or ankylosing sponylitis, and no patient should wait longer than 9 months to commence NICE approved specialist therapies for psoriasis decreasing to 3 months by September 2013.	
Belfast and Western Trusts (networking with NIAS and other Trusts as appropriate) should establish 24/7 primary Percutaneous Cardiac Intervention (pPCI) services at the RVH and Altnagelvin Hospitals and increase the scheduled cardiac catheterisation laboratory capacity in NI to circa 105 per week (to include extended day and weekend working) by September 2013 to improve access to diagnostic intervention and treatment as required.	
Belfast Trust should ensure that by March 2014, 30% of kidneys retrieved in all Trusts in Northern Ireland through Donation after Cardiac Death are transplanted in Northern Ireland; and, continue to ensure the delivery of a minimum of	

50 live donor transplants.	
Belfast and Western Trusts should ensure that arrangements are in place to ensure that, as a minimum, patients can access specialist ophthalmology regimes, such as Wet AMD within a maximum of 9 weeks.	
All Trusts should pilot the regionally agreed patient journey for Duchenne Muscular Dystrophy.	NHSCT should work to achieve the regional objectives as specified.
All Trusts should ensure that patients commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and multiple sclerosis in line with the Commissioning Plan Direction.	NHSCT should work to achieve the regional objectives as specified.
Belfast Trust should: Progress full implementation of network arrangements for specialist paediatric services, as per the Royal Belfast Hospital for Sick Children Network plan. • Put in place additional capacity of 4 paediatric intensive care beds in line with projected demand expand specialist children's transport and retrieval services to support an increase in hours of cover.	
Belfast Trust will lead on the development and establishment of a specialist service model in line with the Strategic Framework for Intestinal Failure and Home Parenteral	

Nutritional Services for Adults.	

Unscheduled Care

Regional Commissioning Objectives	**Local Commissioning Intent 2013/14**
Ministerial target: From April 2013, 95% of patients attending any Type 1, 2 or 3 A&E Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.	
Ministerial target: By March 2014, secure a 10% reduction in the number of emergency readmissions within 30 days.	
Ministerial target: By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.	
By September 2013, the Ambulance Service will, in collaboration with primary and secondary care clinicians, develop and implement agreed protocols to enable paramedics to assess and treat patients at the scene (including home) without transporting them to hospital, where appropriate.	The Northern LCG will work at a local level with primary, secondary care and the Ambulance service to develop and implement appropriate pathways which would allow paramedics to assess and treat patients at the scene without transporting them to hospital. These pathways will be in line with the Population Plan. This approach will allow resources

<table>
<tr><td></td><td>to be redirected towards emergency and Category A response.</td></tr>
<tr><td>By December 2013, Trusts will agree clear protocols on the management of major trauma patients and further develop collaboratively these as necessary towards establishing a Trauma Managed Clinical Network.[6]</td><td>Commissioners will work with the NHSCT to ensure that the protocols agreed will allow the local population to access the appropriate Trauma services throughout Northern Ireland to meet their health needs.</td></tr>
<tr><td>By December 2013, Trusts and ICPs will ensure that effective arrangements are in place to prevent unnecessary attendances at Emergency Departments including:

• Access arrangements in General Practice (including out-of-hours) for patients requiring urgent unscheduled care, including telephone triage;
• GP direct access to appropriate diagnostics to enhance management of conditions in Primary Care; and
• rapid outpatient assessment or community-based ambulatory assessment (within 1-2 days) following same day discussion between GP and senior hospital doctor and agreed decision on steps to take in patient management.</td><td>The NHSCT will provide a fully functioning GP Access Hub at both Antrim and Causeway sites. This hub will include a fully functioning Acute Medical Assessment Service, available each day on a 9am to 9pm basis.

The Access Hub will include both telephone and email advice service for the following specialties

• Care of Elderly
• Cardiology
• Endocrine & Diabetes
• Specialist Palliative Care
• Respiratory
• Nephrology
• Gastroenterology
• Diagnostics</td></tr>
</table>

[6] Requires further discussion between the Commissioner and provider(s) and /or DHSSPS

	This Access Hub will provide GP direct access to a senior-decision maker at both sites with the aim of preventing ED attendances by allowing rapid outpatient assessment or ambulatory assessment and treatment within 1-2 days. GP direct access to a full range of diagnostic services will facilitate the management of patients within Primary Care.
During 2013/14, all Trusts to confirm that the necessary components are in place to deliver 7-day working on acute sites including access to radiology, pharmacy, and senior medical decision-makers with closer liaison with district/community nursing, AHPs and social care in order to prevent an unnecessary emergency admission through appropriate patient handover and earlier discharge.	The NHSCT will ensure that models are developed to allow services to be in place on a 7-day basis on both acute sites. This must include the senior medical decision-makers, radiology, pharmacy, nursing and other key staff necessary to allow a fully functioning 7-day service delivery. Pilots are currently being tested to promote closer liaison with staff within and across the acute sites and those in community and primary care.
By June 2013, all Trusts and LCGs will have jointly, identified, quantified and agreed the necessary community services required to ensure that Length of Stay (LOS) within hospitals, acute care at home and post-acute care are optimised. Integral to this will be the development, collaboratively among Trusts (including NIAS), by March 2014, of a directory of community services to support timely discharge of patients as well as prevent emergency attendances/admissions.	The NHSCT is expected to quantify the level of community services required to ensure optimisation of Length of Stay (LOS) across these settings. These must be in line with the detail provided, including the targets to be met as detailed in the Population Plan. A directory of services is currently being considered within the development of the ICP structures.

Other Ministerial Targets	
Healthcare Acquired Infections	By March 2014, secure a further reduction of X% in MRSA and Clostridium difficile infections compared to 2012/13. [X to be available in March 2013]
AHPs	From April 2013, no patient waits longer than nine weeks from referral to commencement of AHP treatment.
ICPs	During 2013/14, to implement Integrated Care Partnerships across Northern Ireland in support of Transforming Your Care

Local Commissioning Initiatives

In addition to regional objectives there are local initiatives we would wish to see progressed.

Diagnostics

- Northern Trust should ensure the continued development of 7 day working for key diagnostic services.
- Northern Trust will work with the Northern LCG to support the development and implementation of a local Primary Care facing DEXA scanning service.
- Northern Trust should continue to work with the Northern LCG in developing plans for a 2nd MRI Scanner and identify other potential requirements in additional and/or replacement radiological equipment.
- Northern Trust will work with the Northern LCG in continuing to support the development of ICP/PCPs across the health economy to manage demand, improve patient pathways and ensure continued clinical effectiveness in line with TYC expectations.

To include:-

- Direct Access Ultrasound (MSK, abdominal & transvaginal)
- Improved Lab reporting / Inappropriate testing
- COPD/Respiratory testing
- Coeliac testing
- CTC / Cardiology Imaging
- Balance Testing / Falls prevention
- POC centralised collection at BVH
- Nuclear Medicine – Secat testing for malabsorbtion conditions
- Patient home monitoring of implantable devices

Other specific targets include:-

- From April 2013, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within 2 days of the test being undertaken.

Elective

- Northern Trust will work with the Northern LCG in achieving an increase to day surgery and endoscopy capability (to relevant best practice) on all existing Hospital sites.
- Northern Trust should ensure that only procedures of higher clinical value are undertaken in secondary care settings.

- Northern Trust will work with the Northern LCG to design and implement a fully integrated MSK/Pain Service for the local population.
- Northern Trust will work with the Northern LCG in continuing to support the development of ICP/PCPs across the health economy to manage demand, improve patient pathways and ensure continued clinical effectiveness in line with TYC expectations. To include:-
    - Tele Neurology
    - Dermatology Photo Triage (all acute sites)
    - Direct referral Audiology

Other specific targets include:-

- From April 2013 at least 70% of patients wait no longer than nine weeks for their first outpatient appointment, increasing to 80% by March 2014 and no patient waiting longer than 18 weeks, decreasing to 15 weeks by March 2014.
- From April 2013, at least 70% of inpatients and day cases are treated within 13 weeks, increasing to 80% by March 2014, and no patient waiting longer than 30 weeks for treatment, decreasing to 26 weeks by March 2014.
- By March 2014, reduce the number of excess bed days for the acute programme of care by 10%.
- From April 2013, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

5. Next Steps

Following the end of the consultation period on TYC and in order to progress the work necessary to address these challenges and to take forward the recommendations in TYC, the Northern LCG will be working closely with the NHSCT to consult with the local population on the specific recommendations arising from TYC. There will be a need to ensure ownership of the agenda from key staff in both primary and secondary care. Identifying champions for change will be important as will offering protected time to staff to facilitate the planning and delivery of change. In addition, there is a need for processes to be streamlined to allow change to happen quickly and seamlessly.

Wider community understanding and support for the need for change will be important. A co-ordinated approach to public and patient involvement will be of necessity in terms of bringing communities along on the path of change. The Northern LCG has already engaged with the NHSCT in a programme of visits to local councils and engagement events with the voluntary and community sector. This will need to be developed further to allow statutory and community sector networks to participate in the process of transformational change.

Appendix 1. MEMBERSHIP OF NORTHERN LCG AND CONTACT DETAILS

Northern Local Commissioning Group

Membership

Dr Brian Hunter	Chairman/General Medical Practitioner
Ms Sharon Sinclair	Voluntary/Community Representative
Mrs Linda Clements	Voluntary/Community Representative
Cllr Thomas Burns	Local Elected Representative
Cllr David Barbour	Local Elected Representative
Cllr Thomas Nicholl	Local Elected Representative
Cllr Adrian Cochrane-Watson	Local Elected Representative
Dr Terry Magowan	General Medical Practitioner
Dr Turlough Tracey	General Medical Practitioner
Dr Ian Buchanan	General Medical Practitioner
Mr Laurence O'Kane	Community Pharmacist
Dr Una Lernihan	Social Worker (HSCB)
Mrs Eileen Kennedy	Social Worker (HSCB)
Dr Fiona Kennedy	Public Health Specialist (PHA)
Mr Paul Kavanagh	Nursing Professional (PHA)
Ms Corrina Grimes	Allied Health Professional (PHA)
Mr Derek Manson	General Dental Practitioner

Mrs Bride Harkin, Assistant Director of Commissioning / Northern Commissioning Lead shall attend meetings.

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