SOUTH EASTERN

LOCAL COMMISSIONING GROUP

LOCAL COMMISSIONING PLAN

2012-2013

South Eastern Local Commissioning Plan

2012/13

Contents

FOREWORD

Thank you for taking the time to review our Local Commissioning Plan for 2012/13. The South Eastern Local Commissioning Group (LCG) has been in existence for three years and follows on from previous local commissioning arrangements in place since 2002. The LCG continues to have a prominent role as the local Commissioner for health and social care covering the south east of Northern Ireland.

The last decade has been a period of significant health improvements for our population, enjoying better health thanks to higher standards and greater patient choice. While NHS funding will be constrained in the coming years as a result of the global economic downturn, the LCG is committed to maintaining and building on the health and social care gains made to ensure that our population continues to access quality health care and improving outcomes. Publication of the Quality 2020 Strategy is an important reference point for the LCG in service improvement. In achieving the goals set out in our 2011/12 Local Commissioning Plan, we have a stable platform to move forward and face the significant challenges which will present in 2012/13.

Key messages in this plan are: (1) the need for improved integration both in terms of service planning, design and delivery. In this respect, we look forward to the development of a Health Economy (a forum for input from all stakeholders in health and social care issues). We will take this initiative forward initially with our main partner the South Eastern HSC Trust. (2) We also anticipate that there will be a shift to more services provided in GP surgeries and community settings with opportunities for better arrangements for the communities we serve.

Health and social care is not solely the business of health and social care providers, many improvements in our health status can be attributed to collaborative working with our partners in other government agencies, local Councils and the voluntary and community sectors.

John Compton, the Chief Executive of the Regional Health & Social Care Board and author of the recent Compton Review: “Transforming Your Care”, joined the LCG at our public Board meeting in Ards Town

Hall in January 2012. Here he discussed the content of the Review with the LCG and the significant role identified within it for the LCG in the implementation of the Review's recommendations. The content of this Local Commissioning Plan is therefore very clearly in step with the Compton Review and the LCG is determined to move forward locally to implement its recommendations.

Finally, I would wish to acknowledge the work of the LCG office in developing this plan, the commitment of the LCG Board members over the course of their terms of office and the leadership shown by the GP and pharmacy clinical leads who came forward at a critical time in the development of the four Primary Care Partnerships, now in place across the south east.

Dr Nigel Campbell
Chair, South Eastern Local Commissioning Group

INTRODUCTION

The South Eastern Local Commissioning Group (LCG) is made up of 17 members from a range of backgrounds. A list of the full current membership is set out in Appendix 1.

The LCG covers an area which can be characterized as a mix of urban and rural settlements and covers an area from Glenavy in the north west, to Newcastle and communities at the foot of the Mournes in the south west, to the population of the Ards peninsula in the south east and finally the population in the north east along Belfast lough. A map of our geography is included in Appendix 2. The main population centres include Lisburn, Downpatrick, Bangor and Newtownards. The LCG area covers the local government districts of Ards, Down, Lisburn and North Down and is co-terminus with the boundaries of the South Eastern Health & Social Care Trust. The main hospital managed by the South Eastern Trust is the Ulster Hospital in Dundonald which is geographically in east Belfast. Importantly the east Belfast population access a significant level of their acute hospital care from the South Eastern HSC Trust.

KEY CHALLENGES FOR THE LCG

Population Characteristics and Demographic Drivers

Northern Ireland will see a significant change in its demographic profile, in the next thirty years. This is characterized by a reducing younger population (0-16yrs) as a percentage of the total population and a significantly increased older population (>65 yrs). This regional trend is one which is also recognized in Great Britain and the Republic of Ireland. Within the south eastern area's population 21% (71,449 persons) are children and young people aged under 16 years, 61% (212,380) are adults (18-64), while 15.5% (53,744) are 65 years and older. The total population of the south eastern area is 346,800, equating to just over 19% of the total population of Northern Ireland. The distribution of residents across the 4 local council districts is shown in Table 1. These areas equate to the four Primary Care Partnership (PCP's) areas (described on page 10) within the SE locality.

Table 1 South Eastern LCG / LGD Population (MYE 2010)

Area	MYE 2010	% Of LCG *NI
ARDS LGD	78,248	22.6%
DOWN LGD	70,770	20.4%
LISBURN LGD	117,836	34.0%
NORTH DOWN LGD	79,940	23.1%
SE LCG	346,794	*19.3%
NI	1,799,392	-

Source: http://www.nisra.gov.uk/demography/default.asp42.htm

The LCG has undertaken an analysis of changing demographics as they relate to the local government districts of Ards, Down, Lisburn and North Down and Ards. This analysis is featured in Appendix 3.

In the South Eastern LCG locality in 2010 the population size was 346,800 and for 2015 it is forecast to be 355,500 – an increase of 2.5%.

In terms of births, the locality has seen a 7% rise from 1999-2009. In 2010 there were 4,550 births and the projected number of births for 2011/12 based on figures to the end of December 2011 is 4,575.

The locality has a higher percentage of older people (15.10%) than the Northern Ireland average (14.23%) and within the local council areas, the proportion of over 65s and over 80s differs as Table 2.0 below indicates. A key feature of our population is that it is ageing. Increasing longevity of expected life is to be celebrated and is due in part to the advances in health and social care over the years. Meeting the growing needs of our population, particularly our older residents, presents the health and social care system and the LCG with significant challenges.

Of particular significance is the 85 years and over age group who are the most intensive users of health and care services. The current population of 85+ in the locality is 6,500. This figure is set to rise by 29% by 2015 to 8,000.

Table 2 Demographic Changes South Eastern LCG Relating to 65+ Age Group

	Numbers				
Age Group	**Ards**	**Down**	**Lisburn**	**N. Down**	***SELCG***
Total Pop.	78200 (22.5%)	70800 (20.4%)	117800 (34.0%)	79900 (23.0%)	*346800(100%)*
65+	13000 (3.7%)	10100 (2.9%)	16000 (4.6%)	14500 (4.2%)	*53700 (15.5%)*
65-84	11500 (3.3%)	8800 (2.5%)	14431 (4.2%)	12500 (3.6%)	*47300 (13.6%)*
85+	1500 (0.4%)	1300 (0.4%)	1600 (0.5%)	2000 (0.6%)	*6500 (1.9%)*

Castlereagh district council area (which is within the Belfast LCG area) will see an increase of 22% in the over 65 year old age group and 3.6% in the over 85 year old age group before 2021. This population accesses most of its acute care at the Ulster Hospital. North Down is predicted to see the highest increase in Northern Ireland i.e. 24.1% in the over 65s and 3.8% in the over 85s.

Addressing Inequalities ('shift left')

The LCG has an important role to play in addressing inequalities, particularly as it relates to our significant rural population in terms of accessing services. In addition 18 of the 180 Super Output Areas (SOA's) in the south east now fall within the top 20% most deprived areas in Northern Ireland. It is estimated that 36,792 people live within these areas representing some 10.8% of the south eastern population.

Furthermore the Quality and Outcomes Framework (QOF) registers held within General Practice indicate that the population within the South East area has higher levels in the following disease areas compared to all other LCG areas – asthma, cancer, dementia and stroke, and has the second highest in respect of diabetes.

Our Primary Care Partnerships (PCPs) have developed a lead role in tackling some of the health inequalities and issues within the locality. They are doing this by developing patient centred integrated care pathways which seek to manage demand into secondary care by developing appropriate alternative diagnostic and treatment services in primary and community care settings, thus reducing the need for hospital attendances. The care pathways are condition specific and patient focused. They map the patient's potential journey and indicate at what stages and in which settings the most appropriate care can be given, whether this is in a GP surgery, health and care centre, local or acute hospital. Examples of Care Pathways currently being developed in the South Eastern LCG locality are ones for deep vein thrombosis

(DVT), services for the frail elderly, dermatology, sexual health and musculoskeletal conditions. The overall aim is to ensure that patients, depending on the urgency and seriousness of their condition, are cared for in the type of environment most appropriate for their needs. A challenge for Commissioners will be to ensure that there is an appropriate mechanism to allow a shift in resources into primary and community care to support the new services which does not destablise the acute system.

Commissioning Care Closer to Home

Transforming Your Care: A Review of Health and Social Care in Northern Ireland (December 2011)[1] made 99 recommendations across all service areas. Central amongst those recommendations is the goal of transferring care appropriately from primary to secondary care - emphasizing home as the hub. The LCG will be at the centre of this change process. Our priorities will be to: have a stronger focus on health improvement and wellbeing; increase the scope of all independent contractors; involve an integrated multi-disciplinary approach based more on a social as opposed to medical model of care; manage long-term conditions within the home or local community; harness the contribution that voluntary and community organizations provide and incorporate a reablement approach to care in order to provide service users with greater independence and empowerment. The opportunities developing from the Connected Health Initiatives will also be promoted by the LCG. Ambulance services are important in managing patient flows. The LCG will continue to work closely with NIAS to ensure that their commitments to meeting patient needs in terms of unscheduled care are met.

Analysing Demand

Often our need for hospital or social care can be lessened by self management and putting a greater focus on primary care at an earlier stage of illness. The Health Improvement Programme aims to help prevent ill health by ensuring we understand the life style options which will safeguard our health and wellbeing. The LCG will continue to spend time analyzing ongoing demand for services so that we can ensure that our population is treated by the right person, in the right place, at the right time to achieve the right outcome. An aim of the LCG in 2012/13 will be to spend more time with our PCPs in discussion about referred

[1] http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

rates into secondary care, trying to establish and understand variations in referral rates across practices at PCPs, LCG and regionally.

Improving Prescribing

The South Eastern LCG encompasses 54 GP practices with an annual prescribing budget of £70m. The locality is serviced by 90 community pharmacies.

The LCG has established a Prescribing and Medicines Management Committee. It is comprised of GP clinical leads and community pharmacy leads aligned to the 4 PCP areas that engage with local colleagues and identify and implement improvements for medicines management. SET medical and pharmacy input is also included. The LCG has endorsed a Prescribing and Medicines Management Strategy taking into consideration the regional initiatives under way through the Medicines Management Forum and also the local context in the SELCG area in terms of prescribing priorities.

The Strategy aims to promote the delivery of improved clinical and cost-effective medicines management; improve patient safety and reduce risk in relation to the use of medicines and foster improved relationships between healthcare professionals across the LCG area and particularly across the acute and community interface to promote partnership working with other sectors of the NHS. The Strategy has set a savings target in-year of £5.3m to be achieved through targeted cost-effective prescribing and medicines management efficiencies. The potential to generate savings will allow the PCPs to reinvest funding within the local health economy. In terms of local initiatives the LCG has supported the Prescribing and Medicines Management Committee in: (1) putting in place a Local Enhanced Service which allows practices to employ practice-based pharmacists to undertake cost-effective prescribing initiatives and (2) commissioning a Community Dietician to work with nursing homes in the locality to promote the Department's 'Food First' initiative thus reducing wastage and promoting the appropriate use of oral nutritional supplements.

Resources

The South Eastern LCG's funding to commission services in meeting the Health and Social Care needs of their population in 2012/13 is £522m. As detailed in the table below, this investment will be across each of the 9 Programmes of Care, through a range of service providers. The

Family Health Services planned spend of £147m noted below reflects the LCG's capitation share of the FHS budget.

Table 3 LCG Spend by Programme of Care

Programme of Care	£m	%
Acute Services	215	41.2
Maternity & Child Health	22	4.2
Family & Child Care	35	6.7
Elderly Care	115	22.0
Mental Health	37	7.1
Learning Disability	45	8.6
Physical and Sensory Disability	18	3.5
Health Promotion	19	3.6
Primary Health & Adult Community	16	3.1
POC Total	**522**	**100.0**
Family Health Services Spend	**147**	
Grand Total	**669**	

This investment will be made through a range of service providers as follows:

Table 4 LCG Spend by Provider Trust

Provider	£m	%
BHSCT	135	25.8
NHSCT	1	0.2
SEHSCT	361	69.2
SHSCT	1	0.2
WHSCT	0	0
Non-Trust	24	4.6
Provider Total	**522**	**100.0**
Family Health Services Spend	**147**	
Grand Total	**669**	

Whilst ED services have not been assigned to LCGs as these are regional services, the planned spend in 2012/13 in respect of Emergency Care by the South Eastern Trust is £20m.

The level of funding for each local area varies depending on the size and age/gender profile of its population, the level of need they experience and any local factors that Commissioners are aware of.

In arriving at the above investment, the Commissioning Plan for 2012/13 includes a significant range of service developments and other cost pressures most notably inescapable pressures such as Pay and Price

Inflation and additional funding to take account of the demographic changes in the population of the South Eastern area.

Meeting Ministerial Targets

The LCG will work with the local Trust in relation to meeting the Ministerial Targets outlined in The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2012. The South Eastern Trust has confirmed in its Trust Delivery Plan (TDP) that most of the targets are achievable and affordable. SELCG will work with the Trust to ensure that those that cannot be met in full at this stage are followed up and performance monitored with a view to meeting them in year.

HOW THE KEY CHALLENGES WILL BE ADDRESSED

Engagement through Personal and Public Involvement (PPI)

The south east locality has a strong and vibrant community development culture and infrastructure in the form of many voluntary and community groups and networks. The LCG has been able to work with these networks to identify health and social care priorities and implement programmes within communities. The LCG has been able to work with these networks to identify health and social care priorities and implement programmes with communities. The LCG has also taken the opportunity to meet with all our local Councils.

The LCG has initiated a number of engagements in the form of public meetings, workshops at which statutory and voluntary organizations have the opportunity to make presentations, meetings with voluntary and community organizations and on-going links with the Patient and Client Council. We will build on the engagements we had with service users in 2011/12 in the areas of stroke, heart failure and diabetes.

As we pursue the redesign of care pathways we will ensure local professionals, patients and carers have an opportunity to influence how future services are shaped.

Integrated Care Partnerships (ICPs)

The LCG established and supported with infrastructure PCPs, incorporating independent contractors within our geographical localities. GP and Pharmacy clinical leads were nominated within each of our four PCPs to develop and drive patient focused care pathways that deliver the most effective and sustainable care. In this coming year, our expectation is that PCPs will evolve into Integrated Care Partnerships (ICPs). These will join together the full range of health and social care services in each of these localities and will include primary care services, community health and social care providers, consultant services outreaching into the community and representatives from the independent and voluntary sector. These providers will work together in an integrated way within the context of the local health economy.

ICPs will have an important contribution to make in shaping future Primary Care infrastructure. The LCG has commenced work with independent contractors and SET to put in place a 'hub and spoke' model of facilities which will maximize the potential for service redesign as detailed in 'Transforming Your Care'.

Examples of services that the LCG would like to see ICPs provide are: access to specialist multidisciplinary teams for people with long-term conditions in-reach into nursing homes by specialists and GPs; managing palliative and end of life care in people's homes and nursing homes; reablement and rehabilitation services for older people; recovery services for those with mental health problems; child and vulnerable adult protection services and improved domiciliary care services.

The LCG sees the work within existing PCPs in terms of care pathway design as the forerunner of a more integrated model of provision envisioned by the ICPs. The design of more integrated and patient focused care pathways have already necessitated the type of co-operation between primary, secondary, independent and voluntary sectors that we would expect to see much more of as the ICPs develop and mature. There must also be a corresponding redistribution of funding and resources to support the future work of the ICPs.

The Development of a Collaborative Population Plan

The next few years will see an unprecedented challenge to meet increasing needs within a constrained healthcare budget. This challenge will have to be met through closer working across the HSC system, streamlining processes to realise greater efficiency and

achieving higher productivity within current resources. Central to this change is a strong focus on maintaining high quality care and improving this where possible. All LCG are now taking forward new collaborative arrangements with their local Trusts and main partner organisations to establish a local Health Economy (HE). Structures for the south eastern HE are being developed with the SET with a view to having a Population Plan in place before July 2012 and to ensure timely implementations.

Using the skills and expertise of stakeholders in the local HSC Economy Group the Plan will: guide us as to how reform and modernisation will deliver the objectives of Transforming Your Care (TYC); detail the timelines for delivering TYC; identify the processes and tasks ahead for the local health economy;outline a communication strategy to involve all stakeholders in establishing new service models and develop preferred service model configurations and care pathways.

COMMISSIONING INTENTIONS 2012/13

Communication and engagement with all stakeholders and those who avail of HSC services in the LCG area are of paramount importance in realising the new structures and services proposed. The LCG recognises the importance of close, effective working and will work with the matrix of organisations involved in redesigning health and social care. The LCG has already engaged specifically with the Patient Client Council in this regard.

Management of Demand

As with any service, waiting times increase for elective care when there is insufficient supply of that service to meet demand. Understanding demand patterns is a key issue for the LCG. LCG members, Board and Public Health Agency (PHA) officers will continue to work with the regional elective care commissioning team to determine service capacity and demand. To date there has been a considerable focus on elective capacity and regular performance meetings between the Board and Trust have led to a timely informed understanding of hospital activity.

This focus has identified where recurrent investments are required in the coming year and the LCG is working with the Trust to increase appropriate staffing capacity in 2012/13. However, additional capacity into the acute sector is only one option in addressing the demand gap. The LCG and Board will continue to work with the Trust to develop new

ways of working to help meet increased demand and improve performance. During 2012/13 the Board will continue to measure Trust performance and support the Trust in its plans to meet the levels of best performing Trusts in GB.

With regard to unscheduled care across programmes, the LCG will work with the Trust and primary care to understand demand patterns and establish how best to improve services. At present emergency departments across Northern Ireland are working hard to meet Government targets of waiting times less than 4 hours (95%) and 12 hours. The LCG will continue to monitor the performance at the Ulster Emergency Department which has been under particular pressure since the changes to ED services following the BCH temporary closure in November 2011.

New approaches to care are needed that will make better use of available resources through networking and closer working with the NI Ambulance Service. Opportunities are also evident for primary care to take a greater part in the provision of urgent/out of hours services and we will follow up these opportunities with our PCPs.

Key Local Actions Specified in Regional Plan

There are now 12 service specifications in place. These have been developed by the HSCB's Regional Service Teams. The specifications have identified a range of key actions. We have selected specific specifications and actions that we can focus on locally and which we will now take forward with the South Eastern Trust in 2012/13. These actions are set out below in 'life cycle' order.

Maternity, Paediatrics and Child Health

- Work with the PHA and others to encourage a "get fit for pregnancy" approach by promoting healthy lifestyle choices and the benefits of folic acid to women of childbearing age, and to support obese women to lose sufficient weight to lower their risk prior to conception
- Ensure secondary care specialists advise all women of child bearing age who have long term conditions about pregnancy, even if they are not actively planning a pregnancy
- Ensure that robust arrangements are in place to facilitate collaborative and coordinated discharge planning for children with complex physical needs to the community. Local economies should ensure that the UNOCINI 4 level model for children in need is in place

- To put in place arrangements the by March 2013 with the South Eastern Trust for the formal evaluation of the Downe MLU as described in the business case which establish the unit.
- Increase the percentage of normal births and reduce unexplained variation in intervention rates
- Reduce unexplained variation in postnatal lengths of stay

Children and Families

- Develop integrated planning arrangements for family support at local level
- Work with SET and PHA to ensure that children with disabilities / autism can access services that are equitable, easily accessible and person centred
- Work with CAMHS services to ensure that a stepped care model is adopted that will provide a service that is consistent, reduces service variation and supports better integration of CAMHS within children's services

Health and Social Wellbeing Improvement

Within the south eastern area the LCG and PHA will work together to address the following priorities with communities and partners under the following headings:

- Giving every child and young person a best start in life
- Work with others to ensure a decent standard of living
- Ensuring a decent standard of living
- Building sustainable communities
- Making healthy choices easier. This will cover the following areas:
    - Promoting healthy weight and physical activity
    - Alcohol, tobacco and drug misuse
    - Mental health and wellbeing and prevention of suicide
    - Teenage pregnancy and sexual health
    - Accident prevention

Unscheduled Care

- During 2012/13 SELCG will work with GP practices to better understand demand and capacity requirements
- Within the local health economy the LCG will commission an acute care at home service that operates as a 'community ward' with active management of patients to ensure timely treatment and patient flow
- The LCG will work with the local health economy to prevent unnecessary admissions, and analyse capacity and reinvestment costs for domiciliary care, supported housing and residential and nursing home care
- Work to reduce palliative care admissions to hospital in preference for palliative care to be provided at home or residential and nursing homes through available community services

Elective Care

- Work with SET to ensure that, as a minimum, elective core capacity is delivered
- For those elective specialties where there are recurrent capacity gaps, make targeted investment to secure additional capacity in Trusts and/or primary care, with a particular focus on those specialties where Independent Sector solutions are not readily available
- Complete outstanding elements of radiology capacity planning work for key modalities including plain film, MRI, CT and non-obstetric ultrasound to identify core capacity within Trusts
- Complete outstanding elements of AHP capacity planning work to identify core capacity within Trusts
- Develop agreed electronic referral protocols on a phased basis for priority service areas
- Support the commencement of the Abdominal Aortic Aneurysm (AAA) programme from April 2012
- Work with SET to ensure that from April 2012, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures (linked to orthopaedic services)

Cancer

- Work with SET on the implementation of the Transforming Cancer Follow Up programme for Breast, Colorectal and Head and Neck cancers

Mental Health and Learning Disability

- The LCG will ensure that service implementations in primary care and the voluntary and community sector are aligned with Protect Life and Mental Health Promotion resources and service models.
- The LCG in partnership with Integrated Care pharmacy colleagues will seek to improve our understanding of mental health prescribing patterns across our PCPs to agree guidelines to assist with more effective primary care based interventions
- The LCG will support local developments of regionally agreed models in terms of Psychological Therapies, Stepped Care, Crisis Resolution/Home Treatment, Personality Disorders, Eating Disorder and Forensic services
- Work with SET to ensure that in line with 'Transforming Your Care' no one is living in a mental health hospital by the latest date of 31 March 2015
- The LCG will consider the Full Business Case for the development of new service arrangements in regard to the proposals around the new adult resource centres proposed for the North Down and Ards localities

Long-Term Conditions

- During 2012/13 the LCG will work with HSCB/PHA and Trusts to ensure effective arrangements are in place to progress:
    - Risk profiling of patients with LTCs
    - Regular primary care review
    - Integrated community teams
    - Escalation procedures to seek advice and involve specialist services
    - Patient education and self management programs
    - Effective medicines management

- Remote tele-monitoring and its expansion to reach a specified target by 2014/15

- Care pathways across primary and secondary care for the clinical management of acute episodes due to asthma, COPD, diabetes, heart failure and atrial fibrillation

Community Care, Older People and Physical Disability

- Work closely with service providers to ensure the implementation of the Reablement model of support and care for both Older People and People with a Physical Disability or Sensory Impairment
- Work with the Trust and voluntary and community organisations to provide enhance respite opportunities and support the work of the regional Carers Strategy Group
- Promote the health of older people through a re-balancing of services to provide good nutrition, healthy ageing and early interventions and thus deliver prolonged healthy independent living
- Support action plans associated with the Dementia and Physical Disability strategies

Palliative and End of Life Care

During 2012/13 the HSCB/PHA will work with LCGs and Trusts to ensure effective arrangements are in place to progress:

- To have systems and processes in primary, community and secondary care to:

    - Identify those approaching the end of life as per regionally agreed prognostic indicators and placed on GP registers
    - Appropriately assess those in the last year of life to ensure that symptoms are controlled – physical, psychological, social, financial & spiritual e.g. using NISAT.
    - Have care plans developed and reviewed for those in the last year of life. These should include DNAR wishes and referral for carer's assessment.
    - Ensure that people identified as being in the last year of life have been given the opportunity to have an advance care plans developed at the appropriate time.

- Ensure that all people on admission to a nursing home have been offered the opportunity to have an advance care plan developed within three months of admission.
- Ensure that all people who have an anticipated deterioration in their condition in the future e.g. on diagnosis of dementia have been offered the opportunity to have an advanced care plan developed.
- Ensure that a standardised approach, such as the Care of the Dying Pathway (e.g. LCP), is implemented according to quality standards across all care settings
- Ensure that processes put in place that care for individuals identified as being in the last year of life are co-ordinated across organizational boundaries
- We would wish to see an increase in general palliative care services in the community, with a shift from acute to community.
- Ensure that those approaching the last few weeks of life have access to all necessary equipment required in their homes within 24 – 48 hours to maintain people at home and enable rapid discharge from hospital.
- Ensure that patients in the last few weeks/days of life can be transferred within 24-48 hours by the effective commissioning of ambulance and other transport services from hospital to die at home
- There is appropriate provision of specialist palliative care services to support primary, community and secondary care general palliative care services. This includes:
  - Community palliative care multidisciplinary teams (AHP, social care, consultant, specialist nursing)
  - Palliative care day hospice and out-patient services
  - Hospice inpatient service
  - Education and training

- Patients have access to advice from specialists in palliative care irrespective of diagnosis or location. This service should be available face to face seven days a week 9-5 and by telephone seven days a week up to 11pm.

- Nursing homes are supported to meet the standards currently being developed in conjunction with RQIA (in place at the end of 2014).
- Proposals are developed to ensure the sustainability of palliative co-ordinator posts beyond 2012/13.

SELCG CONTACT DETAILS

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Website: www.hscboard.hscni.net

APPENDIX 1: LCG Management Board Members

Ms Oriel Brown, Nursing Representative, PHA

Dr Nigel Campbell, General Practitioner (Chair)

Cllr Angus Carson, Elected Representative

Cllr Dermot Curran, Elected Representative

Dr Paul Darragh, Consultant in Public Health Medicine, PHA

Mr Donal Diffin, Social Work Representative, HSCB

Mr John Duffy, Social Work Representative, HSCB

Cllr Cadogan Enright, Elected Representative

Cllr Andrew Ewing, Elected Representative

Mr Brendan Forde, Allied Health Professional, PHA

Mr David Heron, Community & Voluntary Sector Representative

Dr Garth Logan, General Practitioner

Dr Paul Megarity, General Practitioner

Mrs Heather Monteverde, Community & Voluntary Sector Representative

Mr Peter Mullan, Dental Practitioner

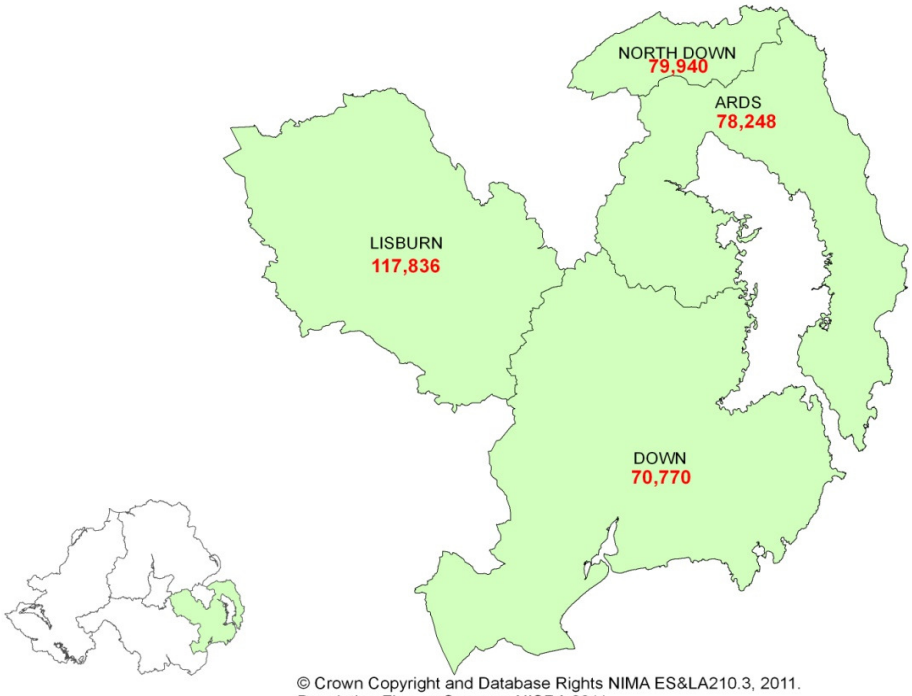
Dr Ultan McGill, General Practitioner

Mrs Louise Seymour, Community Pharmacist

Mr Paul Turley, Commissioning Lead

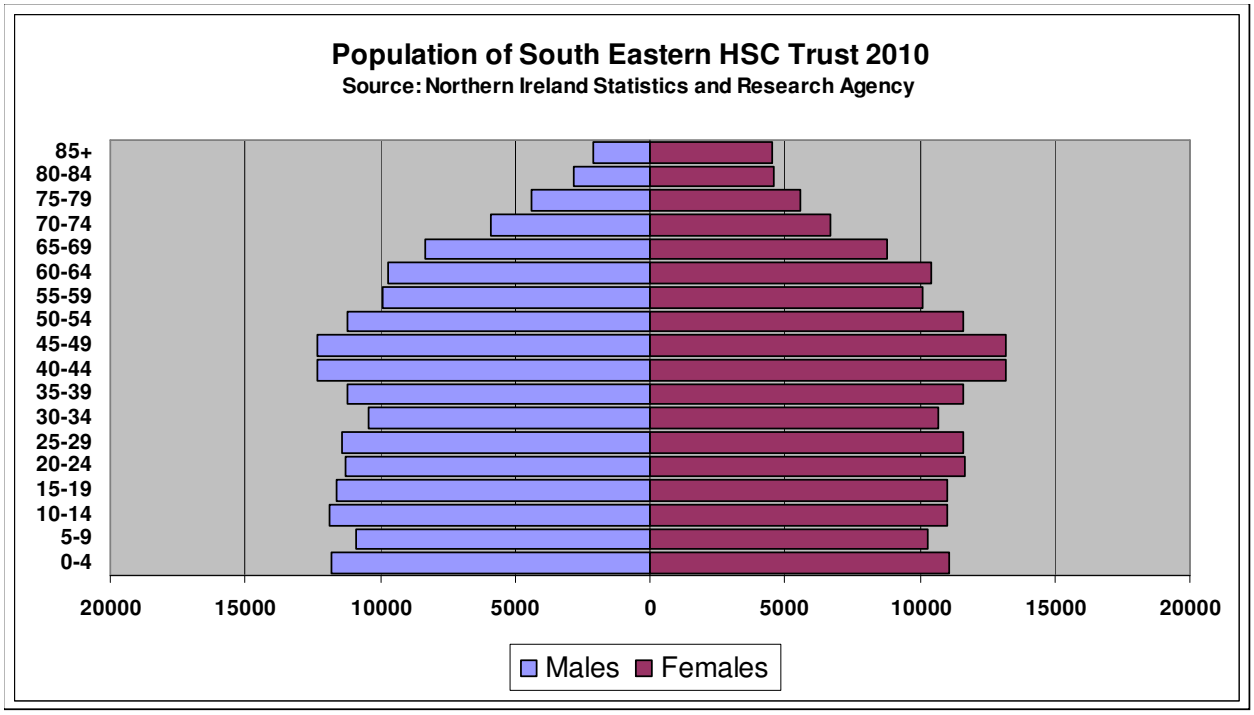
APPENDIX 2

Geography of the Health Economy covering South Eastern Local Commissioning Group - Local Government District Populations (MYE 2010).



The Local Government Boundaries within the area are co-terminus with the four PCP localities within the South Eastern area. The East Belfast PCP due to its proximity will also contribute to developments within the South Eastern Health Economy

APPENDIX 3


Population of South Eastern HSC Trust 2010
Source: Northern Ireland Statistics and Research Agency
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
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5000
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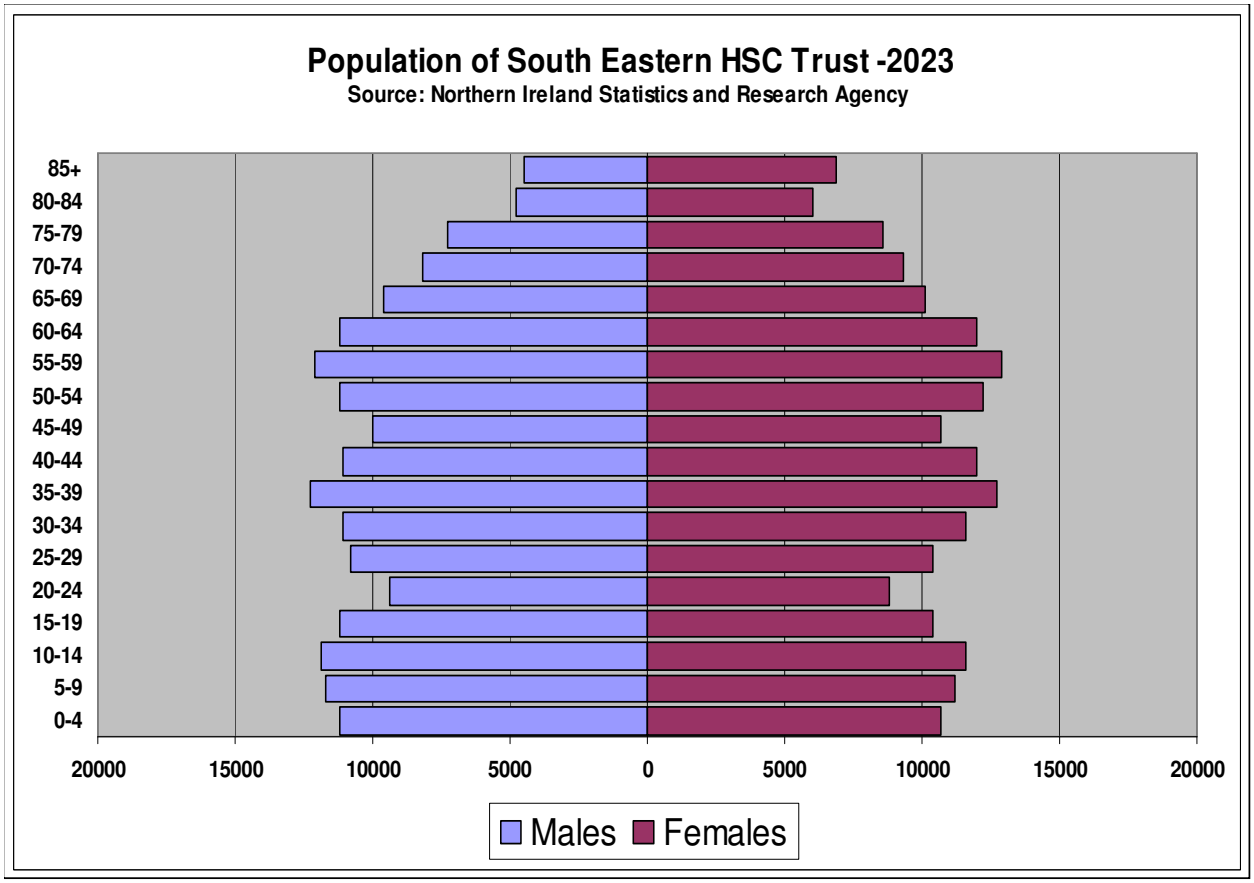
20000
Males
Females


Population of South Eastern HSC Trust -2023
Source: Northern Ireland Statistics and Research Agency
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
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Males
Females