NORTHERN LCG
Local Commissioning Plan
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FOREWORD

I am delighted to present this Local Commissioning Plan for 2011/12 on behalf of the Northern Local Commissioning Group. As we have progressed in our development, we have continued to deal with many challenges and we know that further significant challenges lie ahead particularly in relation to the growing demand on services in a time of constrained resources.

Informed by the key themes in the Commissioning Plan agreed by the Health and Social Care Board and the Public Health Agency, this local Plan describes priorities which will be progressed in the coming year. The Plan has also been informed by the report produced in November 2010 by the Patient and Client Council “The People’s Priorities” which identifies the top ten priorities suggested by a wide cross section of the general public surveyed by the Council.

In addition to progressing actions in the different service areas, the ongoing work to establish and develop Primary Care Partnerships will be a key focus for the Northern LCG in 2011/12.

With a diverse membership including primary care practitioners, health professionals, voluntary sector representatives and local councillors, the Local Commissioning Group is well placed to take forward the commissioning agenda locally. I look forward to progressing a forward thinking plan which will deliver efficient and effective services enabling us to face the challenges ahead, while at the same time continuing to meet the needs of our local population.

Our challenge will be to do as Albert Einstein has suggested in the past “Out of clutter find simplicity; From discord find harmony; In the middle of difficulty lies opportunity.”

Dr Brian Hunter
Chair, Northern Local Commissioning Group
OVERVIEW

Statutory Responsibilities of the Local Commissioning Group
Section 9 of the Health and Social Care (Reform) Act (Northern Ireland) 2009 requires the Board to appoint a prescribed number of Local Commissioning Groups (LCGs) as Committees of the Health and Social Care Board (HSCB). LCGs have responsibility for addressing the needs of their local populations, working within regional policy and strategy frameworks, available resources and performance targets.

LCGs have responsibility to commission services for the populations they cover; they are the point of local leadership in commissioning health and social care.

Each LCG has to comply with the Standing Orders and Standing Financial Instructions of the HSCB.

General Responsibilities and Accountabilities
LCGs have:

- responsibility for the development of Commissioning Plans as part of the Joint Board and Agency Commissioning Plan;

- flexibility to introduce initiatives to involve primary and community care practitioners and community and voluntary groups at a local level, to actively engage in designing and reshaping services to better meet the needs of their local communities;

- as Committees of the HSCB, a statutory duty to pay due regard to the views of the Public Health Agency (PHA) in addressing the wider determinants of health and well-being; and

- arrangements in place for regular and meaningful engagement with elected representatives in Local Government and with advocacy groups, patients, carers, and the wider public, consistent with Ministerial policy on “Personal and Public Involvement”.
LCGs are required to:

- adopt an inclusive approach to decision-making, recognising the distinctive contribution of all professional groups, lay representatives, patients, carers, the community and voluntary sector, locally elected representatives and the wider public;

- play a critical role in relation to the improvement of public health and well-being. They are forging partnerships with other appropriate bodies, including the PHA, to commission programmes of health improvement and to address health inequalities;

- manage and undertake robust and regular needs assessments that establish as comprehensive an understanding as possible of current and future health and social care needs and requirements;

- prioritise investment according to local needs, service requirements and Ministerial policy and objectives;

- be agents of innovation and continuous improvement;

- work in partnership with service providers, seeking to realise all opportunities to secure delivery of significantly higher standards for safe good quality care and improved health and well-being;

- pursue all opportunities to secure enhanced value for money and improved resource utilisation while contributing to the maintenance of sound financial stability of the local health and care economies.

In addition, LCGs will contribute to shaping commissioning decisions in other areas which impact on local populations. As such, LCGs must work collaboratively on areas of mutual interest to ensure that, across the region, consistent approaches underpin needs assessment, service planning, procurement and performance management.
How the LCG does its work
Membership of LCGs has been set as follows by the Department of Health and Social Services & Public Safety (DHSS&PS):

- 2 Voluntary sector/Community sector representatives
- 4 local elected representatives
- 4 General Medical Practitioners
- 1 Community Pharmacist
- 1 General Dental Practitioner
- 2 Social Workers (HSCB)
- 1 Public Health Specialist (PHA)
- 1 Nursing Professional (PHA)
- 1 Allied Health Professional (PHA)

In advance of each year the Board determines, in consultation with LCGs, the range of services to be commissioned by the Groups and identifies the corresponding budgets. LCGs are not responsible for the operational management of service delivery.

LCG Principal Functions
Principal functions of LCG Members, collectively, are to:

- take ownership and control of their local commissioning agenda;
- set the commissioning direction and priorities within the context of the overall regional commissioning frameworks.

LCGs are required to engage their respective local populations and explain to them how they plan, oversee investment and manage performance to improve health and well-being outcomes on their behalf.

Within the context of the agreed Joint Commissioning Plan, they make care commissioning decisions having due regard for:

- the identified needs of their population;
- available resources; and
- the advice of the PHA.

In forming their views, LCGs take account of:

- care needs of their populations;
- Ministerial and regional priorities;
- views of service users, carers and the wider public;
• views of, and performance by, service providers; and
• available evidence and best practice.

Financial Governance and Stewardship
LCGs must ensure that their annual expenditure remains within the resources allocated by the HSCB. They must also ensure that this expenditure is undertaken consistent with DHSS&PS and HSCB policy and established best practice.

The HSCB Finance Director has made available necessary professional advice and support to LCGs to enable them to fulfil their responsibilities in this regard.

Primary Care Partnerships (PCPs)
With the development of LCGs comes the responsibility to progress PCPs. GPs and primary care teams, as gatekeepers to health and social care services, are a major determinant of health care utilisation in terms of the model of care that a patient receives and how patient choice is exercised. Linking gatekeeper clinical and financial responsibility has the potential to raise the standard of patient care, improve provider efficiency and make the services they provide more responsive to patients.

PCPs are networks of primary care providers based on geographical communities. They are clinically led, multi-professional and inclusive of all gatekeeper GP practices and other primary care providers. Their role is to work closely with the LCG to improve services to patients and clients, and so better align clinical decision making with decisions concerning the most effective use of resources.

In particular, the PCPs have been asked to examine patient pathways and medicines management. The focus is on building an understanding of the patterns of demand for secondary care, primarily for outpatient assessment and treatment of elective conditions. They should also identify opportunities for enhancing the capacity of primary care to assess and manage patients to reduce the need for referral to secondary care, where appropriate, or to commission alternative pathways for patients that are more efficient, effective and equitable.

The interim GP leads for each PCP are assisted by the Commissioning Lead’s staff in providing information on referral trends and medicines usage and setting up forums for discussion of this data.
Within the Northern LCG, a GP stakeholder event was held in September 2010 at which the concept was discussed and proposals for initial pathfinder schemes were initiated. Following this event, significant discussions have taken place with the other key stakeholders and work is progressing to introduce initiatives which will deliver key long term results.

**Further Development of PCPs**
A workshop on 23rd March 2011, which was well supported by GPs in the LCG area, allowed the establishment of four discrete localities to be confirmed.

Clear identification of areas for improvement came from the four locality groups. The main focus was on pathways of care and, in particular, the way the patient journey and efficiency could be improved.

**Causeway locality**
- A small, local project focusing on prescribing in nursing and residential homes will be progressed.
- A project to maximise the use of existing GPs with Special Interest in dermatology within a primary care setting will be taken forward. The development of dermatology services within primary care will have to be matched by a reduction in referrals to secondary care.

**Mid Ulster locality**
- As with Causeway, a similar project on dermatology will be progressed. The potential to replicate this in other areas, eg ENT and ophthalmology is also being explored.

**East Antrim locality**
- A review of prescribing in nursing and residential homes (including the use of oral nutritional supplements) will be taken forward on a small pilot basis.

**Antrim/Ballymena locality**
- Three care pathways will be reviewed - DVT, chest pain and carpal tunnel syndrome.
There was particular interest in reviewing unscheduled care pathways to manage the flow of patients into A&E.

GPs were clear that they wanted to work together in a very structured way.

Although there were different issues and concerns across each of the four localities, a degree of commonality existed in that the following issues were shared in more than one area:

- DVT pathway improvement;
- Knee problems and MRI;
- Carpal tunnel and nerve conduction studies;
- Referral within x-ray facilities for further investigation; and
- Haematuria, direct cystoscopy service.

It was agreed that GPs have a pivotal role to service design and an undertaking was given to develop these specifically as we look at specific pathway change in the coming weeks. Success in these will allow further developments as the focus extends to new areas of service design.
Engagement Process in Developing the Local Commissioning Plan 2011/12

A draft of the Northern Local Commissioning Plan has been tabled and discussed at a LCG workshop. Informed by last year’s programme and the general direction of travel set by the Regional Service Teams, the Northern Plan seeks to give a local focus to the priorities set for the year ahead.

In considering local priorities, the Northern LCG has also taken into account the recent report published by the Patient and Client Council (PCC): “The People’s Priorities”. This document reflects the opinions of a wide range of people on the priorities which they rate as important in relation to issues affecting health and social care in Northern Ireland. The majority of the top ten priorities feature significantly in the work which the LCG will be progressing in the coming year. In taking forward the key actions embedded in this Plan, the LCG will continue to engage with local stakeholders, including the Northern Trust and Primary Care contractors, over the coming months.

Engagement on the draft Plan will take a number of different forms, such as:

- individual officers attached to the LCG will represent the views of the LCG in a range of fora;

- LCG members will be responsible for sharing with primary care, voluntary sector and Council colleagues the detail of the Plan. However, conscious of the forthcoming Assembly elections, LCG members will be mindful of the guidance on the conduct of business in the run up to an election; and

- the LCG will engage with the wider community as it progresses the key actions within the Plan in accordance with the regional policy on Personal and Public Involvement.

The LCG has been engaging with local GP practices about the appropriateness of a range of products available on prescription. This has been taken further with the PCC drawing up a questionnaire to canvas the views of the wider community. Feedback from this exercise will help inform prescribing initiatives that can be taken forward both locally and regionally.
HEALTH AND WELL BEING IMPROVEMENT

Demographic Characteristics of Population
Northern LCG covers an area of 1,670 square miles and includes ten Local Government Districts (LGDs). Despite having some large urban areas, the LCG area has a large rural hinterland which in itself poses particular issues in terms of accessibility to services.

The population of each district is as follows:

<table>
<thead>
<tr>
<th>LGD</th>
<th>% of Total Pop</th>
</tr>
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<tbody>
<tr>
<td>Newtownabbey</td>
<td>18%</td>
</tr>
<tr>
<td>Ballymena</td>
<td>14%</td>
</tr>
<tr>
<td>Coleraine</td>
<td>13%</td>
</tr>
<tr>
<td>Antrim</td>
<td>12%</td>
</tr>
<tr>
<td>Magherafelt</td>
<td>10%</td>
</tr>
<tr>
<td>Carrickfergus</td>
<td>9%</td>
</tr>
<tr>
<td>Cookstown</td>
<td>8%</td>
</tr>
<tr>
<td>Larne</td>
<td>7%</td>
</tr>
<tr>
<td>Ballymoney</td>
<td>7%</td>
</tr>
<tr>
<td>Moyle</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: NISRA, Mid-Year Estimates 2009
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The age profile of the NLCG population is as below:

### Northern LCG Area - Population by Age Band

<table>
<thead>
<tr>
<th>Children (&lt;18 yrs)</th>
<th>Adults (18-64 yrs)</th>
<th>Older People (65+ yrs)</th>
<th>TOTAL Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>% of Total Population</td>
<td>Number</td>
<td>% of Total Population</td>
</tr>
<tr>
<td>109,320</td>
<td>24</td>
<td>279,973</td>
<td>61</td>
</tr>
</tbody>
</table>

Source: www.nisra.gov.uk - 2009 Mid Year Estimates

### Population Projections

The Northern LCG is calculated to have an overall population growth of 8.8% between 2009 and 2023. This is slightly higher than the Northern Ireland average. The number of children under 18 is expected to increase by 1.2%, while the number of adults aged between 18 and 64 is expected to rise by 2.5%. Not surprisingly, the greatest increase is found in the number of older people as this is expected to rise by 42%. This has particular implications for services and for budgets: while older people tend to have a healthier old age than before, they tend to be greater users of services in their advanced years. The focus will increasingly be on supporting older people to be as independent as possible for as long as possible. Promoting healthy lifestyle choices among all ages and sectors will also be important in maintaining people within communities.

Population projections across the LCG vary across Council areas: of the ten council districts in the Northern area, Cookstown is projected to have the highest overall increase (16%), while Coleraine is predicted to have an actual decrease in population (-3%).
Northern LCG Population Projections across LGDs 2009-23

<table>
<thead>
<tr>
<th>LGD</th>
<th>% Increase 2009-23</th>
</tr>
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<tbody>
<tr>
<td>Antrim</td>
<td>15%</td>
</tr>
<tr>
<td>Ballymena</td>
<td>8%</td>
</tr>
<tr>
<td>Ballymoney</td>
<td>12%</td>
</tr>
<tr>
<td>Carrickfergus</td>
<td>5%</td>
</tr>
<tr>
<td>Coleraine</td>
<td>-3%</td>
</tr>
<tr>
<td>Cookstown</td>
<td>16%</td>
</tr>
<tr>
<td>Larne</td>
<td>2%</td>
</tr>
<tr>
<td>Magherafelt</td>
<td>15%</td>
</tr>
<tr>
<td>Moyle</td>
<td>7%</td>
</tr>
</tbody>
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Life Expectancy
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 2006 and 2008, life expectancy is higher than the Northern Ireland average.

<table>
<thead>
<tr>
<th>Life Expectancy for people born between 2006 - 2008</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Local Commissioning Group</td>
<td>77.31</td>
<td>81.76</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>76.42</td>
<td>81.26</td>
</tr>
</tbody>
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However, closer inspection shows that women in Antrim, Carrickfergus and Moyle have a lower life expectancy than the Northern Ireland average while men in the Cookstown district have a lower life expectancy than the Northern Ireland average. The improvements in life expectancy and the resulting health inequalities have been the focus of discussion at the LCG and there is support for joint working initiatives with local Councils to address these issues.

Aside from the demographic challenges, the LCG is working within a constrained financial climate but is nonetheless prepared to face the challenges ahead.
Main Features of the Health and Well Being Status of the Population – Inequalities

The LCG will work with colleagues in the PHA to understand the priorities and processes involved in improving health and tackling inequalities. This collaboration will shape the future development of both joint and local commissioning plans and take cognisance of the local inter-sectoral partnership groupings, such as Investing for Health, which have come together to tackle the wide ranging causes of poor health and health inequalities. The overarching priorities will include focused work to reduce inequalities in health and well being between socio-economic groups, geographic areas and minority groups. The work will focus on the following over-arching objectives:

a) Give every child and young person the best start in life;
b) Ensure a decent standard of living for all;
c) Build sustainable communities; and
d) Make healthy choices easier.

The following are some of the key actions and outcomes to date which the LCG is keen to consolidate during the course of 2011/12 and beyond.

a) Early years and young people
   • reducing smoking in pregnancy and increasing breastfeeding particularly in women from deprived areas would significantly improve the health of their babies; and
   • extend the Roots of Empathy programme to a minimum of one school in Northern Health and Social Care Trust.

b) Ensure a decent standard of living for all
   • maintain programmes which tackle poverty (including fuel poverty) and maximise access to a range of services and support;
   • ensure current health and wellbeing programmes are tailored and focused to meet the needs of those at risk of poverty, including Travellers, Looked After Children, lone parents and homeless people; and
   • poverty - progress in this area includes implementation of a local action plan to tackle fuel poverty by assisting households to access grant support programmes and the continuation of
the Advice for Health initiative providing advice and support to those who are most vulnerable.

c) Build sustainable communities
   • extend joint working with community networks, including rural support networks working in Northern area, to increase community participation in health and social well-being improvement.

d) Make healthy choices easier (note a number of actions outlines in this section also contribute to the other areas identified above).

Smoking cessation - The focus is on improving access to smoking cessation services for manual workers and pregnant women. A specific workplace programme to target workplaces with higher numbers of lower paid staff is in place. In addition specific services and training will need to develop within ante/post-natal settings to ensure pregnant women (and those who have recently given birth) have access to timely information and support.

Obesity - Physical activity and obesity action plans are being implemented across the LCG area. Key actions include encouraging healthy eating through enhancing cooking skills and providing nutritional advice for healthy family diets through programmes such as “Cook It”.

The LCG has been briefed on the success of the MOTIVATE programme which is a structured self-help programme. The programme actively seeks to promote change within an individual’s behaviour in relation to their health. More specifically, it aims to help people with weight loss and maintenance of weight loss over time. The LCG will support the further roll-out of a Managed Obesity Network for the Northern area and explore the opportunities for joint working with primary care.

Levels of obesity are rising, and there is strong evidence of the higher health risks for obese pregnant women and their babies. Reducing maternity obesity and improving pre-conception and pregnancy care for obese women would reduce deaths and illness in mothers and babies.

Alcohol and Drugs - Local priority actions include addressing young
people’s drinking, including targeting education and prevention programmes to address the needs of young offenders. Work is also underway to deliver a local Hidden Harm Action Plan as part of a regional initiative. Another key priority will be training for health professionals in delivering brief alcohol interventions.
Population Screening Programmes
Population screening is an important public health activity that focuses on the early detection of disease, allowing for earlier intervention contributing to improved outcomes.

Emotional & Mental Wellbeing including Suicide and Self-Harm - A local action plan is being developed targeted at vulnerable and at risk groups. It includes a community grants programme to promote local actions and community awareness events to reduce stigma in relation to suicide. A key priority during 2011/12 will be to proactively target programmes to areas of greatest disadvantage and to provide support to those who self harm. The LCG has had a recent update from PHA staff on the various actions being taken forward under the “Protect Life Strategy” and is supportive of the work being progressed throughout the LCG area. Another key action during this incoming year will be to support the development of the new regional mental and emotional wellbeing strategy and work with key partners to develop an implementation plan.

Sexual Health & Teenage Pregnancy – A Teenage Pregnancy and Parenthood/Sexual Health Strategy Group has been established and a local action plan has been developed to deliver key priorities including: personal development programmes for young men and young women; and an outreach sexual health service within the Further Education Colleges.

Local Priorities
The LCG will:
• continue to support the work of local partnerships tasked with addressing health inequalities and will explore opportunities for joint working with Primary Care and joint commissioning of services between HSCB and PHA;

• reduce the number of women who start a pregnancy overweight or obese;

• reduce the number of mothers who smoke during pregnancy;

• promote an increase in breastfeeding, particularly among disadvantaged mothers;
• continue to support the work of the HSCB and PHA in implementing new population screening programmes;

• continue to support the work of the HSCB and PHA in ensuring the quality and uptake of existing screening programmes; and

• continue to support the work of the HSCB and PHA in ensuring that appropriate diagnostic and treatment services are available that meet national/regional standards.
MATERNITY, PREGNANCY RELATED GYNAECOLOGY, FERTILITY, PAEDIATRICS AND CHILD HEALTH

Regional Overview
In 2011/12, the focus will be on maternity services, in particular on ensuring safety and quality in all maternity units in Northern Ireland and normalising birth. A regional review of maternity services will report in 2011, the recommendations of which will provide direction both regionally and locally for maternity services across the Province.

The provision of safe and sustainable maternity services remains a commissioner priority. Ever progressing standards for the medical care of women around the time of birth (the intrapartum period) mean that it is increasingly difficult to sustain small consultant obstetric units. There are also difficulties in sustaining paediatric medical services at smaller hospitals due to staffing issues, such as problems in recruiting junior doctors and reliance on locums. The commissioner wishes to maintain as much access to local maternity and paediatric services as possible, however, there is a need to consider the best models for these services to ensure that quality and safety standards are met, and that the services are sustainable. Implementation of the Regional Review of Maternity Services will be pursued in 2011. There are also recognised inequalities in health and wellbeing, for example in variations in rates of smoking in pregnancy, breastfeeding and obesity levels, especially in hard to reach and disadvantaged women.

In 2011/12, the focus of the Maternity & Child Health Service Team will be to:

- ensure the provision of safe and sustainable maternity services remains a commissioner priority;
- consider best models for obstetric and paediatric services; and
- pursue the implementation of the Regional Review of Maternity Services in 2011.
Local Priorities
There are two consultant obstetric units in the Northern LCG area, one at Antrim Hospital that has approximately 2,800 births annually and one at Causeway Hospital that has approximately 1,400 births annually. There are no midwife units in the Northern LCG area. A number of mothers resident in the Northern LCG area choose to attend a maternity unit in a hospital outside the area, particularly hospitals in the Belfast Trust. Births to mothers resident in the Northern LCG area increased in recent years to over 6,376 in 2008, but then reduced to 5,978 in 2009 (a decrease of 6%). This was the largest fall in births across all LCG areas (NI average decrease 3%). Births are projected to gradually decrease over the next decade.

The LCG will:

CHILDREN

Regional Overview
The Regional Children Service Team deals primarily with services that are required by legislation. The Team also considers circumstances where additional supports are required to assist families to care for their children.

The Service areas include:

- Family Support/ Early Years;
- Child Protection;
- Looked After Children including residential child care and foster care;
- Adoption;
- Leaving Care and After Care;
- Children with a disability;
- Child & Adolescent Mental Health Services (CAMHS).

In 2011/12, the focus of the Children Service Team in taking forward this agenda, will be to:

- work in conjunction with relevant stakeholders to progress the development of the Regional Fostering and Adoption Recruitment and Training service. There will be a focus on securing placement as per assessed need and collaborative working;
- progress a review of the Allied Health Profession Service in Special Schools to ensure equity of access and fit with the core service;
- take forward a review of Trusts’ Early Years Services to encompass the regulatory functions as well as the potential for skill mix and charging;
- continue to progress the strategic direction as outlined within the Healthy Futures Strategy;
- conclude a Regional Review of Residential Child Care provision to provide greater differentiation. Account to be taken of Individual Funding Requests (IFRs), some of which result in out of country
placement;

- undertake a review of the multi-disciplinary teams for children with a disability. The review will focus on the quality and effectiveness of the teams and regional consistency;

- progress the commissioning of an Intercountry Adoption Service within one lead Trust and explore the feasibility of this service being self-financing;

- support the Regional Autistic Spectrum Disorder Network (RASDN), the Bamford Task Group and the Regional Acquired Brain Injury Groups to deliver on actions relating to children. This will include a review of the Family Trauma Centre;

- progress a regional review of accommodation needs of care leavers and young homeless; and

- ensure close working relationships with the Team looking at maternity and child health as there are mutual areas of concern, specifically for children with a disability but also in the consideration of support services for families.

Local Priorities

The LCG will:

- be committed to early intervention which allows families and communities to offer the best possible care and maximise the potential to their children. Where there is a need for statutory intervention this will be premised on acting in the best interests of children to, if at all possible, allow them to continue to be looked after by their parents or family of origin. Where alternative arrangements are required the placement should be secured in a timely fashion and address the assessed needs of children and young people for safety, security and stability; and

- work with the HSCB, PHA and other stakeholders to progress the regional priorities identified above as it is important that there is consistency in service provision across the region.
ELECTIVE CARE (including Diagnostics)

Regional Overview
Since 2006 there has been a sustained focus on improving elective waiting times. The last three years in particular has seen some significant improvements in waiting times for elective treatment, albeit that for some the waiting times have extended for a number of specialties. The PfA target for March 2010 was to sustain the March 2009 position of 9/9/13 weeks. This was reflected further in 2010/11 PfA where the “majority of patients are to be treated within 13 weeks with no-one waiting longer than 36 weeks.

Outpatients
In the Northern LCG area, the number of patients waiting more than 9 weeks for a first consultant-led outpatient appointment was 10,170 at the end of March 2011. The largest numbers of patients waiting were in dermatology, ENT and general surgery.

Inpatients/Day cases
In relation to inpatients and day cases, the number of patients waiting more than 13 weeks for treatment in the Northern LCG area was just under 2,000 at the end of March 2011. Specialties most affected by longest waits were gastroenterology, general surgery, gynaecology and urology. Some 37 people were waiting more than 36 weeks for treatment at the end of March 2011.

It is recognised that there is a need for a continued focus on the modernisation of the patient pathway and how review patients are managed. The LCG will want to ensure that care and treatment are delivered outside the hospital settings where it is safe and appropriate to do so. Pathways need to be better integrated and co-ordinated from both the patient and clinical perspective. In tandem with this, the promotion of self-care and self management are important.

While steady improvements in efficiency and productivity have been made by Trusts in recent years, there still remains significant scope to secure further gains. Service redesign, based on a more sophisticated understanding of capacity, is a key component of the reform and modernisation agenda. It is expected that the SBA Capacity Planning Exercise will identify those areas where more work is required to improve the elective patient pathway and maximise existing capacity.
For the first time in Northern Ireland, the commissioner will have a full picture of consultant job plans and the staffing profile for each specialty together with all the key supporting staff providing capacity and funded theatre sessions. The LCG will seek to gain a better understanding of the nature of demand in the system and how it might be more efficiently and effectively managed.

Local Priorities

The LCG will work with Commissioner colleagues and the Trust to:

- reduce length of stay and improve admission and discharge processes;
- maximise theatre capacity in line with the recommendations from the Acute Capacity Planning exercise;
- reduce cancellations and DNAs;
- promote appropriate and timely use of diagnostics;
- develop condition based commissioning pathways for each of the highest volume specialities reflecting good practice in order to:
  - challenge existing practice;
  - utilise service improvement tools and techniques;
  - reduce waiting times; and
  - improve patient experience of the care pathway.

Early areas for action for Northern LCG will include dermatology and ENT and this agenda will be progressed through the emerging Primary Care Partnerships.
UNSCHEDULED CARE

Regional Overview
The Unscheduled Care Service Team remains committed to completing acute reconfiguration in line with “Developing Better Services” by 2013 and going further to sustain quality services in view of financial constraints, workforce changes and best practice.

In 2011/12, the focus of the Unscheduled Care Service Team will be to:

- bring forward short and medium term proposals for future provision of unscheduled care services, including Accident and Emergency (A&E), across each of the Trusts;
- develop and commission care pathways for key conditions based on best practice and in light of the recent review of acute capacity;
- complete a review of acute bed utilisation with a view to reducing average length of stay; and
- specify and address the impact of these changes on emergency transport services.

In due course, the Regional Team will:

- further develop the role and function of the local hospital network in providing access to diagnostics, outpatients, day and ambulatory care and establishing care pathways through the rest of the hospital system; and
- develop new clinical partnerships with larger acute providers in the Republic of Ireland and facilities in Britain as well as continuing with the programme for establishing local Clinical Networks to ensure Northern Ireland services are delivered to the highest possible standards.

Local Priorities
In order to assist the Trust to manage demand within A&E in Antrim Area Hospital, it has been agreed to introduce a Primary Care Stream within the A&E Unit. A GP presence will be provided during the out of hours’ periods from 6pm to 10pm on weekdays and from 10am to 10pm on Saturdays and Sundays. The Trust will be responsible for ensuring
that triage system accurately identifies and selects those patients who can be treated by a GP.

There will be an evaluation of the project focusing on the Key Performance Indicators (KPIs) listed below:

- numbers treated and waiting times;
- waiting time triage to doctor;
- admission rate;
- patient satisfaction; and
- Adverse Incident reports (AIs).

The LCG will:

- play an important role in the local outworkings of acute redesign, working closely with local hospitals to shape the care pathways so that they are responsive to local need and connect seamlessly to the rest of the hospital network;

- engage on and articulate local priorities and issues facing local populations and, in turn, play an important role in agreeing the services and specialties available in local hospitals in the future;

- review GP referral patterns into A&E and, through PCPs, consider opportunities to redesign pathways into secondary care. There will be a particular emphasis on diagnostics and urgent care with a need to develop alternative services in primary care which lead to more effective patient management;

- review emergency referrals from Dalriada Urgent Care (DUC) to Northern Ireland Ambulance Service (NIAS) to ensure pathways are appropriate;

- with PCPs, play a central role in managing demand into secondary care specialties, focusing on specialties where pathways from primary care could be redesigned to reduce the need for secondary care consultation; and

- work with the PCC to involve patients and the wider public in taking forward redesign, building public awareness of the
challenges and managing expectations in terms of choice and local provision.
MENTAL HEALTH / LEARNING DISABILITY

Regional Overview
The Mental Health and Learning Disability Regional Service Team is committed to working in partnership with the LCG and Trusts to deliver a major programme of reform, modernisation and standardisation.

Some of the additional strategic drivers include:

- the Regional ‘Protect Life’, Suicide Prevention and Promoting Mental Health and Wellbeing Strategy;
- the New Strategic Direction for Drugs and Alcohol;
- the Psychological Therapies Strategy:
- the Personality Disorder Strategy;
- the Autism Action Plan; and
- the Regional Peri-natal Strategy.

Mental Health
In 2011/12, the focus of the Regional Team will be:

- stepped care model – implement the agreed model of care;
- crisis resolution/home treatment – identify an evidence based high fidelity service model;
- acute inpatient care services – secure agreement regarding the overall configuration and size of acute and Psychiatric Intensive Care Unit (PICU) inpatient services;
- to promote mental and emotional wellbeing; and
- resettlement – all long stay patients in mental health hospitals will be resettled by 2014/15.
Learning Disability

In 2011/12, the focus of the Regional Team will be:

- resettlement - all long stay patients in learning disability hospitals will be resettled by 2014/15;

- day services - continue to develop and implement a consistent model of provision;

- improved physical and mental health - implementation of the Directed Enhanced Service for Learning Disability which provides annual physical and mental health checks in primary care for all adults with a learning disability in Northern Ireland; and

- family support - supporting families and carers who care for someone with a learning disability to live in the community.

Local Priorities

Mental Health

The LCG will:

- seek to improve understanding of mental health prescribing patterns across primary care to agree guidelines to assist with more effective primary care based interventions;

- aim to progress the alignment of primary care with local protect life and mental health promotion resources and service models;

- support the local development of regionally agreed mental health service models, eg stepped care service model, crisis resolution/home treatment, personality disorders, forensic services and eating disorders; and

- consider the strategic outline business case for the replacement of Holywell Hospital in partnership with Northern Trust.
Learning Disability

The LCG will:

- support the development of plans for the resettlement of the remaining long stay population from the Muckamore Abbey Hospital site;

- support work to achieve a better understanding of the capacity of existing resources to deal with the needs of ageing carers; and

- promote the development of local community support options by the Trust in partnership with local housing, employment, further education and leisure providers.
SPECIALIST SERVICES

Regional Overview
Due to the small population size in Northern Ireland, many of the more specialist services are becoming increasingly unsustainable as specialist teams are small, often delivering services with only one or two lead clinicians. Whilst this level of staffing is sufficient to meet the needs of the numbers of patients presenting, it is not a sustainable model in providing all year round availability of the service on the 24/7 basis that we need.

In 2011/12, the focus of the Specialist Services Team will be to:

- develop options to secure sustainability of key specialist services including the development of clinical networks with providers in Republic of Ireland and Great Britain;
- agree processes to support decision making on the introduction and availability of high cost drugs. This will be progressed by the Regional Specialist Services Team supported by the HSCB Director of Commissioning and the PHA Director of Public Health;
- benchmark usage of relevant high-cost drugs against other areas of the UK. This will be progressed by the HSCB and PHA; and
- introduce regional arrangements for the management of Individual Funding Requests (IFRs).

Local Priorities
The LCG will:

- work with the Regional Team to ensure that the local population have equal access to highly specialised tertiary care, which tends to be delivered through a single Trust in Northern Ireland, eg heart surgery, kidney transplantation or from a specialist centre in Great Britain, eg heart, lung and liver transplants; and
- work with the Regional Team to ensure that those specialist services which can be delivered locally, eg kidney dialysis, are accessible to Northern LCG residents and that there is sufficient capacity within the overall system to meet patient...
LONG TERM CONDITIONS

Regional Overview
In 2011/12, the Long Term Conditions Service Team will focus on long-term conditions related to heart disease, vascular disease, respiratory disease, stroke, and diabetes in adults and children.

In 2011/12, and beyond, the focus of the Regional Team will be to:

- develop and test a programme of enhanced primary care management of cardiovascular risk factors, in collaboration with local communities. This will start in areas of deprivation and with practices with below average performance on Quality Outcomes Framework (QOF). The first programmes will be in place by 31\textsuperscript{st} March 2012;

- review the impact of investments in patient education programmes to promote self management, remote monitoring and case/disease management in people with Chronic Obstructive Pulmonary Disease (COPD), heart failure and stroke. This will be undertaken during 2011. The Regional Team will review the content and format of existing patient self-management programmes, learning from effective chronic disease management models from elsewhere. This will be completed by 31\textsuperscript{st} March 2012;

- work with relevant stakeholders to develop care pathways for key conditions covered by the Cardiovascular and Respiratory Frameworks. Three care pathways will be developed by 31\textsuperscript{st} March 2012;

- develop/revise existing systems to measure clinical quality routinely through quality improvement projects, supported where appropriate by clinical networks, other clinical forums, and/or the HSC Safety Forum. This will be linked to the work on the Service Frameworks and the timescales associated with them;

- work with existing patient forums in Trusts, community/voluntary groups, clinical networks etc, and use standard tools to facilitate data collection and analysis. The Regional Team will review the results with service providers and use the results to
continuously revise and improve the quality of care. Data collection will start during 2011;

- review the existing support to smokers who are admitted to hospital with ischaemic heart disease, cerebrovascular disease, diabetes, and COPD to ensure that those smokers receive appropriate support and follow-up to stopping smoking. This will be completed by 31st March 2012.

The Regional Team will ensure that nursing, medical and AHP staff working in cardiology, respiratory and general medicine are trained in providing brief interventions to support smokers to quit. Training needs assessment will be carried out and a training plan will be implemented during 2011;

- work with GPs and Trusts to identify ways to improve the detection of people with high cholesterol through active family tracing. This work will be completed by 31st March 2012;

- work with adult and paediatric cardiologists, through the Cardiac Network, to ensure that adults with major congenital heart disease receive specialist care, including access to a consultant specialist and appropriate diagnostic services. Service to be in place by 31st March 2013;

- work with the Cardiac Network and service managers in all Trusts to review the allocation of resources for regional and local cardiac catheterisation services, with the aim of providing equitable and timely access to cost-effective interventional cardiology services. We will look carefully at the results of the primary angioplasty pilot in the Belfast HSC Trust, and other evidence, and work with the Cardiac Network to identify a service model for Northern Ireland. Review carried out, service model identified and action plan agreed by 31st March 2012;

- identify the resources to enable investment in additional insulin pumps for children and adults beginning in 2011/12; and phased over the next three to five years;

- work with Trusts to ensure that patients with stroke and transient ischaemic attack (TIA) have access to treatment and care that meets national quality standards consistent with the recommendations of the Review of Stroke Services in Northern Ireland. This work will be ongoing over the next three years;
• work with relevant stakeholders to develop a Northern Ireland vascular network and agreed patient pathways and protocols for patients with vascular disease; beginning with a care pathway for people with abdominal aortic aneurysm (AAA). The network and the AAA care pathway will be developed by 31\textsuperscript{st} December 2011;

• work with relevant stakeholders to develop community respiratory services in those areas where they currently are not available. The HSCB / PHA will identify the resources required to develop screening and diagnostic services for Tuberculosis (TB) in accordance with identified need. A service development plan will be developed by 3\textsuperscript{1st} December 2011.

The HSCB/PHA will identify the resources required to develop paediatric asthma and allergy services in accordance with identified need. A service development plan will be developed by 3\textsuperscript{1st} December 2011; and

• review the pilot projects on pre-pregnancy care and structured patient education (SPE) programmes for children and adolescents being run by the five Trusts. These run until 2013 and at that stage a decision about future funding will have to be made.

Local Priorities

The LCG will:

• work with the Regional Team to take forward the outworkings of the actions identified above at a local level.
CANCER SERVICES

Regional Overview
Cancer was responsible for 27% of all deaths occurring in Northern Ireland in 2009 (Registrar’s General Annual Report, 2009). Rates of new cases of cancer in Northern Ireland are fairly static, if increasing slightly, in the last few years although the actual number of cases is increasing due to the ageing of the population. Despite this, as survival continues to improve, cancer can develop as a result of factors related to environment, lifestyle and heredity. While our current understanding of the causes of cancer is incomplete, many risk factors that increase the possibility of getting cancer have been identified.

There is a national project to achieve a higher proportion of cancer diagnoses earlier in the development of the disease. However, what is not clear is how to encourage those patients with worrying symptoms to present earlier, yet not swamp the system with referrals of the 'worried well'. If too many non-cancer referrals are made, they may delay the assessment and diagnosis of those who do have the disease.

Local Priorities
The LCG will:

- promote early identification of the signs and symptoms of suspected cancer including primary prevention; and

- work with the Regional Team to implement regional care pathways for breast, lung, colorectal, ovarian including patient self-management.
PALLIATIVE AND END OF LIFE CARE

Regional Overview
The Palliative and End of Life Care Service Team aims to:

- improve quality of life and meet the patient/carer(s) needs in the last year of life;

- meet the bereavement needs of families; and

- improve the overall quality of care, by reducing the level of inappropriate admissions to hospital for people in the dying phase of an illness.

At a local level, the new Specialist Palliative Care Unit on the Antrim Area Hospital site will open in June 2011. This is the first of its kind in Northern Ireland. This is a joint venture with MacMillan and the new 12 bedded Unit will provide specialist palliative care for all patients who require this service, not just those with a cancer diagnosis.

Local Priorities

The LCG will:

- support the development of plans in each LCG area for the enhanced provision of a 24 hour palliative care support service, taking account of existing models of service and investment; and

- support the development of advice and helpline for patients and carers out of hours.
OLDER PEOPLE AND OLDER PEOPLE WITH A PHYSICAL DISABILITY AND/OR SENSORY IMPAIRMENT (OPDSI)

Regional Overview
The significant rise in the numbers of older people will have huge implications for health and social services as older people are major users of services.

Enabling people to live at home is a key objective for the commissioner. Health and Social Care (HSC) Services need to be designed to promote independence, and to support individuals to live fulfilling lives. This requires a continuum of integrated primary and community care services, supporting independence and reducing inappropriate reliance on hospitals and other institutional care.

Historically, although the volume of services to support people in the community has increased, investment has been considerably less in the community than for nursing and residential home care. There is a need to increase home-based care and support services by shifting the balance of funding.

The Service Framework for Older People and the Regional Dementia Strategy will be issued in 2011. The former will identify the standards needed to underpin service change while the latter will focus attention on the projected 30% increase in the number of people over 65 with dementia and will signal the necessary actions to be implemented to deal with the challenges this presents.

It is estimated that between 17-21% of our population have a disability with 37% of households including at least one person with a disability. Recent research indicates that approximately 8,800 people have a visual impairment; 11,700 are hearing impaired and over 35,000 have a mobility problem. Whilst a small proportion of this population is in regular contact with HSC services, the prevailing need is for community based day and domiciliary support, specialist equipment and therapeutic interventions. A high proportion of people receiving Direct Payments have a physical and/or sensory impairment.

The Regional Physical and Sensory Disability Strategy (2011-2015) has been recently published. It contains a challenging action plan which sets out to improve the lives of those with a disability by promoting independence and supporting a more personalised approach to the
provision of services in terms of choice, control and self directed support.

The Board was instrumental in overseeing the development of the Northern Ireland Safeguarding Partnership (NIASP) and five Local Adult Strategic Partnerships (LASPs) who will be responsible for the safeguarding of vulnerable adults. It is essential that the voice of vulnerable adults is at the centre of safeguarding and protection systems and the newly established partnerships are in the process of forming a new Adult Safeguarding Forum to allow effective engagement with individuals in their communities.

The main challenge for commissioning will be to ensure a change in the organisation of services to promote the development of re-ablement and personalisation. There will need to be a reduced reliance on permanent placements; the development of further supported living arrangements in partnership with Supporting People; the provision of support services within the voluntary/community sector which are targeted to meeting identified need and the further development of primary care initiatives specifically targeted at meeting the needs of older people and those with a disability.

In 2011/12 and beyond, the focus of the Team in relation to Older People will be to:

- take forward the recommendations of the Regional Dementia Strategy, in particular the needs of carers;

- introduce a Re-ablement Model which enhances self management, increases the capacity of the voluntary and community sector and promotes healthy ageing, so reducing by more than 70 per cent the number of people who require assessment for ongoing care;

- reduce the number of statutory residential homes and take forward the further development of supported housing schemes;

- extend the proportion of people cared for at home and reduce reliance on nursing home care by reviewing current assessment and discharge processes from hospital to home, patterns of demand and costs;
• ensure reasonable waiting times are maintained for the assessment and provision of care delivery to patients with continuing care needs.
In 2011/12 and beyond, the focus of the Team in relation to People with a Physical Disability or Sensory Impairment will be to:

- take forward the recommendations of the Regional Physical Disability Strategy, in particular the needs of carers;

- work with Department of Social Development (DSD) and the Northern Ireland Housing Executive (NIHE) to take forward the findings of the Joint Housing Adaptations Review;

- ensure current waiting times are maintained for the provision of wheelchairs;

- review the current arrangements for the delivery of the regional brain injury service, and more generally ensure reasonable waiting times are maintained for the assessment and treatment for people with a brain injury;

- increase the uptake of Direct Payments and other models of self directed support;

- increase the flexibility of respite provision in support of service redesign and modernisation;

- update Adult Protection procedures and review the effectiveness of current safeguarding arrangements;

- promote individualised care planning and improve the quality and co-ordination of assessment through the full implementation of the Northern Ireland Single Assessment Tool (NISAT).
Local Priorities:

In relation to both Programmes, the LCG will:

- work with the Regional Team to take forward the actions identified above at a local level;

- continue to develop the re-ablement model with the Northern Trust and voluntary/community sectors to promote rehabilitation, self care and independence; and

- work with the Trust and Supporting People to bring forward proposals for the development of supported housing and other supported living arrangements.
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
Mrs Louise Marsden   Local Elected Representative
Clr David Barbour   Local Elected Representative
Clr Thomas Nicholl   Local Elected Representative
Clr 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)

One General Dental Practitioner is still to be appointed.

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

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