Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Paul Cavanagh
Director of Hospital Care
Strategic Planning and Performance Group (SPPG).
Department of Health
Castle Buildings
Stormont
Belfast
BT4 3SQ

5 July 2023

Dear Sir

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring Witness Statement & the production of documents

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry is investigating the matters set out in its Terms of Reference. A key part of that process is gathering all of the relevant documentation from relevant departments, organisations and individuals.

In keeping with the approach we are taking with other departments, organisations and individuals, the Inquiry is now issuing a Statutory Notice (known as a 'Section 21 Notice') pursuant to its powers to compel the production of relevant documentation.

This Notice is issued to you as Director of Hospital Care SPPG. It relates to documents within the custody or control of the SPPG. The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Department of Health has responded to our earlier Section 21 Notice requesting documentation. If the documentation previously provided deals with a request made within this S21 Notice request, please highlight the relevant document and bring it to the Inquiry's attention. In addition, if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Department and has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you, your officials and/or the Department's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

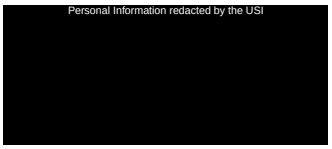
If there is any difficulty in complying with this time limit your organisation must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty. The Inquiry will be pleased to receive your documents in tranches; you do not have to wait

until you are in a position to fully comply with the Notice before you begin to send documents. Indeed it will greatly assist the progress of the Inquiry's work if you immediately begin the process of forwarding documents to the Inquiry.

If your organisation does not hold documentation in respect of some of the categories of document specified in the Section 21 Notice, please state this in your response. If it is possible to indicate by whom such information might be held, if it is not held by your organisation, the Inquiry would find that of assistance.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully



Anne Donnelly
Solicitor to the Urology Services Inquiry

Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 17 of 2023]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO: **Paul Cavanagh**
Director of Hospital Care
SPPG
Department of Health
Castle Buildings
Stormont
Belfast BT4 3SQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

DOCUMENTS TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(b) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry the documents set out in the Schedule to this Notice by **12.00 noon on 16th August 2023.**

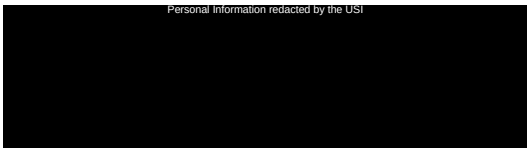
APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **12.00 noon on 9th August 2023.**

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 05th July 2022

Signed: 

Christine Smith QC
Chair of Urology Services Inquiry

SCHEDULE

[No 17 of 2023]

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include:

   (i) an explanation of your role, responsibilities and duties within the Health and Social Care Board / Strategic Planning and Performance Group (HSCB / SPPG) and

   (ii) a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns or governance issues arising.

   It would greatly assist the inquiry if you would provide the above narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the Urology Services Inquiry ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the HSCB/SPPG's Solicitor, or in the alternative, the Inquiry Solicitor.

3. Please also address the following questions. If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your position(s) within the HSCB / SPPG

4. Please summarise your qualifications and your occupational history prior to commencing employment with the HSCB / SPPG.

5. Please set out all posts you have held since commencing employment with the HSCB / SPPG. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

6. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

HSCB/your role

7. Please set out how HSCB assessed the quality of the commissioned care provided to patients with the SHSCT?

8. Please set out how HSCB assessed risk in the commissioned care provided within (i) SHSCT and (ii) urology services in particular?

9. How, overall, did HSCB satisfy itself as to the quality and safety of care provided?

10. How, if at all, did the meeting of performance targets and targets generally impact on your ability to properly assess care quality and risk? Did a focus on outcomes mean that less focus was place on quality and risk? Please explain your answer in full, providing documentation as relevant.

11. Were any concerns regarding staffing, equipment, or any other matters which might impact care provision brought to your attention regarding urology services? If so, please explain in full.

Concerns Prior to 31 July 2020

12. Were you or the HSCB aware that a formal process under the framework contained within Maintaining High Professional Standards in the Modern HPSS commenced in December 2016 (in relation to Mr Aidan O'Brien), in part, as a response to information uncovered during the investigation into the SAI for Patient 10 (RCA Personal information redacted by USI? If so, outline when and in what circumstances the HSCB became so aware and outline the HSCB's understanding of how that process progressed. If the HSCB was not made aware of the commencement of this MHPS process, should it have been made aware?

13. When, if at all, and in what circumstances did you or the HSCB first receive information which identified or could have identified concerns regarding Mr. O'Brien's practice in relation to the following four areas:

    I. Un-triaged referrals;
    II. Patient notes tracked out to Mr. O'Brien and not returned;
    III. Undictated patient outcomes from outpatient clinics; and
    IV. The preferential scheduling of private patients.

14. If you or the HSCB were aware of the four areas of concern identified at paragraph 13 above, what, if any, action did the HSCB take to ensure that these matters were being addressed and that patient safety was not undermined.

15. Prior to 31 July 2020, were you, or others within the HSCB, aware of any concerns in relation to Urology Services within the Trust, including service capacity or waiting list issues, or in relation to the practice of Mr. Aidan O'Brien

in particular. If you or others were so aware of any concerns relating to Urology Services, outline the following:

I. The date on which you or others within the HSCB became aware;
II. The identity of the individual who told you of those concerns if applicable;
III. The specific information communicated to you in relation to any concerns;
IV. What, if any, action you took on behalf of the HSCB to log, monitor, assess or address those concerns.

31 July 2020 – 30 October 2020

16. When and in what circumstances did you first become aware of the contents of an Early Alert Communication from the Trust to the Department on 31 July 2020?

17. Outline all steps taken by yourself and the HSCB upon receipt of the information contained within the Early Alert Communication from the Trust to the Department on 31 July 2020. Specifically, outline the following:

I. The immediate action (naming each actor) taken by the HSCB on receipt of the information contained within the Early Alert Communication;
II. The individuals within the HSCB to whom the contents of the Early Alert Communication was shared;
III. The nature of any discussions which officials from the HSCB had with the Trust concerning the contents of the Early Alert Communication or related matters;
IV. The nature of any discussions officials from the HSCB had with the Department, the PHA, the Regulation and Quality Improvement Agency ("the RQIA") and any other relevant organisation concerning the contents of the Early Alert Communication or related matters;

V. The nature of any internal discussions within the HSCB regarding the content of the Early Alert Communication, or related matters, and next steps.

18. From the HSCB's perspective, what is the purpose of an Early Alert, and was it properly used by the Trust in these circumstances?

19. Did the HSCB reach any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to communicate and escalate the reporting of issues of concern within the Trust to the Department, the HSCB or any other relevant body? If so, fully outline the view which has been reached and set out the reasons for the view which has been reached. If the HSCB has not evaluated this issue, please explain why.

20. Did the HSCB reach any view concerning the effectiveness of the corporate and clinical governance procedures and arrangements within the Trust in the context of the matters which gave rise to the need to issue an Early Alert? If so fully outline the view which was reached and set out the reasons for the view which had been reached. If the HSCB did not evaluate this issue, please explain why.

21. Outline what advice, if any, was given to the Trust by the HSCB in response to the Early Alert and related matters.

22. After receipt of the Early Alert, outline whether the HSCB gave any consideration to, or advised the Trust of the availability and appropriateness of, utilising the Departmental Guidance contained within "*Practical Guide to Conducting Patient Service Reviews or Look Back Exercises: Regional Governance Network Northern Ireland Sub Group*" (February 2007) ("the 2007 Departmental Guidance").

23. As appropriate, outline what, if any, advice was given to the Trust with regard to the application of the 2007 Departmental Guidance and in particular with

regard to paragraph 1.4 of that Guidance. If no such advice was given, please explain why it was not given.

24. Please consider the following extracts from Mr Aidan Dawson's (PHA) and Mr Ryan Wilson's (DOH) evidence to the Inquiry Panel.

Extracts from Mr Aidan Dawson's Response to Section 21 Notice:

> …**WIT-61585 para 14** Following this, a group was established by HSCB. This group titled the Southern Urology Co-Ordination Group, was chaired by the HSCB Director of Commissioning, Paul Cavanagh; the PHA representative was Dr Farrell and Dr Helen Rogers represented Integrated Care in HSCB, along with Southern Trust Senior Offices. At a meeting of this group in August 2020 it was reported that the SHSCT was continuing to scope the extent of the problem, to clarify the GMC responsible officer role now that Mr O'Brien had retired, organise the level 3 SAI review, and make progress regarding the Invited Service Review from the Royal College of Surgeons.
>
> …**WIT-61628 para 30** A series of regular meetings were held between the SHSCT and HSCB / PHA. Most issues relating to planned lookback were discussed at the HSCB/PHA Trust meetings that were organized by the HSCB / SPPG and minutes of all the meetings are available from SPPG.

Extracts from Mr Ryan Wilson's Response to Section 21 Notice:

> …**WIT-50731 Para 68** In the days subsequent to the receipt of the Early Alert, I engaged in discussion with senior management within the Trust and HSCB in order to ask the above questions and to seek further details about the lookback exercise for the purposes of ascertaining the appropriate level of response and commissioner or Departmental oversight that may be required and advising the Minister accordingly. A record of my discussions including dates and times is not available, however the information that I gleaned was used to prepare an advice submission to the Health Minister.

Para 69 My discussions with the HSCB at the time were with Paul Cavanagh, the then Acting Director of Commissioning. My recollection of our discussions was that

they were focused on assessing the emerging information as known at that time, and how best the Department and HSCB could support and oversee the Trust's completion of the lookback exercise in order to reach an informed position from which the appropriate next steps could be agreed upon.

25. Outline any meetings or discussions between officials from the HSCB and the Trust, the Department, the PHA, the RQIA and any other relevant organisation from the date of receipt of the Early Alert on 31 July 2020 to the first meeting of the Urology Assurance Group on 30 October 2020 concerning the handling of the concerns raised in the Early Alert, or related issues. With regards to each meeting or discussion, specify:

    I. The date;
    II. The attendees;
    III. The matters discussed;
    IV. Any decisions taken;
    V. Any advice provided by the Department or received by the HSCB;
    VI. Disclose or refer to any and all documentation relating to same.

Establishment of the USI

26. Outline the decision making process which the HSCB understands led to the announcement of the establishment of a public inquiry by the Minister on 24 November 2020. Specifically please address:

    I. The steps which were taken as part of this process, and whether HSCB participated in that process and if so, in what way;
    II. The factors which led to the decision to establish a public inquiry;
    III. The individuals involved in reaching that decision; and
    IV. Any consultation the HSCB had with any of the following persons/bodies as part of the process leading to the establishment of the public inquiry:
        A. The Trust;
        B. The Department;
        C. The PHA;

D. The RQIA;

E. Mr. O'Brien's representatives; and

F. Any other relevant person or organisation.

'SCRR' Process and 'Lookback Review'

27. Outline the HSCB's understanding of, and its involvement, if any, in the process leading to a decision by the Trust to adopt a SCRR process as opposed to utilising the Serious Adverse Incident ('SAI') process. In answering this question reference should be made to all relevant meetings, discussions or correspondence. Provide copies of all relevant documentation.

28. What assurances did the HSCB seek and receive (if any) with regard to the appropriateness of the use of a SCRR process in the context of the concerns about patient care and safety which were made known to the HSCB, as opposed to utilising the SAI process? In particular, the Inquiry is concerned to understand the extent to which the HSCB sought to obtain assurances as to the robustness and thoroughness of the SCRR process, the assurances provided, how they were tested and whether the assurances were considered satisfactory.

29. With specific reference to all relevant meetings, discussions or correspondence, outline the HSCB's understanding of and involvement in the decision by the Trust to engage in a Lookback Review.

30. What assurances did the HSCB seek and receive (if any) with regard to the appropriateness of the use of the Lookback Review undertaken in relation to the patients of Mr. O'Brien from 1 January 2019 to 30 June 2020? In particular, the Inquiry is concerned to understand the extent to which the HSCB sought to obtain assurances as to the robustness and thoroughness of the Lookback Review process and its comprehensiveness in terms of the patient group which was to be reviewed and the temporal parameters of the review, the assurances provided, how they were tested and whether the assurances were considered satisfactory.

Oversight mechanisms now in place

31. The Inquiry understands that the oversight structures regarding urology and/or public inquiry engagement consists of the following:

Within the Trust

Urology Lookback Steering Group – Chaired by the Director of Acute Services

Within the Trust's internal Public Inquiry Governance structure

3 Strands –

(i) Urology Oversight Steering Group
(ii) Trust's Public Inquiry Steering Group
(iii) Trust's Public Inquiry Quality Assurance Group

Outside the Trust within the Strategic Performance and Planning Group ("SPPG") (formally HSCB),

Southern Urology Co-ordination Group – Chaired by the Acting Director of Planning and Commissions at SPPG and made up of Senior Trust Staff from SHSCT.

Outside the Trust within the Department

Urology Assurance Group – Chaired by the Permanent Secretary and made up of Senior Trust Staff from SHSCT.

You are asked to confirm that the Inquiry's understanding of the existence of these structures is correct to the best of your knowledge. If there are additional working groups or committees working in these areas which are not referred to above, you should identify them. You are asked to briefly outline the function and/or terms of reference of those working groups or committees referred to above or otherwise identified by you, which involve or are engaged

with personnel from the Department. As relevant, explain how all such structures (working groups / committees) in place within the HSCB / SPPG, the Department and the Trust interact and share information and learning, if at all. Your reply should detail the names of the group members as relevant to the HSCB / SPPG, and dates of all meetings, the frequency of meetings as well as all recommendations and actions to date.

Ongoing Assurance

32. In addition to the structures referred to above, outline the SPPG's ongoing role and steps taken, if any, in monitoring, seeking assurance and ensuring patient and general public safety arising out of the concerns about patient care and safety raised by the Trust. In addressing this question outline any engagement the SPPG has had or continues to have with any of the following concerning these matters:

    I. The Trust;
    II. The staff working within the Department, but outside of the SPPG;
    III. The PHA;
    IV. The RQIA;
    V. Mr. O'Brien's representatives; and
    VI. Any other relevant person or organisation.

33. Please set out:

    I. What, if any, reforms the HSCB / SPPG is aware of the Trust having made to clinical governance arrangements to address any issue which may have been identified?
    II. What, if any, processes have been implemented or steps taken by the Trust to monitor or provide assurance that the clinical governance arrangements within the Trust are to the HSCB /SPPG's satisfaction and ensure patient safety?

III. What, if any, assurances has the HSCB /SPPG sought and received from the Trust with regard to any reforms to clinical governance arrangements?

IV. What, if any, monitoring has the HSCB /SPPG implemented to ensure that the clinical governance arrangements within the Trust protect patient safety?

34. How, if at all, have any reforms or assurances been tested? In addressing this question also outline what, if any, assurances the SPPG received or continues to receive, and outline whether the assurances received to date are considered by the HSCB /SPPG to be satisfactory.

35. Does the HSCB /SPPG consider there remains outstanding work to be done by the Trust before its governance structures are sufficiently robust to prevent a reoccurrence of the issues which arose within the Trust's Urology Services? Whether your answer is yes or no, please explain.

36. In light of the Minister's Oral Statement to the Assembly on Tuesday 24 November 2020, where he stated:

> The consultant also had a significant amount of private practice and that much of this was carried out in private domestic premises, therefore sitting outside of the regulatory framework which requires registration and external assurance of facilities in the Independent Sector in which clinicians may undertake private practice. This is also of significant concern to me as many of these patients may be unknown to the Southern Trust or the wider HSC system.
>
> …
>
> *The Minister went on to list actions to be taken, which included the following:*
>
> Thirdly, in relation to his private patients who are not known to the Southern Trust, I have requested that his solicitors outline how Mr.

O'Brien intends to provide a similar independent process to ensure that those private patients are alerted to issues arising and that their immediate healthcare needs are being met. Whilst the Department has no explicit duty to take this particular matter forward, as part of our wider healthcare responsibilities, I want to do all I can to safeguard patients who may have received care or treatment in a private capacity from this consultant.

What, if any, assurances has the HSCB / SPPG sought and received regarding the care and governance of Mr. Aidan O'Brien's private patients from:

I. The Trust;
II. Mr. Aidan O'Brien;
III. Mr. O'Brien's legal representatives; or
IV. Any other relevant person, organisation or source.

37. If assurances have been sought and provided in respect of Mr. O'Brien's private patients, how has the HSCB /SPPG tested the effectiveness of these assurances? Is the HSCB /SPPG satisfied by the assurances provided? If not, what are the HSCB /SPPG's proposed next steps, if any, regarding Mr. O'Brien's private patients?

38. Has the HSCB / SPPG reached any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to address the issues of concern and ensure patient safety? If so, fully outline the view which has been reached and set out the reasons for the view which has been reached. If the HSCB /SPPG has not evaluated this issue, please explain why.

Learning

39. From the information available to the HSCB / SPPG to date, what does it consider went wrong within the Trust's urology services and with regard to Trust governance procedures and arrangements? Has the HSCB / SPPG reached any view on how such issues may be prevented from recurring? Has the HSCB / SPPG taken any steps with a view to preventing the recurrence of such issues?

40. Does the HSCB / SPPG consider that it did anything wrong or could have done anything differently which could have prevented or mitigated the governance failings of the Trust?

41. From the HSCB / SPPG's perspective, what lessons have been learned from the issues of concern which have emerged from urology services within the Trust? Has this learning informed or resulted in new practices or processes for the HSCB / SPPG? Whether your answer is yes or no, please explain.

42. Please provide any further details which you consider may be relevant to the Inquiry's Terms of Reference.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 17 of 2023

Date of Notice: 5th July 2023

Witness Statement of: Paul Cavanagh, Director of Hospital Care, Strategic Planning and Performance Group, Department of Health

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I, Paul Cavanagh, will say as follows:

Introduction

1. I make the following statement for the purpose of the Urology Services Inquiry (USI) (hereafter referred to as "the Inquiry").

2. The statement is made on behalf of the Strategic Planning and Performance Group (SPPG) in response to a request for evidence by the Inquiry Panel. This is my first statement to the Inquiry. SPPG previously provided a statement signed by Sharon Gallagher, Deputy Secretary, Department of Health who is the SPPG lead officer. She provided the statement [redacted]. However, I had the opportunity to review a draft in advance of it being submitted on 25 October 2022.

3. My statement below begins with a summary of my personal qualifications and career history, including the roles and responsibilities that I have held during my time of employment at the Health and Social Care Board (HSCB) and subsequently within SPPG. To provide background and context for the specific questions asked of me, I

then set out some information on the structure of the Health and Social Care (HCS) system in Northern Ireland; the role and functions of the HSCB / SPPG; and its key relationships with other HSC organisations in discharging its duties. I then address each of the queries asked of me in the schedule to the section 21 Notice (hereafter referred to as "the Notice").

4. I have separated my statement into 11 sections. The table below summarises which of the Inquiry's questions are dealt with in each section:

Table 1 – Statement Sections

Section	Section Title	Paragraph Reference	Section 21 Reference
1	Qualifications, Career History and Responsibilities	Paragraphs 7 to 15	Q1(i) and Q4 to Q6
2	Overview of Health and Social Care Structures in Northern Ireland	Paragraphs 16 to 86	Background information
3	Policies and Procedures: Monitoring the Quality and Safety of Care through the HSCB Commissioning and Performance Management functions	Paragraphs 87 to 226	Q7 to Q11
4	Concerns Prior to 31 July 2020	Paragraphs 227 to 308	Q1(ii), Q12 to Q15, Q42
5	Overview of period 31 July 2020 to 30 October 2020	Paragraphs 309 to 374	Q1(ii), Q16 to Q25

Urology Services Inquiry

6	Establishment of the Urology Services Inquiry	Paragraphs 375 to 377	Q26
7	SCRR Process and Lookback Review	Paragraphs 378 to 402	Q1(ii), Q27 to Q30, Q42
8	Oversight Mechanisms now in place	Paragraphs 403 to 414	Q31
9	Ongoing Assurance	Paragraphs 415 to 444	Q32 to Q38
10	Learning	Paragraphs 445 to 467	Q39 to Q41
11	Conclusion	Paragraph 468	
12	Declaration of Truth	Paragraph 469	

5. This witness statement contains some information which cuts across a number of Directorates in SPPG. I therefore sought assurance from the current Directors of SPPG and the SPPG Deputy Secretary that it is factually accurate to the best of their knowledge and our records. They have confirmed that it is.

6. To aid the review of this statement I have attached a list of abbreviations that are used in this statement (**PC Appendix 1 – Abbreviation List**).

Urology Services Inquiry

Section 1 – Qualifications, Career History and Responsibilities

7. I have worked in the HSC system since 2002 in senior management and director roles. Prior to this I worked in a number of community and voluntary sector bodies, from 1989.

8. I am currently (since June 2023) Director of Hospital Care within Department of Health's Strategic Planning and Performance Group (DoH-SPPG). My various appointments in the SPPG, the HSCB and its predecessors are set out in the table below. For the more senior posts within SPPG and the HSCB I have included the relevant job description, which are each confirmed in an appendix, along with the duties and responsibilities for each role, although senior managers are expected to operate in a flexible manner.

Table 2 – Current and previous appointments in HSC

Appointment	**Date of appointment**	**Appendix**
Director of Hospital Care within Department of Health's Strategic Planning and Performance Group (DoH-SPPG)	June 2023	**PC Appendix 2 – JD Director of Commissioning - 2021**
Director of Commissioning (DoH-SPPG)	May 2022	**PC Appendix 2 – JD Director of Commissioning - 2021**
Interim Director of Planning and Commissioning (HSCB)	July 2020	**SG Appendix 177 - SPPG-E-00441 JD Interim Director of Planning and Commissioning 2020 - WIT 71954 to WIT 71969**

Appointment	Date of appointment	Appendix
Assistant Director of Commissioning (HSCB)	July 2009	**PC Appendix 3 - JD Assistant Director-Local Commissioning Lead 2009**
Commissioning Manager (WHSSB)	July 2007	
Manager of the North-West Local Health and Social Care Group (WHSSB)	July 2003	
Health Action Zone Manager of the Western Health and Social Services Board (WHSSB)	February 2002	

9. Prior to joining Health and Social Care, I worked in the following roles in the community and voluntary sector:

Table 3 – Previous appointments in the community and voluntary sector

Appointment	Dates
Chief Executive of City Centre Initiative, Derry	May 2001 - January 2002
Coordinator of North-West Community Network	May 1995 - April 2001

Manager of Limavady Community Development Initiative	February 1994 - April 1995
Development Officer of Save the Children Fund, Strabane	November 1992 - January 1994
Training Coordinator of Gingerbread NI	October 1989 - October 1992

10. My current post as the SPPG's Director of Hospital Care relies on my earlier job description for Director of Commissioning (**PC Appendix 2 – JD Director of Commissioning – 2021**) with a greater focus on acute hospital services across NI. Four assistant directors (ADs) currently report to me:

- Veronica Gillen, Assistant Director, Commissioning
- Sophie Lusby, Assistant Director, Commissioning
- Teresa Magirr, Assistant Director, Commissioning
- Paula Tweedie, Assistant Director, Commissioning (interim)

11. In my previous post as SPPG Director of Commissioning Personal Information redacted by the USI a week after being appointed in May 2022 and was absent from work until late October 2022. On return to work, I was supported by the organisation to rebuild my portfolio of responsibilities and focused in particular (during the period October 2022 to June 2023) on:

- cancer planning and performance;
- oversight for SPPG input to public inquiries and lookbacks; and
- preparations for the new Integrated Care System (ICS) NI.

One AD reported directly to me during this period, Cara Anderson, Assistant Director, Commissioning.

12. As Director of Commissioning and now as Director of Hospital Care, I am responsible to Sharon Gallagher (who provided the first SPPG statement to the Inquiry), the Deputy Secretary of Department of Health with responsibilities for the SPPG.

13. As Interim Director of Planning and Commissioning of HSCB (July 2020 to April 2022) I had strategic oversight of HSC efforts to manage the response to the Covid-19 pandemic. I managed 7 assistant directors. I put in place respiratory surge plans for adult and children services; oversaw the refocus of Trust service delivery plans in line with Departmental requirements; directed the introduction of Covid-19 preventative treatments; facilitated collaboration on sustaining cancer services, including leading the development of the Cancer Recovery Plan; and supported the establishment and ongoing work of the Critical Care and Respiratory Operational Hub. As a member of Gold Command (the strategic level group established as part of the Department of Health's emergency response plan arrangements), I reported regularly on service response to the Covid-19 pandemic and recovery thereafter. In addition, I coordinated regional actions on coping with unscheduled care and pandemic-related hospital pressures. I responded to service issues within Health and Social Care Trusts (Trusts), including oversight of a number of lookback exercises, namely the Belfast Trust neurology recall and Southern Trust urology lookback.

14. As Assistant Director of Commissioning (July 2009 - June 2020) I had a lead role on commissioning of HSC services in the Western Area, working closely with the Western Trust, primary care providers, local government bodies, community and voluntary sector organisations, and patient and carer groups. I also held a number of regional commissioning responsibilities, including ambulance services, radiotherapy services, major trauma care; cross-border partnerships and tertiary care of individual patients outside NI. I managed a large group of senior managers, whose names are provided in a separate document exhibited to my statement (**PC Appendix 4 – Staff List**). I reported initially to the Chief Executive of HSCB, John Compton until the first Director of Commissioning, Dean Sullivan was appointed in 2010. Mr Sullivan was my line manager from 2010 until 2017 and was replaced by Dr Miriam McCarthy who was my line manager until May 2020.

15. In terms of my qualifications, I hold a Bachelor of Science degree with honours and two Master of Science degrees in Development Management and in Systems Thinking in Practice.

Section 2 – Overview of Health and Social Care Structures in Northern Ireland

Introduction

16. To be helpful to the Inquiry, I would like to provide some information on the overall structure and governance of the HSC system in Northern Ireland and, in particular, the core functions of the HSCB. The next 19 pages provide this background and context, along with information on the HSCB's key relationships with other HSC organisations in Northern Ireland.

17. Health and social care services in Northern Ireland were integrated in 1973. Since then there have been a number of restructuring exercises, following broad patterns established across the UK. The Health and Social Care (Reform) Act (Northern Ireland) 2009 reinforced in statute the Department's responsibility to promote an integrated system of health and social care in Northern Ireland. It also provided for a single Health and Social Care Board (HSCB), working in conjunction with a Public Health Agency (PHA), commissioning services to meet assessed need and promote general health and wellbeing. A full range of HSC services are provided by five Health and Social Care Trusts, with a sixth Trust providing ambulance services for the region.

18. These structures are unique to Northern Ireland because, in England, Scotland and Wales, provision of social services remain the responsibility of Local Authorities.

19. Integration provides the opportunity for comprehensive assessment of both health and social care needs, and allows the Department to plan services on the basis of Programmes of Care (POC). A single budget has also promoted the coherent development of objectives within a unified strategic planning process, which spans acute and community-based care.

20. The Department of Health (DoH) has a statutory responsibility to promote an integrated system of HSC designed to secure improvement in:

- the physical and mental health of people in Northern Ireland;
- the prevention, diagnosis and treatment of illness; and

- the social wellbeing of people in Northern Ireland.

21. The Department discharges its duties both by direct departmental action and through its 16 Arm's Length Bodies (ALBs). The Department's statutory responsibilities under the Health and Social Care (Reform) Act (Northern Ireland) 2009 are to:

    - Develop policies;
    - Determine priorities;
    - Secure and allocate resources;
    - Set standards and guidelines;
    - Secure the commissioning of relevant programmes and initiatives;
    - Monitor and hold to account its ALBs; and
    - Promote a whole system approach.

22. Northern Ireland has a fully integrated system of healthcare and personal social services, referred to as "Health and Social Care" (HSC). In terms of a hierarchy, the Department of Health (previously called the Department of Health, Social Services and Public Safety (DHSSPS) up to May 2016), headed by the Minister of Health, sits at the top. As the elected representative, the Minister's strategic vision and priorities for in Northern Ireland are implemented by the Department. The Department also manages the general funding of HSC services from the allocation provided to it by the Northern Ireland Executive.

23. The Department's Sponsorship Branch supports the Department's Governance Unit with its responsibilities to ensure effective governance and sponsorship of all of the Department's ALBs. This branch was (and continues to be) responsible for undertaking the sponsorship arrangements for the Department's ALBs. This means ensuring that ALBs' plans align with Departmental aims and targets, that they demonstrate compliance with financial controls, and that they demonstrate compliance with safety

and quality, governance and risk management requirements. As part of this the Department's Sponsorship Branch undertake periodic assessment of risk.

24. Health and Social Care Trusts (hereafter referred to as “Trusts”), which operate as ALBs of the Department, were established under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991 and are the main providers of HSC services to the public. There were originally 18 Trusts, but this number reduced to 6 in April 2007 as part of the NI Executive Review of Public Administration. Those 6 still remain in existence today. They are:

- Belfast Health and Social Care Trust;
- South Eastern Health and Social Care Trust;
- Northern Health and Social Care Trust;
- Southern Health and Social Care Trust;
- Western Health and Social Care Trust; and
- The Northern Ireland Ambulance Service Trust (NIAS), which is a regional Trust.

25. The Trusts are statutorily independent corporate ALBs within the HSC system, responsible for the delivery of HSC services in line with Ministerial priorities, standards and targets, as commissioned by the HSCB. Trusts were responsible for exercising the statutory functions delegated by the Department to the HSCB.

26. Trusts were accountable to the HSCB for the availability, quality and efficiency of the services they provided against agreed resource allocations. They were also accountable to the Minister through the Department and HSCB for performance against Ministerial targets, including compliance with their statutory obligations.

Role and Functions of the HSCB

27. The HSCB was established on 1 April 2009 pursuant to section 7 of the Health and Social Care (Reform) Act (Northern Ireland) (the 2009 Act). Prior to that there were four separate area-based Health and Social Services Boards.

28. The HSCB was an ALB of the Department until its closure in March 2022.

29. Its statutory functions were set out in section 8 of the 2009 Act. From May 2012 until April 2022, section 8 stated:

"8. Functions of the Regional Board

(1) The Regional Board shall exercise on behalf of the Department—

(a) such functions as are transferred to it by section 24; and

(b) such other functions of the Department (including functions imposed under an order of any court) with respect to the administration of health and social care as the Department may direct.

(2) The Regional Board must exercise its functions with the aim of—

(a) improving the performance of HSC trusts, by reference to such indicators of performance as the Department may direct; and

(b) establishing and maintaining effective systems—

(i) for managing the performance of HSC trusts;

(ii) for commissioning health and social care;

(iii) for ensuring that resources are used in the most economic, efficient and effective way in commissioning such care.

(3) The Regional Board must in respect of each financial year prepare and publish a document ("the commissioning plan") setting out such details as the Department may direct concerning—

(a) the health and social care which the Board is to commission in that year; and

(b) the costs to be incurred in that regard.

(4) The Regional Board—

(a) must, in drawing up the commissioning plan, consult the Regional Agency and have due regard to any advice or information provided by it; and

(b) must not publish a commissioning plan unless it has been approved by the Regional Agency.

(5) The functions mentioned in subsection (1)(a) and any function conferred on the Regional Board by any other statutory provision (whenever passed or made) are deemed to be functions which the Department has directed the Regional Board to exercise under subsection (1)(b).

(6) For the purposes of carrying out its functions the Regional Board may, on behalf of the Department, exercise the Department's general power under section 3 or its power under section 3A.

(7) It is the duty of the Regional Board to carry out its functions in the manner which it considers is best calculated to discharge the Department's general duty under section 2(1).

(8) Subsections (6) and (7) apply subject to any directions given to the Regional Board by the Department under section 6."

30. The HSCB had responsibility for commissioning health and social services and for putting in place systems to monitor performance against Ministerial targets and using indicators provided by the Department with a view to improving those services, as well as ensuring finite resources were used efficiently.

31. Article 34 of the Health and Personal Services (Quality, Improvement and Regulations) (Northern Ireland) Order 2003 is also relevant. It states that the HSCB and the Trusts had a duty in respect of quality:

"34. Duty of quality

(1) Each Health and Social Services Board and each HSC trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—

(a) the health and social care which it provides to individuals; and

(b) the environment in which it provides them.

(2) The Department may, by regulations extend the duty in this Article to any special agency specified in the regulations."

32. The HSCB was responsible for ensuring that there were arrangements in place for monitoring and improving the quality of health services available to the local population through its commissioning and performance management processes. The Trusts also have a statutory duty of quality in their role as the direct provider of services to the local population.

33. Article 34 has been in place from 2009 through to April 2022 when it was amended when the HSCB was closed.

DHSSPS Framework Document

34. The DHSSPS Framework Document September 2011, which will hereafter be referred to as "the 2011 Framework Document" (**SG Appendix 6 - SPPG-E-00484 dhssps-framework-document-september-2011 – WIT 66312 to WIT 66368**), was prepared by the Department to meet the statutory requirement placed on it under Section 5 of the 2009 Act. The Framework document sets out the responsibilities of each HSC body, the manner in which each body should discharge its functions, and how it should conduct its working relationship with the Department and the other HSC bodies. The 2011 Framework document should, therefore, be considered alongside the statutory duties for further guidance on how each body is expected to discharge its functions.

HSCB Standing Orders

35. The HSCB had a number of responsibilities. Its Standing Orders, (**SG Appendix 9 - SPPG – E – 00451 HSCB Standing Orders 20-21 WIT 66701 to WIT 66952**) described the following key functions:

a) Establish the overall strategic direction of the organisation within the policy and resources framework determined by the Department/Minister;

b) Oversee the delivery of planned results by monitoring performance against objectives and ensure corrective action was taken when necessary;

c) Ensure effective financial stewardship through value for money, financial control, financial planning and strategy;

d) Ensure that high standards of corporate governance and personal behaviour maintained in the conduct of the business of the whole organisation.

e) Appoint, appraise and remunerate senior executives;

f) Ensure effective dialogue between the organisation and the local community on its plans and performance that are responsible to the needs of the community; and

g) Ensure robust and effective arrangements are in place for clinical and social care governance and risk management. The purpose of risk management in this context, on behalf of the commissioning organisation, the HSCB, is not to remove all risk but to ensure that risks are recognised and their potential to cause loss fully understood. Based on this information, action could be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

36. In summary, the HSCB had responsibility for commissioning HSC services and for putting in place systems to monitor performance against Ministerial targets with a view to improving those services, as well as ensuring finite resources were used efficiently. It also had to ensure there were arrangements in place for monitoring and improving

the quality of HSC services through its commissioning and performance management processes. This included setting the baselines for Service and Budget Agreements (SBAs).

37. Urology Services were one of a number of acute specialties within the SBA agreed between the HSCB and each Trust. Through the management of the SBA, the HSCB would performance manage Urology Services. The ways in which this worked are outlined in the sections below.

Commissioning

38. As noted in Sharon Gallagher's statement to the Inquiry, the Director of Commissioning is responsible for the "end to end" process comprising:

- assessment of need;
- prioritising need within available resources;
- building capacity of the population to improve their own health and wellbeing;
- engaging with stakeholders;
- securing, through Service and Budget Agreements SBAs), the delivery of value for money services that meet standards and service frameworks for safe, quality care;
- safeguarding the vulnerable; and
- using investment, performance management and other initiatives to develop and reform services.

My newly created role as Director of Hospital Care in SPPG (June 2023) reflects this with a particular emphasis on commissioning acute hospital services.

39. The HSCB was responsible and accountable for the commissioning of all health and social services in Northern Ireland under section 8(2)(ii) of the 2009 Act. The HSCB was the 'commissioner' and the Trusts were/are the 'providers', replicating much of the

internal National Health Service (NHS) market in Britain. The discharge of this function and the HSCB's relationship with the PHA are set out in sections 3 and 4 of the 2011 Framework Document and summarised further below.

40. Resources were and continue to be allocated by the Department on an annual basis. Each year, it allocated the majority of its resources to the HSCB. In accordance with Section 4 of the 2011 Framework Document, the funds allocated to the HSCB were:

    a) *"Committed to secure the provision of health and social care services for local populations by the six Trusts, Family Health Services (FHS) and other providers;*

    b) *Used to allow the HSCB to discharge its functions and to fund its own staff, goods and services*."

41. As well as allocating funding on an annual basis, the Department also set the strategic context for the commissioning of HSC services. This was communicated to the HSCB through publication of the Department's 'Commissioning Plan Direction' (CPD). The strategic priorities and targets set within the CPD changed over time; in order to provide an example, the last Departmental CPD for 2019/20 is provided at (**PC Appendix 5 – Commissioning Plan Direction 19/20**).

42. Under Section 8(3) of the 2009 Act, the HSCB was required to produce its own annual Commissioning Plan in response to the Department's CPD. The HSCB developed its Commissioning Plan in conjunction with the PHA. The HSC required the PHA's approval of its Commissioning Plan under section 8(4) of the 2009 Act.

43. The sequence, then, was the Department's CPD first; followed by the HSCB's Commissioning Plan second; and the HSCB's Commissioning Plan required the PHA's approval before it could be finalised and published.

44. The purpose of the HSCB's Commissioning Plan was to translate the higher-level strategic objectives, priorities and standards, set by the Department in its CPD, into the commissioning of services from the Trusts on the ground.

45. A copy of the HSCB/PHA Commissioning Plan 2019/20 is provided at (**SG Appendix 7 - Commissioning Plan 2019-20 SPPG-E-00470 - WIT 66369 to WIT 66606**).

46. I have referred above to both the Department's CPD and the HSCB's Commissioning Plan from 2019/20 and appended them as examples of the commissioning process. The CPD contained Ministerial targets for HSC, including waiting time objectives within the acute setting. Paragraphs 4.11 to 4.13 of the Department's CPD for 2019/20 outlined its waiting time objectives for urology (and other) services.

47. The Department's Commissioning Plan Direction for 2019/20 set out the following waiting list targets:

> *"4.11 By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.*
>
> *4.12 By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.*
>
> *4.13 By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks."*

The targets for cancer services were set out in paragraph 4.10 of the same CPD:

> *"4.10 During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days."*

48. Waiting times, as outlined within the Ministerial HSC targets, are also an important metric for patient safety. They can speak to mortality rates, as well as quality of life for patients. For example, the following table 2 provides a summary of performance against key cancer targets (31 days and 62 days) for Northern Ireland and for Southern Trust as a subset of this. The Southern Trust performance in urology has been consistently higher than the region as a whole.

Table 4 - HSC performance for urology services against ministerial targets for cancer access times (31 days and 62 days) for Northern Ireland and Southern Trust for the period 2017/18 to 2022/23. Source: SPPG Information

	<31 days		<62 days	
	NI	**Southern**	**NI**	**Southern**
2017/18	85.93%	99.40%	52.71%	59.00%
2018/19	88.40%	99.35%	41.18%	56.00%
2019/20	89.28%	98.70%	28.54%	45.00%
2020/21	90.47%	94.00%	29.55%	36.00%
2021/22	89.19%	98.27%	24.94%	32.00%
2022/23	82.82%	95.00%	16.24%	17.00%

49. Sections 5.1 and 5.3 of the HSCB's 2019/20 Commissioning Plan outline the strategic priorities and provider requirements for Cancer Services and Elective Care at that time. These are relevant to urology services and set out waiting times for outpatients, day cases, diagnostics and inpatient procedures, as well as timelines for first definitive cancer treatment. Its Appendix 2 Outcomes Framework further reflects the targets set out in the Department's CPD.

50. While the HSCB's 2019/20 Commissioning Plan document referred above is titled in the appendix as a 'draft' document, it is in fact the final version available, as that year there was no Minister in post to formally approve it. Further, due to the Covid-19 pandemic, the Department's CPD and the HSCB's Commissioning Plan were rolled forward in both 2020/21 and 2021/22 (when the HSCB closed).

51. In response to the HSCB's annual Commissioning Plan, the Trusts were in turn each required to produce a Trust Delivery Plan (TDP). The TDPs required HSCB agreement, in consultation with the PHA, before being presented to the Department for approval. A copy of the TDP prepared by the Southern Trust in 2019/20 is exhibited to this statement at (**PC Appendix 6 – SHSCT Trust Delivery Plan 2019/20**).

52. Also attached is the paper that was submitted by the HSCB Director of Commissioning to the HSCB Board recommending the approval of the TDP prepared by the Southern Trust, referenced in (**PC Appendix 7 – TDP HSCB Board Paper 10-10-19**).

53. In simple terms, the Department set the strategic objectives and targets in its CPD, which the HSCB then translated through its Commissioning Plan and, in turn, the Trusts produced their respective TDPs detailing the services they would deliver to the public and how they would achieve the Department's goals. Once approved, the Trusts were required to deliver the services detailed in their TDP.

54. Through its Commissioning Plan, the HSCB would further require Trusts to respond to commissioning priorities relating to services pressures, emerging evidence and best practice from other places, and additional policy prerogatives. The Commissioning Plans referred explicitly to quality and safety.

55. The HSCB sought to agree an SBA with each Trust on an annual basis. This document was essentially the contract held between the commissioner (HSCB) and the provider (the Trust). SBAs set out the services to be provided and they link volumes and outcomes to costs. The last SBA between the HSCB and the Southern Trust from 2019/20 is attached at (**PC Appendix 8 – SHSCT SBA 19-20**). Roll forward arrangements were agreed for the subsequent year due to the focus on COVID at that time. The priority with Trusts since has been to deliver as a minimum the activity delivered in 2019/20 as a baseline in recognition of HSC recovery following the pandemic and rising demand for services.

Performance Management

56. Performance management was the method by which the HSCB had oversight of services commissioned and delivery of those services against determined targets/indicators set by the Minister in the Departments annual CPD.

57. Section 8(2)(a) and 8(2)(b)(i) of the 2009 Act, which was referred to earlier, dealt with performance management:

"(2) The Regional Board must exercise its functions with the aim of—

(a) improving the performance of HSC trusts, by reference to such indicators of performance as the Department may direct; and

(b) establishing and maintaining effective systems—

(i) for managing the performance of HSC trusts;"

This process was described in section 2 of the 2011 Framework Document:

"2.38 Trusts must provide services in response to the commissioning plan, and must meet the standards and targets set by the Minister. Service and Budget Agreements (SBAs) are the administrative vehicle for demonstrating that these obligations will be met. SBAs are established between the HSCB and Trusts setting out the services to be provided and linking volumes and outcomes to cost.

2.39. Working with the PHA as appropriate, the HSCB is responsible for managing and monitoring the achievement by Trusts of agreed objectives and targets, including financial breakeven. At the same time, the HSCB and PHA also work together closely in supporting Trusts to improve performance and achieve the desired outcomes."

58. 'Holding to account' is how HSCB ensured that commissioned services were delivered and utilised for the purposes intended.

59. Performance management within the HSCB was the responsibility of all of its Directorates. The Directorate with lead responsibilities for monitoring performance

against CPD targets / indicators was the Performance Management and Service Improvement Directorate (PMSID). Following the creation of SPPG in 2022, PMSID was renamed the Performance, Safety and Service Improvement Directorate (PSSID) and remains part of SPPG.

60. Further information on the performance management function and its application to monitoring Urology Services is included in section 3, paragraphs 93 to 111 of this statement.

Resource Management

61. A key component of the HSCB's commissioning work was resource management. The Department's budget dictated the funds available for commissioning services during each financial year.

62. The HSCB worked with Trusts to agree levels of service to be provided and associated funding, informed at a higher level by Departmental policy.

63. Trusts were asked to ensure a balanced opening financial plan which was monitored to ensure that Trusts did not overcommit financial resources, taking account of the total resources available in each financial year's budget.

64. Trusts had a responsibility to deliver their TDPs on an annual basis. These were monitored by HSCB to ensure that services were being delivered in the quantity expected and that the Trust remained in budget. Escalations were in place for deviation from the opening agreed position, including development and delivery of contingency and recovery plans. Monitoring also considered efficiency markers, performance and equitable access to services or available resources for populations.

65. The HSCB Finance Directorate was responsible for the co-ordination and review of Trust expenditure monitoring returns. These returns were provided on a monthly basis and set out the budget, expenditure projections, assumed income and projected the overall financial position.

66. The introduction of new services was assessed through a 'business case' process, including a value for money assessment. While this system has developed and

changed over the years, in general, the commissioner outlined what the new or additional service requirements were. In turn, Trusts provided a response outlining how these could be delivered, including the resource requirements (staff and non-staff) and the expected activity/outcome. The HSCB, along with PHA, assessed the Trust case and allocated resources accordingly.

67. A detailed overview of the resource management function of HSCB was previously requested by the Inquiry and can be found at paragraphs 52 to 106 of the Statement prepared by Sharon Gallagher dated 25 October 2022.

68. These resource management arrangements continue within SPPG.

HSCB's Relationship with the Department of Health

69. A Management Statement and Financial Memorandum was in place between the HSCB and Department to define the relationship, setting out the control framework within which that relationship was to be managed, and laying down the main duties to be performed by each party. Any proposed changes required Departmental agreement and, if significant, would also require approval by the Department of Finance. The Management Statement and Financial Memorandum for HSCB is provided at (**SG Appendix 161 - SPPG – B – 00157 HSCB MS FM signed WIT 71722 to WIT 71777**).

70. The HSCB essentially had oversight of the HSC system on behalf of the Department. The Department led on policy and direction, ALB governance, including oversight on risk; whereas the HSCB worked with HSC providers to agree the contracted levels of service, make payments and deal with other administrative duties associated with the oversight of service delivery.

71. The HSCB was accountable to the Department. The Department arranged Mid-Year and Year-End Assurance and Accountability Meetings to both seek assurances focusing on the Board's systems of internal control and to hold it to account for their performance against Departmental targets and priorities.

HSCB's Relationship with the Public Health Agency

72. The Public Health Agency (PHA) was established under Section 12(1) of the 2009 Act.

73. Its primary functions are summarised in the Department's 2011 Framework Document (**SG Appendix 6 - SPPG-E-00484 dhssps-framework-document-september-2011 - WIT 66312 to WIT 66368**) as being Service Improvement, Health Protection and Service Development.

74. The Framework document further notes the anticipated interaction between the HSCB and PHA in discharging their respective statutory functions. The HSCB and PHA worked together in integrated Multi-Disciplinary Teams (MDTs) to support the commissioning processes at local and regional levels, as well as to support providers to improve performance and deliver desired outcomes.

75. In the most general terms, the PHA brought clinical expertise to its working partnership with the HSCB. It provided clinical input and oversight for the commissioning process. In comparison, the HSCB's role was mainly managerial, although the HSCB did employ some HSC professionals (i.e. doctors, nurses, social workers, pharmacists and opticians) to fulfil roles in relation to planning and performance.

76. The HSCB was required by the 2009 Act to have regard to advice and information provided by PHA and could not publish its Commissioning Plan without first obtaining PHA approval.

77. The Trust's TDPs (which were in response to the HSCB's Commissioning Plans) also required PHA approval. This was to ensure that each Trust was planning its services in line with its population needs, demographic growth and other change factors; and that clinical services were being provided in line with National Institute for Clinical Excellence (NICE) guidance and recognised standards, including Royal College and other professional bodies, as appropriate.

HSCB's Relationship with the HSC Trusts

78. The Trusts provided HSC services to the public in Northern Ireland, as commissioned by HSCB, with support from PHA.

79. Working with the PHA as appropriate, HSCB had responsibility for managing and monitoring the achievement by Trusts of agreed objectives and targets, including waiting list targets and financial breakeven.

Transfer of HSCB Functions to DoH and formation of SPPG

80. On 4 November 2015 the then Minister of Health announced his intention to close the HSCB. The decision was re-affirmed following public consultation in March 2016, and further confirmed with the launch of *Health & Wellbeing 2026: Delivering Together* in October 2016. Minister Swann took the decision to close the HSCB in early 2020.

81. Work was undertaken to give operational effect to this decision, and legislation progressed leading to the Health and Social Care Act (Northern Ireland) 2022. The 2022 Act provisions were commenced on the 1 April 2022 and provided for the following:

- The closure of the HSCB and the transfer of its legislative functions in the main to the Department;
- Responsibility for the exercise of prescribed Social Care and Children functions are now placed directly upon HSC Trusts with oversight of the exercise of these functions now the responsibility of the Department;
- Local Commissioning Groups (LCGs) which were Committees of the HSCB remain in place beyond the closure of the HSCB. They remain in place until such times as the Department makes regulations via the draft affirmative process to establish local area bodies, Area Integrated Partnership Boards (AIPBs) as part of the development of an Integrated Care System (ICS) for NI (see below);
- Transfer Schemes for the Assets and Liabilities of the HSCB and its staff; and
- The necessary transitional provisions required to safeguard operational delivery post HSCB closure.

82. Since 1 April 2022 the newly established Strategic Planning and Performance Group in the Department has undertaken the former functions of the Health and Social Care Board as prescribed in the Health and Social Care Act (Northern Ireland) 2022.

83. The former HSCB staff continue to carry out their previous roles within the Department's Strategic Planning and Performance Group although they are employed by the Business Services Organisation (BSO) under a hosting arrangement, retaining their status as public servants with the same terms and conditions as before.

84. The closure of the HSCB has provided the system with an opportunity to transform how we plan, manage and deliver our services in line with the vision set out in *Health and Wellbeing 2026: Delivering Together* which articulates the need to empower local providers and communities to plan integrated continuous care based on the needs of their population, with specialised and regional services planned, managed and delivered on a regional basis.

85. In line with this vision, Minister Swann approved a programme of work in October 2020 on the development of an Integrated Care System (ICS) model in NI. The model will promote and enable improved integration, partnership working and collaboration both within and outside traditional HSC boundaries. This will allow the wider determinants of health and wellbeing to be addressed and will deliver care on a population health-based needs approach with the person at the centre of the model.

86. SPPG is accountable to the Minister with the Head of Group (Deputy Secretary) reporting directly to the Department's Permanent Secretary. The Deputy Secretary responsible for the SPPG is a senior civil servant in the Department and a member of the Department's Top Management Group (TMG) and the Department's Board.

Section 3 – Policies and Procedures: Monitoring the Quality and Safety of Care through the HSCB Commissioning and Performance Management functions.

87. Article 34 of the Health and Personal Social Services (NI) Order 2003, referred to earlier at paragraphs 31 to 33, places a responsibility on both the Trust and the HSCB to have in place arrangements for monitoring and improving the quality of health and social care which it provides to individuals and the environment in which it provides them.

88. I have extracted the HSCB commissioning and performance management processes from the 2011 Framework Document which were used to ensure quality and safety in secondary care services below:

At section 4 it states:

"4.13 The HSCB and PHA must maintain appropriate monitoring arrangements in respect of provider performance in relation to agreed objectives, targets, quality and contract volumes.

4.14 The HSCB incorporating its LCGs must have appropriate monitoring arrangements to confirm that commissioned services are delivered, to benchmark comparative performance, and to ensure that quality outcomes, including positive user experience, are delivered."

At section 6, it states:

"Safety and Quality Dimension

6.13 The HSCB, working with the PHA on (i) to (viii) and (xii) below, is responsible for monitoring and reporting to the Department on:

i. Compliance with Priorities for Action safety and quality requirements at least quarterly e.g. quality improvement plans;

ii. Implementation of the RQIA and other independent safety and quality review recommendations in accordance with agreed plans;

iii. Implementation of National Institute for Health and Clinical Excellence (NICE) technology appraisals endorsed by the Department;

iv. Application by Trusts of lessons from adverse incidents and near misses… and communicating, acting upon and reporting action taken in relation to safety information issued through the Northern Ireland Adverse Incident Centre Safety Alert Broadcast System (SABS);

v. Evidence of provider-initiated action to improve safety and quality

6.15. Joint Commissioning Teams led by the HSCB or PHA, as appropriate, are responsible for monitoring:

…

iii. Compliance with safety and quality and clinical and social care governance requirements specified by the commissioners of HSC services.''

89. The day-to-day arrangements to provide quality care in Urology Services is the responsibility of the provider, namely the Trust.

90. The HSCB's statutory obligation to monitor and improve the quality of care was discharged through the commissioning and performance management of the services delivered by the HSC Trusts, and through the application of relevant governance processes in addressing concerns raised.

91. Trusts employ professional staff in specific clinical governance roles with an emphasis on quality and safety of care. These include the Medical Director, Director of Nursing, Acute Specialty Clinical Directors and Leads, and Infection Control lead. The Trust's Board, made up of Executive and Non-Executive Directors, has an overarching responsibility for clinical and corporate governance and must provide assurance to the Department of Health through established channels. This includes patient safety.

92. The HSCB administered a number of safety and quality processes in order to discharge its responsibility. With the exception of the Northern Ireland Cancer Network (NICAN),

they were general in nature and would apply to any area, rather than being specific to urology:

- Performance Management
- Northern Ireland Cancer Network (NICaN)
- Complaints
- Serious Adverse Incidents, (SAIs) including Interface Incidents
- Early Alerts
- Safety and Quality Alerts (SQAs)

Each of the above is considered in turn below.

Performance Management

93. The HSCB required metrics against which Trust performance could be considered. These were provided by the Department in its annual CPD (mentioned earlier in this statement). The targets relating to Urology Services are set out in section 2 of this statement, paragraphs 47 to 48.

94. PMSID regularly reviewed management information reports and updates to enable performance to be scrutinised and challenged where necessary.

95. The Trusts were held to account for any discrepancy at scheduled performance meetings with HSCB. Performance was also reported to the HSCB Board in reports which were in the public domain. Sample copies of performance reports have been included as appendices, namely from December 2014, (**PC Appendix 9 – HSC Board Performance Report 11.12.14 – Final**), May 2015, (**PC Appendix 10 – HSC Board Performance Report 19 May 2015 - 14_15 EOY Assessment Final**) and February 2017, (**PC Appendix 11 – HSC Board Performance Report - M9 - Final 9.2.17**).

96. The HSCB did not have a direct role in organising the delivery of services. This was for the Trusts although any proposed change or closure of service required HSCB and PHA

support following appropriate consultation with the public in line with Departmental policy. Trusts are accountable for the delivery of care and services provided to patients and for ensuring patient safety in the provision of that care. It was not within the remit of the HSCB to hold individual clinicians to account for their part in activity plans and/or meeting targets. Performance by individual members of Trust staff was a matter for each Trust. The HSCB's role was to manage the performance of the overall service against the agreed activity, as opposed to the performance of individuals clinical practice.

97. The HSCB's Director of Performance and Director of Commissioning met regularly (at least quarterly) with Trusts at Director level to monitor performance across a range of target areas, including elective care and cancer services. These Performance Meetings would have included consideration of Urology as one of a large number of elective surgical specialities, as well as other hospital and community care services (including mental health), and hospital acquired infections. The PHA would have been included in the circulation list seeking agenda items in advance of these Performance Meetings. A PHA representative attended the meetings where there was an agenda item listed on which they were the lead, for example, Allied Health Professional performance.

98. The meetings included monitoring the delivery of commissioned volumes of core activity at specialty level, with an assessment of performance against the HSCB's SBA. Data was sourced from Trust's Patient Administration System (PAS). Through an automated process, the Trusts produced management information reports detailing their performance against each of the targets. Essentially this process records the waiting times for outpatient, inpatient, day case, and diagnostic tests, as well as timelines for first definitive cancer treatment (refer to Section 2 above) for the elective care and cancer services targets that were relevant in respect to urology services).

99. Waiting times and the number of patients whose wait breached the Ministerial Targets were key metrics used in management of performance within Acute Services.

100. The Trusts' reports were routinely discussed between the HSCB, PHA and Trusts at the regular performance review meetings.

101. Additionally, in the case of specialties where cancer treatment was a feature, which included urology services, there would be additional protocols and guidance to be followed as outlined by the work undertaken *via* the NI Cancer Network (NICaN). Further information on NICaN is provided at paragraphs 112 to 118 below.

102. Benchmarking among HSC Trusts and with similar bodies in Britain has also been employed in performance management of specific services (such as intermediate care and palliative care); peer review (notably cancer peer review); and capacity modelling from Royal Colleges (e.g. in agreement of clinic templates) have been used from time to time.

103. An example of the notes of a HSCB / Trust Performance meeting with the Southern Trust from February 2017 is attached (**PC Appendix 12 – HSCB-SHSCT Directors Meeting - 1.2.17-notes**). This example includes reference to Urology Services in the Southern Trust.

104. While these meetings took place on a quarterly/bi-monthly basis, discussions regarding performance continued in the intervening periods between relevant HSCB/PHA and Trust colleagues as part of normal business.

105. Where monitoring identified a concern about a Trust's performance or highlighted a serious risk to achievement of targets, a range of escalation measures were available. Performance of urology services fell within this. Potential escalation measures included the Trust to provide detailed recovery plans, additional monitoring, and/or more frequent review meetings with Trust Chief Executives and their senior teams until performance improved.

106. When concerns remained, they would be escalated to the Department using its accountability process (mid-year and end of year ground clearing and accountability meetings). These meetings were attended by senior management from the Department and the HSCB.

107. In addition to the Performance meetings referenced above, PMSID, along with colleagues from other HSCB Directorates, met with Trusts on a regular basis to discuss performance across a range of other target areas where there was a need for a more

focused approach, for example mental health, hospital acquired infection, domiciliary care performance and nursing home performance.

108. Following the decision to close the HSCB in 2015, a review of the HSC performance management arrangements was undertaken and a new HSC Performance Management Framework was developed to strengthen the HSC systems for planning and performance, service improvement, quality and safety and resource management. The Framework was introduced during 2017/18. (**SG Appendix 13 - SPPG-A-00045 Draft revised HSC Performance Framework - WIT 66966 to WIT 66973**). As Sharon Gallagher pointed out in her statement, paragraph 19 of the new 2017/18 Framework made it clear that primary performance function was the responsibility of Trusts and that the regional forum for holding providers to account for performance was via the Department's existing accountability review meetings. HSCB reports on Trust Performance were incorporated into the Department's meetings.

109. Demand for health and social care is increasing in the main and the ageing population has increasing complex needs which is placing pressure on services at a time of growing financial constraint. Therefore, Ministerial targets are becoming more difficult to achieve. The new Framework, introduced in 2017/18 (mentioned above), introduced Performance Improvement Trajectories in recognition of the need to have deliverable improvement. Where Trusts deviated from agreed Performance Improvement Trajectories, they were required to describe actions being taken to address this and HSCB would agree a revised level and pace of improvement. If there was a failure to meet the revised trajectory, HSCB would escalate the deviation to the bi-annual accountability meetings between the Permanent Secretary and Trust Chair and Chief Executive.

110. Also, each Trust's Board has an important role in holding the organisation to account for achieving targets and the delivery of commitments within TDPs and SBAs.

111. In response to the COVID-19 pandemic, the focus of HSCB was on rebuilding HSC services as well as coping with the additional pressures caused by the pandemic. PMSID was responsible for monitoring and reporting performance in rebuilding against

the activity projections associated with Trusts' 3-monthly Delivery Plans, which detailed how capacity would be increased following reductions caused by the pandemic.

Northern Ireland Cancer Network

112. The Northern Ireland Cancer Network (NICaN) was formed in 2004 and was Northern Ireland's first regional clinical network. It is a managed clinical network that brings together those who use, provide and commission services with the aim of making improvements in patient pathways using an integrated, whole system approach. NICaN does not actively deliver patient care, but works in collaboration with HSC organisations, academic organisations, charities, cancer specialists and service users to improve cancer services.

113. NICaN sat under HSCB until March 2022 and was operationally accountable to the Director of Commissioning who was a member of the NICaN Board. In October 2022, following the publication of the Cancer Strategy for Northern Ireland, NICaN Board was stood down and its oversight is now provided by the Cancer Programme Board, which was established in early 2023.

114. NICaN's focus was on delivering safe and effective care; improving cancer clinical outcomes; and enhancing patients' and carers' experience and quality of life. Clinical Reference Groups (CRGs) formed the clinical structure of NICaN. They had a diverse membership drawn from MDTs covering primary, secondary and tertiary care who care for patients within each Trust. CRGs were categorised under:

a) Tumour site (12 groups, including Urology);

b) Treatment (2 groups: Systematic Anti-Cancer Therapy (SACT) CRG and radiotherapy CRG);

c) Service (teenage and young adult service, and acute oncology service groups); and

d) Professional Groups (nurse leaders, pharmacy group, SACT nurses, allied health professional group).

115. Each CRG acts as a resource for consultation and advice on clinical guidelines and supports the regional work programme, aiming to enhance patient experience through collaboration, sharing best practice and highlighting areas of service improvement. The Terms of Reference (TOR) for the Urology CRG are attached at (**PC Appendix 13 – NICAN Urology CRG TOR**).

116. In respect of the HSCB's role in monitoring and improving the quality of cancer related care provision within urology services, the following NICaN-led work has been particularly relevant in recent years:

a) NICaN informed the development of MDTs, which relates to implementation of multi-disciplinary discussion and decision making in the delivery of cancer services. NICaN's role included the development of standard operating procedures, protocols and arrangements for data collection to support the MDTs. A copy of the MDT Operational Policy for the Southern Trust Urology MDT is attached, (**PC Appendix 14 – SHSCT Urology MDT Operational Policy Final 13.5.15**).

b) NICaN commissioned NHS England to undertake a rolling programme of National Cancer Peer Review (NCPR) from 2014 to 2020. NCPR was a national quality assurance programme for NHS cancer services. The programme involved both self-assessment by cancer service teams and external reviews by professional peers, against nationally agreed "quality measures". Further relevant details of the Peer Review process and its outcomes are outlined in section 4 of this statement (the next section).

c) NICaN CRGs also developed clinical management guidelines for every tumour site and modality. The relevant NICaN 2016 Clinical Guidelines for Urology Cancer have been appended, (**PC Appendix 15 – NICAN Urology Cancer Clinical Guidelines 2016**).

117. NICaN ultimately supports members to:

- deliver cancer services that are evidence based;
- ensure equity of access and quality of cancer services;

- encourage innovation in how services are provided;
- provide clinical advice and leadership to support decision making and strategic planning.

118. NICaN, which has been coordinated by HSCB, played an important role in supporting HSCB in enacting its duty of quality in respect of cancer-related services, including urology. Although NICaN cannot compel the use of the guidelines or protocols developed, it acts as a regional CRG to gain consensus on quality and safe clinical approaches, as well as treatment pathways based on evidence. It was confirmed at the NICAN Board meeting in February 2018 that it is the responsibility of individual Trusts, all of which are members of the Urology CRG, to adopt these guidelines and protocols, (**PC Appendix 16 – NICAN Board Minutes February 2018**).

Complaints

119. The HSC complaints procedures and standards are set out in two documents:

- Complaints in HSC Standards and Guidance 2009 (**SG Statement – Appendix 199 – SPPG – D – 0001 File 1 HSC Complaints Guidance 2009 - WIT to 72419 to WIT 72518**) and;
- HSC Complaints Procedure (updated 2019), (**PC Appendix 17 – HSCB Complaints Procedure 2019 – April 2019**).

120. In accordance with the HSC Complaints Procedure, (**PC Appendix 17 – HSCB Complaints Procedure - April 2019**), the HSCB formulated its own policy on the management of complaints. Attached is the most recent version of the HSCB Complaints Policy, (**PC Appendix 18 – HSCB Complaints Policy amended 2020**).

121. As well as dealing with complaints against HSCB, the Board also analysed complaints made about Trusts with a view to sharing on a regional level any learning from that analysis.

122. The HSCB was required to monitor how it and its commissioned services, including those provided by Trusts, dealt with complaints. This included monitoring complaints

processes, outcomes and service improvements. The Standards for Complaints Handling provided a level against which HSC service performance can be measured (Annex 1 Page 54 of (**SG Appendix 199 – SPPG – D – 0001 File 1 HSC Complaints Guidance 2009 - WIT 72419 to WIT 72518**) refers).

123. The HSCB would review to identify any trends of concern or clusters of complaints. However, the information the HSCB received from Trusts was anonymised (both the complainants and the practitioners). Therefore, if complaints kept arising in respect of the same practitioner, unless this detail was specified by the Trust in the body of its report, the HSCB would not be directly alerted to this. The HSCB's role was to identify trends in the more general sense. When identified, any resulting learning was shared on a regional basis.

124. In order to provide effective oversight of safety and quality processes, including complaints, the HSCB created joint working/decision making groups.

125. A Regional Complaints Group was established in 2009 and chaired by the then Director of Social Care. Membership of this group also included HSCB Directors, HSCB complaints staff, PHA staff, and the Patient and Client Council (PCC). The Regional Complaints Group reviewed monitoring reports, prepared by HSCB complaints staff, of complaints received from the respective HSC Trusts.

126. Following the establishment of the Quality Safety and Experience Group (QSE) in 2013/14 (as further described below), the Regional Complaints Group became the Regional Complaints Sub-Group (RCSG) of the QSE. A copy of the terms of reference for the QSE group is attached as an appendix (**PC Appendix 19 – Final Terms of Reference QSE Sept 2015**).

127. The RCSG reviewed complaints information received from Trusts and any complaints received by the PHA. To inform the RCSG, specific categories of complaint would be sent to designated professionals in the HSCB and PHA for review/consideration and determine if any further action was required.

128. From 2020, the RCSG was jointly co-chaired by the HSCB Complaints and Litigation Manager and the PHA Nurse Consultant for Patient Safety/ Quality and Experience.

The latest Terms of Reference of the RCSG are attached (**SG Appendix 201- SPPG – D – 0002 File 2 Terms of Reference RCsG April 2021 - WIT 72535 to WIT 72539**).

129. After 2013/14, the RCSG reported into the QSE. The QSE reviewed issues arising from SAIs, complaints and patient experience with the aim of identifying learning. The QSE reported to the HSCB Senior Management Team (SMT), which was responsible to the HSCB Governance/Governance and Audit Committees through to the Board of the HSCB, which was ultimately responsible to the Department.

130. Patterns of concern in the complaints received from Trusts, updates arising from the RCSG or learning identified were considered by QSE and subsequently *via* quarterly reports to SMT and twice yearly to the Governance and Audit Committee. An example of a quarterly complaints report has been included as (**PC Appendix 20 – HSCB Quarterly Complaints Report - Jan to Mar 2021**). An example of an annual complaints report has been included as (**PC Appendix 21 – HSCB Annual Complaints Report _2020 to 21**).

131. Between April 2020 and May 2021, meetings of the QSE were significantly impacted by pressures associated with Covid. Consequently, the QSE group was stood down in 2020/21 and replaced by a weekly Director-led Safety Brief meeting from May 2021 at which any concerns relating to complaints were raised. The Safety Brief meeting was jointly led by the HSCB Director of Strategic Performance and the PHA Director of Nursing and Allied Health Professionals. Escalation of any issues arising at the Safety Brief would have gone to the HSCB SMT meetings

132. The above escalation structure through the weekly Safety Brief replaced the need for the QSE Group. A separate Safety and Quality Oversight Group was established in January 2021 to draw on information from a variety of safety and quality processes to identify and progress regional learning in a triangulated manner – that is learning from complaints, SAIs, potentially adverse incidents (AIs) and patient experience. That allowed us to combine learning and share it in a meaningful way *via* articles and newsletters. The Safety and Quality Oversight Group supports learning from safety and quality processes with outputs requiring sign off from the Safety Brief outlined above.

The Terms of Reference for the Safety and Quality Oversight Group are attached as an appendix, (**PC Appendix 22 – Final TOR joint safety and quality oversight group**).

133. Under previous arrangements a standing item on the QSE agenda required the RCSG to provide regular updates on complaints issues and/or developments. A quarterly report advising of any key issues or trends arising from complaints and any learning identified from them was also submitted to meetings of the HSCB SMT, the HSCB Governance and Audit Committee and Annual Reports to the Department via the Governance and Audit Committee.

134. To enable it to fulfil its responsibilities in respect of complaints, the HSCB did the following:

a) Received monthly monitoring reports from each Trust through an agreed Monitoring Protocol (**SG Appendix 202 - SPPG-D-0003 Monitoring Return Protocol (June 2022) - WIT 72540 to WIT 72546**) which ensures an anonymised summary of each complaint and its respective response is reported to the HSCB on an agreed template.

b) Categorised information into specific areas of complaint.

c) Shared information with designated professionals within the HSCB and PHA, who sat as members of the RCSG, and, if deemed necessary, further information was requested on occasions for clarification.

d) Required Trusts, *via* the Monitoring Protocol (**SG Appendix 202 - SPPG-D-0003 Monitoring Return Protocol (June 2022) - WIT 72540 to WIT 72546**) to indicate if a complaint was escalated into the SAI process and, if so, to provide the SAI reference number. This was to ensure cross-reference with the HSCB Governance Team that the SAI had been reported and to ensure that any learning identified was shared with the Complaints Team. Furthermore, if the professional review of the complaint deemed that it met the threshold for a SAI, this was discussed at the relevant SAI Professional Group and, if considered appropriate, the Trust was requested to submit an SAI notification to the HSCB. SAI Professional Groups were fully established

for all Programmes of Care in May 2021 in order to provide a multi-disciplinary discussion on SAI review reports as opposed to a single Designated Review Officer (DRO). A copy of the terms of reference for the Acute Services SAI Professional Group, which would be the group relevant to urology services, is attached for information (**PC Appendix 23 – FINAL TOR for acute SAI Sub-Group 2018**).

e) Required Trusts, via the Monitoring Protocol, to forward, using a shared learning template, details of those complaints in which learning had been identified by them that may merit considered for regional dissemination.

f) Met bi-annually with Trusts to discuss themes of complaint and learning examples. The Terms of Reference of this Monitoring Group have been provided at (**SG Appendix 203 – SPPG – D – 0004 File 4 SPPG HSC Trust Monitoring Group TOR - WIT 72547 to WIT 72549**).

135. The above complaint monitoring structures which were in place at the material times did not identify any matters of concern in urology in the Southern Trust.

Southern Trust Complaints

136. A summary of the complaints received in respect of Southern Trust Urology Services was reviewed for the period April 2009 to September 2021 and the outcome of this is summarised in the table below, along with reference to relevant appendices.

Table 5 – Review of Southern Trust Complaints

File Number	Information
SG Appendix 205 – SG Appendix 283 SPPG-D-0006 –SPPG-D-0084 (WIT 72560 to WIT 73196)	Summary of Complaints information received from the HSC Trust

SG Appendix 284- SG Appendix 286 SPPG-D-0085 –SPPG-D-0087 (WIT 73197 to WIT 73242)	Action logs of the RCSG at which there was discussion regarding Urology services complaints
SG Appendix 287 (WIT 73243 to WIT 73244) and SG Appendix 290 SPPG -D-0088 & 89 (WIT 73280 to WIT 73282)	Lookback review from the HSCB review of urology services and email trail regarding complaints
SG Appendix 291 SPPG-D-0090 (WIT 73283 to WIT 73295)	Information relating to a complaint concerning Urology Services which appeared in the quarterly SMT monitoring report
SG Appendix 292 to SG Appendix 296 (WIT 73296 to WIT 73311)	Emails between HSCB and SHSCT regarding the above complaint following receipt of the Trust monitoring report, through to request for further information from the HSCB/PHA professional adviser and closure

137. The HSCB did receive anonymised complaints concerning the urology service in Southern Trust as part of the monitoring process (**SG Appendix 205 to SG Appendix 286 SPPG-D-0006 to SPPG-D-0087 - WIT 72560 to WIT 73242**). No trends of concern or clusters of complaint were identified within those complaints.

138. As part of the review of urology services, a lookback of complaints was undertaken by a nursing professional for the period 2014/15 (as distinct from the more recent lookback exercise). The 2014/15 lookback involved a review of urology complaints regionally

from all Trusts. This information has been provided at (**SG Appendix 287 - SPPG-D-0088 SHSCT April 2015 - March 2016 Urology Complaints - WIT 73243 to WIT 73244**). No concerns, patterns or clusters of complaints were identified from the information reviewed by the nursing professional.

Serious Adverse Incidents (SAIs) including interface incidents

139. An adverse incident is described as "*any event or circumstances that could have, or did lead to harm, loss or damage to people, property, environment or reputation*" arising during the course of the business of an HSC. Trusts are responsible for reporting, management of and learning from AIs within their own organisation. Each Trust holds its own Adverse Incident Policy to be used in conjunction with the Regional Procedure for the Reporting and Follow Up of Serious Adverse Incidents (2016) (**SG Appendix 301 - SPPG – C- 00410 File 410 HSCB Procedure for the Reporting and Follow up of SAIs November 2016 - WIT 73380 to WIT 73487**). Section 4.2 of the procedure sets out the criteria to be applied to determine whether an AI constitutes a SAI, which was then reported by the Trust to the HSCB.

140. SAI reviews should be conducted at a level appropriate to the incident under review. Reporting Organisations may use a Regional Risk Matrix to determine the level of 'seriousness' and subsequently the level of review to be undertaken (HSC Regional Risk Matrix – refer Appendix 16) (**SG Appendix 301 - SPPG – C- 00410 File 410 HSCB Procedure for the Reporting and Follow up of SAIs November 2016 - WIT 73380 to WIT-73487**). There are three levels of SAI reviews: *Level* 1 reviews required a Significant Event Audit (SEA) which could be undertaken for less complex SAI reviews; Level 2 and Level 3 continued to be reviewed using Root Cause Analysis (RCA) methodology. Each level is summarised below:

a) **Level 1 Reviews.** A Level 1 review requires a Significant Event Audit (SEA) to be undertaken and submitted to the HSCB within 8 weeks of the SAI being notified. Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

- assess what has happened;

- assess why did it happen;
- what went wrong and what went well;
- assess what has been changed or agree what will change;
- identify local learning and regional learning.

If the outcome of the SEA requires a more detailed review, a level 2 or 3 will then be undertaken by the reporting organisation.

b) **Level 2 Reviews.** A Level 2 Root Cause Analysis (RCA) review may involve two or more organisations. It is a more complex review and must be conducted to a high level of detail. It should include use of appropriate analytical tools and will normally be conducted by a multi-disciplinary team (not directly involved in the incident) and chaired by someone independent to the incident, but who can be within the same organisation. The terms of reference and team membership of the review team had to be submitted to the HSCB within 4 weeks of the SAI being notified and the final RCA report within 12 weeks.

c) **Level 3 Review.** A Level 3 Root Cause Analysis Independent review is undertaken for SAIs that are particularly complex, involving multiple organisations, and have a degree of technical complexity that may require expert advice. In some instances, the whole team may be independent to the organisation where the incident has occurred. The timescales for reporting Chair and Membership of the review team and submission of the final RCA Report will be agreed by the HSCB/PHA DRO at the outset.

The level of review (1, 2 or 3) was (and still is) determined by the Trust and stated on the SAI notification form, although the HSCB and PHA could advise that it should be changed.

141. The HSCB took over responsibility for the administration of SAIs from the Department in 2010. A Circular, HSC (SQSD) 08/2010 (**SG Appendix 14 - SPPG – C – 00455**

Circular HSC (SQSD) 08/2010 Phase 2 Learning from Adverse Incidents and Near Misses reported by HSC orgs and FPS - WIT 66974 to WIT 66982), was issued on 30 April 2010 which advised on the revised arrangements for the reporting and follow up of SAIs from 1st May 2010. The HSCB worked jointly with the PHA and collaboratively with the Regulation and Quality Improvement Authority (RQIA) in overseeing SAIs.

142. On 22nd April 2010, the HSCB Chief Executive issued the HSCB Procedure for the Reporting and follow up of SAIs (**SG Appendix 297 - cover letter (WIT 73312 to WIT 73313), and SG Appendix 15 - SPPG – C – 00408 (WIT 66983 to WIT 67009**).

143. In October 2013, an updated procedure was issued. Attached are the covering letter (**SG Appendix 298 - SPPG – C- 00444 File 444 Cover letter to HSCB Procedure for the Reporting and Follow up of SAIs October 2013 - WIT 73314 to WIT 73317**) and procedure (**SG Appendix 299 - SPPG – C- 00409 File 409 HSCB Procedure for the Reporting and Follow up of SAIs October 2013 - WIT 73318 to WIT 73376).** A further updated procedure was issued in November 2016 – attached is the covering letter (**SG Appendix 300 - SPPG – C- 00445 File 445 Cover letter to HSCB Procedure for the Reporting and Follow up of SAIs November 2016 - WIT 73377 to WIT 73379**) and procedure (**SG Appendix 301 - SPPG – C- 00410 File 410 HSCB Procedure for the Reporting and Follow up of SAIs November 2016 - WIT 73380 to WIT 73487).**

144. The role of the HSCB Governance Team was to ensure an effective administration system was in place to manage the regional process and to have in place structures to ensure notifications and subsequent review reports were reviewed by professionals/senior staff from both the HSCB and PHA. As with the complaints processes outlined in the subsection above, the purpose was to identify any learning recommendations and the most appropriate methods of sharing them across the region.

145. A DRO was selected for each SAI. This was a senior professional/officer who could be employed by either the HSCB or PHA. They were selected in line with their professional knowledge or expertise relevant to the issues in a particular SAI on a case-by-case basis. That expertise could be clinical, estates related or information governance related. The DRO was required to:

a) Liaise with reporting organisations:

   i. Regarding any immediate action to be taken following notification of a SAI;

   ii. When it is believed the SAI review is not being undertaken at the appropriate level;

   iii. Where there may be concerns regarding the robustness of the level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented;

b) Agree the Terms of Reference for Level 2 and 3 RCA reviews;

c) Review completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaising with other professionals (where relevant);

d) Liaise with reporting organisations

e) Identify regional learning, where relevant;

f) Monitor SAIs to identify patterns/clusters/trends.

146. The following paragraphs, 148 to 160, outline the steps the HSCB would take when notified of a SAI review. There were essentially three stages: notification; monitoring of ongoing review; and conclusion of the review.

147. On receipt of a notification, the DRO or SAI Professional Group would consider the level of review proposed by the Trust and request more information from the reporting Trust, following which the level of review may be revised. It was expected that Trusts would use the HSC Regional Risk Matrix (**SG Appendix 301 - SPPG – C- 00410 File 410 HSCB Procedure for the Reporting and Follow up of SAIs November 2016 - WIT 73380 to WIT 73487**) provided to assist in determining the level of seriousness and therefore the level of review to be undertaken.

148. The SAI process was configured to protect the confidentiality of patients, service users and staff. This was intended to promote openness, transparency, and encourage candid

reporting. As the role of HSCB and PHA was to identify and disseminate learning regionally, the identification of individuals was not necessary to discharge that function.

149. Any AI that met the criteria for a SAI should have been reported within 72 hours of the incident being formally discovered by the Trust. However, there could be a period of delay between the date an incident occurred and when the Trust became aware of it.

150. Following receipt of a SAI notification, the HSCB Governance Team advised the Trust of timescales for submission of Terms of Reference, Team Membership (only applicable for level 2 and 3 reviews), and the Final Review Report.

151. If notification of Terms of Reference or Team Membership was overdue by one week a reminder was sent to the Trust by the HSCB Governance Team (**SG Appendix 303 - SPPG – C – 00460 SPPG Governance Team Operational Manual for the Administrative Process in Relation to SAIs and Early Alerts - WIT 73508 to WIT 73613**). A second reminder was sent the following week if still outstanding. If the information remained outstanding following two reminders, it was escalated to Assistant Governance Managers and the Governance Manager within the HSCB Governance Team to be followed up with the relevant Trust.

152. In respect of overdue review reports from Trusts, a quarterly report was sent by the HSCB Chief Executive to the Chief Executive of the relevant Trust setting out where delays had occurred and the requirement to act. It would also request submission of the outstanding reports and advise on concerns regarding the number of overdue reports. (**SG Appendix 304 to Appendix 307 - SPPG – C – 00461 to SPPG – C – 00464 - WIT 73614 to WIT 73619**).

153. Given the pressures which arose because of Covid-19, alternative arrangements were put in place and, given the effectiveness of the new streamlined approach, remain in place:

a) All notifications are included in a daily report to directors and relevant staff.

b) All new SAI Notifications are reviewed on a weekly basis by a multi-disciplinary group to ensure immediate action is taken forward, if required.

154. Upon receipt of a final review report, the DRO reviews the report to:

a) ensure the robustness of the level 2 and 3 Root Cause Analysis (RCA) reviews, providing assurance that an associated action plan has been developed and implemented;

b) identify patterns, clusters or trends; and

c) identify any learning for regional dissemination.

155. If no regional learning is identified, the Trust is reminded at closure of the SAI of its responsibility to take forward any local recommendations or further actions identified within the report and monitor these through the Trust's internal governance arrangements.

156. In some instances, an assurance may be required from the Trust based on the learning. A level of assurance, as outlined in the Safety and Quality Alerts paragraphs, 176 to 180 below, required from Trusts, was agreed by professionals/governance staff before disseminating. To ensure compliance, responses to such requests were monitored by a designated professional with expertise in the area and issues and concerns were escalated to the HSCB and PHA directors responsible for Quality & Safety (i.e. HSCB Director of Performance and PHA Director of Nursing and Allied Health Professionals) *via* a weekly Safety Brief Meeting. These in turn could be further escalated, as required, to the HSCB Chief Executive and/or PHA Chief Executive.

157. In addition, bi-monthly Safety and Quality Performance meetings were held involving HSCB/PHA and Trust Senior Staff to discuss all overdue assurances in relation to SAIs, and Safety and Quality alerts (SQAs).

158. Upon completion of SAI Review Reports, Trusts were required to identify local learning within their organisation and subsequent action to be taken forward internally. In addition, following the review of a SAI report by HSCB/SPPG and PHA professionals, regional learning may be identified which is shared across the system by HSCB/SPPG and PHA.

159. The role of the HSCB was not to undertake the SAI investigation review, rather it was to have oversight and to review the final report to ensure it had been undertaken at the right level, the robustness for level 2 and 3 reviews and, finally, to identify any regional learning.

160. The HSCB disseminated regional learning by sharing SAI review reports and issuing learning letters, reminders of best practice and 'learning matters' newsletters. For example, the following were taken forward in respect of SAIs closed in 2021/22.

a) 7 Reminders of best practice guidance letters

b) 3 Professional letters

c) 3* learning letters

d) 32 Newsletter articles

e) 11 cases were referred to other specialist groups such as the radiology network and the regional maternity collaboration.

[* To note - the earlier statement provided by Sharon Gallagher for this Inquiry contained a typographical error which advised that point (c) above related to 32 learning letters; only 3 learning letters were issued.]

161. A position paper on SAIs was brought to the HSCB's SMT meeting in December 2020 (**SG Appendix 309 - SPPG-C-00465 SMT Paper Update on SAI position both internal and from HSC Trusts - WIT 73684 to WIT 73686**). As a direct result of this, the HSCB Chief Executive wrote to all Trusts in January 2021 highlighting concerns and outlining the intention to establish a dedicated team to develop a Safety and Quality Improvement Plan. The correspondence also required the appointment of a lead for SAIs to develop a Trust specific improvement plan, monthly touchpoint meetings and quarterly safety and quality meetings were established between Trusts, the HSCB and PHA.

162. The Safety and Quality Improvement Plan was finalised in February 2021 (**SG Appendix 310 - SPPG-B-00166 File 1 Improvement Plan - WIT 73687 to WIT 73690**)

with a clear objective to ensure oversight of SAIs to drive improvements in timely dissemination of regional learning. This plan had both an 'internal' performance focus on the HSCB and PHA and 'external' performance focus on Trusts in respect of the SAI Procedure.

163. Internal (HSCB/PHA) focus – following the introduction of SAI professional groups for all programmes of care in accordance with the improvement plan mentioned in the paragraph above, there was a reduction in the number of "open" SAI reports on the HSCB system. In December 2020 there were 219 open SAI reports which had been submitted by Trusts to the HSCB/PHA for reviews which had not been completed; this had reduced significantly to 64 by end of February 2021. This was a considerable improvement by the HSCB.

164. External focus – despite the improvement plan there was little improvement in the timely submission of SAI review reports by Trusts. Southern Trust was not an outlier in this as all Trusts experienced delays in submitting reports. While the HSCB and PHA secured improvement in concluding their reviews of SAI reports, thereby bringing them to a close, there were still delays by Trusts submitting the SAI reports to them. In response to this the HSCB and PHA commissioned an external body, Clinical Leadership Solutions (CLS) to provide training to Trusts in Spring 2022. This did not secure the desired improvement. Therefore, the HSCB, with assistance from PHA, secured funding to commission CLS to work alongside Trust colleagues to review Level 1 overdue reports. This work remains ongoing at the time of the submission of this statement.

165. The SPPG continues to press Trusts to reduce the backlog of overdue reports, particularly in light of the redesign of a new SAI process. This work includes the continuation of assistance from CLS and promoting the use of 'incident/hot debriefs' as a sufficient tool for level 1 SAIs, which is in line with current policy.

166. In April 2018, RQIA was commissioned by the Department to examine the application and effectiveness of the SAI procedure. The time taken to complete RQIA's review was significantly impacted by the Covid-19 pandemic. However, its 'Review of Systems and Processes for Learning from SAIs' report was published in June 2022 (**SG Appendix**

308 - SPPG – C – 00457 DoH RQIA Review of the Systems and Process for Learning from SAIs in NI - WIT 73620 to WIT 73683).

167. A project to redesign the current SAI Procedure commenced in July 2023. It is being led by the Department's Healthcare Policy Group. It will address the recommendations from the Inquiry into Hyponatraemia-related Deaths and the Independent Neurology Inquiry, alongside the recommendations in the RQIA's 2022 report. The recommendations in these reports provide a strong evidence base to support the introduction of a new framework for the identification and embedding of learning from adverse healthcare incidents or events.

168. It should be noted that, on receipt of SAI reports, HSCB/PHA did not receive the details of individual staff members who were associated with the issues relating to an SAI. This information is held only by the reporting Trust. The HSCB and PHA reviewed Trust SAI reports to ensure the level of investigation was appropriate (level 1 to 3); to identify patterns; and to identify learning which can be shared on a regional level. It was also open to Trusts to identify local learning from their SAI reports which could be shared internally within the Trust.

Early Alerts

169. The 'Early Alert' system is designed to ensure the Department and Minister receive prompt notification and details of events (including potential SAIs) which may require urgent attention and possible action by the Department.

170. The Early Alert process was introduced by the Department in June 2010 through Circular HSC (SQSD 10/10), Establishment of an Early Alert system (**PC Appendix 24 – Circular HSC SQSD 10-2010 – Establishment of an Early Alert System 28 May 2010**). An Early Alert goes to the Department and Minister, however organisations are required to alert SPPG of all Early Alert notifications using the same template that is

issued to Policy Leads in the Department. The current circular also requires the reporting organisation to notify the PHA of the event as required.

171. That original Departmental circular was superseded by the following:

a) HSC (SQSD) 07/14, October 2014, (**PC Appendix 25 – CMO Letter DH11283057 – HSC(SQSD)**)

b) HSC (SQSD) 64/16, November 2016, (**PC Appendix 26 – Circular HSC SQSD 64-16 – Early Alert System 28 Nov 2016**)

c) Circular HSC (SQSD) 5/19, February 2019, (**PC Appendix 27 – Circular HSC SQSD 5-19 – Early Alert System 27 Feb 2019**)

d) Circular HSC (SQSD) 5/19, November 2020, (**PC Appendix 28 – Circular HSC SQSD 5-19 – Early Alert System 12 Nov 2020**)

172. While the Department was responsible for the Early Alert process, the HSCB and PHA Internal Protocol for the Management of Early Alerts was introduced in 2012, (**PC Appendix 29 – Early Alert Procedure June 2012**) and was superseded in 2017, (**PC Appendix 30 – HSCB-PHA Protocol for the Reporting and Follow up of the DoH Early Alert System – Feb 2017**)

173. The HSCB's protocol required the appointment of a Lead Officer who reviewed the Early Alert and liaised with other relevant professionals within the HSCB and PHA to determine:

a) If further/immediate action is required; and

b) If, in their professional opinion, a SAI should be submitted; or

c) If no further action is required by HSCB/PHA, the Early Alert could be closed on Datix.

174. These processes have evolved and whilst the protocol has not been revised, the management of Early Alerts has changed:

a) Pre-2020, Early Alerts were copied to the appropriate staff within the HSCB and PHA professionals after initial receipt and consideration by the organisation.

b) Since 2020, all Early Alert notifications were included in a daily report circulated to all HSCB directors and relevant staff and reviewed by a multi-disciplinary group.

175. Details of the Early Alert received in July 2020 concerning urology in the Southern Trust are set out in Section 5 of this Statement.

Safety and Quality Alerts (SQAs)

176. The Department, HSCB, PHA and other organisations issued a variety of correspondence collectively referred to as Safety and Quality Alerts (SQAs). SQAs focus on the dissemination of regional learning for the HSC system and are issued to service providers to support improvement in practice.

177. The Regional Procedure for SQAs was first introduced in June 2012 (see **PC Appendix 31 – HSCB PHA Protocol for Implementation of Safety and Quality Alerts June 2012**), then updated in August 2013, (**PC Appendix 32 – HSCB PHA Protocol for Implementation of Safety and Quality Alerts August 2013**) May 2015, (**PC Appendix 33 – HSCB PHA Protocol for Implementation of Safety and Quality Alerts May 2015**) July 2016, (**PC Appendix 34 – HSCB PHA Protocol for Implementation of Safety and Quality Alerts July 2016**), and March 2017 (**PC Appendix 35 – HSCB PHA Protocol for Implementation of Safety and Quality Alerts March 2017**). The latest version was introduced in 2018, (**PC Appendix 36 – HSCB PHA Regional Procedure for SQA July 2018).** It provides guidance on monitoring compliance with regional learning that has been disseminated.

178. Depending on the level of assurance required, Trusts may have been required to provide the HSCB and PHA with assurance that any specified actions identified by the SQA have been actioned. The Trust response was then considered by the HSCB and PHA professionals to assess compliance.

179. The learning identified in SQAs may arise from information provided from a variety of sources including SAIs, complaints, reviews by the RQIA, legislative changes, medicine regulators, equipment or device failures, national safety systems, independent reviews and Learning Notifications.

180. In May 2021, the HSCB introduced a process, whereby, upon issue, SQAs were categorised by the degree of assurance required by the HSCB and PHA. There are three categories or assurance:

a) 1st Line Assurance SQA – no response is required by the HSCB and PHA;

b) 2nd Line Assurance SQA – a response to the HSCB and PHA is required within 4 weeks confirming the actions have been added to the organisation's safety and quality assurance work plan; and

c) 3rd Line Assurance SQA – a response to the HSCB and PHA is required within 12 weeks confirming actions specified within the SQA have been completed.

Summary

181. Sections 2 and 3 above provide information on the HSCB's structure, functions, and relationships with the Department and other HSC organisations in the discharge of its statutory responsibilities. It also provides an overview of the governance processes administered by the HSCB in respect of safety and quality matters. This background information is relevant to my responses to the questions in paragraphs 7 to 10 in the schedule to the Inquiry's section 21 Notice set out below.

182. Paragraph 7 in the schedule to the section 21 Notice asks:

"Please set out how HSCB assessed the quality of the commissioned care provided to patients within the SHSCT"

183. The day-to-day arrangements for providing quality care in Urology Services is the responsibility of the Trusts through its Executive Team, Medical Director, Director of Nursing and, ultimately, its Trust Board.

184. The HSCB's statutory duty was to have arrangements in place to monitor and improve the quality of care provided to individuals and the environment in which it was provided ("*Each Health and Social Services Board and each HSC trust shall put and keep in place arrangements for the purpose of monitoring and improving … quality"*). There were structures and processes in place, as set out in sections 2 and 3 above, to satisfy this requirement.

185. The HSCB utilised the performance management process, the complaints procedure, the SAI procedure, and Early Alerts to monitor the quality of care provided by Trusts to identify issues with the delivery and/or quality of care and to drive continuous improvement through learning. The HSCB (and PHA) ensured the correct level of review was undertaken by the Trust: it reviewed the final reports to assess whether any regional learning should be shared; it shared that learning; and, when appropriate, sought assurances in respect of complying with that learning.

186. This sat alongside other proactive work that was undertaken to assess and improve the quality of the service, such as the work of NICaN in respect of cancer services through its CRGs.

187. The timeliness of providing care speaks to quality and the Minister/Department set targets in respect of waiting times with the objective of securing timely provision. The HSCB, in turn, sought to ensure timely provision in line with those waiting list targets. It did so through its performance management processes. The HSCB held Trusts to account in meeting those targets. However there has long been an acknowledgement that patient demand exceeds capacity in the HSC.

188. In addition to waiting times, the HSCB also held Trusts to account in respect of providing the volume of services they were contracted to and to do so within available budget.

189. Moreover, there was recognition that ongoing care, including patient review, had to be factored into service capacity, i.e. Trusts had to ensure that sufficient capacity was deployed to continue care and review of existing patients as well as providing diagnostics and treatment for new patients. The HSCB routinely monitored the Trust waiting lists for assessments and treatments of new patients. While there were no

targets for reviews, Trusts were expected to actively monitor patients on the review list to ensure that they did not go past their review date. Where necessary, clinical templates could be adjusted to ensure that there was sufficient capacity for this cohort of patients.

190. In relation to cancer services, the following represented a significant drive for practice consistency and quality of care: the coordination of CRGs; commissioning of peer review exercises; establishing multi-disciplinary discussion and decision making (MDTs); and the development of clinical guidelines.

191. Paragraph 8 of the schedule to the section 21 Notice asks:

"Please set out how HSCB assessed risk in the commissioned care provided within (i) SHSCT and (ii) urology services in particular"

192. As an ALB, it was the responsibility of the Southern Trust to assess risk in its delivery of care to patients and report it to the Department's Sponsorship Branch if identified, in accordance with the 2011 Framework Document. The Department's Sponsorship Branch would, in turn, have noted significant risks in the delivery of commissioned care.

193. Furthermore, the Trust's Standing Orders stipulate, within the 'Schedule of Powers Reserved to the Board' (Section B, Para 1.1 (7)), that the Southern Trust's Board was required:

"*To ensure that the Trust has robust and effective arrangements in place for clinical and social care governance and risk management.*"

194. Paragraph 2.31 of the 2011 Framework Document states that:

"2.31 In common with all Arms Length Bodies (ALBs), on issues of governance and assurance, all the HSC bodies are directly accountable to the Department."

195. Paragraph 6.5(x) of the 2011 Framework Document further noted that:

''6.5 All HSC bodies shall:

...

(x) ensure compliance with the checklist of actions required of sponsorship branches in the Department in obtaining assurance from their respective body's covering: roles and responsibilities; business planning and risk management; governance; and internal audit."

196. The primary responsibility for assessing risk lay with the Trusts through their respective Boards. Trusts reported risk directly to the Department. The Trusts, including the Southern Trust, submitted their risk registers directly to Sponsorship Branch at the Department. There was no requirement for Trusts to copy their risk registers to the HSCB.

197. The HSCB was therefore not responsible for overseeing or managing the governance arrangements of Trusts, including their risk management processes. HSCB could become aware of risk/s through its commissioning and performance management functions.

198. The HSCB had multi-level relationships with the Trust and was required through its commissioning and performance management functions, described in sections 2 and 3 above, to work with the PHA to monitor the achievement by Trusts of agreed objectives and targets. It was through this commissioning and performance management cycle that the HSCB could become aware of potential risks.

199. That included the HSCB's regular performance meetings with the Trust to review the red flag (i.e. suspect cancer) and urgent waiting times and agree remedial actions to improve the performance as necessary.

200. Alongside those performance management processes, the HSCB's quality and safety governance processes set out in section 3 (complaints, SAIs, Early Alerts and SQAs) provided it with information that might relate to potential risks in respect of the delivery of commissioned care in the Southern Trust, when this information was made known to it by the Trust.

201. Also, through its oversight of NICaN, the HSCB obtained further insight into issues and potential risks in respect of the cancer-related elements of urology services at the Southern Trust, e.g. through the periodic Peer Review processes as outlined in section

3.In discharging its own accountability responsibilities under section 6 of the 2011 Framework Document, the HSCB was required to prepare and submit its own Corporate Risk Register to the Department's Sponsorship Branch on a 6-monthly basis, as the Trusts did. This was in accordance with the requirements of the Management Statement and Financial Memorandum in place between the Department and the HSCB (**SG Appendix 161 - SPPG – B – 00157 HSCB MS FM signed - WIT 71722 to WIT 71777**). For the purposes of this statement, my team has checked the HSCB risk registers submitted by HSCB to the Department in 2019, 2020 and 2021. The HSCB risk registers submitted do not contain any reference to urology services in the Southern Trust.

202. The HSCB's Standing Orders (**SG Appendix 9 - SPPG – E – 00451 HSCB Standing Orders 20-21 - WIT 66701 to WIT 66952**) further required the production of a fully functioning risk register at both Directorate and Corporate levels. The Corporate Risk Register was approved by the HSCB's SMT on a quarterly basis and by the HSCB's Governance Committee at least three times per year in line with Governance Committee meetings.

203. In conclusion, the HSCB focused its attention on risk only in relation to the delivery of commissioned services, including unscheduled care and elective care (assessment, diagnostics, treatment and review). Performance against key targets, and in line with mechanisms such as clinical or service review (including peer review), offered the HSCB insight on service delivery ability and risk. The HSCB service stock-take review of Urology Services in 2014 is an example of such a review which led to service realignment and additional investment in staffing and service capacity. The Southern Trust, through its clinical governance structure and processes, led by its Medical Director and Director of Nursing in particular, was and remains responsible for ensuring the quality of care meets its standards in line with Departmental guidance. Assurance is provided to the Department directly and managing risk is a key component of this assurance.

204. Paragraph 9 of the schedule to the section 21 Notice asks:

"How, overall, did HSCB satisfy itself as to the quality and safety of care provided"

205. I refer to my response to Questions 7 and 8 above which also address Question 9.

206. Paragraph 10 of the schedule to the section 21 Notice asks:

"How, if at all, did the meeting of performance targets and targets generally impact on your ability to properly assess quality and risk? Did a focus on outcomes mean that less focus was placed on quality and risk? Please explain your answer in full, providing documentation as relevant."

207. I do not think HSCB was unduly focused on targets and patient outcomes at the expense of quality and risk. Performance, quality and risk are intrinsically linked. Performance targets are an important indicator of quality and should not be viewed as being at odds with quality and the management of risk in the HSC. Ministerial targets focus on timely access to care which represent an important quality standard of considerable interest to the public.

208. The HSCB's core function was to commission HSC services. It also had a duty to improve quality which, if achieved, should have the beneficial consequence of reducing risk.

209. The HSCB sought to improve quality through performance management, by monitoring targets and indicators which were set by Department, through its governance processes (including reviewing complaints, SAIs, early alerts etc.) and through the learning opportunities described earlier in this statement.

210. There was a statutory requirement for HSCB to monitor HSC performance against targets / indicators set by the Department.

211. Furthermore, HSCB sought to focus on the prerogative of achieving Ministerial targets and to ensure continuing care in the context of rising demand and workforce challenges. Indeed, this is to a large degree patient outcome focused rather than target focused. At its core is the importance of pathways of care which seek to maintain quality and minimise risk.

212. There were processes in place to measure performance against the waiting time metrics set by the Department. There were other separate structures in place, such as

SAIs, Early Alerts and complaints, to alert the HSCB and potentially the Department to problems with quality. (The Trust reported directly to the Department on risk.)

213. There also are examples of when HSCB's focus on quality of care adversely impacted on achievement of targets by Trusts. Two such examples are set out below:

(i) In compliance with NICE guidelines, the HSCB approved a move to Magnetic Resonance Imaging (MRI) prior to scope for suspected prostate cancer. This made the waiting lists longer (as the clock was no longer paused following an invasive procedure prior to MRI) which acted adversely against a key performance indicator set by the Department, but it provided better quality care. This is an example of the HSCB putting quality of patient care before a performance target.

(ii) Similarly, the 2014 stock-take review by the HSCB resulted in agreement by the then Director of Commissioning that the implementation of the improvement plan would take precedence over SBA performance. Again, performance targets were treated as secondary to quality. Further details on this are set out in section 4, paragraphs 230 to 234.

214. There are other examples of work undertaken to improve quality, such as asking for improvements in ratios for new patients and review (follow-up) patients which sought to strike a balance between the continuing care needs of existing patients with the needs of new patients, which was the focus of Ministerial access targets. Performance targets focus on access to diagnostics and treatment for newly referred patients, whereas targets for reviewing patients and continuing care are not specifically monitored. In this way, HSCB did not focus solely on driving for performance against Ministerial (access) targets, but also sought to ensure care throughout the patient pathway was being delivery in a timely manner.

215. The Urology Planning and Implementation Group also introduced initiatives to improve quality of services, as well as ensuring performance against Ministerial standards. It was established to agree the future service profile of urology services, develop clinical

pathways, explore cross Trust working, and identify current and future needs for urology services at a regional level.

216. The regional Urology Planning and Implementation Group developed a system wide approach to the organisation and profile of urology services across Northern Ireland. It proved instrumental in service improvement, both locally and regionally.

217. A good example of regional pathway reform was the development of the one-stop vasectomy service which negated the need for an outpatient assessment and released clinic capacity to address other services pressures.

218. Also, during the initial period the Regional Urology Planning and Implementation Group continued to monitor demand and available capacity in order to reduce variation in waiting times across the region. This focus on equalisation of waits included agreeing interim referral arrangements to address the consultant workforce issues that existed in Team North. These arrangements, which were effective from February 2015, included the temporary redirection of urology patients from BT80 to the Southern Trust, reflecting its position as higher performing against waiting time targets. This was important to ensure equal access across the region enabling patients to be seen as soon as practicable irrespective of their home Trust.

219. Paragraph 11 of the schedule to the section 21 Notice asks:

"Were any concerns regarding staffing, equipment, or any other matters which might impact care provision brought to your attention regarding urology services? If so, please explain in full."

220. In 2019, Southern Trust raised a concern with the HSCB at the lack of specialist nurses and consultant staff within its Urology Service. Following discussion and consideration, the HSCB provided recurrent funding to enable the Trust to expand its specialist nursing staffing. However, it was decided not to provide further permanent funding for additional consultant posts as the Trust was unable to fill all of its 6 substantive consultant posts at that time. The HSCB encouraged the Trust to make every effort to fill these posts and it could return to the issue of permanent funding if they were so able.

221. Another issue raised in relation to Urology Services was access to Robotic Retropubic Prostatectomy (RRP). The service had not been available in Northern Ireland and patients who would benefit from the service had been sent to Addenbrookes Hospital in Cambridge. Trusts contended that having this service available in NI would, as well as providing improved care for patients (around 100 per year), would attract urologists to take up posts here.

222. In late 2017, Belfast Trust was allocated capital funds to purchase a Da Vinci Robot and begin a phased introduction of an RRP service on the Belfast City Hospital (BCH) site, reducing the Addenbrookes contract incrementally over a three-year period. By 2021/22, the funds were invested in Belfast Trust. However, due to physical infrastructure limitations at BCH and staff constraints, the Trust has not yet been able to fully deliver the expected volumes and continues to use the underspend to transfer patients to Republic of Ireland for this treatment.

223. These examples, investment in staffing in Southern Trust urology services and robotic prostatectomy, highlight the HSCB was committed to assisting the Trusts and was responsive to addressing service pressures when raised.

224. The HSCB supported requests from Trusts for resources to develop cancer tracking. In June 2018, HSCB produced a paper on cancer tracking resource, analysing capacity and demand. The paper noted that Southern Trust, with 3.9 whole time equivalent (WTE) funded trackers, required a further 8.6 WTE to meet demand at an anticipated cost of approximately £138,000. Since then, year-on-year, HSCB/SPPG provided funding to increase the funded establishment to 11.6 WTE. Appendices (**PC Appendix 37 – HSCB Cancer Tracking Resource - Analysis of demand capacity - Aug18v3**) and (**PC Appendix 38 – Cancer tracking SHSCT 24 Jan 23**) refer.

225. It is also important to be realistic about the financial constraints inherent in the HSC system. The funds available were finite and this always constrained, to varying degrees, what was possible to be developed and delivered.

226. In summary in respect of my answer to the question at paragraph 11 of the Notice, issues were raised by the Southern Trust about equipment and staffing, including a request for funding for urology consultants, and were addressed accordingly.

Section 4 – Concerns Prior to 31 July 2020

Background

227. The questions at paragraphs 12 to 15 of the schedule to the section 21 Notice ask about the extent of the HSCB's knowledge of specific events and circumstances. Before responding to each of these questions directly, the paragraphs below provide background information on the HSCB's knowledge of concerns and actions more generally in respect of urology services, both regionally and in the Southern Trust, prior to the 31st July 2020.

228. By way of brief introduction, there was a review of urology services in 2009, a further stocktake in 2014 following up on that review, and then the HSCB asked each Trust to submit to it an Improvement Plan in order to establish a robust system of providing quality urology services. A new Urology Planning and Implementation Group (PIG) was established. Therefore, there were considerable efforts to improve urology services generally, including in the Southern Trust. The steps taken are set out in chronological order in the subsections below.

229. After those steps are set out, my statement then summarises the three SAIs the HSCB was notified of by the Southern Trust concerning their urology services in the period from March 2016 to September 2017.

Review of Urology Services 2009 and Urology Stocktake 2014

230. A regional review of Adult Urology Services was undertaken by the DHSSPS Service Delivery Unit during September 2008 to March 2009. This review was in response to concerns regarding the ability to manage growing demand; meet cancer and elective waiting times; maintain quality standards; and provide quality elective and emergency services. The review made 26 recommendations covering a range of issues including patient pathways, centralisation of radical pelvic surgery, workforce, and the development of a 3-team model. The review did not look at individual consultant performance. It analysed data for each Trust and each site.

231. In December 2013, the HSCB Director of Commissioning requested a regional stocktake of adult urology services in Northern Ireland to assess what progress had been made in the 5 years since the review. The stocktake was undertaken in February 2014 and examined individual Trust performance. A copy of the Terms of Reference for the stock-take exercise is attached as an appendix, (**PC Appendix 39 – Terms of Reference for Urology Review Stocktake 2014**) The narrative report on the urology review stocktake, (appended at **PC Appendix 40 – Report on the Urology Review Stocktake 2014**), which included suggestions for continuing to improve urology services, was shared with Trust Directors and HSCB ADs of Commissioning in May 2014.

232. Following the stocktake, the Director of Commissioning wrote formally to all HSC Trusts in July 2014 asking the Trusts to bring forward proposals for the establishment and maintenance of a robust sustainable model for urology provision through the submission of an improvement plan. The letter issued to the Southern Trust is appended at **SG Appendix 317 - SPPG-A-00027 Letter to Debbie Burns regarding Urology Modernisation - WIT 73765 to WIT 73766**).

233. The Southern Trust submitted a Urology improvement plan to the HSCB in September 2014 (**PC Appendix 41 – 20140901 – SPPG – B – 00132 File 1 UrologyVisionBoardPaper1Sep14(V2)**) was subsequently given approval to begin implementation of the model, which started in December 2014.

234. The HSCB agreed that the implementation of the improvement plan by the Trust would take precedent for a period over delivery of agreed activity required within the SBA as noted in correspondence from Mairead McAlinden, Chief Executive Southern Trust, to Valerie Watts, Chief Executive HSCB, on 19 December 2014 (**PC Appendix 42 – 20141219 – SPPG – B – 00131 File 1 CExSHSCTLett19Dec14ToHSCBCEx-UnderdeliveryCoreVols**).

Establishment of Urology Planning and Implementation Group

235. In June 2015, the regional Urology Planning and Implementation Group (Urology PIG) was established to develop a system wide approach to the organisation of urology services across Northern Ireland. The overarching aim of the Regional Urology PIG was to improve on the capacity and quality of urology services within the budgetary constraints.

236. This group was established to agree the future service profile of urology services, develop clinical pathways, explore cross Trust working and identify current and future needs for urology services at a regional level. The terms of reference of the Urology PIG are appended at **SG Appendix 318 - SPPG-A-00009 Terms of Reference for Urology Review Stocktake - WIT 73767 to WIT 73768**.

237. At its inception, the Group was chaired by the HSCB Director of Commissioning and has since been chaired by other senior officers. Minutes of these meeting have been provided as evidence in **SG Appendix 319 to Appendix 323 - SPPG-A-00014, SPPG-A-00015, SPPG-A-00016, SPPG-A-00018, SPPG-A-00021 - WIT 73769 to WIT 73782**.

238. The Regional Urology PIG monitored demand and available capacity to help reduce variation in waiting times across the region. This focus on equalisation of waits in the period prior to July 2020 included agreeing interim referral arrangements to address the consultant workforce issues that existed in Team North. These arrangements, which were effective from February 2015, and included the temporary redirection of urology patients from BT80 to the Southern Trust because of workforce issues in Team North. The disparities within the region were thereby evened out.

239. The PIG worked with Trusts to agree a system wide approach to the organisation and design of urology services across Northern Ireland. This work included the development of regionally agreed referral destinations and referral guidance on the Clinical Communications Gateway (CCG), i.e. the electronic system used by General Practitioners (GPs) to make referrals to secondary care. A medical workforce plan for

urology was also completed in 2017 and is appended at **SG Appendix 324 - SPPG-A-00044 Draft Urology Workforce Review - WIT 73783 to WIT 73792.**

2015 NICaN Peer Review

240. As outlined in section 3, NICaN was responsible for commissioning review exercises by NCPR from NHS England. One such review was carried out in 2015. The team was made up of visiting reviewers, cross Trust clinical reviewers and lay reviewers (i.e. patients with lived experience). As part of this Peer Review, the Southern Trust local Urology MDT and the regional Specialist Urology Cancer MDT (located in the Belfast Trust) were separately reviewed in June 2015. A document which sets out the National Peer Review Programme measures for Urology Cancer is attached, (**PC Appendix 43 - Peer Review - Resources Measures Urology_Jan2014**).

241. In keeping with standard practice, after the Peer Review visit the quality surveillance team from NHS England wrote directly to the Trust Chief Executive to outline immediate risks and any serious concerns raised at the visit. The HSCB and NICaN would typically have been copied into such correspondence, although my team has searched for this and is unable to locate it. The Trust was then given one month to respond to the NHS England quality surveillance team with their action plan. If the quality surveillance team was content with the plan there was no further communication and it was assumed that the Trust would take forward actions as outlined. If the quality surveillance team had queries with the quality of the plan submitted, they would request clarification.

242. Trusts received their own outcome report and Trusts were each required to develop a local action plan. Where issues raised related to concerns prevailing at a regional level, the HSCB Urology PIG would take this forward.

2015 Southern Trust Local MDT Peer Review

243. While I have been unable to locate a copy of the relevant outcome letter, the key themes arising across cancer services in the Southern Trust were summarised in the overview of the findings from the 2015 National Peer Review of Cancer Services in Northern Ireland (which is appended at **PC Appendix 44 – Northern Ireland Cancer Network Report 2015**). The issues raised were as follows:

- Procedures being undertaken outside specialist centre or by consultants who are not members of or attend the appropriate MDT;
- Absence or inadequate Clinical Nurse Specialist (CNS) provision;
- Delays in seeing routine referrals;
- Shortage of consultants in the specialty or over reliance on locum consultants;
- Absence of core membership of, or lack of attendance at, MDT leading to a significantly low percentage of MDT meetings being quorate; and
- Lack of specialist radiologist or histopathologist input to the service or MDT.

244. In accordance with the agreed process, the Trust would take forward the local issues. The regional issues relating to Urology were taken forward via the Urology PIG and HSCB commissioning and are set out in paragraphs 252 to 256 in this section.

245. The Trust subsequently submitted to the NHS England quality surveillance team a Peer Review Self-Assessment of Urology MDT in 2016, which was signed by the MDT Urology Lead, Mr Aidan O'Brien, and the Trust's Chief Executive on 28th September 2016. This is attached at (**PC Appendix 45 – Self Assessment Report - SHSCT Urology Local MDT_Sep16**). This assessment stated that there were no immediate risks or serious concerns; and it identified the following three 'concerns':

- Availability of the clinical oncologist and radiologist at all of the MDT meetings;
- Highest percentage increase in red flag referrals across the region;
- Operating theatre capacity and operator time.

2015 Specialist Urology Cancer Multidisciplinary Team Peer Review Outcomes

246. The Specialist Urology Cancer Multidisciplinary Meeting (MDM) is based in the Belfast Trust at the BCH and it serves as the Regional MDM for the discussion of urological cancer patients who are to undergo specialist treatment, including:

a) Patients with Kidney Cancer who are to receive surgery or chemotherapy

b) Patients with invasive Bladder Cancer

c) Patients with Prostate Cancer who go on to have surgery, radiotherapy or brachytherapy

d) Patients with Penile or Testicular Cancer

This regional pathway would have served urology cancer patients from the Southern Trust (and all Trusts) if they were identified as requiring specialist treatment shown above.

247. The Specialist MDM based in the Belfast Trust also served as the local MDM for the Belfast Trust and South Eastern Trust. All new patients with a urological cancer diagnosis from these areas were discussed at their meetings.

248. In June 2015, the Belfast Trust's Specialist Urology MDM was assessed as part of the NHS Peer Review Visit programme mentioned above. The Review identified shortcomings concerning the duration of MDM and the number of patients to be considered:

- The time allocated for the meeting is not sufficient for the workload undertaken;
- The meeting regularly overruns due to the volume of patients for discussion;
- Each patient is nominally allocated a 2-minute discussion time; and

- Some patient discussions are deferred (due to the cap) and therefore all patients that should be discussed at the MDM were not actually being discussed.

249. The Peer Review report concluded that there is a serious concern in relation to the current MDM capacity:

"The MDT is scheduled to last for one hour and 45 minutes and this is inadequate to discuss the 50 patients listed in sufficient detail and means that some patients are delayed until the following meeting. The cap at 50 patients also means that not all patients with cancer are being discussed at the SMDT, e.g. low risk bladder cancer and penile cancer."

250. Following Peer Review, the Belfast Trust was asked to bring forward an options appraisal outlining options to address the pressure on the MDM which was submitted on the 15th November 2016, attached (**PC Appendix 46 – Urology MDM Paper – FINAL - Updated - 15.11.16**). It was agreed that the preferred option would be to remove discussion of South Eastern Trust local patients from the Specialist MDT through the establishment of a stand-alone South Eastern Trust MDT.

251. To facilitate this, the HSCB provided recurrent funding towards MDT staff, enabling a weekly 1.5 hour standalone meeting to be established for South Eastern Trust MDT from 1st November 2017, (**PC Appendix 47 – Establishment of Standalone SET Urology Local MDM - Allocation Ltr Oct17**). This intervention improved the capacity of the Specialist MDM, enabling time to be focussed on those patients with specialist treatment needs from across the Region. This improved the quality of the service.

2015 Regional Peer Review Outcomes taken forward via PIG

252. As outlined above, an overview of the findings from the 2015 National Peer Review of Cancer Services in Northern Ireland was summarised in the NICaN Report 2015 (which is appended at **PC Appendix 44 – Northern Ireland Cancer Network Report 2015).** The issues about urology services prevailing at a regional level were to be taken forward *via* the HSCB Urology PIG. These regional issues and a summary of actions taken forward are as follows:

- Delays for routine and urgent urology appointments – this was taken forward by the Regional Urology PIG.
- Nephron sparing surgery being undertaken outside of Specialist MDT – Peer review emphasised that this surgery was taking place in too many sites. In response, HSCB commissioned the introduction of radio frequency ablation for renal cancer in Belfast Trust as a treatment option and that the relevant interventional radiologist would join the Specialist MDT as necessary. The consultant urologist in Southern Trust also in-reached to Belfast to undertake surgery within the Specialist MDT.
- Inadequate time for Urology Specialist MDT – this issue was considered by the HSCB in conjunction with the Belfast and South Eastern Trusts, ultimately leading to additional recurrent funding being made available to support additional capacity from November 2017, as outlined above.
- The development of regionally agreed referral destinations and referral guidance on the CCG, i.e. the electronic system used by GPs to make referrals.
- A medical workforce plan for urology which was completed in 2017.
- Expansion of the urology capacity across the region – recurrent funding was allocated to Trusts in 2019 to increase the Urology Clinical Nurse Specialist Workforce. In terms of the Southern Trust this allowed the development of 8.5 clinical sessions for urodynamics and LUTS service and a further 8.5 clinical sessions for prostate biopsies and nurse-led PSA follow-up service, (**PC Appendix 48 – 20190918 - SPPG - A - 00033 - Urology Expansion**).

253. Further recurrent funding was secured for the Southern Trust in 2020 to allow the expansion of funded consultant urology posts (i.e. from 6 posts to 7 posts). Unfortunately, the Trust was unable to fill this post and the funding was used non-recurrently in the interim. The Trust has only recently been successful in appointing to this post.

254. In recognition of the pressures being experienced by the Southern Trust urology team, HSCB agreed additional recurrent investment would be provided to the Western Trust

(5th August 2020), (attached at **PC Appendix 49 – LMcW121 Western Trust Urology allocation**), which would allow them to expand their catchment area to include the County Fermanagh population, an area previously served by the Southern Trust on a temporary basis following the 2015 HSCB Urology Review. The focus has been on both increasing capacity and reducing demand on the Southern Trust urology service.

255. The HSCB (and latterly SPPG) has continued to support the urology team in the Southern Trust. Non–recurrent funding was allocated in 2021, 2022 and 2023 to facilitate the transfer of urgent referrals to the independent sector. In addition, the Trust continues to have access to the additional TP biopsy capacity in South Eastern HSC Trust and further urology capacity has been secured from Hermitage Dublin which has helped reduce the current waiting time for transurethral resection procedures (TURP). The Trust has also recently received funding to develop a new regional extracorporeal shockwave lithotripsy (ESWL) service on the Craigavon site which should help recruit and retain staff. Plans are at an advanced stage to develop a regional percutaneous nephrolithotomy (PCNL) service in the Trust.

256. In terms of chronology, the first of the three SAIs was received at this point and should slot into this stage of the narrative. However, the SAIs are dealt with as a separate subsection later in my statement just before answering the next series of Inquiry questions.

2017 Southern Trust Peer Review Self-Assessment

257. The Trust submitted a further Peer Review Self-Assessment report to the NHS quality surveillance team in NHS England in 2017. While HSCB and NICaN were not party to this report, they were copied in on the External Verification Report response (**PC Appendix 50 - SHSCT Urology MDT External Verification Report 2017)** which noted that there remained two serious concerns outstanding as follows:

a) Single handed radiologist with no cover

b) No quoracy due to low clinical oncology and radiology attendance.

258. The external reviewer recommended a further self-assessment in 2018. However, the NCPR system was then stood down and replaced by quality surveillance programme, which changed the self-assessment and external validation process. As such, the self-assessment and external validation process did not take place thereafter in NI. NI did not have the required data stipulated by NHS England to participate in the external validation process.

Peer Review of Proposed Programme of Visits 2018 - 2020

259. Following the change to the Peer Review arrangements mentioned above, a discussion was held by the NICAN Board in February 2018, (**PC Appendix 16 – NICAN Board Minutes February 2018**) about which organisation was responsible for acting on peer review findings. There was clarification that Trusts remained responsible for developing action plans to address serious concerns or immediate risks identified during a Peer Review.

260. In contrast, the HSCB was to address any regional issues identified within the peer review process.

Southern Trust's Urology Service SAIs (2016 & 2017)

261. In 2016 and 2017, there were 3 SAIs relating to urology services in Southern Trust. Each is considered in turn below.

1) SAI – RCA Personal information redacted by USI

262. All correspondence relating to SAI Personal information together with a position report from the DATIX risk management database have already been shared with the Inquiry team through Sharon Gallagher's statement (**SG Appendix 331 to SG Appendix 555 SPPG-C-00159 - SPPG-C-00383 WIT 73818 to WIT 74647**) and (**SG Appendix 620-694 SPPG-C-00001 to SPPG-C-00075 WIT 74913 to WIT 75480**).

263. The HSCB was notified about the SAI *via* the SAI mailbox on 22nd March 2016. The notification explained that the incident had occurred in January 2016, meaning there were 10 weeks from the date the incident before it was reported to HSCB. The HSCB was not informed of the date the Trust formally discovered an incident occurred. As per

the SAI procedure outlined in Section 3 of this statement, Trusts are required to inform the HSCB within 72 hours of the incident being discovered.

264. Upon receipt of the Terms of Reference for the level 2 review on 5 April 2016, the DRO encouraged the Trust to consider "*adding someone from outside the Trust to the team membership"*. (**SG Appendix 632 - SPPG-C-00013 - Email from DRO with query re Team Membership - WIT 74936 to WIT 74937**). Following discussion between the DRO and Trust Governance Lead, as would be the practice, it was agreed the membership would remain unchanged, though expert opinion would be requested during the course of the review, if required.

265. The Final RCA Report for SAI Personal information was due to be submitted to HSCB within 12 weeks from notification of the SAI, by 14th June 2016. The report was not received until 16th March 2017, i.e. 39 weeks after the agreed date of receipt.

266. Correspondence was issued from the Chief Executive of the HSCB to Trust Chief Executives on all overdue reports across the region on a quarterly basis. Letters highlighting concerns regarding all reports overdue from the Southern Trust were sent from Valerie Watts, Chief Executive of HSCB, to Francis Rice, Interim Chief Executive of Southern Trust, in August 2016 and January 2017. (**SG Appendix 304 to SG Appendix 307 - SPPG – C – 00461 – SPPG – C – 00464 WIT 73614 to WIT 73619**)

267. Following consideration of the RCA Report by the Acute SAI Professional Group on 6th June 2017, the following queries were sent by the DRO to the Trust. It responded on 15th September 2017. The queries and the Trust's responses are set out in the table below.

Table 6 - SAI – RCA Personal Information redacted by USI *– Queries & Trust response*

Query from DRO	Trust Response
Request further clarification on who ordered the CT scan, Ultrasound and MRI and why the results were not	The CT MRI and US were ordered by or on behalf of an individual Consultant General Surgeon. A further CT was ordered by a

Query from DRO	Trust Response
acted on. It should be noted to the Trust the onus for following up on investigations is on the person who request the investigations.	Breast Surgeon. The Trust currently has a short life working group reviewing systems and processes for the management of results I am checking if the case was presented at M&M for wider learning.
The HSCB note the triage of urology referrals is unacceptable. Can the Trust advise this has been addressed?	This SAI was in relation to triage by one urologist, the Trust has addressed this issue with the Consultant involved. Electronic triage has been rolled out for Urology, this should mitigate against late or uncompleted triage within the specialty.
Ensure Trust Urologists are compliant in accordance with the Integrated Elective Access Protocol (IEAP).	The Trust Urology team have been made aware of the requirements within the IEAP in relation to triage of clinical referrals.

268. This SAI was listed for discussion at the Acute SAI Professional Review Group on 20th November 2017 to consider the Trust's responses. Following that discussion, it was agreed that, whilst there was no identification of trends or requirement for the dissemination of regional learning, the SAI would be referred to the Regional Scheduled Care Group in respect of its views on timely triage and categorisation.

269. On 10th April 2018, the Trust provided an update on the two local recommendations outlined in the RCA report regarding clinical triaging and escalation of triage non-compliance in accordance with Integrated Elective Access Protocol (IEAP) and the challenges involved in triaging GP referral letters within Urology. The Trust advised these actions had been completed.

270. The Trust update was forwarded to the DRO. She responded on 18th April 2018 to say she was content. The SAI was closed with no regional learning identified and no further action required.

271. Although there was no regional learning to be distributed, as mentioned above, the SAI Professional Review Group agreed the SAI would be referred to the Regional Scheduled Care Group for consideration of timely triage and categorisation because of the delays. On 19th April 2018, correspondence was received to the HSCB's SAI Mailbox advising that members of the Regional Scheduled Care Group had discussed the learning outcomes with the relevant specialty leads/clinicians. (**SG Appendix 689 – SPPG – C – 00070 WIT 75461 to WIT 75462**)

2) SAI – RCA Personal information redacted by USI

272. The second SAI was notified to the HSCB *via* its SAI mailbox on 21st September 2017. The notification outlined that the Southern Trust had become aware of the incident on 12 May 2017, some 4 months before (the notification should have been within 72 hours). The report referred to concerns about the care of four patients during 2016.

273. Upon receipt of the notification, DRO forwarded 3 queries to the Trust on 21st September 2017 (**SG Appendix 311 - SPPG-C-00081 DRO's immediate queries forwarded to Trust (**Personal information **- WIT 73691 to WIT 73692**) and the Trust responded promptly on 29th September 2017 (**SG Appendix 312 - SPPG-C-00082 Trust response to DRO's queries (**Personal information redacted by USI**- WIT 73693 to WIT 73695**). Those queries and the Trust's responses are set out below:

Table 7 - SAI – RCA [redacted] *Queries and Trust response*

Query from DRO	Trust Response
What action has been taken to prevent further referrals slipping through processes like this?	Electronic referral process is being piloted which make triage more accessible and timelier. It allows

Query from DRO	Trust Response
	easy identification of referrals that have not been triaged & reporting of same.
Has the Trust assured itself that there are no other urology referrals have slipped through?	There has been a look back exercise within urology to identify any other referrals which were not triaged, this review is complete.
Have they considered if this is likely to be a problem in other specialities?	If Consultants fail to comply with the IEAP process and there are delays in triaging this is escalated to the Head of Service (HoS) & Assistant Director (AD) for action.

274. However, the next recorded action occurred on 18 February 2020, some 132 weeks later at which point the Southern Trust submitted a Terms of Reference for a level 3 review.

275. As previously noted, generic letters highlighting concerns regarding overdue reports were sent routinely from HSCB Chief Executive to the Southern Trust's Chief Executive. No specific follow up action was taken in relation to this SAI **(SG Appendix 304 - SPPG-C-00461 Letter to SHSCT Chief Executive re SAIs - Outstanding Review Reports 31.07.2016 - WIT 73614 to WIT 73614**).

276. ToR and Team Membership were considered at the Interim Safety and Quality Meeting on 4th May 2020, a meeting set up as part of HSCB/PHA safety and quality contingency arrangements during the initial Covid surge. The meeting did not agree the ToR and team membership submitted as these did not meet the requirements of a level 3 review. Further information was requested from the Trust on 22nd May 2020. A response was received on 2nd July 2020. Those further queries and the Trust's responses are set out below:

Table 8 - SAI – RCA Personal information – Further queries and Trust response

Query from DRO	Trust Response
Was there a review of these cases carried out individually when they occurred and were there recommendations at this stage and have they been implemented?	The origins of the review were following the completion of a SAI - Datix Personal information chaired by Mr Glackin and the recommendations contained within, which brought about this review into delay in triage for urology patients.
Can the Trust review and ensure required changes have been made in light of these cases?	Yes. The Trust have implemented e-triage which automatically records the referral electronically to ensure they are triaged according to their clinical priority. These happened in 2017 so therefore changes should have been put in place when these were identified.
These happened in 2017 so therefore changes should have been put in place when these were identified.	Yes, as above.

277. The SAI record states that, at the meeting on 4th May 2020, Denise Boulter (PHA) agreed to discuss the possibility of a thematic review with Dr Brid Farrell (PHA). A thematic review is an in-depth review examining similar types of SAI to ensure that patterns are considered within the regional context.

278. The corporate record states the RCA report was received on 29th May 2020 and was shared with the DRO. It was also discussed at the Interim Safety and Quality meeting on 1st June 2020 with agreement that actions from this SAI would now be taken forward by the Acute SAI Professional Group.

279. On 3rd December 2020, the Southern Trust confirmed this SAI (ref no. Personal information would not be included in the overarching review. The RCA Report was reviewed at the Acute Professional Group Meeting on 12th April 2021 and closed. No regional learning was identified.

280. On 11th June 2021, Mrs Denise Boulter (PHA) forwarded the SAI Action Plan arising from the review of the SAI to the HSCB AD of Commissioning for Cancer services, advising there were a number of recommendations within the action plan for HSCB. They are set out below:

For HSCB

- **Recommendation 1 -** HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

- **Recommendation 2 -** HSCB should consider GPs providing them with assurances that the NICE guidance has been implemented within GP practices.

- **Recommendation 3 -** HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

For HSCB, Trust and GPs

- **Recommendation 4 –** GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging, e.g. use of mandatory entry fields.

281. In response to these recommendations to HSCB, I can state the following:

a) Recommendation 1 - CCG is updated whenever there is a revision of the NICaN Primary Care Referral Guidance. Urology referral guidance was amended in September 2019 (**PC Appendix 51 – Letter re NICaN referral guidelines for suspect cancer Sept 2019**) and August 2022 (**PC Appendix 52 – LETTER NICaN to Primary Care-re Suspect Cancer Referral Guidance_ Aug_2022**) and letters issued to GPs are appended.

b) Recommendation 2 – It would not be usual practice to seek assurances from GPs but rather to support GPs to implement guidance. The letter issued provides advice to GPs. Guidance for GPs was updated on the CCG and the NICaN website. NICaN facilitates a rolling programme of GP education which aims to highlight where updates have taken place.

c) Recommendation 3 – NICE NG12 relates to suspect cancer referral guidelines. This has not been fully implemented in Northern Ireland. NICaN Board in June 2019 took a decision that "*unless significant mitigating actions could be put in place to increase diagnostics and outpatient capacity, it would not be appropriate to proceed with full implementation*". Rather it was decided to introduce on a phased basis through NICaN CRGs. The NI Cancer Strategy includes a commitment to implement NICE guidance, including NG12 in coming years although this will depend upon funding being available.

d) Recommendation 4 – The overwhelming majority of GP referrals, including relating to cancer, are made through the CCG. In turn, acute specialty teams will undertake triage to verify or amend the relative priority assigned by GPs, i.e. red flag cancer, urgent or routine. Following the successful introduction of an electronic referral form for suspect breast cancer, it is intended to introduce an electronic referral form for urology referrals in the near future.

282. The following documents are relevant to this SAI:

- (**SG Appendix 311 to SG Appendix 312 - SPPG-C-00081 and SPPG-C-00082 - WIT 73691 to WIT 73695**);

- (**SG Appendix 695 to SG Appendix 699 - SPPG C 00076 to SPPG C 00080 –WIT 75481 to WIT 75491**);

- (**SG Appendix 700 to SG Appendix 742a - SPPG C 00083 to SPPG C 00125 and SPPG-C-00404 WIT 75492 to WIT 75651**).

3) SAI – RCA Personal information redacted by USI

283. The above (third) SAI was notified to the HSCB via the SAI mailbox on 22nd September 2017, marked as a level 1 review. The notification indicated the incident had occurred on 10 July 2016. There was therefore a delay of 62 weeks from the date of the incident until it was reported to the HSCB - it should be reported within 72 hours. The HSCB was not informed of the date the Trust formally discovered that an incident occurred.

284. There was a further delay of 115 weeks before the final review report was submitted by the Trust to the HSCB on 6th February 2020. As referenced above, letters highlighting concerns about all overdue reports was sent from the HSCB Chief Executive to Southern Trust Chief Executives on 8 occasions. Detail of all correspondence sent is outlined in the position report (**SG Appendix 313 - SPPG-C-00143 SAI Position Report as of 26 AUG 22 (S11486) - WIT 73696 to 73698**)

285. Although the Trust initially submitted the incident as a level 1 requiring an SEA review, they later submitted an RCA report, advising that a level 3 review was conducted as they wished to involve an independent person on the review panel.

286. Following consideration of the report on 14th May 2020 by the Safety and Quality Nursing Team, PHA and the Governance Team in the HSCB, it was agreed that the ToR and team membership submitted did not meet the requirements of a level 3 review. The Trust was advised that the review undertaken would be considered as a level 2 review.

287. Following a review of this SAI by the Acute Services SAI Review Team on 30th June 2020, it was agreed that a newsletter article reiterating the importance of communication between all teams/specialities involved in the care and treatment of a patient would be issued. The importance of communicating with the patient was also

noted. The regional distribution of this learning was initially delayed due to the fact that PHA colleagues who were responsible for the drafting the articles and disseminating the newsletter were redeployed during the Covid19 pandemic.

288. Subsequently, an administrative error was noted within our system in August 2021 when the HSCB Governance Team realised the Trust had not been advised the SAI was closed in June 2020 and that learning was to be distributed *via* a newsletter article. This was raised at an Acute Professional Group meeting on 24th August 2021. By that time, the issues regarding the urology lookback were better understood and it was agreed that learning would not be issued as there was the potential for much wider learning as 9 further SAIs regarding Mr O'Brien's practice. That learning, which was intended to be developed as part of a newsletter article, had not therefore progressed. Whilst this discussion is not detailed on the position report, the Assistant Governance Manager has provided an update from her written record of the meeting (**SG Appendix 314 - SPPG-C-00407 Hand-written record of meeting held on 24.08.21 - WIT 73699 to WIT 73699**) and the agenda for the meeting is (**SG Appendix 315 - SPPG-C-00406 - Agenda Acute SAI Review Team Meeting 24.08.21 - WIT-73700 to WIT 73701**).

289. The following documents are relevant to this SAI:

- (**SG Appendix 313, Appendix 314, Appendix 315 - initial reports and discussion points in relation to the SAI WIT 73696 to WIT 73701**)
- (**SG Appendix 743 to SG Appendix 759 – correspondence WIT 75652 to WIT 75703**)
- (**SG Appendix 760 - final SAI report WIT 75704 to WIT 75704**)
- **(SG Appendix 313 to 316 – WIT 73696 to WIT 73764) and (SG Appendix 759 -SPPG-C-00142 Email to SHSCT re level of review (S11486) WIT-75702 to WIT-75703) and (SG Appendix 760 - SPPG-C-00405Email from L Herron to D McCormick (S11486) WIT-75704 to WIT-75704)**

Inquiry Questions

290. Paragraph 12 in the schedule to the section 21 Notice asks the following questions:

"Were you aware that a formal process under the framework contained within Maintaining High Professional Standards in the Modern HPSS commenced in December 2016 (in relation to Mr Aiden O'Brien), in part as a response to information uncovered during the investigation into the SAI for Patient 10 (RCA Personal information *?*

If so, outline when and in what circumstances the HSCB became so aware and outline its understanding of how that process progressed.

If the HSCB was not made aware of the commencement of this MHPS process, should it have been made aware?"

291. During initial meetings with Southern Trust colleagues in August 2020, after the Early Alert, I was made aware that the Trust had previously utilised the MHPS framework in relation to Mr O'Brien.

292. Neither I nor the HSCB were made aware of this prior to August 2020, nor was there any requirement on the Trust to notify us unless the process identified service failings or impacted on service capacity.

293. The DHSSPSNI framework "Maintaining High Professional Standards" (MHPS) November 2005 is "*a framework for handling concerns about the conduct, clinical performance and health of medical and dental employees*". It provides arrangements for "*a coordinated process for handling concerns about the safety of patients posed by the performance of doctors and dentists when this comes to the attention of the HPSS*" (the HPSS is now known as the HSC).

294. The MHPS framework document is a management tool used by employers in the HSC section after concerns have been identified about a practitioner's performance. It focuses on preventing harm to patients. It is used by the employer, which in the case of Mr O'Brien was the Trust.

295. Paragraph 13 of the schedule to the section 21 Notice asks:

"When, if at all, and in what circumstances did you or the HSCB first receive information which identified or could have identified concerns regarding Mr O'Brien's practice in relation to the following four areas:

I. Untriaged referrals;

II. Patient notes tracked out to Mr O'Brien and not returned;

III. Undictated patient outcomes from outpatient clinics; and

IV. The preferential scheduling of private patients."

296. As highlighted in the paragraphs earlier in this section, prior to 31 July 2020, the HSCB was not aware of any concerns regarding Mr O'Brien's practice.

297. There have been operational challenges within urology services for some years. However, all Trusts faced similar challenges and Southern Trust was not an outlier. The concerns raised during that period related mainly to capacity issues and attendance at MDT meetings. They did not relate to the practice of Mr O'Brien, specifically, or any other Urology Consultant. Through the work undertaken in the 2014 Urology Review Stock-take; via the Peer Review work commissioned through NICaN; and through the reporting of the 3 SAIs detailed above, the HSCB sought to increase service capacity and improve patient care in response to these challenges.

298. Regarding triage, the first of the three urology services SAIs, submitted on 22nd March 2016 (SAI Personal information highlighted triage issues. As outlined in table 8 above, the DRO specifically asked if the triage issues had been addressed. The Trust's response advised that electronic triage had been rolled out for Urology and that this should mitigate against late or uncompleted triage within the specialty.

299. Regarding tracking patient notes and undictated patient outcomes, to the best of my knowledge, at no point prior to July 2020 were any concerns raised with the HSCB about these issues.

300. Regarding the preferential scheduling of private patients, the HSCB was not aware of this prior to August 2020. The Trust noted the possibility of preferential scheduling of

private patients in initial briefings during August 2020. Subsequently, Trust colleagues examined this possibility, however I do not recall any evidence being provided to demonstrate that private patients were actually being scheduled preferentially.

301. Paragraph 14 of the schedule to the section 21 Notice asks:

"If you or the HSCB were aware of the four areas of concern identified at paragraph 13 above, what if any, action did the HSCB take to ensure that these matters were being addressed and that patient safety was not undermined."

302. As outlined in the response to question 13, only the triage issue had been raised previously with the HSCB, prior to July 2020. The triage issue was acted upon and HSCB subsequently received a satisfactory assurance from the Trust in response.

303. In initial discussions with Southern Trust (August-September 2020), the Trust did note concerns regarding preferential scheduling of private patients, but did not subsequently provide evidence that this had taken place.

304. To the best of my knowledge at no point during that period were any of the other concerns raised, therefore no action was taken in response.

305. Paragraph 15 of the schedule to the section 21 Notice asks:

"Prior to 31 July 2020, were you, or others within the HSCB, aware of any concerns in relation to urology services within the Trust, including service capacity or waiting list issues, or in relation to the practice of Mr Aiden O'Brien in particular. If you or others were so aware of any concerns relating to Urology Services, outline the following:

I. The date on which you or others within the HSCB became aware;

II. The identity of the individual who told you of those concerns, if applicable;

III. The specific information communicated to you in relation to any concerns;

IV. What, if any, action you took on behalf of the HSCB to log, monitor, assess or address those concerns.

306. The HSCB was aware of some service capacity issues in urology in the Southern Trust (and other Trusts within the region) raised during the 2014 stocktake. However, the HSCB was not aware of any such issues specific to Mr O'Brien prior to 31 July 2020.

307. As explained in Section 4 above paragraphs 232 to 234, HSCB sought improvement plans from Trusts, including Southern Trust. The Southern Trust's Plan was approved and HSCB accepted this would take precedence over extant agreed activity (through the SBA). However, the HSCB expected that the Trust would return to agreed activity at the earliest opportunity.

308. Furthermore, HSCB established the Urology Planning and Implementation Group (PIG) as a regional vehicle to improve urology services regionally.

Section 5 – Overview of period 31 July 2020 to 30 October 2020

309. Paragraph 16 of the schedule to the section 21 Notice asks :

"When and in what circumstances did you first become aware of the contents of an Early Alert Communication from the Trust to the Department on 31 July 2020?"

310. I first became aware on 21st August 2020. This is explained below.

From the Early Alert to 1st meeting of UAG

311. On 21st August 2020 I received an email from Jackie Johnston, Deputy Secretary in the Department, about an Early Alert (EA 181190) received from Southern Trust regarding urology services. The email was also directed to Olive McLeod, Chief Executive of PHA. Jackie Johnston attached the Early Alert form from Dr Maria O'Kane, Medical Director, Southern Trust, which outlined the Trust's concerns about delays in treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. It also said that a "*lookback*" exercise had been conducted of the Consultant's work for a 17-month period (January 2019 to May 2020) to ascertain if there were wider service impacts. The Early Alert Form noted the initial actions the Trust had taken (**SG Appendix 761 - SPPG-B-00172 Email trail between Hugo Van Woerden and Paul Cavanagh to discuss lookback review – WIT 75705 to WIT 75711**).

312. The Department's Early Alert system is designed to ensure that the Department and the Minister receive prompt and timely details of events (including potential SAIs) which may require urgent attention or possible action by the Department. The Early Alert notification sent by the Trust on 31st July 2020 provided necessary details to alert the Department and explained the Trust's efforts to ascertain the extent of concerns regarding the practice of the Consultant in question.

313. The Departmental Early Alert circular issued on 27th February 2019 requires organisations to notify the Department of any event meeting the Early Alert criteria within 48 hours and the notification proforma must be completed and forwarded to both Department and HSCB within 24 hours after notification. The Trust did not meet this requirement.

314. The Early Alert explained that the Trust had become aware of the potential concerns on 7th June 2020 and had undertaken a lookback exercise bounded to a 17-month period (1st January 2020 to 31st May 2020). The lookback identified concerns with patient care and two potential SAIs. The Trust also referred to steps it had taken to raise concerns about the Consultant's practice and initiate a Review of Service.

315. The HSCB was not notified of the issue prior to receiving the Early Alert. The Trust could have raised the issue with the HSCB earlier through established channels given that there would be an impact on service delivery due to any lookback activities.

316. It is important to emphasise the actions which followed took place in the context of ongoing work to manage the HSC's pandemic response, most notably planning for the second and more challenging wave of infection anticipated in late Autumn 2020. Work had largely moved online with colleagues and I linking remotely through video conferencing facilities. Moreover, work-life balance had become problematic for senior managers and clinicians across the entire sector, all of whom, myself included, were working long hours, including at weekends, without prospect of any break in sight.

317. Jackie Johnston's (DoH) email to me and Olive McLeod (PHA) said the Department would look to the HSCB and PHA to provide advice on the need for a recall/lookback of identified patients and oversee the governance and process of any recall/lookback if required (**PC Appendix 53 - FW HPRM MM01212020 -CONFIDENTIAL EARLY ALERT – Urology**).

318. Paragraph 17 of the schedule to the section 21 Notice asks:

> *"Outline all steps taken by yourself and the HSCB upon receipt of the information contained within the Early Alert Communication from the Trust to the Department on 31 July 2020. Specifically, outline the following:*
>
> *I. The immediate action (naming each actor) taken by the HSCB on receipt of the information contained within the Early Alert Communication;*
>
> *II. The individuals within the HSCB to whom the contents of the Early Alert Communication was shared;*

III. The nature of any discussions with officials from the HSCB had with the Trust concerning the contents of the Early Alert Communication or related matters;

IV. The nature of any discussions official from the HCSB had with the Department, the PHA, the RQIA and any other relevant organisation concerning the contents of the Early Alert Communication or related matters;

V. The nature of any internal discussions within the HSCB regarding the content of the Early Alert Communication, or related matters, and next steps."

319. Following review of Jackie Johnston's email, I telephoned Aldrina Magwood, Director of Planning and Performance in Southern Trust, who confirmed the contents of the Early Alert and the issues relating to the Consultant's practice. I responded to Jackie Johnston's email and offered my initial thoughts regarding pressures on Southern Trust urology service.

320. In the days that followed, I liaised with colleagues in HSCB and PHA to get initial views on what response the HSCB and PHA should take to the emerging situation. I was updated by Jackie Johnston (DoH) by email following a meeting he had on 24 August 2020 with Southern Trust colleagues at which there was consideration of actions to be taken in response to the concerns identified (**PC Appendix 54 - Email 2 - HPRM-MM011212020- CONFIDENTIAL EARLY ALERT**).

321. On 27 August 2020, I met online with Trust senior colleagues to discuss the situation in more detail. I was joined by Dr Brid Farrell from PHA. The Trust updated me on initial proposals for a lookback exercise. They referred to an earlier investigation into Mr O'Brien under MHPS in 2018. They referred to plans to undertake an investigation into a number of SAIs which had been identified. They referred to inviting the Royal College of Surgeons to undertake a 5-year lookback/case note review. There was also some discussion about the Consultant's private patients and the need to check if the Consultant continued to practice in any independent sector facility.

322. On 28 August 2020, a further meeting was held with Trust and PHA and also involving Jackie Johnston. At this, the Trust confirmed that the Consultant had been referred to the GMC. There was discussion about informing other Trusts and independent sector

providers of concern with the Consultant's practice. At that point in time 3 SAIs had been identified and a further 4 cases were being screened to see if they were relevant. Terms of Reference for a formal review were being drafted and an internal Trust review was commencing into how the Consultant bypassed Trust protocols.

323. In the period that followed through September and October 2020, I met weekly or fortnightly (**PC Appendix 55 - PC Handwritten Notes - Sept_Oct 2020**) with the Trust, supported by HSCB, PHA and Departmental colleagues. In order to assure Departmental colleagues, I led these meetings with a focus on both understanding Trust actions, as well as reporting and providing assurance to senior colleagues on progress. During this period, the Trust made preparations for an independent SAI investigation; negotiated the undertaking of the invited review by the Royal College of Surgeons; and developed communication plans, including communicating with GPs and arranging a helpline(s) for patients, families and staff. Departmental colleagues informed me of the Minister's plans to issue a statement to inform the general public of issues pertaining to the Consultant's practice. I was not involved in preparation for the statement.

324. Efforts to identify patients for both the lookback period (January 2019 to June 2020) and the invited review (5 years to June 2020) was a key task for the Trust during this period.

325. Given the inclusion of Fermanagh patients in Team South as part of the reconfiguration of urology services following the 2009 urology review, the Trust sought HSCB support to 'repatriate' Fermanagh patients back to the Western Trust (which hosted Team North) in order to provide some extra staff capacity to undertake the patient recall. This was enacted in late 2020 with support from Western Trust.

326. The Southern Trust Chief Executive provided a Trust report on 14 October 2020, entitled "Clinical Concerns with Urology". It contained a summary of the Trust's clinical concerns about the Consultant's practice and its plans to minimise any risk or harm to patients. The report included an appendix relating to previous concerns about the Consultant since March 2016, including previous SAIs and action under MHPS. I shared the report on 15 October 2020 with Ryan Wilson, who was at that time the Acting Director of Secondary Care Policy at the Department; I also copied in Dr Brid Farrell

(PHA), Sharon Gallagher (HSCB) and Jackie Johnston (DoH). The report is attached in (**SG Appendix 556 - Appendices to Report – WIT 74648 to WIT 74657 and Appendix 557 - Full Report SPPG-B-00170 & SPPG-B-00171 – WIT 74658 to WIT 74662**).

327. As the lookback continued, further cases were screened in as SAIs. For example, at the meeting on 1 October 2020, 8 SAIs were confirmed and a further 5 cases were being screened against the SAI criteria.

328. The Trust was undertaking a range of actions to identify patients of concern, involving consultant and specialist nurse resource. Concerns were emerging around patients who received emergency stent surgery; elective care; review of pathology, cytology and radiology results; actioning of decisions at MDMs; backlog awaiting review; and counselling for patients receiving a drug called bicalutamide. At this point, I found it difficult to see the whole picture and it was suggested that some patients may have had several discrepancies in care. I sought to get a single picture of the overall position.

329. I attended a meeting with senior Departmental colleagues on 22 October 2020. I do not have any minutes of this meeting. At the meeting, 9 SAIs were confirmed and an external panel had begun to consider these. It was agreed that a Departmental-led assurance group should be put in place. The Urology Assurance Group (UAG) would involve Department, HSCB, PHA and Southern Trust and an urgent meeting would be arranged.

330. In his written statement to the Assembly on 27 October 2020, Minister Swann communicated the issues around the lookback work and announced the establishment of the UAG.

331. I joined the first meeting of UAG on 30 October 2020 on behalf of the HSCB. It was agreed that the assurance arrangements in relation to the lookback/recall would be the Department-led Urology Assurance Group (UAG), providing internal and external oversight, and there would be a Trust-led urology working group, reporting to UAG and at which the HSCB and PHA would be represented.

332. Trust colleagues at the UAG meeting provided a written update to the group. The Trust stated that, for the period from January 2019-July 2020, a total of 2,327 patients were treated by the consultant (excluding the Consultant's private patients) and they were all subject to lookback. However, the Trust emphasised that scoping work was continuing. The Trust also noted that helplines had opened to the public and GPs on 26 October 2020. By 30th October 2020, 134 calls from the public and 1 GP call had been received.

333. Questions 18, 19 and 20 of the schedule to the section 21 Notice ask about the HSCB's view in regards to the Early Alert and associated communication and reporting arrangements employed by the Southern Trust.

334. Paragraph 18 of the Notice asks:

"*From the HSCB's perspective, what is the purpose of an Early Alert, and was it properly used by the Trust in these circumstances?"*

335. The purpose of an Early Alert is to bring significant events to the attention of the Department and the Minister. It was used properly in this case as the subject matter and its consequences were sufficiently serious to warrant an Early Alert, although it was not submitted in the timescales stated in the policy material.

336. Paragraph 19 of the Notice asks:

"*Did the HSCB reach any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to communicate and escalate the reporting of issues of concern within the Trust to the Department, the HSCB or any other relevant body? If so, fully outline the view which has been reached and set out the reasons for the view which has been reached. If the HSCB has not evaluated this issue, please explain why."*

337. Paragraph 20 asks:

"*Did the HSCB reach any view concerning the effectiveness of the corporate and clinical governance procedures and arrangements within the Trust in the context of the matter which gave rise to the need to issue an Early Alert? If so, fully outline the view which*

was reached and set out the reason for the view which had been reached. If the HSCB did not evaluate this issue, please explain why."

The responses to these two questions are set out in the paragraphs below:

338. Clinical governance is a matter for Southern Trust through its Medical Director and clinical leaders. Corporate governance is the responsibility of the Trust Board made up of Executive and Non-Executive Directors who are accountable to the Department. The HSCB does not oversee Trust governance, but rather commissions services; manages performance; and seeks to improve quality.

339. The HSCB was concerned about delays in the reporting of SAIs by the Trust, measured against the timeframes set out in the guidance. Delays in the notification of SAIs, submission of terms of reference, where appropriate, and the submission of final reports were evident in Southern Trust. However, it is important to emphasise that similar delays were evident in other Trusts and Southern Trust was not an outlier. For this reason, the HSCB and PHA had issued several reminders to Trusts, including the Southern Trust, and escalated to Chief Executive level in an effort to expedite in a timely manner. This had limited success and was largely put down to ongoing service pressures, the resolutions to which were occupying senior Trust managers.

340. Other than delays in progressing SAIs in line with guidance, it is my understanding that the Southern Trust undertook its SAI processes in line with requirements and worked constructively with the HSCB's and PHA's respective DROs in concluding any outstanding issues raised.

341. Of the 3 SAIs of interest to the Inquiry, only one had closed in advance of July 2020 (RCA Personal information redacted by USI) and did not lead to regional learning. The Trust had provided assurance that the local actions had been completed in relation to IEAP and triaging GP referrals. A second SAI (RCA Personal information redacted by USI) was being considered in May/June 2020 and communication of learning was impacted by the Covid response.

342. In relation to the submission of the Early Alert on 31st July 2020, it is notable that the Trust became aware of potential concerns on 7th June 2020. There was therefore a gap of 8 weeks between the Trust discovering the problem and issuing the Early Alert.

While it is recognised that the Trust immediately set in motion efforts to prevent harm to patients through undertaking a lookback exercise, the purpose of an Early Alert is to give initial information in relation to 7 criteria. The criteria include contacting patients about possible harm; potential media interest; and the suspension of staff. Given the significant activities already underway/completed in the Trust, including patient case review, contact with outside agencies, including the General Medical Council (GMC) and restriction of the Consultant's duties, the Trust should have raised the Early Alert much sooner following discovery in early June 2020.

343. The Trust does not appear to have raised the issue with anyone in the HSCB or PHA in advance of the Early Alert. While Trusts are not required to give HSCB or PHA advance notice of such an alert, it is often common practice to link with the commissioning bodies when there are particular service issues and to seek advice. Even in the midst of the extreme pressure due to the ongoing pandemic response, there would have been opportunities to link with HSCB or PHA officers. Given the seriousness of what had been discovered, there should, in my opinion, have been at least some informal indication about what was happening. This did not happen during that 8-week period.

344. Paragraph 20 asks about clinical governance in the context of the matters which gave rise to the need to issue the Early Alert. This is not a question which I can answer authoritatively. The HSCB did not oversee Trusts' clinical governance. However, the actions taken in the weeks before and after the Early Alert shows that the Trust was focused on clinical governance issues at that time, prioritising patients at higher risk (e.g. patients requiring stent removal) and considering patients who may meet the criteria as an SAI. Steps had been taken to restrict the Consultant's practice, following advice from NHS Resolutions, and making reference to his private practice.

345. Paragraphs 21 to 23 are answered together below.

346. Paragraph 21 of the schedule to the section 21 Notice asks:

"Outline what advice, if any, was given to the Trust by the HSCB in response to the Early Alert and related matters."

347. Paragraph 22 of the schedule to the section 21 Notice asks:

"After receipt of the Early Alert, outline whether the HSCB gave any consideration to, or advised the Trust of the availability and appropriateness of, utilising the Departmental Guidance contained within "Practical Guide to Conducting Patient Service Reviews of Look Back Exercises: Regional Governance Network Northern Ireland Sub Group" (February 2007)"

348. Paragraph 23 of the schedule to the section 21 Notice asks:

"As appropriate, outline what, if any, advice was given to the Trust with regard to the application of the 2007 Departmental Guidance and in particular with regard to paragraph 1.4 of that Guidance. If no such advice was given, please explain why it was not given."

349. Upon receiving the Early Alert on 21st August 2020, I sought to understand the issues to date and what actions Southern Trust had initiated which appeared wide ranging and progressing. I highlighted the extant guidance regarding lookbacks which the Trust should follow, i.e. the 2007 guidance referred in the question above.

350. The Trust was advised to follow this guidance by myself and Dr Brid Farrell, as would be standard for any such process being undertaken in Northern Ireland. This included the application of paragraph 1.4 of this guidance, although I do not recall that particular paragraph being specifically drawn to their attention.

351. Paragraph 24 of the schedule to the section 21 Notice asks me to consider the evidence from Aidan Dawson (PHA) and Ryan Wilson (DoH), which is quoted in the schedule and refers to setting up the Southern Urology Co-Ordination Group and associated meetings. It is important to emphasise that the Urology Coordination Group was established in November 2020 following agreement at the Departmental-led UAG. Until this time, I was involved in regular meetings with Department, Trust, HSCB and PHA at which we sought to fully understand Trust efforts to scope out and commence lookback activities relating to the Consultant's practice.

352. As previously explained, the initial meetings commenced in August 2020 and continued on a weekly/fortnightly basis until October 2020. Jackie Johnston (DoH) initially led these meetings and I took on this role in September 2020. These meetings were not formally minuted.

353. I agree with Mr Wilson's recollection of these initial meetings as set out at Paragraph 24 of the schedule to the section 21 Notice. My focus was on understanding the extent of potential for patient harm and to consider the Trust actions to undertake lookback activities and other actions planned, including scope of recall, SAI investigation, referral to GMC, communication with patients and the public in general.

354. Paragraph 25 of the schedule to the section 21 Notice asks:

"Outline any meetings or discussions between officials from the HSCB and the Trust, the Department, the PHA, the RQIA and any other relevant organisation from the date of receipt of the Early Alert on 31 July 2020 to the first meeting of the Urology Assurance Group on 30 October 2020 concerning the handling of the concerns raised in the Early Alert, or related issues."

355. I have drawn on my limited handwritten notes to respond to this question (**PC Appendix 55 - PC Handwritten Notes - Sept_Oct 2020**). I am not aware of any other record of the meetings in this period.

356. The first meeting I had with Southern Trust colleagues was on 27th August 2020. Attending on behalf of the Trust was Dr Maria O'Kane, Melanie McClements, Stephen Wallace, Ronan Carroll and Martina Corrigan. This meeting was to allow the Trust to brief me on the issues and initial Trust activities in response.

357. I became aware of the following initial actions taken by the SHSCT:

a) Advice was sought from NHS Regulations (formerly NCAS) who recommended restrictions of clinical practice.

b) Referral of these concerns in respect of Mr O'Brien was made to the GMC.

c) In consultation with MHS Resolutions and the GMC, from discovery until the date of termination of contract, restrictions were placed by the Trust on Mr O'Brien's practice. He was no longer allowed to undertake clinical work and could not access or process patient information either in person or through others in hard copy or electronically. A request was also made that he voluntarily undertakes to refrain from seeing any private patients at his home or any other setting and same was confirmed in writing via Mr O'Brien's solicitor.

d) Given that Mr O'Brien had retired on 29th July 2020 and was no longer employed by SHSCT, the Trust made it clear that the Responsible Officer authority had passed to the GMC.

e) In keeping with the Regional Guidance and following the procedure for reporting and follow up of SAI reviews, the Trust established a panel to undertake the SAI reviews identified in the course of reviewing Mr O'Brien's patients. This process was chaired by an Independent Chair (Dr Dermot Hughes) and also included a Urology Consultant from England recommended by the Royal College of Surgeons as a Urology Subject Expert.

f) There were preliminary discussions undertaken by the Trust with the Royal College of Surgeons Invited Review Service regarding Mr O'Brien's practice and the potential scope and scale of any independent external reviews.

358. On 28th August 2020 I attended a meeting led by Jackie Johnston. Dr Brid Farrell from the PHA attended and Southern Trust was represented by Dr O'Kane, Stephen Wallace, Ronan Carroll and Martina Corrigan. At the meeting it was noted that the Consultant had been referred to the GMC to consider his practice. Although he had retired from the Southern Trust in July 2020, concerns were expressed as to whether he was continuing to practice either in another Trust or privately.

359. It was noted that 3 SAIs had been raised to date (August 2020) with a further 4 cases being screened. There was discussion about engaging the British Association of Urological Surgeons (BAUS) to review 80 cases. Trust colleagues were developing a Terms of Reference for a lookback review in line with Departmental guidance. The

applicable guidance in place at that time was HSS (SQSD) 18/2007 issued by the Office of the Chief Medical Officer (CMO) on 8th March 2007 (**PC Appendix 56 - 20180724 - SPPG - E - 00382-SMT 24.7.18 HSC (SQSD) 18-07**). However, there were also draft versions of the updated 2021 Departmental guidance available at that time which were also considered in developing the Terms of Reference, particularly in regards to the duty of candour matters prevalent in the new draft guidance. A copy of the final July 2021 guidance is attached for reference (**PC Appendix 57 - 20210701 - SPPG - C - 00438 Policy for Implementing a Lookback Review Process July 2021**). There was also discussion on how best to communicate with the patients involved, as well as with their families and with the general public. The Trust also noted that an internal review was underway to understand how the Consultant had bypassed established protocols.

360. The next meeting I attended was on 3rd September 2020. I do not have a record of who attended this meeting. It was noted at this meeting that the Trust had undertaken a review of radiology results within urology as there had been concerns raised during a previous look back exercise about radiology results not being actioned. It had been agreed that a review of any patient who did not have electronic sign off on the Northern Ireland Electronic Care Review (NIECR) system (which is a regional database used by all Trusts) should be carried out. It was noted that the Trust accepted from the outset that this did not necessarily mean that the patients had not been actioned as the paper report may have been actioned. The review identified that there were 1,028 patients (1,536 episodes) under the care of Mr O'Brien who were on NIECR but had not been electronically signed off.

361. It was further noted at the meeting that the Minister intended to make a statement regarding the situation during September 2020. It was agreed that the Trust would establish a patient helpline for anyone concerned following the Minister's statement. There was some discussion on whether or not to name the consultant. Communication with GPs was also highlighted given that GPs would be likely to have inquiries from concerned patients. HSCB would liaise with the Trust on communicating with GPs.

362. The lookback process, including patient review and recall, which commenced in June 2020, continued until early 2023 and is reported on in the recently published *Southern*

Trust Urology Recall Outcomes Report. The SAI process, led by the Expert Panel, dealt with 9 cases identified in the initial phase of the lookback review. Given the decision not to raise further SAIs, any identified beyond the first 9 cases were dealt with within the Structured Case Record Review (SCRR) which began in February 2021.

363. There was some discussion as to whether the lookback would lead to patient recall, although a recall seemed likely. PHA colleagues agreed to consider plans for an invited service review and, in particular, its scope. There was also discussion on patients where there was doubt as to diagnostic results being actioned and action following MDMs. There was also a question regarding regulation of private practice.

364. The next meeting I am aware of took place on 17th September 2020. I do not have a record of attendees. At this meeting it was noted that Hugh Gilbert, a urologist in England, had agreed to join the SAI expert panel. Also, a retired consultant urologist had agreed to review cancer patients remotely. Questions were raised regarding actions from cancer MDMs; actioning diagnostic results; and private patients who may have been added to Trust waiting lists. There was discussion on whether to inform other Trusts of the work in relation to the Consultant's practice.

365. A meeting on 24th September 2020 discussed Trust agreement to delay the invited review. There was also discussion on releasing clinical time to undertake review and recall. It was noted that helplines for both patients and GPs were in place.

366. The meeting on 1st October 2020 noted that 8 SAIs had been confirmed and potentially a further 8 cases that met the requirements to warrant an SAI. There was discussion on stent patients and it was noted that of 147 patients reviewed, 3 patients of concern were identified.

367. At this point, the lookback review was working in a number of different ways through past patient cases. A specialist nurse had reviewed patient notes and 50 patients had been identified as requiring consultant review which I think had also been completed. Through this process, 3 SAIs had been identified with a further 2 cases possibly to be added. 1,136 patients who had radiology tests were being reviewed by clinical nurse

specialist. Consideration of 271 patients who had been discussed at MDMs had identified 2 SAIs.

368. At the meeting on 8th October 2020, Trust colleagues confirmed that there were then 9 SAIs confirmed. The Trust updated on progress of the lookback, including noting delay in actioning pathology and cytology results, and concerns regarding patients prescribed bicalutamide.

369. Trust colleagues noted that they were looking at systems and processes relating to the 2018 Maintaining High Professional Standards. It was also noted that the SAI Expert Panel was developing its Terms of Reference which would be shared with HSCB and PHA in due course.

370. At the meeting on 15th October 2020, there was discussion on prescribing of bicalutamide and, in particular, the need to provide counselling before prescribing and the importance of limiting long-term intake (aside from those with adjuvant treatment). It was also noted that the CMO would write to all Trust Chief Executives to ensure they were aware of the lookback. It was also agreed that the Trust Chief Executive would write to independent sector providers to inform them of the issues being dealt with within the lookback.

371. The next meeting I am aware of took place on 22nd October 2020 and was led by Departmental colleagues. Trust colleagues updated on the lookback activities to that date. There was some discussion about the importance of having an independent process to oversee or supervise the lookback and a suggestion of a potential public inquiry.

372. At the meeting there was some suggestion of mismanagement given that initial concerns were raised in 2009. There was also a question as to whether the MHPS standards were adequate in these circumstances. It was confirmed that there would be a Departmental-led Assurance Group similar to that in place to oversee the Belfast Trust neurology recall with membership drawn from Department, HSCB, PHA and Southern Trust. It was agreed that the first meeting of the UAG would take place on 30th October 2020.

373. Prior to the first UAG, I chaired one final meeting of the initial group which would be formalised with Terms of Reference as the Urology Coordination Group following UAG agreement on 30th October 2020. At the meeting, it was noted that the Trust had issued a letter to GPs regarding the lookback. There was a view expressed that GPs knew about the Consultant's practice and had assumed he was being investigated. I cannot recall who made this comment or any further details about it.

374. There was discussion about the SAI investigation process underway and it was noted that the SAI process was not designed for multiple cases and would prove challenging to complete and to draw out the necessary learning. Another process may be necessary given that more cases could be identified which meet the SAI threshold and could not now be added to the work underway.

Section 6 – Establishment of the Urology Services Inquiry

375. Paragraph 26 of the schedule to the section 21 Notice asks me to

"*outline the decision making process which the HSCB understands led to the announcement of the establishment of a public inquiry by the Minister on 24 November 2020."*

It also asks me to provide specifics on, various matters, including whether the HSCB was involved in the process and, if so, in what way.

376. On 24th November 2020, Robin Swann MLA, Minister of Health, made an Oral Statement in the Assembly regarding the Urology Services in the Southern Trust, outlining serious concerns about the clinical practice of Urology consultant, Mr O'Brien, and the requirement for a statutory public inquiry, under the Inquiries Act 2005.

377. The HSCB did not have any role in advising the Minister on this matter or in the initiation of USI and we were not consulted by Departmental officials on the intention to establish the Inquiry. In turn, the HSCB did not consult with other bodies leading to the establishment of the Inquiry.

Section 7 – SCRR Process and Lookback Review

378. In November to December 2020, Southern Trust raised concerns that, following initial clinical review, further cases had been screened as reaching the threshold for an SAI beyond the 9 cases which were being taken forward by the SAI Expert Panel. It was unusual to see a number of related SAIs (i.e. 9 cases). This was discussed at the UAG meeting on 4th December 2020 and it was agreed to take forward a "Structured Clinical Review" process "to ensure that patients are on the correct treatment pathway and that learning and areas for improvement can be captured, considered and implemented without delay".

379. It was initially proposed that the Royal College of Physicians would conduct the review. For clarity, the SCRR process was alternative to the SAI process and, in due course, was conducted by the Trust itself.

380. The SAI review was overseen through established HSCB and PHA processes (as describe above) and there were connections with the Urology Coordination Group through Brid Farrell. For example, a mid-year SAI outcomes report regarding early identification of learning was shared by the Trust in December 2020 (**SG Appendix 612 – SHSCT (Urology) - SAI (Level3) -Summary of Position SPPG-B-00153 -WIT 74798 to WIT 74814**) with the DRO who in turn provided this to me for information.

381. In January 2021, several workstreams were underway, including the SAI Expert Panel; patient triage and recall; invited review by Royal College of Surgeons; emerging SCRR; and possible support to the Consultant's private patients. There was also ongoing discussion about recording outcomes from any recall in a similar way as had been done as part of the ongoing Belfast Trust Neurology Recall.

382. In early 2021, Southern Trust raised concerns about the additional costs associated with the lookback/recall work with the Department. Non-recurrent deficit support was provided to the Trust during 2021/22 to manage their overall deficit within the financial year, which would have covered any costs the Trust expended on this work.

383. Discussion on including patient representatives in the Urology Coordination Group took place at several meetings in early 2021. However, there was not an obvious charitable organisation or advocacy group involved in issues in relation to urology services. The Trust approached the PCC to consider how patients could be involved in the lookback oversight through the Urology Coordination Group. Ultimately, patients were not directly involved in the Coordination Group. The Trust however would pick up on direct patient contact and involvement at a later time through its own processes in managing the situation.

384. The HSCB held a meeting on Thursday 8th April 2021 with the Department, Trust and PCC. It was agreed at this meeting that the families involved in the SAI process were well-supported and therefore did not require any involvement, at that stage, from the PCC. However, it was recognised that PCC could be available for other affected families going forward.

385. On 15th April 2021, following discussion at the Coordination Group that there was a need to have clear sight of the patients within the scope of the recall, the Trust produced a document entitled "*Patients under the care of Mr O'Brien and currently in process of being reviewed"* to accompany the required report to the UAG. This report provided the fullest picture to this point of the patients within scope of the recall. The excerpt below provides a useful summary of scope and progress to date at that time. Please note that it is possible that a patient may have been included in more than one patient group.

Urology Services Inquiry

Patient Group	Number of Episodes/Patients in Group	Reviewed to date
Elective Cohort	*352 Patients*	*352* *(Administrative Review)*
Emergency Patients (Stents)	*160 Patients*	*160* *(Administrative Review)*
Radiology Results	1025 Patients (1536 Episodes)	511 (Result Review)
Pathology Results	150 Patients (168 Episodes)	168 (Result Review)
Oncology Reviews (IS)	236 Patients	200 (Face to Face ISP)
Post MDM Patients	187 Patients (271 Episodes)	271 (SME Record Review)
Review Backlog	511 Patients (509 Episodes)	40 (Virtual Clinics)
Information Line	154 Patients	6 (reviewed at clinic)
Patients prescribed Bicalutamide	933 Patients	747 (Record Review, 26 Face to Face Reviews)
Patients on Inpatient Waiting List for TURP	143 patients	0
Total	**4321**	**2455**

386. Paragraph 27 of the schedule to the 21 Notice asks:

"Outline the HSCB's understanding of, and its involvement, if any, in the process leading to a decision to by the Trust to adopt a SCRR processes as opposed to utilising the SAI process. In answering this question reference should be made to all relevant meetings, discussions or correspondence. Provide copies of all relevant documentation."

387. The SCRR process was chosen by the Trust in February 2021 over the SAI process after identifying numerous other potential SAIs. My understanding is that the Trust received advice from the Royal College of Surgeons, the Royal College of Physicians and the lead in the PHA that an alternative to the SAI process would be required to deal with the situation. An SCRR process investigates potential harm and allows for patients to be reviewed and appropriate changes made to their care pathway, as well as looking at patterns, processes and potential learning (in line with the SAI focus on learning).

388. Paragraph 27 of the schedule asks for details of meetings of when this was discussed. The decision by UAG to adopt the SCRR process in February 2021 was preceded by several months of investigation and developments. The Trust's process of 'looking back' began in June 2020. The initial review of an 18-month period of Mr O'Brien's clinical activity (from January 2019 to June 2020) raised further queries. It was therefore subsequently agreed that the review needed to be extended in terms of time period and deepened in terms of understanding.

389. The HSCB was made aware that the Trust had met on 21st January 2021 with the Royal College of Physicians (RCP) to finalise discussions for the use of Structured Judgement Review (SJR) methodology to support patient reviews. The SJR was the initial terminology employed by the Trust and would later be called SCRR. The Trust agreed a core virtual training programme with the RCP team for a core group of reviewers and sought ratification from the UAG to use this methodology.

390. The Coordination Group was made aware that the outcome had been that more than 50% of patients investigated via the SJR route were found to have to come to harm as a consequence of the treatment plans assessed and implemented by Mr O'Brien.

391. The Terms of Reference for the SCRR were developed in February 2021 after joint working between Dr Brid Farrell (PHA), the Medical Director's office in the Trust and myself (HSCB). The Terms of Reference of the SCRR were then agreed by the UAG. Progress of the SCRR process continued to be a substantive item of business at both the Urology Coordination Group and the UAG.

392. Paragraph 28 of the schedule to the section 21 Notice asks:

"What assurances did the HSCB seek and receive (if any) with regard to the appropriateness of the use of a SCRR process in the context of the concerns about patient care and safety which were made known to the HSCB, as opposed to utilising the SAI process? In particular, the inquiry is concerned to understand the extent to which the HSCB sought to obtain assurances as to the robustness and thoroughness of the SCRR process, the assurances provided, how they were tested and whether the assurances were considered satisfactory.

393. As explained above, the HSCB relied on the PHA for professional advice on the use of the SCRR process. Dr Farrell was closely involved in this and provided the necessary assurance as to the appropriateness of the approach. The Coordination Group was updated that multiple other potential SAIs had been received and that the Royal Colleges and PHA had advised that something more formal than raising further SAIs was required. UAG was updated regularly and it provided the Trust with the necessary oversight and support for the SCRR process.

394. Paragraph 29 of the schedule to the section 21 Notice asks:

"With specific reference to all relevant meetings, discussions or correspondence, outline the HSCB's understanding of and involvement in the decision by the Trust to engage in a Lookback Review".

395. As stated earlier in my statement, at the point when the Early Alert was received (31st July 2020), the Trust had already been undertaking a lookback review for almost two months. Patient case notes had been reviewed, concerns identified, and several cases had met the threshold of an SAI. To my knowledge, neither the HSCB nor PHA were aware that the Lookback Review was taking place.

396. I think there was an acceptance in late-August 2020 that the Trust-initiated lookback, which commenced in early June 2020, needed to be followed through. The initial contacts I had with Trust colleagues noted concerns about record-keeping; involvement in MDT meetings; care of patients with a cancer diagnosis; bypassing protocols; and likelihood of further SAIs being raised. Efforts to establish an SAI Expert Panel were underway and the question of the consultant's compliance with MHPS was also noted. The Trust then had sought to act in the best interests of patients and I did not focus on delays in raising the Early Alert.

397. Paragraph 30 of the schedule to the section 21 Notice asks:

"What assurances did the HSCB seek and receive (if any) with regard to the appropriateness of the use of the Lookback Review undertaken in relation to the patients of Mr. O'Brien from 1 January 2019 to 30 June 2020? In particular, the Inquiry is concerned to understand the extent to which the HSCB sought to obtain assurances as to the robustness and thoroughness of the Lookback Review process and its comprehensiveness in terms of the patient group which was to be reviewed and the temporal parameters of the review, the assurances provided, how they were tested and whether the assurances were considered satisfactory".

398. The lookback review had been underway almost two months before the HSCB was made aware of the issues and almost three months before I became directly involved. A significant number of patient notes had been reviewed by the Trust during this period and the initial meetings I attended highlighted that there were concerns for a large number of patients. Several actions were underway beyond the lookback with involvement of Royal Colleges as well as efforts to put in place an expert panel to take forward identified SAIs.

399. The timeframe for the lookback had already been set as January 2019 to June 2020. The latter date reflected when the lookback began and the consultant had stopped seeing patients before his subsequent retirement on 29th July 2020. I am unsure why January 2019 was identified aside from it being the beginning of a year and do not recall this being discussed.

400. Clinical advice from the Trust emphasised that the time period January 2019 to June 2020 was relevant as a first phase of any lookback because urology is a surgical specialty and they advised that it may be possible to rectify an issue for a recent patient.

401. In the initial period, I attended weekly (sometimes twice weekly) meetings with Trust, PHA and Departmental colleagues at which the Trust provided updates on progress across the various actions within the lookback and ancillary to it. Trust clinicians, including the Medical Director and lead urology clinician, provided insight into the work underway which provided significant assurance as to the appropriateness of the actions. This close involvement with the Trust provided considerable evidence of thoroughness and robustness of their efforts.

402. I looked to PHA colleagues to be assured as to the clinical appropriateness of the Trust actions. UAG and the Coordination Group discussion also offered opportunities to consider Trust actions and the extent to which these fulfilled the requirements of extant lookback guidance and addressed the needs of patients.

Section 8 – Oversight Mechanisms now in place

403. Paragraph 31 of the schedule to the section 21 Notice sets out the Inquiry's understanding of the oversight structures regarding urology and/or public inquiry engagement and asks that I confirm this understanding is correct to the best of my knowledge. It proceeds to ask:

"If there are additional working groups or committees working in these areas which are not referred to above, you should identify them. You are asked to briefly outline the function and/or terms of reference of those working groups or committees referred to above or otherwise identified by you, which involve or are engaged with personnel from the Department. As relevant, explain how all such structures (working groups / committees) in place within the HSCB / SPPG, the Department and the Trust interact and share information and learning, if at all. Your reply should detail the names of the group members as relevant to the HSCB / SPPG, and dates of all meetings, the frequency of meetings as well as all recommendations and actions to date".

Urology Assurance Group

404. The Urology Assurance Group (UAG) was Department-led and chaired by the then Department's Permanent Secretary, Richard Pengelly and, in his absence, by his then Deputy Secretary, Jackie Johnston. Membership was drawn from the Department, Southern Trust, HSCB and PHA.

405. The UAG is still in place as of October 2023 and now meets quarterly. The group is chaired by the Permanent Secretary for Health, Mr Peter May. The current membership from SPPG comprises Sharon Gallagher, Deputy Permanent Secretary and Head of the SPPG, myself, Director of Hospital Care and Sophie Lusby, Assistant Director of Commissioning.

Urology Co-ordination Group / Urology Oversight Group

406. The Southern Urology Co-ordination Group was renamed as the Urology Oversight Group in November 2021. There was no meeting in December and the first meeting of the Urology Oversight Group took place on 6th January 2022. The revised terms of

reference are in (**SG Appendix 611 - Terms of Reference for the Southern Urology Oversight Steering Group Final Version SPPG-B-00156 – WIT 74795 to WIT 74797**)

407. The Urology Oversight Group became the forum in which the HSCB and PHA tested and sought assurance from the Southern Trust with regards to proposed reform.

408. This Group was chaired by myself until May 2022 when I became critically ill, at which point Sophie Lusby, AD of Commissioning in SPPG, became chair until the Group was wound up in August 2022. Membership was drawn from Southern Trust, HSCB/SPPG, and PHA.

409. The Coordination Group / Oversight Group played an important role in preparation for reporting to UAG and in taking forward actions from UAG meetings.

410. I was aware that Southern Trust had several internal groups supporting work on the lookback/recall and in relation to Trust input to USI, but I did not have any direct involvement nor any detailed knowledge of how the Trust was managing its activities.

411. On return to work in late October 2022, I became re-engaged in the urology lookback programme and subsequently joined the recently constituted Urology Lookback Review Steering Group. I attended my first meeting of this group on 9th January 2023.

412. The Urology Oversight Group was stood down in August 2022 at the request of Southern Trust. The Trust wished to introduce a new management structure and to this end a new Lookback Review Steering Group with membership from SPPG and PHA was launched and chaired by Margaret O'Hagan, who was working with the Trust to lead and manage urology services. This reinvigorated existing governance arrangements. (**SG Appendix 619 - ToR Southern Urology Coordination Group FINAL SPPG-B-00130 - WIT 74911 to WIT 74912**)

413. The key purposes of this group are two-fold:

    a) To oversee the undertaking and communication of all stages and phases of the Urology Lookback Review.

b) To commission appropriate groups and sub-groups to complete the Lookback Review in a way that is compassionate, timely and comprehensive.

414. The management structure across acute services in the Trust had undergone significant change during 2020-2022. The new governance structure of the Lookback Review Steering Group was approved by the subsequent UAG at its meeting on 19 September 2022. Both Sophie Lusby and I are members of the Steering Group.

Section 9 – Ongoing Assurance

415. Paragraph 32 of the schedule to the 21 Notice asks:

"In addition to the structures referred to above, outline the SPPG's ongoing role and steps taken, if any, in monitoring, seeking assurance and ensuring patient and general public safety arising out of the concerns about patient care and safety raised by the Trust. In addressing this question outline any engagement the SPPG has had or continues to have with any of the following concerning these matters:

I. *The Trust;*

II. *The staff working within the Department, but outside of the SPPG;*

III. *The PHA;*

IV. *The RQIA;*

V. *Mr. O'Brien's representatives; and*

VI. *Any other relevant person or organisation."*

416. The transfer of responsibility for the majority of the functions of the former HSCB to the Department of Health (effected through SPPG) on 31 March 2022 has maintained the commissioning function within the HSC system. The SPPG continues its roles in relation to performance management, SAIs, complaints, and early alerts.

417. In the case of the Southern Trust's urology service issues, SPPG remains a member of the Urology Lookback Review Group and of the Urology Assurance Group.

418. The UAG and the Urology Lookback Review Steering Group continue to provide the SPPG with a platform for meaningful and effective engagement with the other stakeholders, including the Trust, other parts of the Department and the PHA, in the event that any further assurances are required.

419. The SAI overarching report, which was submitted to HSCB and PHA on 1st March 2021, contains 11 recommendations and provides assurance against each of these. Reform is underway in the Trust in respect of the following:

    a) The Multi-Disciplinary Team approach;

    b) The tracking of patients from diagnosis onto treatment plans; and

    c) Prescribing, particularly of Bicalutamide.

420. SPPG is directed by the UAG to ensure that appropriate action is taken in the approach to existing patients and new patients. Discussion and testing of assurances around the corrective action is picked up routinely in discussion at the Urology Lookback Review Steering Group and, subsequently, the UAG. The subject matter discussed includes descriptions of clinical harm and action. Minutes of the UAG and Urology Oversight provide evidence of changes to and strengthening of clinical governance arrangements within the Trust. (**SG Appendix 558 to SG Appendix 588 – Agendas SPPG-B-00089 - SPPG-B-00119 WIT 74663 to WIT 74694**) and Minutes (**SG Appendix 589 to SG Appendix 609 - SPPG-B-00019 - SPPG-B-00039 – WIT 74695 to WIT 74791**)

421. An example of this assurance is the reform of the MDT process. The MDT process was an area that was deemed to need strengthening in the treatment and care of patients of Mr O'Brien. This has been subject to a clinical audit process implemented by NICaN which is delivered at Trust level within their managed cancer teams.

422. In respect of the RQIA, the SPPG will be advised of inspections, reports and recommendations that are relevant to its role by RQIA, as are all HSC organisations. SPPG remains open to direct engagement with RQIA, as required, but it has no role in directing the RQIA workload. SPPG can however make suggestions to inform RQIA of concerns which can result in RQIA undertaking inspection activity.

423. In respect of Mr O'Brien, the HSCB and, more recently, the SPPG have had no direct engagement him or his representatives. All issues regarding his practice are worked through the UAG or the Urology Lookback Review Steering Group. As the Urology

Service is operated by the Trust, the onus has been on the Trust to contact Mr O'Brien's representatives and other relevant people/organisations.

424. Paragraph 33 of the schedule to the 21 Notice asks:

"I. What, if any, reforms the HSCB / SPPG is aware of the Trust having made to clinical governance arrangements to address any issue which may have been identified?

II. What, if any, processes have been implemented or steps taken by the Trust to monitor or provide assurance that the clinical governance arrangements within the Trust are to the HSCB /SPPG's satisfaction and ensure patient safety?

III. What, if any, assurances has the HSCB /SPPG sought and received from the Trust with regard to any reforms to clinical governance arrangements?

IV. What, if any, monitoring has the HSCB /SPPG implemented to ensure that the clinical governance arrangements within the Trust protect patient safety?"

425. As detailed previously, the SPPG does not have a role in evaluating the effectiveness of the corporate and clinical governance procedures within the Trust. This is because the Trust is an ALB of the Department with its own prescribed governance arrangements, including its Trust Board. As an ALB, the Trust remains accountable to its sponsoring body, the Department. The relationship between HSCB and the Trust was in the sphere of performance management, commissioning services and financial allocations as opposed to corporate governance, which is under the purview of the Department.

426. The Trust, through its Medical Director, Director of Nursing and, ultimately, its Trust Board must ensure its clinical governance arrangements are fit for purpose and kept updated in relation to clinical guidelines (including NICE and NICaN), RQIA requirements and Departmental direction.

427. Paragraph 34 of the schedule to the 21 Notice asks:

"How, if at all, have any reforms or assurances been tested? In addressing this question also outline what, if any, assurances the SPPG received or continues to

receive, and outline whether the assurances received to date are considered by the HSCB /SPPG to be satisfactory."

428. Insofar as this question relates to reform of the Trust's clinical governance reforms and assurances, I refer to my answer immediately above.

429. Aside from that, SPPG continues to be involved in the Trust-led Urology Lookback Review Steering Group which was established in September 2022 as outlined in paragraphs 412 to 414. Both Sophie Lusby, AD of Commissioning, and I are members of the Group. Assurances on progress of the lookback and related patient recall are provided at these and at UAG meetings. SPPG is largely satisfied with progress in relation to the recall, recognising the difficult times in which it was initiated.

430. Recently, the Trust has produced the *Southern Trust Urology Recall Outcomes Report* (published in August 2023) which provides an overview of the lookback and recall and provides insight into the extent of the impact of the issues relating to the Consultant's practice on patients in what is now known as Cohort 1 (i.e. relating to the lookback between January 2019 and June 2020). This report has been accepted by UAG as a summary of the lookback actions from June 2020 to March 2023, although it appropriately excludes the SAI and SCRR processes as these have separately agreed reporting processes. The Outcomes Report provides an important overview of the impact on patient outcomes uncovered during the lookback exercise.

431. Paragraph 35 of the schedule to the 21 Notice asks:

"Does the HSCB /SPPG consider there remains outstanding work to be done by the Trust before its governance structures are sufficiently robust to prevent a reoccurrence of the issues which arose within the Trust's Urology Services? Whether your answer is yes or no, please explain."

432. The SPPG (and HSCB before it) does not have a role in the oversight of Trust governance structures, this is the responsibility of other parts of the Department.

433. The SPPG has participated in the ongoing RQIA review of the Southern Trust Lookback Review, which was commissioned by the Department and which is due to

report in coming months. The RQIA Review Terms of Reference include an assessment the effectiveness of current arrangements to ensure the delivery of safe care within Urology Services in the Southern Health and Social Care Trust and notes that it will escalate any emerging concerns identified during the course of the Review to the Department of Health and notify the Southern Health and Social Care Trust on any emerging patient safety concerns.

434. I am aware of the efforts of Southern Trust to draw on the learning from the lookback to date and from the SAI reports' recommendations to ensure there is not a recurrence of this kind. It must be emphasised that consultants are leaders within services and their roles and responsibilities require them to have a degree of autonomy to act on behalf of their patients. There is an element of inherent risk in health systems which operate with lone practitioners which can be mitigated through multi-disciplinary working, either locally or regionally. MDTs do not replace a clinician's autonomy but rather ensure consistency of care and practice in line with guidelines.

435. Paragraph 36 of the schedule to the 21 Notice refers to the Minister's Oral Statement to the Assembly on Tuesday 24 November 2020 which referred to Mr O'Brien's private patients and asks:

"What, if any, assurances has the HSCB / SPPG sought and received regarding the care and governance of Mr. Aidan O'Brien's private patients from:

I. The Trust;

II. Mr. Aidan O'Brien;

III. Mr. O'Brien's legal representatives; or

IV. Any other relevant person, organisation or source."

436. Paragraph 37 of the schedule to the 21 Notice further asks the following in respect to private patients:

"If assurances have been sought and provided in respect of Mr. O'Brien's private patients, how has the HSCB /SPPG tested the effectiveness of these assurances? Is

the HSCB /SPPG satisfied by the assurances provided? If not, what are the HSCB /SPPG's proposed next steps, if any, regarding Mr. O'Brien's private patients?''

437. As outlined in section 3 of this statement, as commissioners of HSC services, the HSCB did not have a function in commissioning or regulating services provided to private patients. This remains the case in SPPG. Therefore, the HSCB, and subsequently, the SPPG did not take any action regarding the private patients of the Consultant.

438. From discussion at UAG and the Coordination Group, I was aware of efforts by Southern Trust to seek information on private patients from Mr O'Brien and his representatives and later learned that this was not forthcoming. The Trust sought to reach out to private patients through its communications to the public, including offering advice through its dedicated patient helpline.

439. In August 2023, in preparation for the publication of the outcomes report, UAG agreed that a second cohort would commence and would have a particular focus on private patients as follows:

> *"Private patients of Consultant A seen and treated at any time since from 1 January 2015 and who are currently alive."*

440. From meetings with Trust colleagues, my understanding is that, while some private patients did make themselves known to the Trust and were followed up as necessary, in general, this was viewed to be a relatively small proportion of likely private patients. There was also the possibility that some of these patients may have come from the Republic of Ireland or further afield and that it would be difficult to make them aware of the lookback and any offer of advice and recall from Southern Trust.

441. Paragraph 38 of the schedule to the 21 Notice asks:

"Has the HSCB / SPPG reached any view concerning the appropriateness, quality and timeliness of the steps taken by the Trust to address the issues of concern and ensure patient safety? If so, fully outline the view which has been reached and set out the reasons for the view which has been reached. If the HSCB /SPPG has not

evaluated this issue, please explain why."

442. The Department has commissioned the RQIA to undertake a review of the Southern Trust Lookback process. Its terms of reference are focused on ensuring "concerns for patient safety are addressed in an appropriate and timely manner". I participated in an interview with the RQIA Review Team in May 2023. SPPG will await the report from RQIA and respond as necessary to its findings where they relate to SPPG functions.

443. In June 2020, the Southern Trust acted to address patient safety concerns and commenced a lookback exercise. However, the Trust's delay in raising the Early Alert for almost 8 weeks thereafter was inappropriate, albeit I must acknowledge that this happened in the circumstances of the Trust responding to the first wave of the Covid-19 pandemic. The Trust could also have raised the first SAI earlier which would have had the consequence of notifying the HSCB at an earlier stage.

444. Capacity to undertake the recall relied heavily on one Trust urology consultant which was of concern given the significant pressure this clinician was under. The HSCB's decision to redirect urology patients living in Fermanagh went some way to reducing pressure on the Trust service, although there was limited regional support other than this.

Section 10 – Learning

445. Paragraph 39 of the schedule to the 21 Notice asks:

"From the information available to the HSCB / SPPG to date, what does it consider went wrong within the Trust's urology services and with regard to Trust governance procedures and arrangements? Has the HSCB / SPPG reached any view on how such issues may be prevented from recurring? Has the HSCB / SPPG taken any steps with a view to preventing the recurrence of such issues?"

446. As previously noted, consultants have a degree of autonomy and, as clinical leaders, are expected to act to the highest standards. Mr O'Brien had been a high profile leader in urology at a Trust and regional level. For example, he was previously chair of the Regional Urology MDT and chair of the NICaN Urology CRG and had been involved in developing the guidelines. The peer review commissioned by NICaN did not identify this in the past and delays in acting on SAIs in 2018 had allowed continued practice outside guidelines.

447. From the information that is currently available, the key element of failure appears to be the lack of compliance with the MDT process that Mr O'Brien's practice appeared to have been working outside. The MDT process would have required timely meetings in line, or best efforts to be in line, with the urology cancer guidelines.

448. Every MDT would have required the presence of patient notes and therefore would have flagged the absence of them. In this case, we now know that these were routinely removed to Mr O'Brien's home. This in itself is an inappropriate management of confidential patient data that should have been kept safely and securely on hospital premises. The lack of notes undermined analysis of drug regimes, in this case with regards to bicalutamide prescribing.

449. The MDT process is meant to provide the highest quality forum for patient treatments as it comprises not just the surgeon but a range of health professionals to advise on the correct treatment regime.

450. There have been references to colleagues within the Trust and local GPs having perceived problems with Mr O'Brien's practice, albeit after the event. It is important to note that SPPG (and previously HSCB) is in regular contact with GP practices through its management of the General Medical Services (GMS) contract and no issues were raised in relation to Mr O'Brien's practice through this route. However, it would be unusual for a GP to raise concerns with SPPG about a consultant as it is more likely that any concern would be raised with the relevant Trust directly. Nonetheless SPPG Directorate of Primary Care has checked its records and cannot find evidence of any complaints or AIs reported from GPs relating to Mr O'Brien's practice.

451. Paragraph 40 of the schedule to the 21 Notice asks:

"Does the HSCB / SPPG consider that it did anything wrong or could have done anything differently which could have prevented or mitigated the governance failings of the Trust?"

452. As previously indicated, the SPPG has not undertaken an evaluation of the Trust Governance processes. The responsibility for ensuring that the Trust has robust governance processes in place sits with the Trust through its Board, with oversight from the Department. The Department has commissioned a report from RQIA which includes an assessment of the effectiveness of current arrangements to ensure the delivery of safe care within Urology Services in the Southern Health and Social Care Trust (this report is due in the coming months). In the context of increasing demand for services, the HSCB acted in accordance with the framework within which it operates and in the best interests of the public. Therefore, I think the HSCB fulfilled its role to the best of its abilities and within the resources available.

453. Paragraph 41 of the schedule to the 21 Notice asks:

"From the HSCB / SPPG's perspective, what lessons have been learned from the issues of concern which have emerged from urology services within the Trust? Has this learning informed or resulted in new practices or processes for the HSCB / SPPG? Whether your answer is yes or no, please explain."

454. HSCB did learn from the issues of concern in and around urology services in the Southern Trust and this learning is helping to shape future processes.

455. On 22nd June 2021, I brought a paper to the HSCB SMT containing an update on the SAI overarching report**.** (**SG Appendix 613 - Submission to Chief Executive from Paul Cavanagh SPPG-E-00375 - WIT 74815 to WIT 74827**).

456. The SMT paper considered each of the 11 recommendations within the overarching SAI report and the actions Southern Trust were required to take to address these. The paper explained the necessity to consider how best to apply the known learning regarding MDMs across all cancer MDMs, i.e., across all tumour sites, not just urology. The need to develop a self-assessment tool would be the task of the proposed task and finish group which, in turn, was planned to be issued to an initial group of 27 MDTs and the other at a later date. The paper was agreed and the following appendices refer (**PC Appendix 58 – ITEM10 SMT Paper SHSCT Urology SAI Overarching Report June 2021 final**) (**PC Appendix 59 – Final SMT Mins 22 June).**

457. NICaN agreed to design the MDT assessment tool for Trusts to audit, beginning with urology services. The self-assessment tool was developed based on MDM principles (drawn from *The Manual of Cancer Services Standards: The Characteristics of an Effective Multidisciplinary Team* produced by the National Cancer Action Team (2010); *Improving the Effectiveness of Multidisciplinary Team Meetings in Cancer Services* – Cancer Research UK (2015); and *Streamlining Multidisciplinary Team Meetings* – NHS England (2020)). It set out to define and inform effective MDT working. The audit covered operational principles and standards; communication principles; and standards and governance principles and standards, including:

- the processes for listing patients for discussion at MDM;
- the process for discussion at MDM;
- the process for making decisions outside of MDM;
- how the role of the MDM chair is operationalised and supported; and

- the process for follow-up of patients to ensure that first definitive treatment has commenced in line with MDM advice

458. The tool was tested on all Urology MDTs across NI, i.e. Belfast, South-Eastern, Southern and Western Trusts. This was completed in February 2022. It was evident from the findings that Trusts did not have adequate data to evidence some key principles. However, findings were to be used to identify areas of variation in practice and Trusts were alerted to the need for improvement in some key areas. A draft report of the urology audit outlined actions for Trusts and regional actions (**PC Appendix 60 - MDT Review regional write up mar 22 v2**). The report was not finalised due to changes in structures relating to the Cancer Strategy.

459. Due to a further wave of the pandemic, it was not possible to repeat the exercise for the other key tumour sites. In addition, the lack of available data meant that some aspects of the tool were not viable. This indicated a need for better data resource and infrastructure, including tracking resource in Trusts; changes to patient information system; and additional data collection.

460. The work is intended to lead to the development of updated regional recommendations and procedures that support effective MDM functioning and clinical governance across all MDTs.

461. Beyond this and as part of its commissioning functions, SPPG continues to seek improvement in compliance with SAI guidelines; has recommenced its focus on cancer performance; and continues to work through Urology Planning and Implementation Group to address service challenges.

462. All Trusts need to improve on progressing SAIs appropriately. Southern Trust is not an outlier in this. A particular concern has been compliance with the agreed timescales, which was further exacerbated by the Covid-19 pandemic. In April 2018, the RQIA was commissioned by the Department to examine the application and effectiveness of the SAI procedure. The time taken to complete the review was also significantly impacted by the Covid-19 pandemic. It was published in June 2022.

463. Moreover, the HSCB, and SPPG in recent years, has sought to reduce the backlog of outstanding SAI reports and related actions. In general, this has proven successful and Trusts are progressing these in a more timely manner.

464. A project led by Departmental policy seeking to redesign the current SAI procedure commenced in July 2023. The project will seek to address the recommendations from the Inquiry into Hyponatraemia-related Deaths and the Independent Neurology Inquiry alongside recommendations from the RQIA Review of Systems and Processes for Learning from SAIs. The recommendations from these reports have provided a strong evidence base to support the development of a new framework which will provide for the identification, review, capture and embedding of learning from healthcare incidents or events.

465. At the beginning of 2023, SPPG recommenced its Trust Cancer Performance meetings and now meets bi-monthly with each HSC Trust to discuss cancer performance. A particular focus is on the 4 tumour sites with the highest volume and longest waiting times, i.e. skin cancer, gynaecological cancer, lower gastrointestinal cancer and urological cancer. To support this, each Trust has brought forward performance optimisation plans and the actions required to improve performance are now routinely reviewed at Cancer Performance meetings. These actions often relate to staff vacancies; guidance to GPs making referrals for suspect cancers; and opportunities to improve diagnostic access, including imaging and scopes.

466. As previously highlighted, the Regional Urology PIG continues to monitor demand and available capacity to help reduce variation in waiting times across the region. The group also worked with Trusts to agree a system wide approach to the organisation and design of urology services across Northern Ireland.

467. A patient outcomes focus, established by HSCB, within lookbacks is now an established approach which has framed how these activities will be managed in the future. A focus on patient outcomes is essential to ensure that patient safety concerns are addressed and that the system and the public can be reassured that identified failings have been redressed. The ability to apply this approach initially

to a medical specialty (neurology) and then to a surgical specialty (urology) has also provided models for how future lookbacks of public concern can be managed.

Urology Services Inquiry

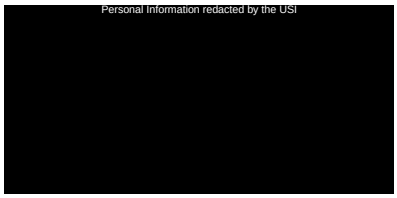
Section 11 – Conclusion

468. In this statement I have provided as much information as I can to assist the Inquiry. I have provided background information and I have sought to answer, as best I can, the questions asked in the Section 21 Notice. If any further queries arise from what I have said, I will seek to assist the Inquiry with these.

Section 12 – Declaration of Truth

469. The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

Signed:



Date: 3rd November 2023

Abbreviations and Acronyms

AI	Adverse Incident
AD	Assistant Director
AIPBS	Area Integrated Partnership Boards
ALB	Arms Length Body
BAUS	British Association of Urological Surgeons
BCH	Belfast City Hospital
BSO	Business Services Organisation
CCG	Clinical Communication Gateway
CLS	Clinical Leadership Solutions
CMO	Chief Medical Officer
CPD	Commissioning Plan Direction
CRG	Clinical Reference Group
DHSSPS	Department of Health, Social Services and Public Safety
DoH	Department of Health, 'The Department'
DoH-SPPG	Department of Health's Strategic Planning and Performance Group
DRO	Designated Review Officer
GMC	General Medical Council
GMS	General Medical Services
GP	General Practitioner
HoS	Head of Service
HSC	Health and Social Care
HSCB	Health and Social Care Board
ICS	Integrated Care System Northern Ireland
IEAP	Integrated Elective Access Protocol
LCG	Local Commissioning Group
LUTS	Lower Urinary Tract Symptoms
MDM	Multi-Disciplinary Meeting
MDT	Multi-Disciplinary Team
MHPS	Maintaining High Professional Standards
MRI	Magnetic resonance imaging
NCPR	National Cancer Peer Review
NHS	National Health Service
NICaN	Northern Ireland Cancer Network
NICE	National Institute for Health and Care Excellence
NIECR	Northern Ireland Electronic Care Record
PAS	Patient Administration System
PCC	Patient and Client Council
PHA	Public Health Agency
PIG	Urology Planning and Implementation Group

Abbreviations and Acronyms

PMSID	Performance Management and Service Improvement Directorate
POC	Programme of Care
PSA	Prostate Specific Antigen
PSSID	Performance, Safety and Service Improvement Directorate
QSE	Quality Safety and Experience Group
RCA	Root Cause Analysis
RCP	Royal College of Physicians
RCSG	Regional Complaints Sub-Group
RQIA	Regulation and Quality Improvement Authority
RRP	Robotic Retropubic Prostatectomy
SACT	Systematic Anti-Cancer Therapy
SAI	Serious Adverse Incident
SBA	Service and Budget Agreement
SCRR	Structured Case Record Review
SEA	Significant Event Audit
SJR	Structured Judgement Review
SMT	Senior Management Team
SPPG	Strategic Planning and Performance Group
SQA	Safety and Quality Alert
TDP	Trust Delivery Plan
The Minister	The Minister for Health, Northern Ireland
The Notice	Section 21 Notice
TMG	The Department's Top Management Group
TOR	Terms of Reference
TP	Transperineal Prostate
Trusts	Health and Social Care Trusts in Northern Ireland
UAG	Urology Assurance Group
USI	Urology Services Inquiry ('The Inquiry')
WHSSB	Western Health and Social Services Board

Health and Social Care

JOB DESCRIPTION

POST:	Director of Commissioning
REPORTS TO	Chief Executive
RESPONSIBLE TO:	Chief Executive
SALARY:	Senior Executive Level 3 (£83,098 – £110,801 per annum)
LOCATION:	Belfast

NOTE TO CANDIDATE

It is expected that the HSCB will cease to exist on 31st March 2022. From 1st April 2022 the HSCB functions will transfer to the Department of Health. Staff will retain HSC Terms of Conditions via a hosting arrangement with the Business Services Organisation.

JOB SUMMARY

The Director of Commissioning will report to the Chief Executive of the HSCB/Deputy Secretary Designate of the Department on Health and will be an Executive member of the Board of the HSCB until the organisation closes in March 2022. This is a significant time of change for Health and Social Care and a key priority for the successful candidate will be leading the development and implementation of a new integrated model for planning for health and social care in Northern Ireland. As a leading stakeholder in the change agenda facing the HSC, he/she will need to bring innovative and dynamic thinking in their vital contribution to the development of future commissioning / strategic planning arrangements within the HSC.

KEY DUTIES / RESPONSIBILITIES

The Director of Commissioning will be required to:

a) Develop and implement a new regional integrated planning model for health and social care.

b) Work with colleagues in the Public Health Agency (PHA) and Local Commissioning Groups (LCGs) to ensure robust and credible needs assessment of health and social care for the population of Northern Ireland to inform the Board's commissioning and planning processes.

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c) Commission high quality, cost effective health and social care services to meet local need.

d) Provide leadership, input and support to a range of regional reform initiatives including: stroke, pathology, diabetes, palliative care, unscheduled and elective care, acute reform etc.

e) Promote effective user and stakeholder engagement in the planning and commissioning of health and social care services.

f) Promote effective partnership working with other HSC bodies and external public, independent, voluntary and community sectors.

g) Support agreed managed clinical networks for which the HSCB is responsible.

h) Represent the Board as required by the Chief Executive in local, RoI and UK forums and in dealing with the media in respect of those services for which he/she is responsible.

In undertaking this role he/she will be responsible for the effective and efficient management of all staff within the Directorate, both at Headquarters and in all of the local offices of the HSCB. He/she will have oversight from a commissioning perspective of a total HSCB annual spend of some £5bn, and particular responsibility for the expenditure associated with those clinical and social care services to be commissioned regionally, including prison health, and Extra Contractual Referrals, high cost cases and specialist services for all programmes of care with an annual estimated value of some £55m.

KEY RESULT AREAS

- Design and implement new planning arrangements to ensure agreed strategic priorities are translated into action through the new integrated care system.
- Support the maintenance and updating of a strategic framework for the Health and Social Care system, which reflects 'Delivering Together' and other key Ministerial policy and priorities and ensures the effective and meaningful engagement of key stakeholders, both internal and external, in the planning processes.
- Act as the point of primary liaison with the DoH in respect of policy development and regional planning systems.
- Work with SMT colleagues to establish and maintain a capability within the HSCB to design and deliver ambitious future programmes of reform. This capability will include internal strategic intelligence capacity and external networks.

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- Develop analytical and strategic planning capabilities generally across the Health and Social Care system.
- Ensure the existence of strong partnerships and active processes of engagement to ensure all strategic planning processes are characterised by active collaborations.

Planning and Commissioning

- To develop and implement a new integrated planning model for health and social care
- To work in partnership with LCGs to plan and commission local, regional and primary care services from HSC Trusts and other service providers.
- To work with Directors and LCGs to design and maintain a coherent and effective commissioning system at local and regional level. This system will include information, planning, contracting, monitoring and financial aspects.
- Ensure coherence between the commissioning system and other elements of the performance management, service improvement and reform programme.
- Lead specified regional commissioning processes including those which relate to specialist services and support for agreed programme of care and managed clinical networks.
- Ensure regional and sub-regional commissioning is guided and informed by regional assessment of population health and social care needs.
- Ensure the existence of strong partnerships and collaborations at a regional level to enable effective commissioning. These partnerships will embrace the voluntary and independent sector and relevant professional groups.
- Ensure effective coordination and communication with the 5 commissioning leads of the LCGs to ensure a coherent and consistent approach across the region.
- Ensure a focus on performance and outcomes in all commissioning processes with a particular focus on Ministerial priorities, quality indicators specified in service frameworks and securing the provision of consistent and equitable services to the population of N Ireland.
- Ensure a focus on stakeholder engagement, value for money, efficiency improvements and financial balance in all commissioning processes.
- Build and develop commissioning capability at all levels in the Northern Ireland health and social care system.

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- Advise the HSCB and Chief Executive on the development of the Board's commissioning systems keeping up to date with best practice outside Northern Ireland and facilitating and promoting the transfer of learning and expertise.

Quality

- Promote collaboration and learning between all staff in the Directorate and other professions and disciplines to ensure a planned, co-ordinated and multi-disciplinary approach to the delivery of health and social care which enables the continual improvement of services to patients and clients.
- Deliver effective governance in accordance with public sector values and the codes of conduct and accountability ensuring that all statutory functions are carried out.
- Ensure that robust performance management arrangements and systems are developed and implemented for all staff within own area of responsibility.

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Leadership/Change Management

- Providing clear, visible and strategic leadership to staff within the directorate to ensure HSCB has a highly skilled, flexible and motivated workforce to provide high quality performance management and system improvement.
- Developing management information on staff utilisation, development and return on investment, which improve management decision making and support a rigorous continuous improvement culture.
- Ensuring that management structures and practices within the directorate support a culture of effective team working, continuous improvement and innovation.
- Creating effective plans, systems and governance to manage a smooth transition to the new operating arrangements on closure of the HSCB.
- Considering fully and respond to the impact of change on organisation culture and structures.
- Develop the capacity and capability of all staff in the Directorate to respond to the change process and deliver successfully on the future vision for the Directorate.
- Promoting a culture of engagement and innovation encouraging staff to engage in the change process. Seek to expand mind-sets and genuinely listen to ideas from employees and stakeholders.
- Leading by example, clearly articulating and displaying commitment to the direction of travel.

Collaborative Working

- Delivering business objectives through creating an inclusive environment and encouraging collaboration which may cut across organisational and wider boundaries.
- Building and maintaining relationships with a wide and diverse range of staff and stakeholders. These include: Ministers and their Special Advisors, Directors of Performance and their senior staff across NI, Senior DoH staff and senior staff in the HSCB, Commissioning Groups, PHA including Executive and Non-Executive Directors.

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- Representing the HSCB and the Department as required on associated working groups.

Financial and Resource Management

- Manage the overall directorate budget ensuring that all financial targets are met.
- Ensure opportunities for financial savings are managed to provide the most efficient service possible within the resources allocated.

Corporate Management

- Contribute to the corporate decision-making of the HSCB.
- Contribute to the HSCB's corporate planning, policy and decision-making processes as a member of the senior management team and ensure objectives and decisions are effectively communicated.
- Develop and maintain working relationships with other Board and SMT members and LCG Chairs to ensure achievement of HSCB objectives and the effective Functioning of the senior management team and Board.
- To provide leadership and participate as appropriate in the development of new strategic initiatives and direction for the changing HSC organisations and system.
- Comply as required with Departmental requirements in respect of policy and strategy development.
- Contribute to the HSCB's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.
- Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HSC Employees.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Organisation supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

- Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives,

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to meet the required performance standards and to achieve continuous improvement in the services they deliver.

- Ensure access to skills and personal development through appropriate training and support.
- Promote a culture of openness and honesty to enable shared learning.
- Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.
- Adhere to and promote Organisational policy and procedure in all staffing matters, participating as appropriate in a way which underpins The Organisation's values.

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

- Lead on and be responsible for the planning, implementation, reporting and all other aspects relevant to the Trust's PPI Strategy within the Directorate. This will include ensuring robust arrangements are in place for active engagement with user groups and the voluntary and independent sectors in the design and delivery of services.

RAISING CONCERNS - RESPONSIBILITIES

- The post holder will promote and support effective team working, fostering a culture of openness and transparency.
- The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the organisation's Whistleblowing Policy and ensure feedback/learning is communicated at individual, team and organisational level.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure The Organisation's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of The Organisation's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her

manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to HSCB policies and procedures relating to infection prevention and control.

6. All employees of The Health & Social Care Board are legally responsible for all records held, created or used as part of their business within the HSCB including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with The HSCB policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

8. Represent The HSCB's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all HSCB staff may be required to serve at any location within The Organisation's area, as needs of the service demand.

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Please note that the Health and Social Care Board operates a "No Smoking" Policy and all employees MUST comply with this.

We are an Equal Opportunities Employer.

Waiting List

A waiting list may be compiled for similar permanent/temporary, full/part time posts which may arise within the next 12 months.

Date: December 2021

Health and Social Care

Health and Social Care Board

PERSONNEL SPECIFICATION

JOB TITLE AND BAND **Director of Planning and Commissioning**

DEPARTMENT / DIRECTORATE **Commissioning**

SALARY **Senior Executive Level 3 (£83,098 – £110,801 PA)**

HOURS **37.5 hours per week**

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note The Organisation reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience / Qualifications/ Registration	1a. A university degree or relevant professional qualification and worked for at least 3 years in a senior management role* in a major complex organisation** delivering across a broad programme of care in health and social care. OR 1b. Have worked for at least 5 years in a senior management role* in a major	Shortlisting by Application Form

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	complex organisation** delivering across a broad programme of care in health and social care. 2. Have delivered against challenging objectives/targets for a minimum of 2 years meeting a full range of key targets and making significant improvements; 3. Have worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years; 4. Successfully demonstrated high level people management, governance and organisational skills for a minimum of 2 years; 5. Led in the successful management of a major change programme addressing significant organisational and service provision change whilst managing competing priorities * "Senior management role" is defined as experience gained at least at Assistant Director or equivalent level reporting to a Director in a major complex organisation. ** "major complex organisation" is defined as one with at least 200 staff or an annual budget of a least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders. *** "Significant" is defined as contributing directly to key corporate objectives of the organisation concerned.	
Other	6. Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. This criteria will be waived in the case of applicants whose disability prohibits driving but who have	Shortlisting by Application Form

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	access to a form of transport approved by The Organisation which will permit them to carry out the duties of the post.	

SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	1. Well-developed change management skills with the proven ability to lead change and deliver results through partnership working; 2. Strong evidence of exercising judgement in complex situations, working with and influencing others to deliver significant improvements within a complex system. 3. Demonstrate a broad understanding and experience of HSC systems, services, challenges and pressures. 4. Proven leadership skills and evidence of articulating a vision and engaging others to deliver results.	Interview / Test Interview / Test Interview / Test Interview / Test
Competencies	Candidates who are short-listed will need to demonstrate that they have the required competencies to be effective in this demanding leadership role. The dimensions concerned are given in the Healthcare Leadership Model (see below link) **http://www.leadershipacademy.nhs.uk/discover/leadershipmodel/leadership-dimensions/** Particular attention will be given to the following: • **Inspiring shared purpose** • **Leading with care** • **Evaluating information** • **Connecting our service** • **Sharing the vision** • **Engaging the team** • **Holding to account** • **Developing capability** • **Influencing for results**	Interview / test

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As part of the Recruitment & Selection process it may be necessary for The Organisation to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

THE ORGANISATION IS AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

Pay and Terms and Conditions

Salary	**Senior Executive Level 3 (£83,098 – £110,801 per annum)** The successful candidate will be employed on a standard senior executive contract. The nature and content of that contract is determined by the Department of Health (DoH)
Hours	Normal full-time hours of duty are **37½** hours per week, exclusive of meal times.
Medical	Appointment will be subject to a successful pre-employment health assessment.
Holidays	27 days each year; 29 days after 5 years' service; 33 days after 10 years' service and 10 statutory and public holidays.
Pension	The postholder can participate in the HSC Scheme. Further details are available on the HSC Pensions Website HSC Pension Service
Probationary Period	You will serve a probationary period of normally six months.
	This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Chief Executive of the HSCB. We will review this Job Description and it may include any other duties and responsibilities we determine in consultation with the jobholder.
Waiting List	A waiting list may be compiled for similar permanent/temporary, full/part time posts which may arise within the next 12 months.

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Closing date	Completed application forms should be submitted by the date stated in the advert. Canvassing, either directly or indirectly, will be an absolute disqualification.

HSC Value	What does this mean?	What does this look like in practice? - Behaviours
 **Working Together**	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
 **Compassion**	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
 **Excellence**	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
 **Openness & Honesty**	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

HSC Health and Social Care

Health and Social Care

Assistant Director – Local Commissioning Lead (4 posts)
Northern
Southern
Western
Belfast and South Eastern

Health and Social Care Board

Job Description

JOB SUMMARY

The Local Commissioning Lead will be responsible to the Director of Commissioning for securing fully integrated commissioning support from the HSC Board (HSCB) and Public Health Agency (PHA) to support the LCG Chair/s and the LCG/s. He/She will be accountable to the LCG Chair/s for supporting LCG/s to develop a clearly articulated vision and purpose aimed at driving up performance and standards and improving services to patients, clients and carers., The post holder will ensure a commissioning approach is adopted which is outcome focussed, devolved and secures active engagement with local communities and other key stakeholders.

The post holder will work in a complex multi-stakeholder environment where success will be enabled by strong partnerships and collaborations, both within health and social care and with external stakeholders. This will include ensuring that there is close and effective working between the staff of the HSCB and the PHA, with clear, corporate and operational processes that link the work of the two organisations within commissioning teams and provide seamless and integrated advice and support to the LCG/s. He/she will participate in the senior management team of the Commissioning Directorate.

KEY RESULTS AREAS

Setting Direction

- To support the Director of Commissioning and LCG Chair/s in the development and implementation of coherent commissioning arrangements which drive up performance and standards in the delivery of health and social care across Northern Ireland and improve services to patients, clients and carers.

- To support the LCG/s in the development of a strategic plan to improve the health and wellbeing of its local population, provide high quality health

outcomes and reduce inequalities that is reflective of prioritised local need and regional and Ministerial priorities.

- To co-ordinate the development of an annual commissioning plan for the LCG/s, in keeping with their strategic plan and in line with a format determined by the HSCB that will feed into the commissioning plan to be approved by the HSCB and PHA.

- To support the LCG/s in meeting their responsibility to the HSCB and their local population for how they plan, oversee investment and manage performance to improve health and wellbeing outcomes.

- To contribute to the design and maintenance of strong planning and reporting systems to connect ministerial and regional priorities to local commissioning processes.

- 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 without undue bureaucracy. This will also require the design and implementation of robust governance arrangements.

- To put arrangements in place that proactively and positively ensure compliance with the statutory duty of the LCG/s to, 'pay due regard' to the views of the PHA in addressing the wider determinants of health and wellbeing and reflecting this partnership in the LCG/s commissioning plan.

Service Delivery

- To act as the Commissioning Lead for each of the LCGs covered by the role.

- To ensure all commissioning plans are informed and guided by robust and regular needs assessment that establishes a full understanding of current and future local health and social care needs and requirements.

- To support the LCG/s in prioritising investment according to local needs, service requirements and regional policies and objectives.

- To establish and lead a Commissioning Support Unit (CSU), comprising staff from the HSCB and PHA, providing a range of capabilities to enable effective commissioning including information, analysis, modelling, finance, procurement and monitoring.

- To directly oversee local commissioning processes ensuring plans and contracting outcomes reflect regional and local priorities and are fully reflective of professional input across the HSCB and PHA.

- To ensure commissioning responsibilities for the local population are discharged effectively, including the planning, procurement and performance management of commissioned health and social care services and of programmes related to health and well-being.

- To ensure robust monitoring of outcomes and delivery from provider organisations with appropriate intervention if there is non-compliance with contract.

- To ensure a strong focus on public health and health inequalities in the work programmes of the LCGs and local communities.

- To work closely with the PHA and allied partnerships in commissioning short, medium and long-term programmes of public health improvement focusing in particular on those areas and communities with greatest health and social care need.

- To work with the Director of Commissioning, LCG Chair/s. the Assistant Director – Regional Services Commissioning, the Assistant Director – Regional Strategic Planning and other Assistant Director Commissioning Leads on the design and implementation of a coherent and effective commissioning system. This system to include information, planning, contracting, monitoring and financial aspects.

- To lead on the development of commissioning capability within a local health and social care economy.

Development and Innovation

- To lead on the development of new models of care delivery within the context of regional policy and service frameworks to promote better outcomes, access or value for money, and which are characterised by appropriate quality, clinical and financial quality processes.

- To provide a focus on the provision of care for those with long-term conditions developing new provision options which can enable responsive, personal care, aimed at promoting independent living in safety and dignity.

- To pursue all opportunities to develop integrated care models involving relevant professional groups in design and implementation processes.

- To explore and develop new and innovative methods of interaction with the general public, including addressing issues that are difficult or contentious, that improve the quality of engagement and outcomes.

Collaborative Working

- To manage external stakeholder relationships on behalf of the LCG.

- To establish strong and purposeful partnerships across the LCGs paying particular attention to the relationship with local government bodies and the opportunities associated with community planning.

- To forge close relationships with relevant professional groups and particularly GPs and other primary care professionals to ensure their engagement in relevant commissioning processes.

- To ensure effective arrangements are in place for regular and meaningful engagement with elected representatives in District Councils and with voluntary advocacy groups, patient, clients, carers and the wider public that provide for an inclusive approach to decision making.

- To personally interact with Executive Teams of provider organisations to create a relationship consistent with a results orientated, outcome focused and businesslike approach.

- To pursue all opportunities to design and implement public health programmes in partnership with other agencies and organisations

Communication and Information Management

- To ensure that the LCG/s operate within the agreed communications protocols of the HSCB and PHA.

- To develop and implement a communication strategy for the LCG/s that identifies internal and external stakeholders and establishes appropriate plans for engagement and communication.

- To secure the information required to support population profiling, needs assessment and capacity planning.

- To lead on the analysis of activity, quality and outcome indicators, exercising judgement in terms of contractual expectations and the need to intervene where appropriate.

Governance

- To work closely with the LCG Chair(s) and other LCG Committee Members to ensure the maintenance of appropriate governance, financial and general management systems within the LCG/s. This includes ensuring the development of plans for the LCG as a corporate body and also establishment of appropriate induction and personal development plans for all LCG members in line with best practice.

- To ensure the establishment, implementation, recording and monitoring of effective systems for the management of potential conflicts of interest on the part of members of the LCG/s.

- To ensure that the LCG/s receives the information they require on financial, performance, HR, quality and safety issues to fulfil their responsibilities at each meeting.

- To monitor compliance with standards of all contracts placed by the LCG (e.g. Service frameworks, NCE, Child protection etc.).

- To work within the requirements of the HSCB's governance framework, ensuring that policies and procedures related to local commissioning and other aspects of the role meet relevant legislative requirements.

- To ensure that the commissioning plan of the LCG/s demonstrates that it has engaged with an appropriate range of professional expertise, community and voluntary groups and other stakeholders in decision making processes.

Financial and Resource Management

- To establish effective financial systems for the allocation and monitoring of commissioning monies through the LCG/s which ensure a sustainable financial position and contain expenditure within allocated resources.

- To liaise with finance colleagues to ensure that timely, relevant and high quality financial information is presented at each meeting of the LCG/s and that agreed actions are implemented as required.

- To negotiate, agree and monitor the budget for the operation of the LCG/s and the Commissioning Support Unit.

- To pursue all opportunities to secure enhanced value for money and improved resource utilisation.

People Management and Development

- To contribute as an effective member of the senior commissioning team of the HSCB.

- To promote the effective collaboration and partnership of staff from the PHA and HSCB, including the establishment and maintenance of agreed organisational arrangements, core values and behaviours that ensure they operate as an effective team in support of the Chair and LCG/s. This will include the establishment of a premises committee.

- To manage the Family Practitioner Services staff and Corporate Services staff based in the Commissioning Support Unit.

- To provide clear and strategic leadership to staff to ensure LCG/s have a highly skilled, flexible and motivated workforce to provide high quality performance management.

- To take responsibility for his/her own performance and take action to address identified personal development areas.

- To lead by example to ensure that the HSCB demonstrates commitment through its culture and actions, for all aspects of diversity in the population it serves and the staff who provide the services.

- To promote the corporate values and culture of the organisation through the development and implementation of relevant policies and procedures, and appropriate personal behaviour.

- Contribute to the HSCB's overall corporate and integrated governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

- Participate in the HSCB's Performance Review Scheme. Review individually on a regular basis the performance of direct reports. Provide guidance on personal development requirements and advise on and initiate appropriate action.

- Maintain good staff relationships and morale amongst the staff reporting to him/her.

- Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.

- Participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the HSCB.

- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the HSCB.

- Promote the HSCB's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for which he/she has responsibility.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the post holder works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Director of Commissioning.

General Responsibilities

Employees of the HSCB will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.

- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.

- Comply with the HSCB's No Smoking Policy.

- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.

- Adhere to equal opportunities policy throughout the course of their employment.

- Ensure the ongoing confidence of the public in service provision.

- Comply with the HPSS code of conduct.

Records Management

Assistant Directors are responsible to their Director for all records held, created or used as part of their business including corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 1998.

Health and Social Care

Terms and Conditions

Salary will be Band 8D, £63,833 - £79,031 per annum.

In addition to 10 public holidays, the annual leave allowance will be as follows:-

- On appointment – 27 days
- After 5 years service – 29 days
- After 10 years service – 33 days

Location:
Western Area – Gransha Park
Northern Area – County Hall, Ballymena
Southern Area - Armagh
Belfast and South Eastern Area - Belfast

The post holder may be required to travel throughout Northern Ireland and, on occasions, within the United Kingdom, the Republic of Ireland, and elsewhere. The successful candidate should have access to a form of transport that will permit him/her to meet the requirements of the post in full and be prepared to travel throughout Northern Ireland and elsewhere, as required.

Any applicant wishing to speak to someone about the process for appointment to the above position should contact the DHSSPS – RPA Unit – Beeches Management Centre (telephone 0[Irrelevant redacted by the USI]

Health and Social Care

Assistant Director – Commissioning Lead (4 posts) (Designate

Health and Social Care Board

Personnel Specification

Applicants must provide evidence by the closing date for application that they are working in a Phase 2 Health and Social Care RPA affected group transferred to one of the new Phase 2 organisations on 1st April 2009.

Knowledge, skills and experience required:

- A university degree or equivalent professional qualification **and** have worked for at least 3 years in a senior management role[1] within a major complex organisation.

  OR

  Have worked for at least 5 years in the last 7 years in a senior management role within a major complex organisation.

  AND

- Demonstrate evidence at senior management level of planning and managing (through allocating, purchasing or contracting) the deployment of significant resources to deliver service change and new performance levels across a major complex organisation.

- Demonstrate evidence of successfully leading a major change programme addressing significant organisational and structural change.

- Have achieved successful outcomes through working with a diverse range of stakeholders both internal and external to the organisation.

- Have strong financial management skills evidenced through experience of budgetary management or monitoring financial allocations.

- Have excellent communication skills, both orally and in writing.

[1] Senior management is defined as experience gained at a senior level in an organisation, i.e. as a Director, Assistant Director, or equivalent.

SHORTLISTING

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework at http://www.nhsleadershipqualities.nhs.uk and Knowledge and Skills Framework as identified in the job description.

- Effective and Strategic Influencing
- Leading change through people
- Holding to Account
- Drive for Results
- Drive for Improvement
- Collaborative Working

HSCB/SPPG Staff Management Responsibility – Paul Cavanagh

1. As Interim Director of Planning and Commissioning (July 2020 to April 2022), I managed 7 assistant directors, namely:

   - Cara Anderson, Assistant Director Commissioning (Appointed June 2011)
   - Iain Deboys, Assistant Director Commissioning (retired March 2022)
   - Veronica Gillen, Assistant Director Commissioning (Interim from January 2022 and appointed on a permanent basis from April 2022)
   - Bride Harkin, Assistant Director Commissioning (retired June 2023)
   - Sophie Lusby, Assistant Director Commissioning (Appointed July 2015)
   - Brian McAleer, Assistant Director Commissioning (July 2020)
   - Paul Turley, Assistant Director Commissioning (appointed December 2011)
   - Teresa Magirr, Assistant Director Commissioning (appointed June 2009)

2. As Assistant Director, Commissioning (July 2009 - June 2020), I managed a group of senior managers, namely:

   - Martin Quinn, Interim Senior Commissioning Manager (Resigned September 2010)
   - Paul Dolan, Senior Commissioning Manager (Retired April 2016)
   - Brian McAleer, Senior Commissioning Manager (Appointed July 2003)
   - Martine Strawbridge, Senior Commissioning Manager (Appointed April 2015)
   - Emma Giddings, Network Manager, Major Trauma Network Appointed January 2017 and left September 2019)
   - Ken Reid, Network Manager, Major Trauma Network (Appointed February 2020)

DIRECTION

2019 No. X

The Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2019-2020

The Department of Health (DoH) [(a)], makes the following Direction in exercise of the powers conferred by sections 6, 8(3) and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009 [(b)]:

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care Commissioning Plan and Indicators of Performance Direction (Northern Ireland) 2019 - 2020 and shall come into operation on 1 XXX 2019.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission, for the period 1 April 2019 to 31 March 2020, for consideration and approval by the Minister. In doing so, it shall detail the values and volumes of services to be commissioned to meet the needs of local populations and meet the standards and targets set out in the Schedule to this Direction. The Commissioning Plan must also include a summary of the financial allocations and set out how commissioning will serve to support the implementation of the Minister's strategic vision (as set out in Delivering Together) to transform the delivery of health and social care services. It should set out clear timescales and milestones for the delivery of commissioning intentions and the transformation of services.

(2) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board align with and support the implementation of the Minister's vision and delivery of priorities for health and social care; extant statutory obligations, including equality duties under the Northern Ireland Act 1998[(c)],

(a) Departments Act(Northern Ireland) 2016 c.5
(b) 2009 c.1 (N.I.) as amended by 2014 c.5
(c) 1998 c.47

the discharge of statutory duty of quality, delegated statutory functions and requirements under Personal and Public Involvement (PPI); and key Departmental standards, policies, strategies and guidelines.

3. The Commissioning Plan must demonstrate that services being commissioned by the Regional Board will contribute to the four overarching strategic themes:

(a)*To improve the health of our citizens*.

(b)*To improve the quality and experience of health and social care.*

(c)*To ensure the sustainability of health and social care services provided*.

(d)*To support and empower staff delivering health and social care services*.

Performance indicators

4.In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the objectives and associated quality and performance indicators for the period April 2019 to March 2020.

5.The Regional Board shall record the information against the objectives and associated quality and performance indicators for the period April 2019 to March 2020.

Commissioning and the use of financial allocations

6.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from April 2019 to March 2020, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

Sealed with the Official Seal of the Department of Health on xxxxxx

Permanent Secretary
A senior officer of the Department of Health

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SCHEDULE

Objectives and Indicators for 2019 - 2020

Introduction

This Direction sets out the priorities, aims and improvement objectives for the HSC for the 2019/20 financial year. The achievement of the objectives set out in this Direction will; support the realisation of the vision for the future of health and social care as set out in "*Health and Wellbeing 2016: Delivering Together*"; contribute to the attainment of the aims of the *draft 2016 – 2021 Programme for Government* (in particular Outcome 4: "We enjoy long, healthy, active lives"), and underpin the Executive's population health framework "*Making Life Better*".

The Direction is structured around the four overarching and linked aims identified in *Delivering Together*, which acknowledge the challenges facing health and social care namely:

- to improve the health of the population;
- to improve the quality and experience of care;
- to ensure the sustainability of the services delivered; and
- to support and empower the staff delivering health and social care services.

Set out under each of the four *Delivering Together* aims are key objectives / goals that will progress the work to meet the future needs of the population and bring about a person centred model of care, including a shift from the treatment of periods of acute illness and reactive crisis approaches, towards a model underpinned by a more holistic approach to health and social care.

To allow progress towards each outcome to be tracked over time a number of associated quality and performance indicators have been identified against which the HSC should monitor progress and take improvement action as required. It is important to note that these indicators do not represent the totality of the information available to the HSC and the Department to ensure the smooth running of the system or inform the development, implementation and evaluation of policy.

The Commissioning Plan, developed in response to this Direction, must demonstrate how the services commissioned regionally and by LCGs in 2019/20 and beyond will contribute to the delivery of the four aims set out in *Delivering Together*, contribute to the identified outcomes in an integrated manner, sustain the pace of transformation and meet or exceed the specific objectives set out below.

Aim: To improve the health of the population

A key aim of the entire health and social care system in Northern Ireland is to improve the overall health and wellbeing of the population and to prevent ill-health. Whilst improvements have been noted, too many people still die prematurely or live with conditions that could have been prevented.

The strategic vision for future health and social care services seeks to support people to take greater control over their own lives and enable them to make healthy choices as well as helping to create an environment that makes such choices easier.

It is accepted that the health and social care service cannot do this in isolation and to achieve this aim we need to work with other partners across government and other sectors to tackle the root causes of ill-health and reduce health inequalities. Maximising the potential of the community planning process and other partnerships will be an important enabler. We will support the development of thriving and inclusive communities through working in partnership with communities and with other sectors.

The population health framework *"Making Life Better"* set the strategic context for the actions required from health organisations and other public bodies to improve health and reduce inequalities. Through implementation of this strategic framework, the Department of Health and other public bodies can create the conditions for individuals, families and communities to take greater control over their lives and be empowered and supported to lead healthy lives.

Key objectives/goals for the HSC for the period 2019/20 and beyond, to improve the health of the population, are set out at **Outcome 1 – Reduction of Health Inequalities.**

Outcome 1: Reduction of health inequalities

Achieving the aims of *Delivering Together* will result in the creation of an environment where people are supported to keep well in the first place. Through ensuring that people have the information, education and support to make informed choices around lifestyle, healthy eating, and the adoption of preventative actions such as maintaining good oral health we will empower people to take control of their own health and wellbeing and support them to stay healthy, well, safe and independent.

Work to support and enable healthy lives, and tackle the causes of health inequality spans the entire life course:

- helping pregnant women and their partners to make the choices that are best for them and their babies;
- ensuring that all children grow up in a stable and healthy environment;
- intervening early to provide support to families before issues become complex and difficult to reverse;
- supporting infant mental health;
- ensuring our young people are equipped for a healthy adulthood, and
- supporting people to continue to live active and healthy lives as they age.

Although we seek to address the needs of the entire population there are those who, at times, may require more focussed support such as people detained in prisons, the homeless, the travelling community and LGBT people.

Objectives/ goals for improvement:

Population Health

1.1 By March 2020, in line with the Department's ten year "*Tobacco Control Strategy*", to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%.

1.2 By March 2020, to have commissioned an early years obesity prevention programme and rolled out a regionally consistent Physical Activity Referral Scheme. These programmes form part of the Departmental strategy, A Fitter Future for All, which aims by March 2022, to reduce the level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children.

1.3 By March 2020, through implementation of the NI Breastfeeding Strategy increase the percentage of infants breastfed at discharge and 6 months as recorded in the Child Health System (CHS). This is an important element in the delivery of the "*Breastfeeding Strategy*" objectives for achievement by March 2025.

1.4 By March 2020, establish 3 "Healthy Places" demonstration programmes working with specialist services and partners across community, voluntary and statutory organisations to address local needs.

1.5 By March 2020, to ensure appropriate representation and input to the PHA/HSCB led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach.

1.6 By March 2020, to establish a baseline of the number of teeth extracted in children aged 3-5 years - as phase 1 of the work to improve the oral health of young children in Northern Ireland over the next 3 years and seek a reduction in extractions of 5%, against that baseline, by March 2021.

1.7 By March 2020, to commence the implementation of a regional prototype bariatric service, subject to the outcome of public consultation, business case approval and available funding in line with the implementation of recommendations set out in the Departmentally endorsed NICE guidance on weight management services.

Supporting Children and Young People

1.8 By March 2020, to have further developed, and implemented the "*Healthier Pregnancy*" approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation.

1.9 By March 2020, ensure the full delivery of the universal child health promotion programme for Northern Ireland, "*Healthy Child Healthy Future*". By that date:

- The antenatal contact will be delivered to all first time mothers.
- 95% of two year old reviews must be delivered.

These activities include the delivery of core contacts by Health Visitors and School Nurses which will enable and support children & young adults to become successful, healthy adults through the promotion of health and wellbeing.

1.10 By March 2020, ensure the full regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 "We give our children and young people the best start in life".

1.11 By March 2020 each HSC Trust will have established an Infant Mental Health Group and produced an Action Plan consistent with and informed by the "Infant Mental Health Framework for Northern Ireland" 2016."

1.12 By March 2020, the proportion of children in care for 12 months or longer with no placement change is at least 85%; and 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer them greater stability while in care.

Improving Mental Health

1.13 By March 2020, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a

Multi Agency Triage Team pilot (SEHSCT) and two Crisis De-escalation Service pilots (BHSCT & WHSCT) to test different models and approaches. Learning from these pilots should inform the development of crisis intervention services and support the reduction of the suicide rate by 10% by 2022 in line with the draft "*Protect Life 2 Strategy*".

1.14 By March 2020, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, including further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol and drug related harm and to reduce drug related deaths.

Supporting those with Long Term Conditions

1.15 By July 2020, to provide detailed implementation plans (to include recruitment status) for the regional implementation of the diabetes foot care pathway, plans should demonstrate an integrated approach making best use of all providers. Regional deployment of the care pathway will be an important milestone in the delivery of the "*Diabetes Strategic Framework*"

Associated quality and performance indicators

Population health (general)

A1 Healthy life expectancy.

A2 Average life expectancy for men and women.

A3 Life expectancy differential between the least deprived and most deprived areas in Northern Ireland, for men and women.

A4 Potential years of life lost from causes considered amenable to healthcare.

A5 Infant mortality.

A6 Age standardised death rate for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas.

A7 Maintenance of population vaccination coverage as reported in PHA Annual Report.

A8 Proportion of adults (aged 16+) consuming the recommended five portions of fruit and vegetables each day.

A9 Level of overweight and obesity across the life course (2 – 15) year olds and 16+.

Smoking

A10 Proportion of adults who smoke.

A11 Number of pregnant women, children and young people, and adults from deprived areas (lower quintile) who set a quit date through cessation services.

A12 Proportion of pregnant women who smoke.

Alcohol and substance misuse

A13 Proportion of adults who report having reached or exceeded the recommended weekly alcohol limit.

A14 Standardised rate of alcohol-related admissions to hospital within the acute programme of care.

A15 Standardised rate of drug-related admissions to hospital within the acute programme of care.

Child health and wellbeing

A16 Rate of births to mothers under 17 years of age (with breakdown against most deprived areas).

A17 Breastfeeding rate at discharge from hospital.

A18 Rate of each core contact within the pre-school child health promotion programme offered and recorded by health visitors.

A19 Proportion of looked after children who have experienced more than two placement changes. (Source is OC2)

A20 Length of time for best interest decision to be reached in the adoption process.

A21 Number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type.

A22 Proportion of school-aged children who have been in care for 12 months or longer, who have a personal education plan.

A23 Percentage of care leavers aged 16 – 18 in education, training or employment by placement type.

A24 Percentage of care leavers at age 18, 19 and 20 years in education, training or employment.

Suicide and self-harm

A25 Achievement of the implementation of Protect Live 2 Strategy Action Plan (source Quarterly Project Board Highlight Reports)

A26 Number of ED repeat presentations due to deliberate self-harm.

A27 Self-reported mental health. (GHQ12 survey)

Long Term Conditions

A28 The number of unplanned admissions to hospital for adults with specified long-term conditions.

Aim: To improve the quality and experience of health and social care.

Delivering Together set out the roadmap for the transformation of health and social care services to deliver an integrated service capable of responding to future needs. Everyone in Northern Ireland will make use of those services at different points in their lives.

It is important that the HSC listens to and learns from their experiences, whether services are delivered well or things go wrong, and strives to ensure that everyone has a positive experience of the care or treatment they receive.

Quality 2020 provides the framework for the delivery of such services that are:

- centred on the needs of the patient/ client—everyone using HSC services should be treated with dignity and respect and should be fully involved in decisions about their treatment, care and support.
- safe—the care, treatment and support the HSC provides should never result in avoidable or preventable harm; and
- effective—everyone accessing HSC services should have the most appropriate treatment or care, in the most appropriate setting, with the best possible outcome.

Delivering Together confirmed the Minister's intention to build on Q2020 and other quality improvement work and to establish an Improvement Institute to better align existing resources in this important area.

Objectives / goals to address the quality and experience of health and social care are contained in the following Outcomes:

2 - People using health and social care services are safe from avoidable harm

3 - Improve the quality of the healthcare experience

4 - Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

5 - People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

6 - Supporting those who care for others

Outcome 2: People using health and social care services are safe from avoidable harm

It is widely recognised that the design and delivery of health and social care must have quality and safety at its heart. The Expert Panel who produced the "*Systems not Structures*" report were clear that "any system that aspires to be world class must take a strong position on quality improvement, with the patient and service user represented as part of this".

To meet this challenge the HSC needs to ensure alignment between quality improvement, partnership with those who use our services, and how we regulate those services. HSC working practices should proactively detect hazards in care settings and implement solutions to reduce risk before harm occurs.

Objectives/ goals for improvement:

Safe in all Settings

2.1 By March 2020 all HSC Trusts should ensure safe and sustainable nurse staffing, including working towards the full implementation of phases 2, 3 and 4 of Delivering Care, maximising the use of any current or new funding, with an annual report submitted to HSC Trust Boards.

2.2 By 31 March 2020:

- Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 3%, as per the established recurring annual targets, taking 2018/19 as the baseline figure; and
- Using 2018/19 as the baseline, by March 2020 Trusts should secure the following in secondary care:
    - a reduction in total antibiotic prescribing (DDD per 1000 admissions) of 1-2%;
    - a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions;
    - a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions, and

    and EITHER

    - that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category,

    OR

    - an increase of 2% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use,

with the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 15% by 31 March 2024.

**For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.*

Safe in Hospital Settings

Reducing Gram-negative bloodstream infections

2.3 By 31 March 2020 secure an aggregate reduction of 17% of *Escherichia coli, Klebsiella spp.* and *Pseudomonas aeruginosa* bloodstream infections acquired after two days of hospital admission, compared to 2018/19.

2.4 In the year to March 2020 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of *Clostridium difficile* infection in patients aged 2 years and over, and in-patient episodes of Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection compared to 2018/19.

2.5 Throughout 2019/20 all clinical care teams should comprehensively scale and spread the implementation the NEWS KPI, and ensure effective and robust monitoring through clinical audit and ensure timely action is taken to respond to any signs of deterioration.

2.6 By March 2020, achieve full implementation of revised regionally standards, operational definitions and reporting schedules for falls and pressure ulcers across all adult inpatient areas.

2.7 By March 2020, all Trusts must demonstrate 70% compliance with the regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group.

Safe in Community Settings

2.8 During 2019/20 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA.

Associated quality and performance indicators

Hospital Care

B1 Staffing levels as reported in regular reports from PHA Delivering Care Implementation Board.

B2 Number of records audited achieving 95% compliance of the accurately completed NEWS charts in all adult in-patient wards (excluding theatres and critical care departments).

B3 Number of incidents of hospital-acquired pressure ulcers (grade 3 and 4) occurring in all adult inpatient wards, and are classed as unavoidable from the current baseline data.

B4 Percentage compliance with the falls safe improvement bundle specified settings including adult acute inpatient and elderly care settings.

B5 Number of emergency admissions returning within seven days and within 8-30 days of discharge.

B6 Clinical causes of emergency readmissions (as a percentage of all admissions) for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF).

B7 Number of emergency readmissions with a diagnosis of venous thromboembolism.

B8 Number of emergency admissions and readmissions in which medicines were considered to have been the primary or contributing factor.

Community Care

B9 Number of revisits required to achieve compliance in (i) residential homes, (ii) nursing homes, in 2016/17 and 2017/18, as published by RQIA.

Outcome 3: Improve the quality of the healthcare experience.

The Health and Social Care system belongs to everyone and those providing services or availing of services can bring valuable insights into how it can best be organised and improved. Through working in partnership and utilising coproduction, patients, service users, families, staff, and politicians can all participate in the development of a person centred service which benefits us all.

In undertaking such work everyone who uses and delivers health and social care services should be treated with respect, listened to and supported to work as real partners.

Staff and patient voices from across the system should be aligned closely to the quality improvement, inspection and regulation systems to ensure issues are raised in as timely a manner as possible and addressed early: before they escalate to a complaint.

Objectives/ goals for improvement:

3.1 By March 2020, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment.

3.2 During 2019/20 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people.

3.3 By September 2019, patients in all Trusts should have access to the Dementia portal.

3.4 By March 2020, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs.

3.5 By March 2020 the HSC should ensure that the Regional Co-Production Guidance has been progressively implemented and embedded across all programme of care, this will include integrating PPI, Co-Production, and patient experience into a single organisational plan.

Associated quality and performance indicators

Palliative Care

C1 Implementation of a protocol to support the identification of patients with palliative and end of life care needs in Primary Care systems. [Source: PHA/ HSCB evaluation report of agreed protocol]

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

Timely access to the most appropriate services is considered a key indicator of quality and the patient experience. People rightly have an expectation that they should be seen and treated within a reasonable time in the most appropriate location. Prompt, early diagnosis and intervention can avoid the need for scarce acute sector services while supporting a high quality of life.

The way services are designed and delivered will continue to change, focussed on providing continuity of care in an organised and integrated way. Transformation will increasingly require working across traditional organisational boundaries within and outside the HSC, and the development of an environment characterised by trust, partnership and collaboration.

It will be important during the transition period that existing services are delivered to agreed standards, in a safe and timely fashion. The continued deployment of new performance/ accountability arrangements and associated Performance Improvement Trajectories will assist in securing steady improvement in existing services. Initially introduced in mid-2017/18 (covering elective, ED, Cancer services, mental health services and ambulance response times) the intention is to expand the arrangements to cover other CPD standards during 2018/19 and beyond.

Technology and new ways of working have a key role to play in transforming General Practice, including increasing access to GP services. Evidence from practices that have introduced telephone triage such as Ask My GP for example, suggests that this has helped increase the capacity to manage demand and consideration should be given to how such initiatives can be further developed and implemented.

Objectives/ goals for improvement:

<u>Primary Care and Community Setting</u>

4.1 By March 2020, to increase the number of available appointments in GP practices compared to 2018/19.

4.2 By March 2020, to have 95% of acute/ urgent calls to GP OOH triaged within 20 minutes.

4.3 By March 2020, reduce the number of unallocated family and children's social care cases by 20%.

<u>Ambulance Services</u>

The NI Ambulance Service faces growing demand for the services they provide. In response to this and other challenges the NIAS are transforming how they deliver their services. Although the introduction of new ways of working, such as Alternative

(or Appropriate) Care Pathways, has contributed to a reduction in the use of Acute Care facilities demand remains high for a prompt response to life threatening events.

4.4 Until the proposed adoption of a new clinical response model, when 72.5% of Category A (life threatening) calls should be responded to within 8 minutes, 67.5% in each LCG area, the HSCB should continue to work with the Trust to ensure performance is maintained at the previous target level.

Hospital Care Setting – Acute Care

When patients and service users need urgent treatment only provided in acute sector settings they often are frustrated by apparently lengthy treatment delays due the failure of the current service delivery model to provide a high quality service in a timely fashion.

The reform of community and hospital services so that they are organised to provide care where and when it is needed, in the most efficient manner, is a high priority. It is inevitable that the role of our hospitals will change as they focus on delivering the highest quality of specialist and acute care for patients across Northern Ireland. In responding to the objectives below it will be essential for the Commissioning Plan to demonstrate how such services are being transformed, with alternative models of care embedded across Northern Ireland: ensuring more people can be seen and treated effectively (including on a same/ next day basis), preventing unnecessary admissions to hospital, and supporting people to recover following periods of ill-health.

Proposals should include working towards the provision of the same level of care for inpatients seven days a week, the deployment of ambulatory care models, the utilisation of technology to provide timely access to specialist advice, cross trust collaboration, and the scaling up and rollout of proven new ways of care delivery.

4.5 By March 2020, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; and no patient attending any emergency department should wait longer than 12 hours.

4.6 By March 2020, at least 80% of patients to have commenced treatment, following triage, within 2 hours.

4.7 By March 2020, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.

4.8 By March 2020, ensure that at least 16% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate.

4.9 By March 2020, all urgent diagnostic tests should be reported on within two days.

4.10 During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently

referred with a suspected cancer should begin their first definitive treatment within 62 days.

Hospital Care Setting – Elective Care

Often patients are referred to specialists for medical or surgical treatment of non-urgent or non-life threatening conditions that nevertheless require medical or surgical intervention. People rightly have an expectation that they should be seen and treated within a reasonable time. However, over the last number of years, meeting the rising demand has been challenging and it is clear that the current service model is no longer suitable.

The longer term goal set out in *Delivering Together* is to significantly reduce the current waiting times for assessment, diagnosis and treatment that have been described as unacceptable. The aim of the introduction of new ways of working, such as Elective Care Centres and Assessment and Treatment Centres, is to return to the maximum waiting times of nine and thirteen weeks that have previously been achieved.

In recognition that the introduction of a sustainable model, in a safe manner, must be undertaken methodically, the goals below represent realistic and achievable objectives that deliver stability.

4.11 By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.

4.12 By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test and no patient waits longer than 26 weeks.

4.13 By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/ daycase treatment and no patient waits longer than 52 weeks.

4.14 By March 2020, no patient waits longer than: nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age).

Associated quality and performance indicators

Primary Care

D1 The number of contacts per 1,000 patients per week, for each GP practice contracting to provide the NILES Demand Management, through submission of a survey to HSCB.

D2 Percentage of routine GP "out of hours" calls triaged within one hour.

D3 Total out of hours GP attendances.

D4 Number of GP referrals to emergency departments.

NI Ambulance Service

D5 Number of ambulance responses where the outcome is that the patient does not attend hospital.

D6 (i) Patient handover times and (ii) ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes).

D7 Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation on arrival at hospital.

Acute Care

D8 Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to 12 hours and 12 hours or more, before being treated and discharged or admitted.

D9 Total time spent in emergency departments including the median, 95th percentile and single longest time spent by patients in the department, for admitted and non-admitted patients.

D10 (a)Number and percentage of attendances at emergency departments triaged (initial assessment) within 15 minutes; (b) time from arrival to triage (initial assessment) for (i) ambulance arrivals and (ii) all arrivals; and (c) time from triage (initial assessment) to start of treatment in emergency departments.

D11 Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage scale at Type 1 or 2 Emergency Departments.

D12 Time waited in emergency departments between decision to admit and admission including the median, 95th percentile and single longest time.

D13 Percentage of people who leave the emergency department before their treatment is complete.

D14 Percentage of unplanned re-attendances at emergency departments within seven days of original attendance.

Stroke

D15 Average length of stay for stroke patients.

D16 90% admission to stroke unit within 4 hours of arrival.

D17 60% discharged to community stroke teams and 40% of these should be Early Supported Discharge.

D18 100% of eligible patients should be reviewed at 6 months.

[As reported in HSCB Stroke Dashboard]

Elective Care

D19 Number of GP and other referrals to consultant-led outpatient services.

D20 Percentage of routine diagnostic tests reported on (i) within two weeks and (ii) within four weeks of the test being undertaken.

Specialist drug therapies

D21 Number of patients waiting longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis or psoriasis.

D22 Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for Multiple Sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS.

D23 Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye, and six weeks for the second eye.

Maternity

D24 Intervention rates, including percentage of babies born by caesarean sections.

D25 Number of babies born in midwife-led units.

Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

Successful implementation of a person centred model of care will rely on a comprehensive understanding of what is important to those delivering care and those receiving that care.

It will therefore be important that the principle of coproduction is at the heart of new initiatives for those with long term conditions, and that patients and service users are partners in the care they receive with a focus on increased self-management and choice.

Objectives/ goals for improvement

Increased Choice

5.1 By March 2020, secure a 10% increase in the number of direct payments to all service users.

5.2 By September 2019, all service users and carers will be assessed or reassessed at review under the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget, Trust arranged services, or a mix of those options, to meet any eligible needs identified.

Access to Services

5.3 By March 2020, no patient should wait longer than 13 weeks from referral to commencement of treatment by an allied health professional.

5.4 By March 2020, have developed baseline definition data to ensure patients have timely access to a full swallow assessment.

5.5 By March 2020, Direct Access Physiotherapy service will be rolled out across all Health and Social Care Trusts on a state of readiness basis.

5.6 By March 2020, to have published the Children and Young People's Emotional Health and Wellbeing Framework for school-aged children and young people in Northern Ireland.

Care in Acute Settings

5.7 During 2019/20, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.

Associated quality and performance indicators

Supporting Independence

E1 Number of client referrals passed to reablement; number of clients starting a reablement scheme; and number of clients discharged from reablement with no on-going care package required'.

Patient Discharge

E2 Percentage of learning disability and mental health discharges that take place within seven days of the patient being assessed as medically fit for discharge.

E3 Number of learning disability and mental health discharges that take place after 28 days of the patient being assessed as medically fit for discharge.

Outcome 6: Supporting those who care for others

Carers are vital partners in providing care and it is important that they are supported while carrying out their caring responsibilities. The contribution of informal carers is crucial to the ability of people who require assistance to live independently in the community.

As the needs of carers continues to change, the type of support required must keep pace with that change. It will be important that they can strike a balance between the duties of the caring role and their right to live their own life and pursue their own goals and interests.

Objectives/ goals for improvement

6.1 By March 2020, secure a 10% increase (based on 2018/19 figures) in the number of carers' assessments offered to carers for all service users.

6.2 By March 2020, secure a 5% increase (based on 2018/19 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care.

6.3 By March 2020, secure a 5% increase on the number of young carers attending day or overnight short break activities.

Associated quality and performance indicators

F1 Number of carers assessments offered, by Programme of Care.

F2 Number of short break hours offered, as reported in HSCB Adult Short Breaks Activity Report.

Aim: Ensure the sustainability of health and social care services provided

The objectives set out under the first two aims seek to improve the health of the Northern Ireland population and the quality of health and social care services provided to patients and service users. It is essential that these overarching aims are achieved within the resources available to the HSC.

The existing pressures and challenges arising from growing demand, patients living longer with complex needs, and an aging population have not diminished. Therefore services must operate as efficiently and effectively as possible, and provide the best possible outcome for patients.

However, operating existing services efficiently is not enough to meet the growing demand and it is clear that the HSC must change how health and social care services are delivered.

This will mean working with a system focus and in an integrated way that makes best use of the expertise and resources of all health and social care providers, and allows innovative ways of working to develop.

The Commissioning Plan should demonstrate that currently commissioned services represent the most efficient use of resources and outline how benchmarking of productivity and efficiency measures across providers has informed commissioning decisions. In addition, it should detail the steps being taken to bring about change that will provide the highest quality care in a cost effective manner—on the basis of single solutions for the region.

Key actions required of the HSC for the period 2019/20 and beyond, to provide sustainable health and social care services, are contained in the objectives set out in **Outcome 7 – Ensure the sustainability of health and social care services.**

Outcome 7: Ensure the sustainability of health and social care services

Established health and social care services are often accompanied by a plethora of checks, lists and forms developed over time to address particular issues.

Transforming such services and the bureaucracy around them, through investment in technology enabled business solutions such as encompass, will harmonise and standardise care and information processes. Such investment will ensure our staff have the required information at hand and are empowered to efficiently deliver a person centred model of care.

While awaiting the introduction of new business solutions it remains important to maximise the impact of the available resources to deliver the best patient outcomes, particularly in the facing of increasing financial pressures. HSC Trusts should therefore continue to develop multi-disciplinary, team-based approaches to delivering care aligned with GP Practices.

The HSCB, PHA and Trusts should demonstrate how they ensure services are operated in an optimal manner, and that all urgent patients referrals are prioritised and, thereafter, that all routine patients are seen in strict chronological order.

To reduce the impact of long waiting lists it will be important to maximise attendance rates, with outpatient appointment dates booked no more than six weeks in advance, and outpatient review appointments only taking place where there is a clear clinical need.

Objectives/ goals for improvement

Primary and Community setting

7.1 By March 2020, to ensure delivery of community pharmacy services in line with financial envelope.

7.2 By March 2020 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users and the baseline activity to measure this.

Hospital Setting

While demand for services continues to grow it is imperative that, in the short term, the HSC makes efficient use of the resources available.

7.3 By March 2020, to establish a baseline of the number of hospital cancelled, consultant led, outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment and by March 2020 seek a reduction of 5%.

7.4 By March 2020, to reduce the percentage of funded activity associated with elective care service that remains undelivered.

7.5 By March 2020, ensure that 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.

7.6 By March 2020, to have obtained savings of at least £20m through the Medicines Optimisation Programme, separate from PPRS receipts.

Associated quality and performance indicators

Hospital efficiency

G1 Number, rate and ratio of new and review outpatient appointments cancelled by hospitals resulting in the patient waiting longer.

G2 Number and percentage of hospital cancelled appointments in the acute programme of care with an impact on the patient resulting in the patient waiting longer.

G3 Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust.

G4 Number of outpatient appointments with procedures (for selected specialties).

G5 Day surgery rate for each of a basket of 24 elective procedures to continue monitoring performance and enable continued benchmarking with rest of UK.

G6 Percentage of patients admitted electively who have their surgery on the same day as admission.

G7 Elective average pre-operative stay.

G8 Percentage of operations cancelled for non-clinical reasons.

G9 Elective average length of stay in acute programme of care.

G10 Excess bed days for the acute programme of care.

G11 Cost of a basket of 24 elective procedures (Day surgery as per G5) by Trust.

Prescribing efficiency

G12 Level of compliance of GP practices and HSC Trusts with the NI Medicines Formulary; and prescribing activity for generic prescribing and dispensing rates.

Aim: Support and empower staff delivering health and social care services

Those who work tirelessly, and with great skill and dedication, to provide our health and social care services are the HSC's most valuable resource. It is vital that the HSC invests in their future and ensures their health and wellbeing is valued and protected.

As the implementation of *Delivering Together* moves forward it is important to have an optimally sized and resourced workforce, with the right skills mix in place to deliver both the existing, commissioned services, promote health and wellbeing and support the transformation work.

In May 2018, the Department, as an outworking of Delivering Together, published the 'health and social care Workforce Strategy 2026', with the aim of meeting our workforce needs – and the needs of the workforce. The Commissioning Plan needs to take the aim, objectives, themes and actions of the strategy into account, and detail how resources will be allocated to support the implementation of the strategy.

While HSC staff include some of the most capable, committed and enthusiastic people in the public sector, the Expert Panel Report was clear that in order to bring about the required transformation they would be asked to change how they undertake their work and would need to develop new skills.

In order to embed the required culture of learning, quality improvement and partnership working throughout the HSC it will be necessary to develop Leadership and Change Management skills, critical to the successful delivery of the required transformation, across the range of health and social care staff and key independent practitioners. These skills will be delivered through the implementation of the HSC-wide Collective Leadership Strategy, and the values which underpin it. The Commissioning Plan should detail how resources will allocated to support the implementation of this work.

Key actions required of the HSC for the period 2019/20 and beyond, to support and develop the capabilities of HSC staff, are contained in the objectives set out in **Outcome 8 – Supporting and transforming the HSC workforce.**

Outcome 8: Supporting and transforming the HSC workforce

The HSC competes with other employers to secure the skills and talents of the best people. It must therefore become an employer and trainer of choice; leading by example; investing in the wellbeing of staff, and making a tangible and positive contribution to the health and wellbeing of not only health and social care staff but society as a whole.

The HSC can realise these goals through supporting the staff who deliver vital health and social care services and seeking to bring about positive change. Continued investment in training and development initiatives, along with the development of new multidisciplinary training programmes that maximise the effectiveness of the workforce will assist in achieving those outcomes.

The implementation of the Workforce Strategy will demonstrate to our health and social care workers that the transformation set out in *Delivering Together* is underway. The actions for 2019/20 described below will contribute to ensuring that an adequately-resourced and skilled workforce is available to take forward work to discharge departmental Programme for Government commitments.

Objectives/ goals for improvement

Implementing the Workforce Strategy

8.1 Contribute to delivery of Phase One of the single lead employer project by 31 July 2019 and Phase 2 by 31 January 2020; in line with the requirements set down by the Department.

Attracting, recruiting and retaining staff

8.2 By June 2019, to provide appropriate representation on the project board to establish a health and social care careers service.

Effective workforce planning

8.3 By March 2020, to have completed the first phase of the implementation of the domiciliary care workforce review.

8.4 By June 2019, to provide appropriate representation to the project to produce a health and social care workforce model.

Build on, consolidate and promote workforce health and wellbeing and staff engagement

8.5 By March 2020, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10 – 14 of the Workforce Strategy.

Supporting our staff

8.6 By January 2020, to ensure at least 50% of Trust frontline healthcare staff and at least 40% of Trust frontline social care staff have received the seasonal flu vaccine.

8.7 By March 2020, to reduce Trust staff sick absence levels by a regional average of 5% compared to 2018/19 figure.

8.8 During 2019/2020 a workforce review of the social work workforce will be progressed to inform future supply needs and commissioning of professional training (subject to resource availability).

8.9 By March 2020, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG.

8.10 Improve take up in annual appraisal of performance during 2019/20 by 5% on previous year towards meeting existing targets (95% of medical staff and 80% of other staff).

Investing in our staff

8.11 By March 2020, 60% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2 by March 2020.

8.12 By March 2020, to have developed and commenced implementation of a regional training framework which will include suicide awareness and suicide intervention for all HSC staff with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services & mental health/addiction services) by 2022 in line with the draft Protect Life 2 strategy.

8.13 By March 2020, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts.

Associated quality and performance indicators

Sickness Absence

H1 Uptake of seasonal flu vaccine by frontline health and social care workers (as reported in PHA return to Dept).

H2 Percentage of HSC hours lost due to sick absence.

H3 Percentage of HSC staff trained in suicide awareness / prevention.

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2019/20

1. The vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the vision and priorities during the year 1st April 2019 to 31st March 2020.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2019/20 financial year are resourced.

4. The objectives and indicators included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year.

5. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

Southern Health and Social Care Trust

Quality Care - for you, with you

TRUST DELIVERY PLAN 2019/20

Version FINAL V1.0
Approved by SMT 17-Sep-19
Approved by Trust Board 26-Sep-19

Contents

1 Introduction

This ***Trust Delivery Plan*** (TDP) represents the response of the Southern Health & Social Care Trust to the Health & Social Care Board (HSCB) & Public Health Agency (PHA) ***Commissioning Plan for 2019/20***

The Commissioning Plan itself is developed in response to the ***Commissioning Plan Direction 2019/20*** published by the Department of Health (DOH). It sets out the priorities, aims and improvement objectives for the Health & Social Care (HSC) sector.

It identifies specific areas of focus for the 2019/20 financial year but also seeks to set these within the context of the broader outcomes that the Department and the HSC want to achieve as we work together to build a world-class health and social care service for the people of Northern Ireland.

It also identifies a number of associated quality and performance indicators against which the HSC should monitor performance and take improvement action as required. The Direction is structured around four strategic aims linked to the vision set out for health in ***Health and Wellbeing 2026 'Delivering Together':***

- To improve the health of our population;
- To improve quality and experience of care;
- To ensure sustainability of the services delivered;
- To support and empower the staff delivering health and social care services.

This TDP will provide a response to the regional commissioning priorities and decisions for 2019/20 set by the Department of Health and the HSCB & PHA as well as priorities and decisions being taken forward at a local level by the Southern Local Commissioning Group. It also advises of the Trust's position in regards to each of the quality and performance indicators identified under each of the key themes.

2 Local Context – Summary Overview

The Trust's current financial plan is set in the context of the Southern Trust's overall position in relation to relative efficiency, capitation and significant demographic pressures compared with the rest of the region:

- We recognise and are appreciative of the fact that for three consecutive financial years, the Trust has not been allocated a share of the regional cash efficiency target in an effort to bridge the capitation inequity gap, however, we can clearly demonstrate a range of efficiencies which have been successfully implemented over a number of financial years.
- **Efficiency:** We have demonstrated through a range of benchmarking exercises that we retain our position as the most efficient Trust in Northern Ireland and the Southern Trust's acute hospital network was reaffirmed as one of the UK's top hospitals.
- **Performance**: While the Trust continues to perform well in a number of key areas relative to regional and wider NHS peers, the Trust can no longer sustain its historically strong performance against the unscheduled care targets as a result of sustained increases in demand and workforce challenges to respond. This is further compounded the Trust's poor physical infrastructure on the acute hospital sites limiting options to support introduction of new models of care and flexible use of bed capacity during periods of peak demand which now prevail throughout the year versus what was traditionally experienced as ''winter pressures' . 2018/19 saw a marked reduction in Trust performance and while improvement trajectories are in place for 2019/20, delivery of core service and budget agreements for elective planned volumes remains a challenge as a result of sustained unscheduled (emergency) care pressures and a constrained financial context.

Some Facts & Figures:

- In 2018/19 the Trust had the highest throughput in the region with 65.3 admissions per bed
- Shortest average length of spell at 4.8 days
- Lowest turnover interval (between admissions) of 0.8 days
- Second highest average percentage bed occupancy at 86.6%
- Lowest Hospital Cancellation rates for outpatient appointments over the last 5 years (6.9%)
- Lowest outpatient DNA rate (7.4%)
- Workforce efficiency measures compare favourably in the region:
  - Turnover 9.0%
  - Sickness and Absence 5.35%

- **Demography:** We have seen local population growth of 23.7% between 2000 and 2017 compared with the NI average of 11.2% and the Southern area is projected to grow at a higher rate within all age groups than the rest of Northern Ireland. An overall 17.3% increase is projected in the total population of the Southern area between 2018 and 2041 compared to a 6.6% increase for Northern Ireland as a whole.

Our approach in 2019/20:

The Trust's operational performance and financial plans for 2019/20 are set in the context of what has already been achieved and evidenced through benchmarking as well as further pressure within our hospital and community services particularly in relation to workforce challenges, demographic growth and increased demand in unscheduled care. While the Trust will achieve a break-even financial position in year, an underlying 'recurrent' deficit position remains. The Trust will prioritise recurrent funding to address service pressures resulting from sustaining delivery of current service models in the first instance.

Should additional in year non recurrent financial allocations or 'slippage' become available, this will be allocated to support patient safety issues and key performance targets in the first instance. The Trust's financial plan for 2019/20 is detailed in Section 4. The Trust anticipates key challenges in 2019/20 related to increasing demand and significant workforce pressures impacting on performance. The Trust's overarching priority will be to deliver safe, high quality health and social care to local service users.

2.1 Planning Context

In line with the NI Executive's ***Programme for Government***, it is expected that Trusts review their strategic plans to align to the revised departmental planning horizon and reflect the **outcomes** and indicators when finalised. During 2019/20, the Trust will continue to assess our plans in this context and in respect of the wider transformation agenda, the Trust will work with Commissioners to support prioritisation and decommissioning plans to enable affordability and sustainability of emerging transformation priorities in line with agreed outcomes / evidence of effectiveness.

'Delivering Together' provides a roadmap for radical transformation in Health and Social Care (HSC) and highlights the critical role that 'Co-production' and 'Co-design' must play in this reform. The Trust welcomes and supports this commitment that will build on the effective community development and strong personal and public involvement (PPI) approaches that are well established in the Southern area.

The Trust will continue to work at a regional level to deliver the service transformation set out in *'Delivering Together'*

In June 2017, the Trust Board endorsed our new four year Corporate Plan 2017/18 – 2020/21 '***Improving Together'.*** This four year plan builds on our previous 3 year Strategic Plan 2015-2018, ***"Improving through Change"*** and sets out the strategic direction for the four year period. It includes challenges and opportunities to create better health outcomes for the population in the Southern area.

Our Corporate Plan recognises the need for service reform as a result of the changing needs of our local population, new ways of delivering care and treatment and the financial and workforce resources available to us.

The key objectives which the Trust will strive to achieve are: -

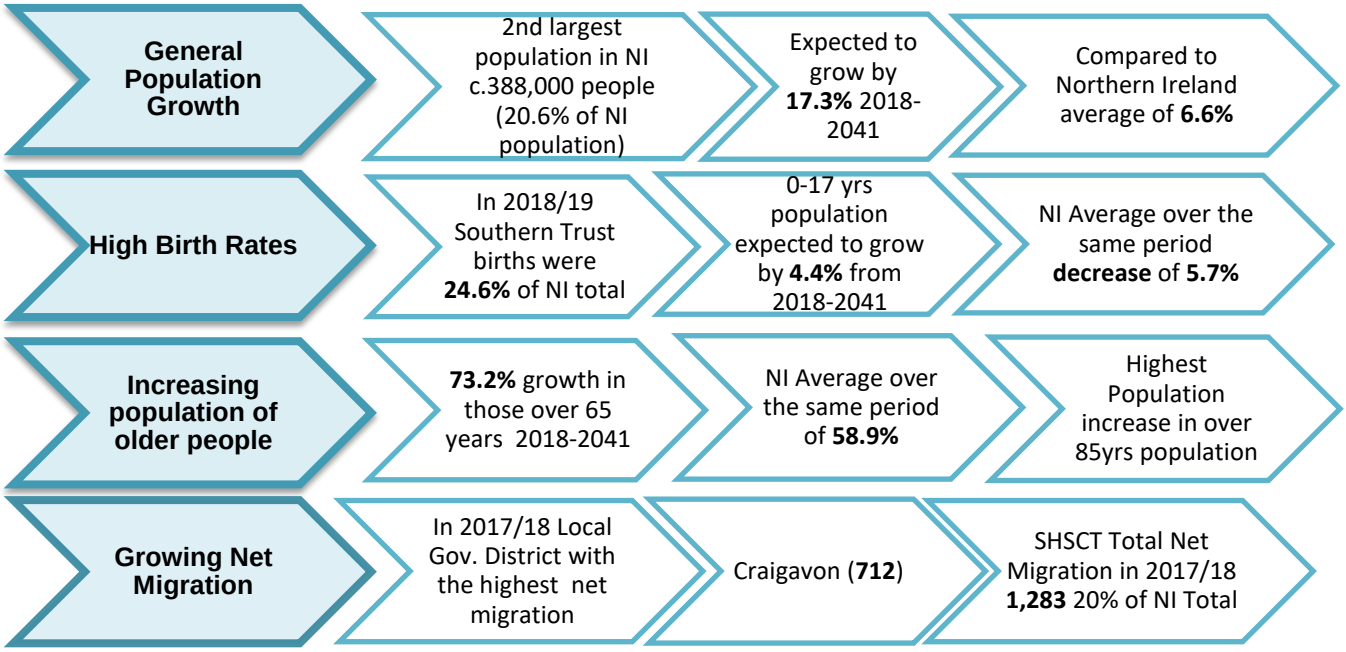
- Promoting safe, high quality care
- Supporting people to live long, healthy active lives
- Improving our services
- Making the best use of our resources
- Being a great place to work, supporting developing and valuing our staff
- Working in partnership

Despite the challenges facing the health and social care sector, we remain committed to the corporate objectives of the Trust and where appropriate we will publically consult with our key stakeholders on service change.

In planning for these changes we will work with our staff, service users and carers, families and our wider local communities to better inform and influence how we develop and improve our services.

2.2 Local Demography and Challenges to Service Delivery

A summary of some of the key features of our local demographic profile that impacts on our Trust Delivery Plan is as follows:



During 2019/20, the service impact of demographic changes alongside broad workforce and financial challenges, the Southern Trust area will be required to respond to:

- **Increased demand, expectations and over reliance on our acute hospital services** - Attendances at our Emergency Departments (ED) continue to increase year on year. A sustainable response that offers a range of enhanced preventative and treatment options in primary and community settings is required to address;
- **Increased numbers of people with one or more long term condition -** Over 52,000 people in the Southern area are on the GP register as suffering from hypertension, and 22,574 people are registered as having asthma. Over 17,000 people (aged 17+) are on GP registers as having diabetes and over 14,000 are registered as having heart disease[1]. Many will be registered as having more than one condition, the likelihood of which increases with an ageing population. In terms of mental health, 3,186 people were on registers in Southern area GP practices as having a mental health condition;
- **Growing gaps in community care provision / providers to support effective patient flow and hospital discharges** - During 2019/20, the Trust continues to respond to reductions in available community and domiciliary care capacity to support individuals in their own home and enable effective discharge from our acute hospitals;
- **Significant workforce recruitment and/or retention challenges –** While progress has been made in some areas particularly where services or specialities are vulnerable, ongoing and further challenges have emerged across a range of

[1] Qualities and Outcomes Framework Data Southern Area 2017

professions and programmes of care that will impact on service delivery and Trust performance in 2019/20;

- **Financial challenge -** resulting from increasing demand and an underlying recurrent financial deficit position, constraining opportunities for further support and investment particularly in response to areas of demographic pressure;
- **Growing demand in meeting health and social care needs of our migrant population** - including child protection, domestic violence, mental health, health protection, vulnerability to non-communicable diseases, experience of health care and cultural beliefs about health/illness;

2.2.1 Acute Services

a) <u>Unscheduled/ emergency care</u>

Unscheduled care pressures are evident throughout the year in terms of high numbers of attendances at the Emergency Departments (EDs) and insufficient capacity to admit patients who require an inpatient stay. This is resulting in lengthy waits for assessment and treatment in the EDs and for admission to an inpatient bed. In addition medical patients often have to 'outlie' to a non-medical ward. Under these circumstances it is difficult to optimise patients' care and treatment and there are fewer beds available for elective care leading to longer waits for surgery.

The Trust continues to work with the commissioner and other providers and partners in the development and submission of the annual **Southern Area Unscheduled Care Resilience plan**. The aim is to provide safe, person centred, effective care to every patient, every time without unnecessary waits, delays and duplication. Learning from regional sharing events and drawing on staff experience has consolidated the key areas of focus for the Trust's resilience plan in the follow areas:

- Early intervention and prevention and demand management;
- Clinically focused and empowered management;
- Maximising hospital capacity and improving patient flow;
- Medical and surgical processes pulling patients from the Emergency Departments;
- 7 day working where possible in key service areas;
- Further promotion of the flu vaccine including enhancing the peer vaccinator role to increase uptake;
- Ensuring care is provided at home where possible;

Utilising management intelligence from audits of delayed discharges and predictive analysis to address short and longer term measures to improve patient flow and effective discharge to support 'home as the hub'.

The Trust will continue to implement improvement work to support management of unscheduled care in 2019/20 utilising non-recurrent funding secured as part of the Confidence and Supply Transformation funding including for example:

- Establishing an effective 'control room' function which enables effective site coordination across our acute hospitals;
- The Direct Assessment Unit developed under the auspices of the Daisy Hill Pathfinder project, providing 'same day' emergency/urgent care services. It aims to assess and treat patients who might otherwise have attended ED;
- Introducing a respiratory ambulatory service including enhancement of the community respiratory team;
- Investment in AHP and Social Work to enable expansion of 7 day working;
- Enhancement to the Acute Care at Home service into the Newry area;
- 'In reach' to nursing home residents.
- Improved operational effectiveness through development of effective system wide 'escalation' response plans.

The Trust anticipates ongoing sustained pressures and the need for system wide escalation. Support arrangements are required to ensure safe high quality care during particular spikes in demand over the 'winter' seasonal period.

The ability to effect timely discharge continues to impact on patient flow and overall unscheduled care performance. Instability and lack of capacity in Independent Sector providers further inhibits timely discharge. In particular a gap in services commissioned (care home placements, step-down and domiciliary care) for clients with dementia, <65yrs physical disability, acquired brain injury and acute alcohol withdrawal requires to be addressed to support improved performance and patient experience.

b) <u>Elective / Planned Care</u>

Delivery of elective / planned surgical care and treatment continues to be impacted by the increased demand for medicine and unscheduled care bed capacity. Demand for elective care services continues to grow with challenges in meeting access targets and addressing long waiting lists. The "capping" of elective surgery as indicated within seasonal unscheduled care resilience plans also affects this. The Trust will work with the regional elective care group to address longest

waiters. However, this will be subject to additional funding and will address 'new' waits only. In addition a task and finish group has been established to scope innovative approaches to managing long waiting lists and in particular to review and risk manage 'review' backlogs for escalation to commissioners;

c) Infrastructure and acute bed capacity

The Trust progressed development of capital plans to enable introduction of modest ambulatory capacity at both acute hospital sites for 2019/20. However, the Trust requires hospital site redevelopment to sustain current services and to make marked improvements in performance and patient experience. The Trust explored time limited options in the interim to increase the bed stock within the very limited footprint available at CAH and DHH. A recent bed modelling exercise completed by the NHS Utilisation Management Unit is in final report stage indicating significant bed deficits, on both sites by 2024. In addition, the following underlying constraints impact on acute service delivery as follows;

- The need for a second permanent CT scanner in Craigavon Area Hospital is supported by the Commissioner due to high activity levels. A modular scanner has been procured to maintain continuity of services until the outline business case for a twin CT scanning suite that has been submitted to the DoH for capital funding has been approved and the project implemented;
- The CT scanner in Daisy Hill Hospital is 8 years old. As the life cycle of a CT is around 7 years, it now is in the process of being replaced. Funding has been identified for a replacement scanner and the implementation plan has been agreed. In 2019/20, the Trust has installed a mobile CT scanner for DHH to stabilise and maintain an accessible CT service in the interim;
- The current low voltage electrical infrastructure is inadequate for a modern hospital service at both Craigavon Area and Daisy Hill Hospital sites. Both the CT projects are frustrated by the lack of low voltage electrical supply and the costs to provide adequate electrical supply for CT scanning has escalated the project costs. A separate project is being taken forward by the Trust to provide additional overall capacity to support future developments;
- The need to replace high cost items of equipment, including medical, laundry, CSSD and catering equipment as it reaches the end of its expected lifespan is challenging. It is also essential to be able to introduce new and innovative technology which can generate significant benefits including improving diagnosis and treatment; reducing recovery time; reducing lengths of stay in hospital and improve efficiency.

The Southern Trust requires significant additional capital investment beyond its current Capital Resource Limit (CRL) to address its full range of service needs and to move from reactive responses to service breakdown to a proactive replacement

programme for large items of equipment and medical devices. In 2019/20, the Trust will continue to engage with the commissioner and the Department of Health to seek to secure funding to maintain existing services and to agree strategic priorities and critical replacement programmes.

d) Workforce Challenges

The greatest challenge to the Trust Delivery Plan in 2019/20 relates to recruitment and retention of staff across all disciplines and specialties:

- Attracting and retaining medical staff is particularly challenging. This is in part due to limited pools of suitable applicants. In many instances other Trusts are in a position to offer job plans with dedicated specialty rotas which mean that staff do not have to provide out of hours cover for general medicine. The high rate of locums and associated risks have been added to the Trust's Corporate Risk Register;
- Insufficient numbers of staff are being generated by regional professional and clinical training programmes to fill existing vacancies and expected retirements etc. Action to increase training places needs to be addressed at regional level to deal with current pressures and to expand the workforce to support the growing and aging population;
- Changes to the NHS pension tax regime are resulting in consultants requesting reduction in their hours, considering retiring earlier than they originally planned and/or being unable to undertake any additional clinical work. Projected impact at this stage is approximately 25% downturn against core and planned additional activity;
- Staff are attracted to leave HSC jobs including medicine and nursing to work in the independent sector due to the higher rates of salary or agency rates. Incentivisation plans agreed regionally to attract staff to work locally would improve efficiency and assist continuity of care;
- The Radiology Service across the Trust is facing increasing pressure; activity has increased significantly. The workforce capacity issues are hindering productivity and the Waiting List Initiative guidance and changes to the tax regime restrict the Trust's ability to mobilise additional internal capacity;
- The opportunity to progress and evaluate transformational projects through confidence and supply funding is welcomed. These new and innovative service models and posts are attractive to staff but in some cases are generating pressures as staff move from core services with limited potential to backfill their posts. The timescale to effectively evaluate this non-recurrent investment in the limited timeframe and sustainability are ongoing concerns; the Trust has progressed with permanent recruitment to posts in the understanding that

adequate vacancies exist across Trust services to mitigate risks should there be no recurrent funding identified to support these developments in the longer term;

2.2.2 Mental Health and Disability Services

The availability of staff across all disciplines remains a significant concern for the Mental Health and Disability Directorate and will affect the achievement of targets, improvement plans, commissioning priorities and proposed service developments. Whilst every effort will continue to be made to recruit staff there is a lack of capacity regionally and nationally affecting all disciplines - psychiatry, psychology, social work, nursing, Allied Health Professionals, Day Care and Supporting People staff. Given that all Trusts are seeking to recruit from extremely limited pools of staff in Northern Ireland, this situation is unlikely to improve until the numbers of staff coming out of training can be substantially increased..

In terms of service transformation, there are two particular areas of pressure:

- The need for investment in **Core Rehabilitation and Recovery Services** which are essential to support throughput from in-patient units for mental health and learning disability units, and additional investment for high cost placements and supported living schemes. In the absence of significant new funding from the DoH and Northern Ireland Housing Executive (NIHE) to create placements to support people in the community our mental health in-patient services will continue to silt up, resulting in delayed discharges and ineffective patient flow. We will also face higher inescapable cost pressures year on year for high cost placements to meet new demand;
- **Development of Community Infrastructure for Early Intervention and Effective Rehabilitation Outcomes** - Currently Trusts operate a range of services, provided directly, or purchased through the independent sector, for those who require complex placements. Over recent years, the number of providers able and willing to provide such support has reduced and the costs for such are increasing week on week. There are a significant number of such placements, which have also failed, and providers have gone on to refuse admission to such facilities for service users who have had a spell in Acute Mental Health Care.

Other challenges include:

- Unscheduled care bed pressures on a daily basis within the Trust and regionally with occasions when there are no beds available for acute admissions across Northern Ireland;

- Referrals to Adult Mental Health Services remain high, which is one of a number of factors impeding the Trust's ability to maintain the 9 week access time target for non-urgent referrals;
- Referrals for opiate substitution services remain high and the service is under pressure to meet the needs of this population;
- Demand for Autism Spectrum Disorder (ASD) diagnosis in adults continues to far outstrip regional needs analysis and contributes to excessively long waiting times in the Southern area;
- Learning Disability services in the Trust continue to experience issues with recruiting sufficient staff in specific areas such as Day Care and Supported Housing;
- On-going and long-standing pressure on the availability of suitable long-term and short break placements for those with complex needs and behaviour that challenges;
- The Trust is seeking to significantly change the profile of those requiring admission to hospital and are very keen to develop alternative pathways in the form of community assessment and treatment services as well as Crisis Response and Home Treatment. These can only be delivered with significant investment in community service;
- Memory services - In order to ensure there are adequate step down arrangements from our acute hospitals the Trust will need investment to develop further the range and availability of specialist nursing care placements;
- The complexity of need and challenges in meeting that need, for children transitioning to adult services, remains both a service and cost pressure for the Trust;
- With reference to the previous point, a significant number of individuals in transition, whose needs challenge services, are now presenting to adult learning disability services requiring long term placement. There is a need for a short term assessment unit to establish the most appropriate accommodation and staffing to meet individual needs. This interim assessment unit/ crisis house will require 3-4 beds with increased specialist assessment and treatment professionals available.

2.2.3 Children and Young People's Services (CYPS)

There are particular challenges in CYPS, these include:

a) Workforce - Recruitment and retention of social work staff across Children and Young People's Services, in particular the Family Intervention Service, and a rise in young people coming into Care. Further workforce challenges include:

- Management of unallocated cases across Gateway, Family Intervention and Children with Disabilities teams;
- Lack of local specialist practice training courses for paediatric nurses;
- Allied Health Professional (AHP) workforce pressures giving rise to difficulty in securing additionality to address the AHP elective waiting list targets unless the AHP flexible pool is temporarily flexed up to enable recruitment of additional staff in particular paediatric occupational therapists;
- Increasing demand for physiotherapy input for children with acute and long term conditions in acute inpatient settings;
- Lack of paediatricians – both acute and community.

b) Financial - Increased numbers of Looked after Children (LAC) in the Southern Trust has associated budgetary implications of this service, pressure include additional basic costs of placement provision and professional supports in addition to significant increase in legal fees. These challenges have also been reflected in a significant increase in staff associated costs as each Looked After Child has to have an identified statutory social worker. There were 560 LAC @ March 2019;

c) Service 'Need'/ Demand - The number of children on the children protection register is the highest across Northern Ireland and the four nations: 550 @March2019, in addition:

- Increased demand for a wider range of placement options for young people presenting with complex needs;
- Difficulties associated with the access to appropriate care placement, specifically within foster care compounded by the growing shortage of foster carers;
- The increased outpatient demand due to the increased age limit for Acute Paediatric Services i.e. referrals are now accepted for children/ young people aged up to 16 years approximately which is having a significant impact on waiting times and service delivery particularly given the current accommodation challenges in the Newry locality;

- Significant increase in referrals into community paediatric services; and increasing demand for specialist paediatric services i.e. diabetes, epilepsy, respiratory /allergy and continence;
- Continued pressures within Community Children's Nursing Services due to children requiring palliative care, increasing complexity, increasing need for respite provision for children and young people with nursing needs;
- Management of some young people who display complex and challenging behaviours which potentially place others at risk;

d) Community Dentistry

- The increase in age for paediatrics has resulted in increased pressure on dentistry waiting times creating inequity when compared to adult waiting times and further compounded by staff shortages in the team due to maternity absence; and an aging workforce with pending retirements which will result in loss of experience in the dentistry service;
- Increased number of referrals and increasing complexity at all ages creating pressures at every point in the Community Dental Service. Many referrals to clinics require onward referral to general anaesthetic lists for treatment due to medical conditions, disabilities and/ or behaviour problems;
- The lack of a current Departmental Oral Health Strategy is causing a lack of direction. This has resulted in a limited recognition of how the community dental service is struggling to continue to deliver a service with an ever-expanding remit;

e) Child and Adolescent Mental Health Services' (CAMHS)

- The Trusts CAMHS services has continued to experience increasing demand,, over the last seven years with no additional CAMHS Core Funding since 2012. This is recognised by HSCB as an unsustainable position;
- In 2017/18 1579 referrals were accepted compared with 669 referrals being accepted in 2011/12 by Step 3 CAMHS. Similarly Step 2 CAMHS referrals have increased in 2017/18 to 821 compared to 645 in 2011/12.
- CAMHS have responded by adopting and developing new ways of working, and actively contributing to local and regional work.
- Despite these challenges, CAMHS have continued to offer specialist based provisions such as CAMHS Eating Disorder Team, Intellectual Disability (ID) CAMHS, Substance Misuse provision, ADHD provision, and Infant Mental Health iCAMHS, as well as consistent core CAMHS provision in meeting waiting time targets;
- The nature and complexity of emotional and mental health clinical presentations have increased in children and young people, with similar changes in families,

community and society as a whole, which subsequently increase the demand and expectations on services such as CAMHS.

2.2.4 Older People and Primary Care Services

As demonstrated in the Trust's local demography outlined at section 2, the number of older people in the population is increasing year on year. In terms of the Trust Delivery Plan for 2019/20, this manifests in the following key challenges:

- **Demand** - Core teams supporting increasing numbers of individuals with complex conditions, in either their own homes or other community settings, to remain as independent as possible. The Trust requires effective support and workforce planning from the region to enhance the existing core teams and services that are experiencing increasing demands due to demographic and epidemiological changes in the populations we serve.

- **Capacity** - in domiciliary care remains a challenge with unmet need. Instability in the market place is a feature with the Trust having to provide contingency care arrangements on an ongoing basis. A range of recruitment and patient centred approaches are in place within the Trust. Support for implementation of the Regional Domiciliary Care Workforce Report '*A Managed Change'* would be welcomed including fair pay/hourly rates to providers, career pathway development and retention approaches.

- **Workforce –** The Older People and Primary Care Directorate also continues to face significant challenges regarding the appointment of all disciplines of staff, including medical staff, given the limited availability of staff across the region. This affects the delivery of core services such as District nursing, AHPs, GP Out of Hours, Non-Acute Hospitals and Acute Care at Home, and may also impact the implementation of transformation projects.

- **Performance & Governance -** Key performance indicators (KPIs) are also affected including GP Out of Hours, which has been moved from the Directorate to the Corporate Risk Register in 2019/20. The Trust is currently scoping alternative primary care service models with key stakeholders and the Assistant Medical Director Primary Care post will support strategic service change across primary, secondary and community services.
- Compliance with Self Directed Support (SDS) targets is of concern in terms of the uptake levels for some groups including older people. Procurement to facilitate "Managed Care Budgets" and equity of access in line with eligibility criteria for traditional services versus SDS options also needs further consideration by the Commissioner.

- Governance arrangements with the Independent Sector including Domiciliary Care Providers and Care Homes need to be strengthened to assure ourselves of quality care and financial probity. Internal arrangements within the control of the Trust have been strengthened and the care homes transformational projects will impact positively on quality care provision. Further regional action to progress system support such as "Live Monitoring" of domiciliary Care is welcomed.

2.3 Workforce Challenges

2.3.1 Nursing Workforce

'Delivering Care' is a policy framework, commissioned by the Chief Nursing Officer, Department of Health, to support the provision of high quality care which is safe and effective in hospital and community settings. This has been progressed through the development of a series of phases to determine appropriate staff for Nursing and Midwifery workforce in a range of major specialties. To date, the only phase that has received full funding in order to implement the agreed safe staffing level is Phase 1, acute medical and surgical wards. The remaining phases are reliant on the funding to implement and a sufficient supply of Registrants to take up post.

Future Nurse - The Nursing and Midwifery Council (NMC), as the United Kingdom regulator for the professions of nursing and midwifery, undertook a radical review of nurse education standards over the past two years. The new standards for nurse education have been ratified by NMC Council and are due for implementation in Northern Ireland in September 2020. The Trust is working with the three local universities, the Department of Health and the other Trusts, to plan for implementation.

The shortage of Registered Nurses across the UK, and indeed globally, continues to impacts directly on the Trust's ability to replace vacant posts. The Trust welcomes the increase in the number of commissioned student nurse and student midwife places by the Department of Health as one measure of contributing to addressing this shortage.

Actions being taken to address:

- The Trust has developed a co-produced Nursing and Midwifery Workforce plan which focusses on improving the recruitment, retention and utilisation of Nursing and Midwifery workforce. The work on the various strands has commenced in 19/20;

- The Trust continues to progress a range of innovative approaches to recruitment including radio/online/social media campaigns, one-stop recruitment days, local, regional and national recruitment activities;
- Enhanced engagement with local students across the three universities with comprehensive support and preceptorship for all newly qualified staff;
- Engagement on regional forums for international recruitment;
- Increasing pre-registration nursing places via a vocational route for support staff with the Open University, both Adult and Mental Health branches of nursing;
- Increasing capacity across the Trust for student placements;

These actions will contribute in the medium/ longer term but are not expected to impact significantly on front line nursing services in 2019/20.

2.3.2 Allied Health Profession (AHP) Workforce

The Trust is experiencing a shortage of staff qualified in a range of AHP disciplines. This is emanating not only from a limited supply qualifying from our universities each year but also due to the expansion of services through a number of transformation initiatives which have seen new roles for AHPs become available, particularly in community services. The Trust, through the Assistant Director for AHP Governance, Education and Workforce is leading a regional plan to explore recruitment from the rest of the UK and ROI to support needs in Northern Ireland. This plan is currently under development.

2.3.3 Medical Workforce

Regional workforce reviews have identified particular challenges and in particular the Southern Trust continues to work to address the short, medium and long term workforce challenges facing our medical workforce including:

- The sustainability of services across all specialties reflecting the expectations of 7 day working;
- The supply and demand challenges in relation to the Consultant workforce. Whilst we have made progress in a number of specialties, particular challenges continue within Emergency Medicine, General Medicine, Paediatrics and a number of surgical specialties;

- The issues relating to trainee experience and working arrangements including Junior Doctor rota compliance and ensuring that our doctors in training get a rewarding training experience;
- The ability to fund and recruit the planned expansion of the range and volume of support roles to help support our medical workforce, including Medical Assistants, Clinical Co-ordinators, Medical Assistant Practitioners and Prescribing Pharmacists.

The Southern Trust continues to work to analyse and improve recruitment and advertising strategies, with the aim of reaching a wider pool of potential medical staff across the UK and further afield – with a focus on hard-to-fill posts. We continue to engage with the ongoing regional International recruitment campaigns. The Trust now has three Medical Assistant Practitioners (previously known as Physician Associates) and is undertaking further recruitment this year.

There continues to be shortages in the provision of doctors in training to training posts, and there has been significant work undertaken in assessing the relative volumes of training posts provided to the Southern Trust compared to neighbouring Trusts. The Trust will continue to escalate these concerns to the commissioner and other relevant parties as appropriate.

Regional Northern Ireland fill rates for Junior Doctor posts from NIMDTA continue to decrease year on year, and increased challenges from August 2019 are being experienced. The Southern Trust continues to monitor and report on the impact these vacancies have on working patterns and the risks associated with European Working Time and safe working hours.

2.3.4 Workforce Challenges in Other Areas

In addition to medical and nursing vacancies, the Trust continues to face challenges linked to the availability of staff in many other professions, including allied health professionals, social work, clinical psychologists, day care support workers and domiciliary care staffing to support community based services and maintaining individuals in their own homes. Investment in transformation programmes across many services has placed increased pressure on core services, increasing vacancy rates across many clinical and social care professions.

3 Detailed Delivery Plans

The Trust Delivery Plan details how the Trust plans to deliver against each of the service requirements which have been identified for 2019/20 in order to provide assurances around the effectiveness of the Trust's governance arrangements and our plans to strengthen existing arrangements to ensure the transparency and accountability of our performance.

During 2019/20 the Trust will be expected to achieve financial break-even and specifically to deliver on challenging performance targets set out in the commissioning plan. Our plans to achieve this are set out in **Section 4** reflecting a balanced approach to pragmatic, in year actions alongside focused processes to identify the local reforms that will contribute towards securing the recurring financial savings required. In particular: -

- With agreement from the commissioner and the Department of Health, the Trust will continue to re-direct 2015/16 demographic funding intended to support unscheduled care reform to maintaining additional workforce costs into 2019/20 associated with ensuring safe, high quality services at the Emergency Department in Daisy Hill Hospital.
- The Trust will implement further actions to support its USC Resilience plan during 2019/20 in line with available in year funding. Challenges remain in securing temporary appointments to support periods of peak demand and a balanced approach to risk in securing recurrent solutions via demographic funding from 2019/20 on will be required in year.

The Trust has implemented the full range of transformation projects commissioned by the HSCB/DoH through the Confidence and Supply funding including recent agreement to introduce multi-disciplinary teams in partnership with the Newry and District Federation of Family Practices. The Trust will work in partnership with HSCB/DoH to further implement and evaluate outcomes of the transformation programme and/or decommission projects and/or other services in line with affordability and sustainability plans agreed by the HSCB/DoH.

The Trust has a culture of quality improvement and continually strives to build capacity and capability that empowers front line staff to make improvements in how we deliver services. The Trust will continue to encourage this approach to ensure that service reforms aimed at improving care, increasing capacity and improving performance are progressed during 2019/20 with particular emphasis on prioritising our resources to address key service pressures in unscheduled care, addressing workforce shortages and improving elective care access where possible.

The Trust has in place robust monitoring and accountability arrangements for the delivery of targets and implementation of the service improvement and reform priorities.

3.1 Trust Response to DOH Commissioning Plan Direction 2019/20

The Trust will continue to work in partnership with the HSCB, PHA and Southern LCG to deliver improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes and experience as set out within the Commissioning Plan for 2019/20.

The Trust remains committed to seeking to maximise performance against specific Objectives and Goals for Improvement (OGIs) and has agreed trajectories for improvement in identified areas for 2019/20 in line with new performance management arrangements. However, this is set in the context of significant unscheduled care, financial and increasing workforce pressures faced by the HSC which have continued from 2018/19 into this financial year.

The sections below detail the Trust's assessment of its anticipated performance against OGIs however, it should be noted that this assessment of performance is subject to possible change linked to the impact of continued workforce pressures and financial challenges as detailed in Section 4.

3.1.1 Responses to Standards and Targets

The Trust's response to each of the target areas has been assessed as:

- Objective is achievable and affordable (Green)
- Objective is partially achievable/achievable with additional resources (Amber)
- Objective is unlikely to be achievable/affordable (Red)

Summary Assessment of Targets

Of the 71 priorities in the Commissioning Plan Direction 2019/20, 4 are identified as not applicable to the Trust and 11 are regional/multi-agency objectives to which the Trust will contribute. For these regional/multi-agency objectives the Trust has assessed its own contribution and made an assessment of achievability of this.

An overall summary of the Trust's assessment of deliverability of the targets / indicators set for 2019/20 against the RAG status index is provided in the table overleaf.

Table to be updated **Deliverability**	**RAG**	**Position 2019/2020**
Objective is Achievable and Affordable	Green	21 (30%)
Objective is Partially Achievable/Achievable with additional resources	Amber	23 (32%)
Objective is Unlikely to be Achievable/Affordable	Red	12 (16%)
'Multi-Agency Objective' The Trust will be unable to report against the totality of this target as its achievability is reliant on a multi-agency approach. The RAG status provided by the Trust relates only to those actions for which it is responsible for.	W	11 (17%) 6 targets 5 targets 0 targets
Objective is Not a Core Trust Objective	B	4 (5%)
TOTAL		**71 (100%)**

The table overleaf provides a summary overview of the Trust's assessment against each individual OGI. It should be noted that a RAG status has been included for individual elements of each OGI where applicable and these have been considered in informing an overall achievability status to the target.

This section also provides a rationale for the assessment of each OGI based on the current known context at time of writing the TDP.

Summary Assessment of 2019/20 Commissioning Plan Objectives and Goals for Improvement (OGIs)	Green	Amber	Red	W (Multi-Agency Target)	B (Not Applicable/Not Trust objective)
1.1 Tobacco Control				X	
1.2 A Fitter Future for All				X	
1.3 Breastfeeding				X	
1.4 Healthy Places				X	
1.5 Make Every Contact Count				X	
1.6 Children's Oral Health				X	
1.7 Bariatric Service NEW					X
1.8 Healthier Pregnancy Programme				X	
1.9 Healthy Child, Healthy Future				X	
1.10 Family Nurse Partnerships				X	
1.11 Infant Mental Health NEW				X	
1.12 Children in Care 1.12.1 Placement Change 1.12.2 Adoption Time Frame		X			
1.13 Protect Life 2 Strategy		X			
1.14 Substitute Prescribing		X			
1.15 Diabetes Feet Care Pathway	X				
2.1 Delivering Care		X			
2.2 Antibiotic Prescribing 2.2.1 Reduce Prescribing in Primary Care 2.2.2 Reduce Antibiotic Use in Secondary Care 2.2.3 Reduce Carbapenem Use 2.2.4 Reduce Piperacillin-tazobactam Use 2.2.5 Increase Antibiotics from WHO Access Aware		X			
2.3 Gram Negative Bloodstream Infections			X		
2.4 Healthcare Acquired Infections 2.4.1 C Difficile 2.4.2 MRSA		X			
2.5 NEWS	X				
2.6 Falls & Pressure Ulcers NEW	X				
2.7 Medicines Optimisation Model			X		
2.8 Residential homes & Nursing Homes,	X				

failure to comply/notice of decision					
3.1 Same Gender Accommodation	X				
3.2 Children in Care Permanence & Pathway Plans	X				
3.3 Dementia Portal		X			
3.4 Palliative Care		X			
3.5 Co-Production				X	
4.1 GP Appointments		X			
4.2 GP OOHs			X		
4.3 Family & Children's Social Care Cases NEW		X			
4.4 Ambulance Service Category A Calls					X
4.5 Emergency Department 4.5.1 4-Hour Target 4.5.2 12-Hour Target			X		
4.6 ED Triage		X			
4.7 Hip Fractures		X			
4.8 Ischaemic Stroke		X			
4.9 Diagnostic Reporting (Urgents)			X		
4.10 Breast Cancer Referrals 4.10.1 14 day target 4.10.2 31 day target 4.10.3 62 day target		X			
4.11 Outpatient Assessment (Elective) 4.11.1 50% <9weeks 4.11.2 0 patient >52 weeks			X		
4.12 Diagnostic Tests (All Modalities) 4.12.1 75%<9 weeks 4.12.2 0 patient >26 weeks			X		
4.13 Inpatient/daycase treatment (Elective) 4.13.1 55% <13 weeks 4.13.2 0 patient >52 weeks			X		
4.14 Mental Health Services (0 patient >9			X		

weeks) 4.14.1 CAMHs 4.14.2 Adult Mental Health Services 4.14.3 Dementia Services 4.14.4 Psychological Therapies					
5.1 Direct Payments		X			
5.2 Self Directed Support		X			
5.3 AHP Referral			X		
5.4 Swallow Assessment	X				
5.5 Direct Access Physiotherapy		X			
5.6 Children & Young People's Framework	X				
5.7 Discharges 5.7.1 Learning Disability 5.7.2 Mental Health Discharge		X			
6.1 Carer's Assessment		X			
6.2 Community based short breaks hours			X		
6.3 Young carers short breaks	X				
7.1 Community Pharmacy Services					X
7.2 Delegated Statutory Functions					X
7.3 Consultant Led Appointments – Hospital Cancelled		X			
7.4 Elective Care Services – SBA levels			X		
7.5 Discharges 7.5.1 Complex discharges <48hrs (90%) 7.5.2 0 Complex discharge >7 days 7.5.3 simple discharges <6 hours		X			
7.6 Regional Medicines Optimisation Programme	X				
8.1 Single Lead Employer Project **NEW**	X				
8.2 HSC Careers Service	X				
8.3 Domiciliary Care Workforce Review	X				
8.4 HSC Workforce Model	X				

8.5 Audit of Existing Provision – Workforce Strategy	X				
8.6 Flu Vaccine		X			
8.7 Staff Sickness Levels	X				
8.8 Social Work Workforce Review NEW	X				
8.9 Regional Healthier Workplace Network	X				
8.10 Annual Appraisal NEW		X			
8.11 Q2020 Attributes Framework - Level 1 & Level 2 training	X				
8.12 Suicide Awareness Training	X				
8.13 Dysphagia Awareness Training	X				
TOTALS	**21**	**23**	**12**	**11**	**4**

2019/2020 Commissioning Plan Direction forming Interim Objectives and Goals for Improvement for 2019/2020 TRUST

RESPONSE TO DOH COMMISSIONING PLAN DIRECTION (71 MINISTERIAL OUTCOMES)

Aim: To improve the health of the population

Outcome 1: Reduction of health inequalities

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
1.1 Tobacco Control By March 2020, in line with the Department's ten year *"Tobacco Control Strategy"*, to reduce the proportion of 11-16 year old children who smoke to 3%; reduce the proportion of adults who smoke to 15%; and reduce the proportion of pregnant women who smoke to 9%. **Lead Directorate – OPPC**	**Regional Objective** **SHSCT Baseline = in 2018/2019 the Trust delivered Stop Smoking Services to 1155 service users with 61% quit at 4 weeks post quit date.** **(Target was 1,657 people to set a 'Quit Date')** The Trust continues to support the achievement of this Regional objective via on-going smoking cessation services and maintenance of smoke free sites. In 2018/2019 the Trust was unable to meets it set a 'quit date' target of 1,657 people due to long term staff sickness absence and vacancies which have impacted on service delivery. The Trust welcomes the reduction of the stop smoking target by the PHA to 1400, recognising a decline Regionally in the uptake of stop smoking services as the population rate of smoking has declined. Staffing issues have improved with recruitment of a new post holder in Newry. A small reduction in hours in the Midwifery Stop Smoking Service will impact this year due to a maternity leave. The Trust is planning enhanced communications to promote uptake of the Stop Smoking services in line with the Regional PHA Stop Smoking Services marketing campaign. The Trust will continue to provide 'Stop Smoking Clinics' across hospital and community HSC settings and workplaces as requested.	Green

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
	The new post holder in Daisy Hill Hospital is networking across wards to increase uptake of the service at ward level and will also utilise the Health and Wellbeing room for outpatient clinics.	
1.2 A Fitter Future For All By March 2020, to have commissioned an early years obesity prevention programme and rolled out a Regionally consistent Physical Activity Referral Scheme. These programmes form part of the Departmental strategy, A Fitter Future for All, which aims by March 2022, to reduce a level of obesity by 4 percentage points and overweight and obesity by 3 percentage points for adults, and by 3 percentage points and 2 percentage points for children. **Lead Directorate – CYPS**	**Regional Objective** The Trust will support the achievement of this Regional objective and has signed up to the Regional plan which will support the delivery of an early years obesity prevention programme. It is anticipated the first stage of the plan will be put in place later this year with full role out over the next two years. The SHSCT offer Active for Life programme which is offered to all Year 8 children with a weight above the 91st centile, this is a physical activity referral scheme. The Public Health Agency is leading the Physical Activity Referral scheme and work is ongoing to establish referral mechanisms which will be via CCG for primary care. The Trust is able to support this Regional objective.	Green
1.3 Breastfeeding By March 2020, through implementation of the NI Breastfeeding Strategy increase the percentage of infants breastfed at discharge and 6 months as recorded in the Child Health System (CHS). This is an important element in the delivery of the *"Breastfeeding Strategy"* objectives for achievement by March 2025. **Lead Directorate - ASD**	**Regional Objective** **SHSCT Baseline = in 2018/2019 50.5% of babies were breastfed at discharge (improving from 49.2% in 2017/2018) and 16.9% at 6-9 month review (just below the 17.1% achieved in 2017/2018)** The Trust will contribute to the achievement of this Regional objective via its Baby Friendly Strategy. The Trust is fully baby friendly accredited and have had reassessments undertaken this year in one hospital and three community localities. To contribute to achievement of this objective the Trust: • Plans to work towards the Gold Accreditation within the next 2-3 years;	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
	• Continues to promote a range of initiatives; and • An application for funding for a Community Infant Feeding Lead will be submitted to PHA. The Trust will seek to continue to improve the breast feeding rates, however, continues to be challenged with midwifery workforce pressures and capacity with a single infant feeding lead. The UNICEF UK BFI recommends 2 full time Infant Feeding Leads for Trusts with 6,000 deliveries per year and BFI standards recommend breast feeding women have access to specialist advice and support. This is difficult to offer across the Trust with a single Infant Feeding Lead. As such the Trust's contribution will only be partially achieved.	
1.4 Healthy Places By March 2020, establish 3 "Healthy Places" demonstration programmes working with specialist services and partners across community, voluntary and statutory organisations to address local needs. **Lead Directorate – OPPC**	**Regional Objective** The Trust will contribute to the achievement of this Regional objective as requested. Further instruction and detail on what the process will entail is awaited from the Public Health Agency who are leading on a process to identify "Healthy Places" demonstration programmes.	Green
1.5 Make Every Contact Count By March 2020, to ensure appropriate representation and input to the Agency/ Board led Strategic Leadership Group in Primary Care to embed the Make Every Contact Count approach. **Lead Directorate – OPPC**	**Regional Objective** This is a Regional objective to which the Trust will contribute as requested. The Regional Group, chaired by Dr Margaret O'Brien, with representation from HSCB; ICPs; PHA; GP Federations; and the five Trusts represented by the Northern Trust, is currently exploring the use of an e-learning platform in relation to Making Every Contact Count and with also the potential alignment to the "Healthy Places" objective.	Green
1.6 Children's Oral Health By March 2020, to collate survey data to establish a baseline position regarding the mean number of teeth affected by dental decay,	**Regional Objective** The Trust will contribute to the achievement of this Regional objective as requested to establish a baseline of the number of teeth extractions in children aged 3 – 5 years. The Trust has a programme ongoing with pre-school children, which is resulting in lower	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
among 5 year old children, and seek a reduction of 5% against that baseline by March 2021. **Lead Directorate – CYPS**	decay rates by the age of 5. However the ability to improve this further over the next 3 years will be subject to the availability of resources to extend the pre-school programme and will need to take cognisance of the challenges faced with oral health by the BME population in the Trust area. In the Southern Trust, 385 children aged 3-5 had teeth extracted under General Anaesthetic in 2018/2019.	
1.7 Bariatric Service By March 2020, to commence the implementation of a Regional prototype bariatric service, subject to the outcome of public consultation, business case approval and available funding in line with the implementation of recommendations set out in the Departmentally endorsed NICE guidance on weight management services. **Lead Directorate – ASD**	**Regional Objective** This is a Regional objective which the Trust will contribute to if requested in year.	Blue
1.8 Healthier Pregnancy Programme By March 2020, to have further developed, and implemented the *"Healthier Pregnancy"* approach to improve maternal and child health and to seek a reduction in the percentage of babies born at low birth weight for gestation. **Lead Directorate– ASD**	**Regional Objective** This is a Regional objective which the Trust will contribute to via the implementation of the 'Healthier Pregnancy' approach locally. Work initiated in 2017/2018 will continue to be embedded across both Acute hospital sites and also within the Community. Actions in year include: • Provision of additional and continuing training sessions; • Implementation of 'the saving babies lives' bundle to identify women who are at higher risk of having a baby of low birth weight and require serial scans. This objective has been assessed as partially achieved and further work will continue to	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
	embed this objective.	
1.9 Healthy Child, Healthy Future By March 2020, ensure the full delivery of the universal child health promotion programme for Northern Ireland, *"Healthy Child Healthy Future"*. By that date: • The antenatal contact will be delivered to all first time mothers. • 95% of two year old review must be delivered. These activities include the delivery of core contacts by Health Visitors and School Nurses which will enable and support children and young adults to become successful, healthy adults through the promotion of health and wellbeing. **Lead Directorate – CYPS**	**Regional Objective** **SHSCT Baseline 82.5% of two year olds had their assessment completed** The Trust continues to support the achievement of this Regional objective. The Trust continues to seek to improve the percentage of two year olds who have their assessment completed; (85% in 2017/2018) however the local position remains below the objective sought. Priority is also given to first time, or vulnerable mothers for antenatal contact visits. The ability to further improve on this position continues to be challenging due to: • Substantive permanent and temporary vacancies in the Health Visiting Teams; • A reduced number of student SCPHN placements this year; and • A high level of children on the Child Protection Register requiring prioritisation. As such this objective continues to be assessed as only partially achievable.	Amber
1.10 Family Nurse Partnerships By March 2020, ensure the full Regional roll out of Family Nurse Partnerships, ensuring that all teenage mothers have equal access to the family nurse partnership programme. The successful delivery of this objective will directly contribute to PfG Outcome 14 "We give our children and young people the best start in life". **Lead Directorate – CYPS**	**Regional Objective** The Trust supports the achievement of this Regional objective with the referral of all teenage pregnancies, identified by the hospital based service, to the Family Nurse Partnership (FNP) Team. Whilst substantive capacity within teams will only support approximately 50% of those referred, temporary capacity should result in up to 75% of those referred being offered the programme. Additional investment is required to meet this objective fully and sustainably and as such this objective continues to be assessed as only partially achievable.	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
1.11 Infant Mental Health By March 2020 each HSC Trust will have established an Infant Mental Health Group and produced an Action Plan consistent with and informed by the "Infant Mental Health Framework for Northern Ireland" 2016. **Lead Directorate – CYPS**	In line with the Infant Mental Health Framework for Northern Ireland the Trust has undertaken a number of actions to achieve this objective: • The Trust is launching a Southern Area Infant Mental Health Strategy on 29 November 2019 which is consistent with the N.I. Framework 2016; • An Infant Mental Health Group (IMG) is in place; and • A multi- agency action plan will be in place by 31. March 2020. This objective is assessed as achievable.	Green
1.12 Children in Care **1.12.1 Placement Change** By March 2020, the proportion of children in care for 12 months or longer with no placement change is at least 85%; **Lead Directorate – CYPS**	**SHSCT Baseline 2018/2019 = 82%; Baseline 2017/2018 = 78% , 2016/2017 = 78%** Performance in this area has remained relatively static over the last 4 years. Continued increase in the number of new Looked After Children (LAC) admissions continues to place fostering and adoption services under considerable pressure, resulting in increased demand for placements which has impacted on permanence, placement security and stability. There are over 570 children in full time care in the Trust which is more than ever previously recorded and this places considerable pressures on placement options resulting in some inevitable disruptions. The Trust continues to develop placement support services to keep disruption to a minimum including the Residential Support Service, expansion of Intensive Support Foster care provision and increased specialist support via the Scaffold Therapeutic service.	Amber
1.12.2 Adoption Timeframe By March 2020, 90% of children, who are adopted from care, are adopted within a three year time frame (from date of last admission). The aim is to secure earlier permanence for looked after children and offer then greater stability while in care. **Lead Directorate – CYPS**	**SHSCT Baseline 2018/2019 = Not Yet Available ; Baseline 2017/2018 = 68%** There has been a reduction in performance in this area during the 2018/2019 year albeit formal returns are not yet available. During 2018/2019 there have only been 10 children placed for adoption, 3 of whom were older children and in care for a number of years. These 3 cases, which are outside the timeframe, negatively impacted the overall performance. For pre-school age children	Red

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
	Adoption was achieved for 100% of cases within the 36 month timeframe. The Trust continues to closely monitor care planning for children where there is an agreed plan for adoption with the objective of avoiding unnecessary delay. Based on the current level of performance this objective has been assessed as not achievable.	
1.13 Protect Life 2 Strategy By March 2020, to have further enhanced out of hours capacity to de-escalate individuals presenting in social and emotional crisis, including implementation of a Multi-Agency Triage Team pilot (SEHSCT) and two Crisis De-escalation Service pilots (BHSCT and WHSCT) to test different models and approaches. Learning from these pilots should inform the development of crisis intervention services and support the reduction of the suicide rate by 10% by 2022 in line with the draft "*Protect Life 2 Strategy*". **Lead Directorate – MHD**	The Trust continues to provide an out-of-hours service to support de-escalation, between 01:00 and 09:00, based in Craigavon Area Hospital, and providing cover to Daisy Hill Hospital in line with initial investment made for this provision. However, the delivery of this service is challenging due to the geographical spread of the two Emergency Departments. A number of Trust actions are in place and ongoing to seek improvement including: • A proposal for development of an enhanced community health infrastructure was made via transformation funding, however, this has currently not been prioritised; • Ongoing review and revision of protocols to further inform on-going safe and effective provision for this challenging service; and • A Zero-Suicide Co-Ordinator has been appointed and the Trust is part of the Towards Zero Suicide Network. Based on the current provision and the limited opportunity to further enhance this in-year, based on access to resources, the Trust has assessed this objective as only partially achievable.	Amber
1.14 Substitute Prescribing By March 2020, to have advanced the implementation of revised substitute prescribing services in Northern Ireland, ncluding further exploration of models which are not based in secondary care, to reduce waiting times and improve access. This is an important element in the delivery of the strategy to reduce alcohol	Within existing resources the Trust is working with one GP practice to support GP prescribing of Methadone; Subutex; and Suboxone on a pilot basis within the Newry & Mourne locality. This initial work will seek to engage Primary Care and support them in the management of substitute prescribing. Achievement of this objective would require additional resources in secondary care to support GPs in Primary Care to manage substitute prescribing with a view to detox of specific patients and as such is subject to availability of resources.	Amber

COMMISSIONING PLAN DIRECTION OUTCOM	PROVIDER RESPONSE	RAG
and drug relation harm and to reduce drug related deaths. **Lead Directorate – MHD**	Constraints include the inclusion of Codeine dependent clients in the new guidance, which to date, has not been part of the service offered or commissioned. Further the lack of training for GPs to RCGP 2 Level in Opiate Substitute Prescribing will be a key constraint in the achievement of this objective. The Trust will participate in a Regional Review of Addiction and Opiate Substitute Workshop planned for October 2019. Whilst the ability to achieve this objective is challenging the Trust is undertaking a review of the Addictions service to consider the current resources against the demand, and ensure optimisation of the current resource. This objective has been assessed as only partially achievable due to the limited scale of the current provision.	
1.15 Diabetes Feet Care Pathway By July 2020, to provide detailed implementation plans (to include recruitment status) for the Regional implementation of the diabetes foot care pathway, plans should demonstrate an integrated approach making best use of all providers. Regional deployment of the care pathway will be an important milestone in the delivery of the "*Diabetes Strategic Framework*".**Lead Directorate – OPPC**	All staff have been recruited and are in post. Progress has been made across each tier of the pathway to standardise podiatry care in line with NICE Guidance and the Regional Integrated Diabetes Foot Pathway. Foot Protection Team (FPT) and Enhanced Foot Protection Team (EFPT) are in place and local pathways are being enhanced to ensure smooth and timely patient flow in Trust and to the Multi-Disciplinary Foot Team. Training of Podiatry Assistants has commenced to provide additional resource to maintain the Tier 1 screening model. This objective is assessed as achievable.	Green

Aim: To improve the quality and experience of health and social care

Outcome 2: People using health and social care services are safe from avoidable harm

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
2.1 Delivering Care By March 2020 all HSC Trusts should ensure safe and sustainable nurse staffing, including working towards the full implementation of phases 2, 3 and 4 of Delivering Care, maximising the use of any current or new funding, with an annual report submitted to HSC Trust Boards. **Lead Director - EDN**	The Trust is unable to achieve the full implementation this objective. Full recurrent funding has not been received for phases 2, 3 and 4 of Delivering Care, which is compounded by the challenges related to ability to attract and secure available workforce related to supply and the presenting demand from new transformational investments. Whilst the position is challenging the Trust continues to take a number of actions to ensure safe levels of nursing staff including ongoing use of bank and agency staff; proactive local, national and international recruitment strategies and use of skill mix and recruitment to bands of staff where staff can be secured as appropriate The Trust continues to monitor the normative levels and has recently submitted its biannual return.	Amber
2.2 Antibiotic Prescribing **2.2.1 Reducing Prescribing in Primary Care** By 31 March 2020: • Ensure that total antibiotic prescribing in primary care, measured in items per STAR-PU, is reduced by a further 3%, as per the established recurring annual targets, taking 2018/2019 as the baseline figure **Lead Directorate – OPPC**	**Not Applicable** This target relates to primary care prescribing. In relation to Bannview Practice, whilst no specific target has been identified for the practice, the Trust will work alongside commissioning colleagues to support this improvement in principle.	Blue
2.2.2 Reduce Antibiotic Use in Secondary Care Using 2018/2019 as the baseline, by	**SHSCT Baseline - Cumulative period April 2018- March 2019 = 10,224 DDD/1000 admissions (**+509 (+5%) DDD/1000 above OGI, 9,715) In 2018/2019 a baseline was established and staffing established with a third consultant	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
March 2020 Trusts should secure the following in secondary care: • a reduction in total antibiotic prescribing(DDD per 1000 admissions) of 1-2%; **Lead Director – Medical Director**	microbiologist appointed and funding approved for a fourth. In addition 4.6 wte pharmacists were appointed in February 2019 with remit for Stewardship and OPAT. Actions ongoing to seek improvement include: • Review of all antibiotic guidelines and migration onto one platform and micro guide smartphone app, with recommendations on duration of therapies; • Ad hoc awareness and induction sessions antimicrobial stewardship delivered by operational team; • Pharmacist lead antimicrobial stewardship ward rounds monthly on each ward, with feedback to medical, pharmacy and nursing staff; and • Restriction on carbapenem prescribing. Not available as ward stock and all patients prescribed a carbapenem are reviewed with a view to limiting duration of therapy or switching to an alternative agent. In year the Trust aims to develop a formal face to face and e-learning educational programme for medical, nursing and pharmacy staff. To improve accountability targets will be devolved to Associate Medical Directors. Based on the range of actions in place to seek improvement the Trust has assessed this objective as partially achievable.	
2.2.3 Reduce Carbapenum Use Using 2018/2019 as the baseline, by March 2020 Trusts should secure the following in secondary care: • a reduction in carbapenem use of 3%, measured in DDD per 1000 admissions; **Lead Directorate –**	**SHSCT Baseline - Cumulative period of April 2018 – March 2019 = 138 DDD/1000 admissions.** (+28 (+25%) DDD/1000 above OGI, 110) In 2018/2019 staffing was established with a third Consultant Microbiologist appointed and funding approved for a fourth. In addition 4.6 WTE pharmacists were appointed in February 2019 with remit for stewardship and OPAT. Actions ongoing to seek improvement include: • Review of all antibiotic guidelines and migration onto one platform and micro guide smartphone app, with recommendations on duration of therapies.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Medical Director	• Ad hoc awareness and induction sessions antimicrobial stewardship delivered by operational team. • Pharmacist lead antimicrobial stewardship ward rounds monthly on each ward, with feedback to medical, pharmacy and nursing staff. • Restriction on carbapenem prescribing. Not available as ward stock and all patients prescribed a carbapenem are reviewed with a view to limiting duration of therapy or switching to an alternative agent. In year the Trusts aims to develop a formal face to face and e-learning educational programme for medical, nursing and pharmacy staff. To improve accountability targets will be devolved to Associate Medical Directors.	
2.2.4 Reduce Piperacillin Use in Secondary Care Using 2018/2019 as the baseline, by March 2020 Trusts should secure the following in secondary care: • a reduction in piperacillin-tazobactam use of 3%, measured in DDD per 1000 admissions **Lead Directorate – Medical Director**	**SHSCT Baseline - Cumulative period of April 2018 – March 2019 = 353 DDD/1000 admissions.** (19 (-5%) DDD/1000 less than OGI, 372) In 2018/2019 staffing was established with a third Consultant Microbiologist appointed and funding approved for a fourth. In addition 4.6 WTE pharmacists were appointed in February 2019 with remit for stewardship and OPAT. Actions ongoing to seek improvement include: • Review of all antibiotic guidelines and migration onto one platform and micro guide smartphone app, with recommendations on duration of therapies. Antibiotic policies where piperacillin/tazobactam is recommended are being reviewed with a view to switching to an alternative agent from the WHO ACCESS category; • Ad hoc awareness and induction sessions antimicrobial stewardship delivered by operational team; and • Pharmacist lead antimicrobial stewardship ward rounds monthly on each ward, with feedback to medical, pharmacy and nursing staff. In year the Trusts aims to develop a formal face to face and e-learning educational programme for medical, nursing and pharmacy staff. To improve accountability targets will be devolved to Associate	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	Medical Directors.	
2.2.5 Increase Antibiotics from WHO Access Aware Using 2018/2019 as the baseline, by March 2020 Trusts should secure the following in secondary care: EITHER • **that at least 55% of antibiotic consumption (as measured in DDD per 1000 admissions) should be antibiotics from the WHO Access AWaRe* category,** OR • an increase in 2% in use of antibiotics from the WHO Access AWaRe* category, as a proportion of all antibiotic use with the aim of reducing total antibiotic prescribing (DDD per 1000 population) by 15% by 31 March 2021. **For the purposes of the WHO Access AWaRe targets, TB drugs are excluded.*	**SHSCT Baseline - Cumulative Period April 2018- March 2019 = 61.4%** In 2018/2019 staffing was established with a third Consultant Microbiologist appointed and funding approved for a fourth. In addition 4.6 wte pharmacists were appointed in February 2019 with remit for stewardship and OPAT. Actions ongoing to seek improvement include: • Review of all antibiotic guidelines and migration onto one platform and micro guide smartphone app, with recommendations on duration of therapies; • Ad hoc awareness and induction sessions antimicrobial stewardship delivered by operational team; • Pharmacist lead antimicrobial stewardship ward rounds monthly on each ward, with feedback to medical, pharmacy and nursing staff; and • The Antibiotic Review Kit (ARK) research study commenced in March 2019 across 30 trusts in the UK, including the Southern Trust. This aims to improve the review and stopping of unnecessary antibiotics by introducing changes to the acute medicine kardex. In year the Trusts aims to develop a formal face to face and e-learning educational programme for medical, nursing and pharmacy staff. To improve accountability targets will be devolved to Associate Medical Directors.	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Directorate – Medical Director		
2.3 Reduce Gram Negative Bloodstream Infections By 31 March 2020 secure an aggregate reduction of 17% of *Escherichia coli, Klebsiella spp. And Pseudomonas aeruginosa* bloodstream infections acquired after two days of hospital admission, compared to 2018/2019. SHSCT Target – 58 Pending formal communication **Lead Directorate – Medical Director**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 65 cases (7 higher than OGI of 58 cases).** In 2018/2019 the Trust was unable to achieve the objective sought. There have been 19 reported cases this year to June 2019 which is above the apportioned target already. A series of audits are being undertaken to identify evidence base to develop a robust action plan for implementation. Preliminary results from a prospective audit looking at Gram negative bacteraemias occurring 48-hours after admission have indicated that a proportion are preventable. A robust action plan has been developed to support the reduction of gram negative bacteraemia, however the 17% reduction will remain challenging. Based on the performance in 218/2019 and performance in year to date this is assessed as not achievable.	Red
2.4 Healthcare Acquired Infections **2.4.1 C Difficile** In the year to March 2020 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of *Clostridium difficile* infection in patients aged 2 years and over compared to 2018/2019.	**SHSCT Baseline - Cumulative period of April 2018 to March 2019 = 45 cases (-10% lower (5 cases) than OGI)** The Trust continues to work towards low incidence of C Difficile against a background of increasing complex clinical needs and an ageing population and achieved an improved position in 2018/2019. However, year to date (July 2019) there has been 22 incidents recorded compared to 11 in the same period last year. The Trust will seek to work to not exceeding a target of 50 in year. There is a CDI trigger system to alert staff to wards with two CDI cases within 30 days, which triggers enhanced IPC and antibiotic stewardship monitoring to provide assurance of sustained good clinical practice and prevent further transmission. Antimicrobial Stewardship Ward Rounds are in place to	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
SHSCT Target – 5 Pending formal communication **Lead Directorate – Medical Director**	identify inappropriate antibiotic use. There is a plan to consider reduction in PIR for CDI in order to better target resources into a multidisciplinary input earlier on in the patient's care journey. Phased implementation plan in January 2020.	
2.4.2 MRSA In the year to March 2020 the Public Health Agency and the Trusts should secure an aggregate reduction of 19% in the total number of in-patient episodes of Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection compared to 2018/2019. SHSCT Target – 50 Pending formal communication **Lead Directorate – Medical Director**	**SHSCT Baseline - Cumulative period of April 2018 to March 2019 = 3 cases (-40% lower (2 cases) than OGI)** The Trust will seek to maintain the low level of incidences of infection reported over the last few years. The Trust continues with its systems and processes to minimise MRSA bloodstream infections and has a range of actions ongoing linked to its infection control strategy. Based on not exceeding a holding target of 5 infections the Trust has assessed this objective as achievable.	Green
2.5 NEWS Throughout 2019/20 all clinical care teams should comprehensively scale and spread the implementation the NEWS KPI, and ensure effective and robust monitoring through clinical audit and ensure timely action is taken to respond to any signs of deterioration.	National Early Warning Score (NEWS) KPIs are in place as required in all inpatient areas and this indicator is part of a range of key performance indicators which the Trust assesses monthly as part of its nursing and quality assurance processes. Robust auditing and reporting is undertaken by senior nurses and reviewed operationally with action plans developed and implemented addressing any weaknesses identified. Some challenges remain with robust record keeping around escalation. Additional training is being provided to improve compliance with this indicator. Information is also presented at the Trust Governance Committee for assurance.	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Directorate – EDN		
2.6 Falls and Pressure Ulcers By March 2020, achieve full implementation of revised Regional standards, operational definitions and reporting schedules for falls and pressure ulcers across all adult inpatient areas. **Lead Directorate - EDN**	This is a Regional objective to which the Trust will contribute. The Trust has participated in Regional work to review and Regionally agree standardised operational definitions and reporting schedules for falls and pressure ulcers. The Trust is auditing and reporting on the Regionally agreed standards and operational definitions relating to Falls and Pressure Ulcers in relevant areas. These are also reported at Trust Governance committee and in operational areas.	Green
2.7 Medicines Optimisation Model By March 2020, all Trusts must demonstrate 70% compliance with the Regional Medicines Optimisation Model against the baseline established at March 2016 and the HSC Board must have established baseline compliance for community pharmacy and general practice. Reports to be provided every six months through the Medicines Optimisation Steering Group. **Lead Directorate – ASD**	**SHSCT Baseline = The compliance assessment completed in May 2019 showed compliance of 46%.** The ability to achieve this objective is resource dependent and whilst the Trust has improved its baseline it is unable to achieve full compliance due to the current level of funded capacity. Trust challenges relate specifically to the administration of medicines including the ability of patients to be able to administer their own medicines where appropriate and the development of a clinical management plan, within 24 hours of admission, which includes discharge planning to help prevent delays on discharge. The Trust will continue to seek to improve this position and report six monthly, however, gains are not anticipated to be significant in year. As such the Trust has assessed this objective as not achievable.	Red
2.8 Residential Homes & Nursing Homes, failure to	The achievement of this objective will require a multi-sectoral approach to which the Trust will contribute as part of its duty of care. The application of The Registration and Quality Improvement	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
comply/notice of decision During 2019/20 the HSC, through the application of care standards, should continue to seek improvements in the delivery of residential and nursing care and ensure a reduction in the number of (i) residential homes, (ii) nursing homes, inspected that (a) receive a failure to comply, and (b) subsequently attract a notice of decision, as published by RQIA. **Lead Directorate - OPPC**	Authority's (RQIA) Minimum Care Standards form part of the Regional residential and nursing home contract which the Trust has in place with all residential and nursing homes that it contracts with. The Trust has processes in place for its statutory residential care homes to ensure compliance with contract terms and departmental standards. The Trust continues to support the delivery of quality care in residential and nursing homes as part of its duty of care and has a range of governance arrangements in place. In 2019/2020 the Trust will review and refresh these governance arrangements encompassing any learning from both the COPNI and Independent Review team findings into the COPNI report Home Truths. The Trust will continue to seek improvement in care standards and take action, as appropriate on any issues highlighted by RQIA. RQIA has responsibility for regulation and inspection and for issuing failure to comply notices as part of its remit.	

Outcome 3: Improve the quality of the healthcare experience

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
3.1 Same Gender Accommodation By March 2020, all patients in adult inpatient areas should be cared for in same gender accommodation, except in cases when that would not be appropriate for reasons of clinical need including timely access to treatment. **Lead Directorate – EDN/ASD/OPPC/MHD/ MD/EDN**	Established guidelines and processes are in place within the Trust to manage patients that are cared for in mixed gender ward environments where the ward infrastructure does not permit single sex or all single room accommodation. Within a mixed gender ward environment same sex patients will be managed in designated single sex 'bays' and single sex 'double side rooms'. There are a number of areas within the Trust that this is not appropriate/achievable due to the patient's clinical need, including for example intensive care environments. Whilst patients are managed in same gender bays, infrastructural issues can prove challenging regarding bathrooms/toilets. These issues cannot be fully resolved until the site-wide redevelopments are undertaken/completed. In-year an audit was undertaken which showed good compliance with same sex accommodation. Mixed gender accommodation events are classified as Never Events and as such an adverse incident will be submitted via Datix should this occur. No incidents were recorded for inpatients in 2018/2019.	Green
3.2 Children in Care Permanence & Pathway Plans During 2019/20 the HSC should ensure that care, permanence and pathway plans for children and young people in or leaving care (where appropriate) take account of the views, wishes and feelings of children and young people. **Lead Director – CYPS**	The Trust continues to work specifically with children and young people to ensure that, in line with age and understanding, that they are fully involved and consulted with in relation to their respective care plans. The Trust has two active Looked After Children service user groups which assist in enabling young people to influence decisions. Trust Board has also adopted a 'LAC Pledge' to seek to discuss issues of relevance with care experienced young people.	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
3.3 Dementia Portal By September 2019, patients in all Trusts should have access to the Dementia portal. **Lead Director – MHD**	The Trust continues to participate in the Patient Portal pilot which started in June 2018. The vision is that the Patient Portal will allow patients diagnosed with dementia to access their appointments on-line along with a range of other resources, once agreed. Phase 2 of the pilot has commenced in July/August 2019. The first phase of this pilot has now completed. The SHSCT 4 Dementia navigators who are funded by the Trust engaged in the pilot. A number of issues have been identified during the pilot which have limited the ability of SHSCT to fully implement use of the portal: • The rural location of some SHSCT service users limits access to the portal due to lack of internet connectivity; • Some service users do not have access to or are unable to use the technology required to use the portal and some do not have an e-mail address; and • Portal users are required to give informed consent and service users identified were unable to provide this due to their advanced dementia. Recruitment has been problematic. To date no service user has successfully engaged in the pilot due to the above challenges. The Trust continues to work towards implementation and will continue to contribute Regionally to development and implementation of the Dementia Portal.	Amber
3.4 Palliative Care By March 2020, to have arrangements in place to identify individuals with palliative and end of life care needs, both in acute and primary settings, which will then support people to be cared for in their preferred place of care and in the manner best suited to meet their needs. **Lead Directorate -**	The achievement of this objective will require input from multiple partners and requires direction from the Regional Palliative Care Programme Board. Two GP practices within the Southern Trust area are participating in a Regional pilot on early identification of patients in last year of life, this pilot funded through PHA has added capacity to district nursing to allow attendance at palliative meetings in these two GP practices and to co-ordinate care with other teams as a result of the care planning decisions made in these discussions. Bannview GP practice continues to work on the delivery of practice based palliative care meetings, these multidisciplinary meeting attended by community nurses aim to identify those in the last year of life and co-ordinate care in response to presenting need. The Community Specialist Palliative Care service have developed a resource folder containing	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
OPPC/ASD	identification tools and care pathways which will support staff in the early identification of those in the last year of life and guidance on end of life care. These resource folders are available to staff working in in-patient wards, community teams and GP practices. The Trust are currently undertaking an option appraisal to consider the feasibility of developing a Palliative Care Register using PARIS , this register could be used by all services who manage electronic patient records using the PARIS system. Whilst the Trust continues with advanced care planning; DNAR; and training/education there are concerns from Clinicians around the identification and engagement of patients who may be in their last year of life. The Trust will work with Clinicians to seek to improve identification of appropriate patients. The Trust is also participating in the Regional end of life care national benchmarking exercise in year.	
3.5 Co-Production By March 2020, the HSC should ensure that the Regional Co-Production Guidance has been progressively implemented and embedded across all programmes of care, including integrating PPI, Co-Production, and patient experience into a single organisational plan. **Lead Directorate - OPPC/EDN**	**Regional Objective** The Trust is committed to the implementation and embedding of the Regional Co-Production guidance across all programmes of care. The Trust will evaluate the process and the impact of the Confidence and Supply Transformation non-recurrent funding allocated to the Southern Trust in 2018/2019 to progress Partnership Working Infrastructure. The Trust will link closely with the Public Health Agency to determine the strategic direction for and local implementation of Citizen's Hubs as defined by DoH. The Trust's Patient Client Committee and Steering Group will continue to ensure that the integration of PPI, Co-production and patient experience remains a strategic and operational priority and work to ensure a single joint plan.	Green

Outcome 4: Health and social care services are centred on helping to maintain or improve the quality of life of people who use them

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
4.1 GP Appointments By March 2020, to increase the number of available appointments in GP practices compared to 2018/2019. **Lead Directorate - OPPC**	**SHSCT Baseline = 15,258 appointments in 2018/2019 made available in Bannview Practice reflecting a small increase on the 2017/21018 position** Whist Bannview sustained and slightly improved the position regarding available appointments in 2018/2019 sustainability continues to be challenging. Capacity during 2018/2019 was impacted by staff planned and unplanned absences and resignations. Recent centralised midwife capacity, in addition to loss of staff capacity due to absence and staff turnover will continue to impact on the number of available appointments. Whilst the practice will work to sustain the position this objective has been assessed as only partially achievable.	Amber
4.2 GP OOHs By March 2020, to have 95% of acute/urgent calls to GP OOH triaged within 20 minutes. **Lead Directorate- OPPC**	**SHSCT Baseline 2018/2019 = 84.3% of urgent calls triaged within 20 minutes** The Trust continues to be challenged to provide full cover in GP Out of Hours despite a range of on-going initiatives and this has impacted on the performance achieved. As with previous years, this target will be very difficult to obtain, due to the increase in the number of vacant GP shifts impacted by supply. The Trust has taken a number of actions to secure the out of hours cover arrangements with enhancement of rotas via skill mix and use of nurses and pharmacists. The Trust will seek to continue to explore alternative options for delivery of the out of hours service. This target is not achievable.	Red
4.3 Family & Children's Social Care Cases By March 2020, reduce the number of unallocated family and children's social care	**SHSCT baseline @ March 2019 = 71 unallocated child care cases, peaking at 104 in December 2019** The ability to reduce the number of unallocated family and children's social care cases is related to demand and capacity of social work teams. Capacity in teams has been impacted by absence and vacancy. In 2019/2020 demography funding has been	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
cases by 20%. **Lead Directorate - CYPS**	identified for Children with Disability teams and recruitment is ongoing to fill vacancies in both the Family Intervention Service and Children With Disability Teams. The Trust anticipates that a 20% improvement via reduction in allocation cases can only be achieved if vacancies are filled and maintained. As such this objective is assessed as only partially achievable.	
4.4 Ambulance Service Category A Calls Until the proposed adoption of a new clinical response model, when 72.5% of Category A (life threatening) calls should be responded to within 8 minutes, 67.5% in performance is maintained at the previous target level. **Lead Director – N/A**	**Not applicable to SHSCT: Northern Ireland Ambulance Service Objective**	Blue
4.5 Emergency Department **4.5.1 4-Hour Target** By March 2020, 95% of patients attending any type 1, 2 or 3 emergency department are either treated and discharged home, or admitted, within four hours of their arrival in the department; **Lead Directorate-**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 68.9%** Performance continues to be challenging in the context of total inpatient hospital demands impacting on flow and ED performance for those admitted and those not admitted. A SPEED project focusing on actions that can be taken within the Emergency Department which will positively impact on patient care and the 4 hr target has been commenced. This is led by the Clinical Director supported by the Head of Service and Lead Nurse who will involve key stakeholders from across the Acute, OPPC, CYP and Mental Health Directorates. Actions include: • Refocus on nurse triage to ensure appropriate levels of staffing in place at peak times for patient safety; • Back to basics approach with timelines for assessment and decision making by senior staff;	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
ASD	• Creation of additional bed capacity over the winter period, to alleviate exit blocks in ED subject to the ability to secure additional staffing to enable this; and • Clear arrangements for management of 'Surge' and 'Full capacity' escalation arrangements. Whilst the Trust does not anticipate achievement of this objective it is working towards the achievement of the performance improvement trajectory, which has been submitted to HSCB, estimated at 69.7%, ie. just over 125,000 patients seen and admitted or discharged within 4 hours this year. The Trust continues to review ED quality indicators to ensure improvement in the quality of care.	
4.5.2 12-Hour Target By March 2020, no patient attending any emergency department should wait longer than 12 hours. **Lead Directorate – ASD**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 6,083** Whilst the Trust has undertaken a significant amount of work, through the Unscheduled Care Plan, to ensure safe and quality care of patients challenges remain, the ability to improve performance against this objective requires a whole system approach and is challenged associated with Specialty medical workforce levels; low level of bed tolerance; 7-day working; nursing workforce; and reliance on other Directorates' input including paediatric assessment; mental health assessment; and non-acute/community input. A SPEED project focusing on actions that can be taken within the Emergency Department, which will positively impact on patient care and the 12 hr target, has been commenced. This is led by the Clinical Director supported by the Head of Service and Lead Nurse who will involve key stakeholders from across the Acute, OPPC, CYP and Mental Health. Actions include: • Continued use of Acute Care At Home and Frailty Assessment Unit as alternatives to hospital admission; • Continued use of DAU in Daisy Hill as an alternative to admission; • Effective use of the Control Room, to enhance patient flow as identified in the Operational Unscheduled Care Plan; • Use and adherence to the Trust escalation plan; • Effective discharge and optimisation of discharge lounges and discharge to assess models of care; • Creation of additional bed capacity over the winter period, however this remains subject to the ability to secure additional staffing to enable this; and	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	• Pilot of pharmacy support to Emergency Department to enhance medicine management for those being admitted. The Trust continues to review ED quality indicators to ensure improvement in the quality of care.	
4.6 ED Triage By March 2020, at least 80% of patients to have commenced treatment, following triage, within 2 hours. **Lead Directorate – ASD**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 74.4%; 63.6 % CAH, 75.4% DHH and 100% STH** At site level, STH was the only site to achieve the target in 2018/2019 with a cumulative performance of 100%. CAH and DHH Emergency Departments failed to meet the 80% target and experienced a drop in performance compared to 2017/2018 levels. This objective was more challenging in 2018/2019 set in the context of increased attendances across all Trust Emergency Departments. Trust actions to seek improvement at an individual site level and corporately include: • Appointment of clinical fellows to support and develop junior medical staff/ training to enhance decision making and improve flow in the ED area; • Refresh and review of ED flow with departmental challenge events; and • Creation of additional bed capacity over the winter period, to free up space for new patients to be assessed within 2 hours of arrival, subject to the ability to secure additional staffing to enable this. The SPEED Project will, as part of the focus on the 4 hour performance standard, include commencement of treatment within 2 hours following triage and whilst the Trust will seek to improve this position the objective is assessed as partially achievable.	Amber
4.7 Hip Fractures By March 2020, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures.	**SHSCT Baseline 2018/2019 = 92.3% of patients waiting no longer than 48 hours (29 patients waited longer than 48 hours)** During 2018/2019 29 patients waited longer than 48-hours for their hip treatment which reflected an improved position compared to 2017/18 (40 patients). Challenges however continue to prevail and the Trust has projected a less favourable position for 2019/2020, anticipated at 92%. Challenges relate to:	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Director – ASD	• A general increase in demand for inpatient trauma (all conditions) which challenges the ability to manage hip fractures within 48 hours; and • The ability to provide 7 day access to surgical services due to commissioned capacity. Patients continue to be prioritised for surgery related to clinical need and the Trust continues to work with the HSCB to secure additional investment for resources and infrastructure to facilitate increased capacity. This objective has been assessed as only partially achievable.	
4.8 Ischaemic Stroke By March 2020, ensure that at least 16% of patients with confirmed ischaemic stroke receive thrombolysis treatment, where clinically appropriate. **Lead Director – ASD**	**SHSCT Baseline - Cumulative period April 2018 to January 2019 = 15.7%** Whilst this objective has a fixed achievement level, clinical decision making ultimately determines when the thrombolysis drug can be delivered to individual patients. Performance, therefore, will continue to be affected by the variable presentation of strokes and clinical decisions which consider clinical risks and benefits and whilst the objective was achieved cumulatively in year this is not a guaranteed position. As such this objective has been assessed as only partially achievable. All presentations of stroke are reviewed monthly and a stroke lysis bed and assessment bed are protected where possible on the CAH and DHH site. A stroke collaborative patient safety dashboard is in place and all aspects of stroke performance are reviewed monthly. Actions to improve the broader qualitative aspects of stroke include: • A Trust stroke working group to identify areas of improvement; • Focus on improvement of the component parts of the SNAPP (national stroke audit); • Interface with the Emergency Department to improve the early identification of stroke cases; and • A stroke collaborative patient safety dashboard is in place and all aspects of stroke performance are reviewed monthly. Acute and Rehabilitative stroke provision is carried out on 4 hospital sites which presents a challenge in the provision of medical workforce. The Trust in year will also consider how best to support the medical workforce in this area.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
4.9 Diagnostic Reporting (Urgents) By March 2020, all urgent diagnostic tests should be reported on within two days. **Lead Directorate – ASD**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 82.9%; 2017/2018 =81.4%** During 2018/2019, the Trust improved performance slightly from the 2017/18 position with 81.9% of Imaging and 94.7% of Non-Imaging Urgent Diagnostic Tests reported within 2 days. **Imaging** – the Trust continues to be challenged to improve performance against this objective associated with a Radiology vacancy rate of c 30% impacting on reporting and reduced uptake of additional clinical sessions. In parallel the Trust continues to appoint patients for diagnostics based on clinical need and therefore, patients may be appointed Friday/Saturday with no formal reporting sessions available within the required timeframes. Actions to improve performance include: • Review of opportunities to increase workforce, including skill mix; and • Ongoing utilisation of external reporting contracts in the independent sector. **Physiological Measurement** – the Trust continues to be challenged to improve performance against this objective, particularly in cardiac investigations which is the largest area. Whilst additional investment has been made by the Commissioner the requirement for validation of reports by senior staff and ongoing recruitment/retention challenges of these senior staff has impeded improvement. In year the Trust will continue to seek to recruit necessary skilled staff. Based on these challenges the Trust continues to assess this objective as not achievable.	Red
4.10 Breast Cancer Referrals **4.10.1 14 Day Target** During 2019/20, all urgent suspected breast cancer referrals should be seen within 14 days **Lead Directorate –**	**SHSCT Baseline 2018/2019 = 99.4% of patients seen within 14 days (19 patients waited longer than 14 days)** The position in 2018/2019 reflected a significant improvement from 2017/2018. This improvement is predominately associated with increased capacity, funded non recurrently, undertaken by the substantive work force. This improvement is set in the context of increasing demand with overall referrals for Breast Assessment increased by +27% (+655) during 2018/2019.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
ASD	Despite this improvement at March 2019, 491 patients remained on the waiting list waiting for routine assessment, with patients waiting up to 40-weeks. Whilst the Trust anticipated substantial achievement of the target for red flag/urgent referrals to be seen within 14 days the challenge to provide a timely service for routine patients remains.	
4.10.2 31 Day Target During 2019/20, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat. **Lead Directorate – ASD**	**SHSCT Baseline 2018/2019 = 99.5% of patients diagnosed received first definitive treatment within 31 days (7 patients waited longer)** The Trust continues to perform strongly against this objective. It is anticipated that performance will remain fairly strong for 2019/20, subject to demand and the Trust's trajectory for 2019/20 reflects this. Performance against cancer services objectives is set in the context of increasing demand for assessment. The Trust's trajectory for 2019/2020 estimates achievement of 100%.	Green
4.10.3 62 Day Target During 2019/20, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days. **Lead Directorate – ASD**	**SHSCT Baseline 2018/2019 = 74.4% of patients referred received first definitive treatment within 62 days** Ongoing increase in red flag referrals across multiple tumour sites continues, leading to pressures throughout pathways with 1st appointment, investigation and diagnostics and surgery. In particular Urology, Upper Gastroenterology, Lower Gastroenterology, Gynaecology and Haematology . This increasing demand is set in the context of reduced additional capacity for red flag assessment in 2019/2020 due to inability to secure clinical sessions at the same level as 2018/2019. 2019/2020 cancer trajectory has been submitted to HSCB highlighting these concerns and projecting a decreasing performance against target. The Trust's trajectory for 2019/2020 estimates achievement of 51.7%. NICAN groups continue to meet to review site specific pathways and make recommendations for any changes.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
4.11 Outpatient Assessment (Elective) **4.11.1 50% <9 weeks** By March 2020, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment **Lead Director - ASD**	**SHSCT Baseline at 31 March 2019 = March 2019 = 29.9% less than 9 weeks.** Demand for elective care services continues to exceed health service capacity seeing wait times increase for those waiting for their first new patient outpatient assessment. At the end of March 2019, the number of patients waiting over 9-weeks increased by +3065 (+11%) from March 2018. Further the total volume of patients on the entire wait list also increased by 6%. Sustainable improvement will not be demonstrated without recurrent investment for capacity gaps and non-recurrent backlog clearance in parallel. To manage risk the Trust continues to: • Direct capacity to red flag/urgent referrals in the first instance with non-recurrent additionality; • Seek to optimise available core capacity to achieve delivery of agreed performance trajectories; • Utilise non recurrent funding as available in year, from HSCB and Confidence and Supply, to deliver additional activity to benefit patients targeted at reducing both red flag and urgent waits in the first instance albeit the levels of clinical capacity available in year is reduced due to lack of clinical uptake; and • Explore options to increase communication with patients on waiting lists, and to ensure lists are valid and robust. Reform of services, as set out in the Department of Health's Elective Care Plan, will be required to see longer-term gains. The Trust continues to monitor those patients waiting beyond clinically indicated timescale for clinical review and is developing an action plan to manage emergent risk and seek improvements in the management of patients awaiting review. The Trust is unable to achieve the objective.	Red
4.11.2 0upatients waiting >52 weeks By March 2020, no patient waits longer than 52 weeks.	**SHSCT Baseline @ 31 March 2019 = 8,514 waiting greater than 52-weeks; longest wait is 167 weeks.** At the end of March 2019, 19.5% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. This position continues to steadily increase.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Director - ASD	Of those waiting over 52-weeks, 80% are in Neurology, Urology, General Surgery and Orthopaedics specialties. For the reasons identified in 4.11.1 above this objective is not achievable.	
4.12 Diagnostic Tests (All Modalities) 4.12.1 By March 2020, 75% of patients should wait no longer than 9 weeks for a diagnostic test **Lead Director - ASD**	**SHSCT Baseline - at 31 March 2019 = 47.5% (12595 patients)** **Imaging = 58.1% (8617 patients)** **Non Imaging = 27.3% (2780 patients)** **Endoscopy = 72.1% (1198 patients)** At the end of March 2019, the total number of patients waiting for diagnostics tests has increased by +3,714 (+16.2%) to 26,677 since March 2018 with the number of patients waiting in excess of 9-weeks increasing by +4,254 (+43.3%) since March 2018 to 14,082. **Imaging** - At June 2019, the majority of >9 weeks waits within Imaging are within Non-Obstetric Ultrasound (NOUS) (39%), Dexa (27%), MRI (23%) and CT (8%). The volume of imaging waits has increased by a further 1,192 in the first quarter of this year. Key issues include capacity gaps and availability of funded workforce. Additional non recurrent funding has been provided for CT and MRI in lieu of capacity gaps identified however this is insufficient to meet demand and clear the backlog. No additional funding has been provided for Dexa and NOUS to date which reflects the greatest proportion of waits over 9 weeks. Whilst investment in NOUS has been made staff are not available. Actions include: • In year the Trust continues to commission additional capacity in CT in house (via leased modular facility) and in the independent sector for specialist areas, and further the establishment of second CT scanner on the CAH site; • Additional capacity is being commissioned for MRI, again funded non recurrently; • Capacity available continues to be directed to urgent and red flag and inpatient demand in the first instance to maintain cancer pathways and patient flow; and • A diagnostics improvement plan will be developed to identify key actions to manage and improve the	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	position in year where possible. **Non –Imaging** - At the end of June 2019, Non Imaging Waits >9 weeks have increased by a further 918 since March 2019. Of those patients waiting >9 weeks at the end of June 2019, 87% are waiting for Cardiology. Increase in demand and reduction in capacity due to vacancies within Cardiology Non Invasive Investigations have contributed to increase. HSCB have offered non recurrent funding however the Trust has not yet been able to source additional capacity to improve the position but anticipates positive recruitment in year which should start to improve the current position. **Endoscopy** - At the end of June 2019, Endoscopy waits greater than 9-weeks have increased by a further 390 since March 2019. Turnover in staff, sickness and inability to recruit key operators has significantly impacted on core capacity, reflected in the Trust's in year trajectories. Further the Trust has not been able to secure the same levels of additional capacity in-year as secured previously due to reduced clinical uptake of sessions. Capacity continues therefore to be directed to red flag and urgent demand and those waiting planned repeat examinations in the first instance. This approach significantly impacts on routine waits Actions to improve include: • Development of a diagnostic improvement plan, identified above, to explore options to increase capacity; and • Further recruitment of nurse endoscopy and key operator posts. Based on the performance in 2018/1029 and in the first quarter on this year this target has been assessed as not achievable.	
4.12.2 By March 2020, no patient waits longer than 26 weeks **Lead Directorate -**	**SHSCT Baseline @March 2019 = 5771 patient waiting in excess of 26 weeks for diagnostics tests Imaging = 1613; Non Imaging = 4048; Endoscopy = 110** Waits in excess of 26 weeks increased by +2,808 (+94.8%) since March 2018. The majority of the increase in waits for diagnostic tests >26 weeks has occurred in Cardiology Non-Invasive Investigations; MRI and	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
ASD	Respiratory Physiology. Challenges identified in 4.12.1 above and inability to secure additional capacity make the assessment of this target as not achievable, even with additional funding.	
4.13 Inpatient/daycase treatment (Elective) 4.13.1 By March 2020, 55% of patients should wait no longer than 13 weeks for inpatient/daycase treatment. **Lead Directorate – ASD/ CYPS**	**SHSCT Baseline @ 31 March 2019 = 35.0% waiting less than <13-weeks** Demand for elective care services continues to exceed health service capacity seeing waiting times increase for those waiting for inpatient and day case treatment. At the end of March 2019, only 35% of patients waiting for inpatient/day case treatment were waiting no longer than 13-weeks. Since March 2018 the number waiting over 13 weeks has increased by +4.9% (+331) and overall numbers waiting for Inpatient/Day Cases has increased by +6% (+651). Achievement of this objective continues to be impacted by multiple factors including increasing demand; insufficient capacity; lack of recurrent investment in capacity gaps; the impact of unscheduled care pressures on bed capacity and the nature of non-recurrent investment. Other challenges relate to the medical workforce where general gaps in the middle and senior level tiers of staff have resulted in priority being given to non-elective requirements. Actions in place include: • Continued prioritisation of available capacity to red flag (cancer) and clinically urgent referrals in the first instance; • Seek to optimise available core capacity to achieve delivery of agreed performance trajectories; • Utilise non recurrent funding as available in year, from HSCB and Confidence and Supply, to deliver additional activity to benefit patients targeted at reducing both red flag and urgent waits in the first instance albeit the levels of clinical capacity available in year is reduced due to lack of clinical uptake; and • Explore options to increase communication with patients on waiting lists, and to ensure lists are valid and robust. The Trust is participating in the planning for development of a number of elective centres and leading the Urology project.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	Sustainable improvement will not be demonstrated without recurrent investment for capacity gaps and non-recurrent backlog clearance in parallel and Reform of services, as set out in the Departments of Health's Elective Care Plan, will be required to see longer-term gains. This objective is not achievable in year even if capacity can be increased. The Trust continues to monitor those patients waiting beyond clinically indicated timescale for planned/repeat procedures and is developing an action plan to manage emergent risk and seek improvements in this.	
4.13.2 By March 2020, no patient waits longer than 52 weeks. **Lead Directorate – ASD/ CYPS**	**SHSCT Baseline @ 31 March 2019 = ; 2,700 >52-weeks; and longest wait 269-weeks** At end of March 2019, the number waiting over 52-weeks for Inpatient/Day Case Treatment has increased by +15% (+343) since March 2018. Waits over 52-weeks largely continue to increase in line with Regional trends. 2,700 people were waiting across 9 specialty areas, over 52-weeks (Breast Surgery; Cardiology; ENT; General Surgery; Gynaecology; Orthopaedics; Paediatrics; Pain Management; and Urology). Whilst the average waiting time is 37-weeks, with the 95th percentile wait at 119-weeks (Pain Management) the longest routine wait remains within Urology at 269-weeks. Achievement of this objective continues to be impacted by multiple factors including increasing demand; insufficient capacity; lack of recurrent investment in capacity gaps; the impact of unscheduled care pressures on bed capacity and the nature of non-recurrent investment. Other challenges relate to the medical workforce where general gaps in the middle and senior level tiers of staff have resulted in priority being given to non-elective requirements. Elective capacity was reduced as part of unscheduled care planning to support bed capacity for emergency admissions. The Trust is participating in the planning for development of a number of elective centres and leading the Urology project. Reform of services, as set out in the Departments of Health's Elective Care Plan, will be required to see longer-term gains. This objective is not achievable even with additional funding in year.	Red
4.14 Access to Mental	**SHSCT Baseline - at 31 March 2019 = 0 patients waiting in excess of 9-weeks.**	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Health Services 4.14.1 By March 2020, no patient waits longer than: nine weeks to access child and adolescent mental health services **Lead Directorate – CYPS**	The Trust was challenged throughout 2018/2019 to achieve this objective associated with demand outstripping capacity and reduced capacity associated with funded workforce challenges. Performance remains strong however and whilst the service anticipated a small number of breaches in year, in line with the submitted trajectory, longer term sustainability is subject to future investment to meet demand. Challenges also prevail with a number of staff due for retirement and the ability to recruit and retain appropriately skilled replacements. In particular, this year a number of staff from the small specialist eating disorder element of this service provision are due to retire. The Trust anticipates, subject to ability to replace and retain staff that this objective is achievable in year.	
4.14.2 By March 2020, no patient waits longer than 9 weeks to access adult mental health services **Lead Directorate – MHD**	**SHSCT Baseline - at 31 March 2019 = 656 waiting in excess of 9-weeks; longest wait 39-weeks** At the end of March 2019 the majority of patients waiting over 9-weeks are within the Primary Care Mental Health Teams. Whilst work is ongoing to optimise capacity, waits continue to be impacted by workforce challenges and ongoing demand. The Addictions Service has seen improvement with recent service improvement plans including the adoption of a Choice and Partnership Approach (CAPA) contributing to this. Service remodelling has allowed a better response to demand for addictions services and the number of service users waiting has improved significantly in year. Workforce pressures associated with vacancies and long term staff absences remains the key challenge in adult mental health services. Unless there is significant improvement in this position the increasing trend in waits in excess of 9 weeks is anticipated to continue. This position has been discussed with the commissioner and reflected in the 2019/20 performance improvement trajectories. Additional capacity secured in the independent sector for low level referrals aims to reduce the number of patients waiting more than 9 weeks and the Trust will seek to continue this subject to funding. However based on the current performance and submitted trajectories this objective has been assessed as not achievable.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
4.14.3 By March 2020, no patient waits longer than 9 weeks to access dementia services **Lead Directorate – MHD**	**SHSCT Baseline - at 31 March 2019 = 10 patients waiting in excess of 9-weeks, longest wait 25-weeks** This is an improving situation, however, the Trust continues to be challenged to improve performance against this objective associated with current and impending increases in demand linked to demography and disease prevalence. Whilst the Regional review and development of a new dementia pathway is not yet finalised the Trust has agreed its pathway; mapped its capacity against the pathway; and confirmed capacity gaps in the delivery of this. Recurrent investment, and the ability to attract and retain key medical staff, will be required to improve this position. The Trust is considering how best to support patients who are waiting greater than 9-weeks and a number of actions are ongoing: • In-year the Trust has become an affiliated member of the Memory Service Accreditation Programme (MSNAP) and is working to review processes against standards for memory services; and • Further work is on-going via Peer Review to assess standards against best practice. Based on the current level of demand against capacity this objective is assessed as not achievable as reflected in the submitted trajectories.	Red
4.14.4 By March 2020, no patient waits longer than 13 weeks to access psychological therapies (any age). **Lead Director - MHD**	**SHSCT Baseline - at 31 March 2019 = 279 patients waiting in excess of 13-weeks, longest wait 71-weeks** The Trust continues to be challenged to improve performance against this objective due to the ongoing Regional workforce pressures. Recruitment and retention difficulties for psychology staff in particular continues to be very difficult as the high demand for posts and the low training numbers in Northern Ireland has created a significant shortfall in qualified staff. Currently the available staffing in post are being used to full capacity in order to try and address the significant demand and reduce the waiting times. However the number and complexity of referrals is continuing to increase year on year and is resulting in longer treatment times in order to affect change. The Trust will continue to try and use the additional capacity within the independent sector for lower level	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	psychological interventions but this will have limited benefit for the more complex and comorbid referrals typically referred to the specialist psychology services. Given the Regional shortage of qualified psychologists this objective will not be achievable, even with additional resources.	

Outcome 5: People, including those with disabilities, long term conditions, or who are frail, receive the care that matters to them

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
5.1 Direct Payments By March 2020, secure a 10% increase in the number of direct payments to all services users. **Lead Directorate - MHD**	**SHSCT Baseline @ 31 March 2019 = 868** The Trust achieved an increase in the level of direct payments in 2018/2019 in comparison to 2017/2018 with an additional 91 recorded, an improvement of 12%, above the objective level sought of +10%. Direct payments are an integral part of Self-Directed Support, as one of the options under this, and it is anticipated that as Self Directed Support gathers momentum, uptake of Direct Payments will also increase. Ongoing actions to improve uptake include: • Incorporation of the anticipated updated service user agreement, to be rolled out from Autumn 2019, to be included in training. This is anticipated to increase uptake of DP/SDS packages. • The Disability Division developed promotional DVD which has been shared via usual multi-media channels to increase public awareness of DPs and to encourage uptake of DPs. Whilst the Trust continues to seek improvement difficulties associated with recruiting domiciliary care staff, experienced in the statutory and independent sectors are now also being experienced within private recruitment, resulting in some of those interested in Direct Payments now choosing to receive a directly provided or procured service. The Trust continues to attend Regional SDS meetings.	Amber
5.2 Self Directed Support By September 2019, all service users and carers will be assessed or reassessed at review under	In line with the HSCB's Analysis of Information Available for SDS for the period until June 2019, the SHSCT has a total of 773 clients recorded as having been in receipt of an SDS service, exclusive of 343 carers and 170 service users who have received a one off service all via Direct payments. The Trust is currently leading the way Regionally in upgrading their Community Information System to electronically capture and report on all aspects of SDS activity. As such, it is anticipated the reporting of SDS	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
the Self-Directed Support approach, and will be offered the choice to access direct payments, a managed budget. Trust arranged services, or a mix of those options, to meet any eligible needs identified. **Lead Directorate– MHD**	activity will reflect an increase in SDS packages being facilitated as reporting becomes more robust in the very near future. Following participation on extensive Level 1, 2 & 3 Self Directed Support Staff Training sessions, Case Managers continue to ensure that service user and carer assessments and re-assessments are facilitated under the Self Directed Support approach. In addition, the SDS Team continue to implement ways of streamlining staff communication and support planning workloads, mirroring recent progress made in integrating the Adult Social Care Outcome Toolkit (ASCOT) into the Paris Information System to reduce team-based administration across all Trust Programmes of Care. In seeking to increase SDS uptake and achieve this commissioning plan outcome, the Trust has implemented a number of key actions including: • A Trust's Senior Management Team decision to adopt the HSCB Regional Minimum Rate; • Revision of Trust SDS and ASCOT implementation plans to increase the momentum and impetus of the Trust's implementation of SDS and measurement of the outcomes this can achieve; and • Continued support for key staff through the establishment of a Trust SDS Practitioner Forum, facilitation of Direct Payment/ ASCOT training Sessions and team based SDS Practitioner Clinics. Whilst the Trust is committed to achieving the SDS project measurable of 100% of social care service users and carers availing of SDS, this is dependent on both streamlining staff workloads as mentioned previously and resolving associated Regional legal, contractual and procurement issues to fully implement Managed Budgets and significantly increase individual choice and control. As such, the Trust has assessed this objective as partially achieved.	
5.3 AHP Referral By March 2020, no patient should wait longer than 13 weeks from referral to	**SHSCT Baseline - at 31 March 2018 = 2,729 >13-weeks; longest wait 61-weeks** At the end of March 2019, the numbers waiting over 13-weeks reduced with 1,223 less patients waiting compared to March 2018, (equating to 31% reduction). This reflected recurrent investment in workforce in 2017/2018 and additional non recurrent funding in 2018/2019.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
commencement of treatment by an allied health professional. **Lead Director – OPPC/ CYPS/ASD/MHD/EDN**	Unfortunately this position is not sustainable as vacancies increase in the core workforce with increased demands for AHPs posts across a number of transformational projects coupled with no allocated non recurrent funding in year for additional capacity and pressures in unscheduled care increase. A number of actions are ongoing to seek to improve this position including: • Development and replenishment of peripatetic pool for AHP would reduce delays in fill time; • Schedule of clinical priority areas to facilitate deployment of available staff to key risk areas; • Development of an improvement plan to seek to manage the emergent risk in patients who wait beyond clinically indicated timescales for review/intervention appointments; • Review of clinical templates and skill mix to maximise capacity for appropriate conditions; and • Review of universal and targeted elements of service to reduce requirement for 1 to 1 appointments. A proposal for more robust validation of waiting lists has been developed, subject to funding. Based on the current backlog and workforce position this objective continues to be assessed as not achievable.	
5.4 Swallow Assessment By March 2020, have developed baseline definition data to ensure patients have timely access to a full swallow assessment. **Lead Director - EDN**	PHA are leading on the development of the baseline data definition and the Trust has provided data to the PHA as part of the Regional work. No Regional baseline definition has been agreed however the Trust continues to participate in the Regional work as part of the ongoing transformational agenda. Whilst it is assumed this work will be concluded in year to establish the baseline and definition, the ability to provide timely access to a full swallow assessment will be subject to sustainable and recurrent resources. The SHSCT has appointed a Dysphagia Support Team as part of the Regional work overseeing the implementation of actions that arose from the PHA Thematic Review of Choking on Food. Actions ongoing: • Trusts have been providing data as requested regarding the various methods of data collection from electronic to paper based systems. No single Regionally agreed data collection tool. Variance in capturing this data across Trusts (coding, new/review multi-factorial activity definitions) so cross-Trust comparisons	Green

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	are not reliable; • Trust figures for dysphagia referrals 2015/16 were shared with PHA; • Trusts have been informally asked if they were in a position to provide current referral figures for dysphagia. Assumption that this data will be sought through a formal request from PHA for 2019/20 period; • One of the Regional priorities was for the PHA to design a single reporting system that offers insights into: o Reporting dysphagia incidents; and o For the development of AI reporting resources to support accurate reporting of dysphagia incidents across acute and community sectors. • Regional Agreement has been achieved to apply Priority 1 for urgent referrals and Priority 2 for routine referrals.	
5.5 Direct Access Physiotherapy By March 2020, Direct Access Physiotherapy Service will be rolled out across all Health and Social Care Trusts on a state of readiness basis. **Lead Director – OPPC/EDN**	Self-referral for primary care patients aged 16 or over has begun in the Newry and Mourne locality from July 2019. The plan is that over the next 9 months it will be rolled out to the other Trust localities i.e. A&D and C&B by May 2020. The self-referral form used by SEHSCT in their pilot/implemented service has now been updated and standardised for the region taking account of GDPR guidance, CCG referrals etc. The form will be part of the implementation of Encompass and its link with IT and intranet systems. On a temporary basis the Trust has received funding for 2.0 WTE Band 7 Advanced Specialist Physiotherapists to implement self-referral in the Trust. One Band 7 post was recruited to in May 2019 and the other post holder will commence in mid-September 2019. Partnership working with the Integrated Care Partnerships and GPs is key to the success of this access to Physiotherapy for patients and evaluation will be formally carried out by the Trust and PHA in relation to impact on patient journey, outcomes, clinical pathways and transformation.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
5.6 Children & Young People's Framework By March 2020, to have published the Children and Young People's Emotional Health and Wellbeing Framework for school-aged children and young people in Northern Ireland. **Lead Directorate - CYPS**	**This is a Regional objective** A Regional group has been established and the Trust will participate in this forum. The line of accountability for this group will be through the Children's Services Improvement Board.	Green
5.7 Discharges **5.7.1 Learning Disability** During 2019/20, ensure that 99% of all learning disability discharges take place within seven days of the patient being assessed as medically fit for discharge **Lead Director – MHD**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 <7-days = 96.7% and >28-days = 0 patients** Whilst improvement has been demonstrated in 2018/2019 this should be noted in the context of a number of patients who remain as in-patients, who cannot be classified as fit for discharge, where the Trust is challenged to secure appropriate accommodation solutions in the community. As such the reported position can mask the waits in acute beds for those awaiting discharge to appropriate placements. The Trust anticipated 50% of the patient cohort delayed at any time impacts on acute hospital flow. Challenges remain with a cohort of learning disability clients who remain in-patients where options for discharge are not available. Challenges include lack of community infrastructure to support placements; challenges with procurement and limited supply of appropriate community placements; a high level of demand, including a growing demand via those clients transitioning to adult services. Trust actions include the development of options of 'step down'/rehabilitation facility to mitigate this impact and pursue of a pathfinder procurement approach in year subject to Regional agreement.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	In the context of these challenges the Trust has assessed this target as only partially achievable.	
5.7.2 Mental Health Discharge During 2019/20, ensure that 99% of all mental health discharges take place within seven days of the patient being assessed as medically fit for discharge and ensure no discharge taking more than 28 days. **Lead Director – MHD**	**SHSCT Baseline - Cumulative period April 2018 to March 2019: <7-days = 94.1% and >28-days = 20** Performance in 2018/2019 has demonstrated a minimal improvement on 2017/2018 against the 7-days objective. The number of discharges taking over 28-days has increased by +67%. It should be noted that the number of patients discharged has increased by +15% (+128) from 845 in 2017/2018 to 973 in 2018/2019. Within Mental Health, patients are not assessed as medically fit for discharge until appropriate accommodation is sourced. Performance reflects those complex needs patients who can be discharged. Sourcing packages of care; suitable accommodation; and eligibility for benefits, which impacts on accommodation upon discharge, are causes for the delays in discharge. In the context of these challenges the Trust has assessed this target as only partially achievable.	Amber

Outcome 6: Supporting those who care for others

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
6.1 Carer's Assessment By March 2020, secure a 10% increase (based on 2018/2019 figures) in the number of carer's assessments offered to carers for all service users. **Lead Directorate - OPPC**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 4,292 assessments offered** Performance during 2018/2019 demonstrates an increase of +832 (+24%) better than its 2018/2019 objective level. Whilst the volume of offers has improved focus now includes the timescale for delivery of assessment for those who accept and further work around the reasons for decline, in that 80% of carers who are offered an assessment decline this. Due to the significant increase in offers in 2018/2019 it may not be possible to achieve a further 10% improvement and as such this objective is assessed as only partially achievable. Directorates will continue to focus on: • The identification of carers and appropriate signposting as required to resources and services; • Promotion of appropriate offers of carer's assessment by team where relationships are established; and • Enhanced recording of offers of carer's assessment by teams. There is monitoring by programme of care in place and the formally launch Version 4 Carers Support and needs assessment is now developed on PARIS but further testing is required before it goes live. The Trust is awaiting the outcome of the Carers conversation wheel Regional Evaluation before progressing with PARIS testing. Within Non Acute Hospital there is a process in place to meet with family within 72 hours of admission. Carer's assessment is discussed and offered at this meeting and at other points in the patient's journey through non-acute hospitals. If it is not appropriate to complete the assessment at this point the key worker in the community is informed of the requirement.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	The Trust has an active Carers Reference Group. Within Mental Health Directorate a Mental Health Forum is in place to ensure a strong voice for those supporting services users living at home and to engage service users and carers in service developments. It also has a robust Carers Forum active in the Adult Learning Disability Service. The Mental Health Director plans to explore the Carers Conversation Wheel approach in year and to evaluate this approach. Within Children's services all parents/carers, currently known to Children with Disability teams, were invited through an expression of interest form to join a newly formed Parents/Carers Forum. This is a new group to provide families and carers of children with a disability up to the age of 18 the opportunity to come together to share ideas, issues and solutions, and to help Trust staff plan services to best meet their needs in the spirit of co-production.	
6.2 Community based short breaks hours By March 2020, secure a 5% increase (based on 2018/2019 figures) in the number of community based short break hours (i.e. non-residential respite) received by adults across all programmes of care. **Lead Director - OPPC**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 512,706 hours.** In 2018/2019 the number of community based short break hours was -4% (-21,950 hours) under the target hours sought for this period albeit an additional 3,509 hours were provided. During this period the Trust provided 680,952 short break hours within residential, nursing home and hospital based short breaks which are not included in the objective and just over 450 cash grants this year to individuals. Individual choice will inform how this is used which may not include short breaks. Whilst the Trust continues to offer service users/carers access to a greater range of flexible, innovative and age appropriate (non-traditional) respite and short-break options in the community some carers seek bed-based respite/short breaks due to complexity and need for nursing care. On-going actions in year continue to focus on:	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	• Identification of carers, as carers support and needs assessment are the gateway for short breaks; • Continued promotion of SDS, cash grant support and other forms of short breaks to decrease the reliance on residential bed based respite/short breaks; and • Monitoring by programme of care with individual internal targets to support ongoing improvement. Whilst the Trust will continue to promote non bed based short breaks it does not anticipate this objective will be achieved.	
6.3 Young carers short breaks By March 2020, secure a 5% increase in the number of young carers attending day or overnight short break activities. **Lead Director – Children & Young Peoples Services**	**SHSCT Baseline - at 31 March 2019 = 219 Young Carers.** Baseline established in 2018/2019 with the number of young carers receiving short breaks during 2018/2019 has increased by +22% (+40) from 2017/2018 when 179 young carers received short breaks. The Trust has a number of actions in place to support the delivery of this objective and seek an increase in the number of young carers receiving short breaks. A Steering Group is in place and will monitor and review activity with key stakeholders; review resources including staffing; and raise awareness about the service. The Trust has an established Service Level Agreement in place for the delivery of short breaks for young carers.	Green

Aim: Ensure the sustainability of health and social care services provided
Outcome 7: Ensure the sustainability of health and social care services

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
7.1 By March 2020, to ensure delivery of community pharmacy services in line with financial envelope.	**Regional Objective** The Health and Social Care Board hold and negotiate contracts for community pharmacy services.	Blue
7.2 By March 2020 to establish an outcomes reporting framework for Delegated Statutory Functions (DSF) that will demonstrate the impact and outcome of services on the social wellbeing of service users and the baseline activity to measure this.	**Regional Objective** The Health and Social Care Board hold and negotiate contracts for community pharmacy services.	Blue
7.3 By March 2020, to establish a baseline of the number of hospital-cancelled consultant led outpatient appointments in the acute programme of care which resulted in the patient waiting longer for their appointment, and by March 2020 seek a reduction of 5%.	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 6,110 hospital cancellations** Utilising the report previously developed to provide this information to the Health Committee, the Trust has established a baseline position on the number of hospital cancelled consultant-led outpatient appointments in the Acute programme, which resulted in the patient waiting longer for their appointment. In 2018/2019 there were 213,548 attendances in the Acute programme with 6,110 having a negative impact on patients. Key on-going actions, to improve performance, include:	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
Lead Director - ASD	• Focus on monitoring the reasons for cancellations; • Review and refreshment of the consultant leave policy; • Preparation of medical rotas to assist clinic planning and minimise impact on booking. An action plan is in place; and • Review/analysis of cancelled clinics by operational teams. Challenges continue to prevail associated with medical workforce issues, including gaps in the junior and middle grade medical staff base which impacts scheduling of out-patient sessions. Based on the comparatively good position the ability to effect further improvement remains challenging and as such this objective has been assessed as partially achievable.	
7.4 By March 2020, to reduce the percentage of funded activity associate with elective care service that remains undelivered. **Lead Directorate – ASD/ CYPS/OPPC**	**Baseline: Cumulative period April 2018 to March 2019 =** New Out-Patients -4% (-2,768); Review Out-Patients -7% (-9,551); Elective In-Patients -37% (-2,524); Day Cases +10% (+2179) *(Note: 995 new outpatients under delivered related to services not managed by the Trust i.e. Ophthalmology (-881) and Paediatric Cardiology (-114).)* The ability to improve the level of funded activity associated with elective care is challenging. Planned delivery of elective care is defined in the submitted Performance improvement trajectories for 2019/2020. Challenges in delivery predominantly relate to: • Workforce challenges, including vacancies in middle and senior doctor rotas and an increase in reduced clinical sessions impacting on core provision; • Continued unscheduled care pressures resulting in prioritisation of capacity to this area. Elective capping and prudent scheduling over the heightened unscheduled care periods	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	have significantly impacted delivery of core elective activity; and • The need to revise and update some historic Service and Budget Delivery volumes to reflect changes in service and practice. A medical workforce group is in place to agree measures which could improve recruitment of consultant staff. It is unlikely that this target will be achieved; however, the Trust anticipates achievement of submitted performance trajectories.	
7.5 Discharges 7.5.1 By March 2020, ensure that 90% of complex discharges from an acute hospital take place within 48 hours **Lead Director - ASD**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 83.1%** The Trust will seek to improve its complex discharge position in year and this remains a key focus. Challenges in achievement include complex delays associated with patients requiring discharge to another Trust area, patients waiting for discharge support in environments supporting acquired brain injury and other physical disabilities, those requiring support for challenging behaviours and complex social problems. Actions in place and ongoing include: • Control room function and increased co-ordination of discharge planning and flow; • Embedding and scale of discharge to assess models of care implemented over the last year; • Increased provision for those with confusion and deliriums in step down beds in statutory residential homes; and • Development of psychiatric enhanced liaison services to support more timely management of appropriate patients. Inpatient flow and discharge are key areas of focus in year and establishment of SPEED project to seek improvement will support this.	Red

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
	The Trust will seek to improve its position and as such has assessed this objective as partially achievable.	
7.5.2 By March 2020, ensure no complex discharge taking more than seven days **Lead Director - ASD**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 118** This objective remains one that has a dedicated focus and will remain so. The Control Room function, as part of management of patient flow, will see an increased scrutiny on patient level detail and improved data robustness. There is a daily report that reflects and shares data across the directorates in SHSCT that are intrinsically involved in these very complex discharges, engagement from these divisions support all possibilities to progress discharge without added delays. Based on this improved engagement and support an improving position on the 7 day delay is anticipated for 2019/2020.	Amber
7.5.3 By March 2020, ensure all non-complex discharges from an acute hospital, take place within six hours. **Lead Director - ASD**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 94.1%** Discharge management continues to be a focus of the Trust planning around unscheduled care with key actions including: • 'Home for Lunch' campaign; • Use of SAFER model on wards; • Implementation of SPEED project focused on elements of review, diagnosis, discharge preparation; • Utilisation of both CAH and DHH discharge lounges; • Additional investment in ward based pharmacy to support junior medical staff; promoting ward flow and earlier discharge; and • On-going focus on patient flow via the daily 'control room' function. Based on the submitted trajectories and previous performance this objective has been assessed as maintaining and improving on previous performance.	Amber

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
7.6 Regional Medicines Optimisation Programme By March 2020, to have obtained savings of at least £20m through the Medicines Optimisation Programme, separate from PPRS receipts.	This objective applies to both Primary and Secondary Care pharmaceutical services, with the Trust's share set at £1.04for 2019/2020. The Trust continues to contribute to this objective and based on the current predicted level of savings by the 31 March 2020, this is achievable by the Trust. As such this objective has been assessed as achievable.	Green

Aim: Support and empower staff delivering health and social care services

Outcome 8: Supporting and transforming the HSC workforce

COMMISSIONING PLAN DIRECTION OUTCOME	PROVIDER RESPONSE	RAG
8.1 Single Lead Employer Project Contribute to delivery of Phase One of the single lead employer project by 31 July 2019 and Phase 2 by 31 January 2020; in line with the requirements set down by the Department. **Lead Director – HROD**	The Medical Staffing Department will work with HSC Colleagues and DoH to continue to contribute to the delivery of Phase One of the single lead employer by 31 July 2019 and phase two by 31 January 2020. Key HR staff will continue to contribute to a Regional work stream to deliver on this outcome.	Green
8.2 HSC Careers Service By June 2019, to provide appropriate representation on the project Board to establish a health and social care careers service. **Lead Director – HROD**	The Trust will provide appropriate representation to the project board to establish a health and social care careers service, when requested.	Green
8.3 Domiciliary Care Workforce Review By March 2020, to have completed the first phase of the implementation of the domiciliary care workforce review. **Lead Director - OPPC**	**Regional Objective** This is a Regional objective that the Trust will contribute to and actively engage with. As such the Trust's contribution is assessed as achievable. The Domiciliary Care Workforce Review, including proposals for a common hourly rate across all Trusts, has not yet been concluded. However a Regional investment proposal is currently being finalised that should progress this. NISCC are leading on a workforce Review which will include agreeing a training programme for Domiciliary care workers.	Green

8.4	**HSC Workforce Model** By June 2019, to provide appropriate representation to the project to produce a health and social care workforce model. **Lead Director – HROD**	The Trust will provide appropriate representation to the project to produce a Health and Social Care Workforce Model, when requested.	Green
8.5	**Audit of Existing Provision – Workforce Strategy** By March 2020, to provide appropriate representation and input to audits of existing provision across the HSC, in line with actions 10-14 of the Workforce Strategy. **Lead Director – HROD**	The Trust will provide appropriate representation and input to audits of existing provision across HSC, in line with actions 10-14 of the workforce strategy, when requested.	Green
8.6	**Flu Vaccine** By December 2019, to ensure at least [40%] of the Trust staff (healthcare and social care staff) have received the seasonal flu vaccine. **Lead Director – HROD** Target to be confirmed	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 29%** The Trust is implementing once again, in 2019/2020, a Peer vaccination model to assist in improving the uptake of flu vaccine. An increased number of vaccinators have been nominated, and are being trained by CEC. A Flu Vaccine Steering Group has been established to oversee the programme and to ensure increased leadership from Senior Managers across Directorates. Enhanced communications are being prepared for this year to seek to increase uptake, and dispel myths relating to the vaccine.	Amber
8.7	**Staff Sickness Levels** By March 2020, to reduce Trust staff sick absence levels by a Regional average of 5% compared to 2017/18 figure. **Lead Director – HROD**	**SHSCT Baseline - Cumulative period April 2018 to March 2019 = 940,640 hours** The monthly percentage sickness absence rate fluctuated throughout 2018/2019 resulting in a cumulative level of sickness absence at March 2019 of 5.35%, an increase of 0.24% compared to 2017/2018. The Trust will continue to work with managers to support staff to achieve improved attendance at work. The Trust's target absence level, set by the Department of Health for	Green

		2019/2020, is 5.16%.	
8.8	**Social Work Workforce Review** During 2019/20, a workforce review of the social work workforce will be progressed to inform future supply needs and commissioning of professional training (subject to resource availability). **Lead Director – EDSW/ HROD**	This is Regionally led by the Department with input from across the Trusts, to represent all POC's and Support Directorates. Representatives from Children and Adult Mental Health services are members of this group.	Green
8.9	**Regional Healthier Workplace Network** By March 2020, to have an agreed and systematic action plan to create a healthier workplace across HSC and to have contributed to the Regional Healthier Workplace Network as part of commitments under PfG. **Lead Director HROD/ OPPS**	**Regional Objective** This is a Regional objective to which the Trust will contribute. The Trust is represented on the Network and plays an active role in a number of work streams.	Green
8.10	**Annual Appraisal** Improve take up in annual appraisal of performance during 2019/20 by 5% on previous year towards meeting existing targets (95% of medical staff and 80% of other staff). **Lead Director HROD/Medical Directorate**	**SHSCT Baseline 2018/2019** **Medical staff @ March 2019 = 93%** **Other Staff @ March 2019 = 60%** Medical staff - The Trust will seek to sustain and improve the current 93% appraisal rate. This objective will be challenging in year due to the implementation of the new online re-validation and appraisal system as staff become familiar with the new process. Face to face and on line training has been provided to promote use of the new system. Other Staff - 60% of AFC staff at 31 March 2019 had an appraisal, this has improved to 67% for the quarter ended June 2019. Appraisal rates are monitored through Chief Executive Accountability meetings across all Directorates and Directors are requested to	Amber

		take action to achieve increase each quarter. Based on this, the 5% improvement sought is assessed as partially achievable.	
8.11	**Q2020 Attributes Framework – Level 1 & Level 2 training** By March 2020, 60% of the HSC workforce should have achieved training at level 1 in the Q2020 Attributes Framework and 5% to have achieved training at level 2 by March 2020. **Lead Director HROD/ OPPS**	**SHSCT Baseline - Total number trained from April 2018 – March 2019** 4,696 staff achieved Level 1. 126 staff achieved Level 2. **Cumulative number trained from April 2016-March 2019** 8.960 (72%) achieved Level 1. 481 (3.8%) staff achieved Level 2. Level 1 - The Trust continues to raise awareness and to strengthen staff quality improvement knowledge through 'The Introduction to Quality Improvement' e-learning module available to all staff groups. This in-house training programme aligns to the Q2020 Level 1 as per the Quality Attributes Framework and complements a range of other packages. Level 2 - The Trust remains committed to supporting staff in quality improvement across all health and social care services. Delivery of the Quality 2020 vision will continue to be embedded in all programmes. A range of initiatives are in place to support level 2 training programmes. However achievement of this target is more challenging associated with the current level of resources and capacity available to support/ deliver the required training and the timeline associated with Level 2 training, as typically the programmes are of a longer duration and may not be completed in year. Examples of programmes in place include: • Foundation in Quality Improvement (Level 3 Certificate) – externally accredited by Open College Network maps to Q20:20 Level 2; • Taking the Lead & SHSCT Middle Management Programmes also maps to the Attributes Framework at Level 2; • Quality Improvement Leader Programme (Level 5 Diploma) – externally accredited by Open College Network maps to Q20:20 Level 3;	Green

	• The IHI Personal Advisors course, commissioned by the DoH, maps to Level 3 but places are limited to 1-2 per year; • IHI Improvement Advisor programme (hosted by SET) maps to Q20:20 Level 3 but places are limited to approximately 10 per year; and • Scottish Quality and Safety Fellowship Programme (SQS Fellowship) maps to Q20:20 Level 3 but usually only 1 person is supported to undertake this per year.	
8.12 **Suicide Awareness Training** By March 2020, to have developed and commenced implementation of a Regional training framework which will include suicide awareness and suicide intervention for all HSC staff, with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services and mental health/addiction services) by 2022 in line with the draft Protect Life 2 strategy. **Lead Director – MHD**	**Regional Objective** This is a Regional objective to which the Trust will contribute. The SHSCT will participate in the Regional work to bring forward the objectives of the NI Mental Health Patient Safety Collaborative project 'Toward Zero Suicide'. The collaborative supported by funding from the Transformation Implementation Group and HSC Trusts will focus efforts, initially over the next 3 years, aimed at leading a co-ordinated internal effort to reduce suicide in the Northern Ireland mental health patient population. Workstream 3 of the Regional collaborative will develop a stratified and competency based Suicide Intervention skills Training Plan for multi-disciplinary suicide prevention commensurate with roles and therapeutic input in the furtherance of this objective. The Trust has established its own multi-disciplinary group to oversee the implementation of collaborative recommendations including training. The Towards Zero Suicide Co-ordinator is in post and the Trust is actively participating in Workstream 3 of the Regional collaborative. A range of other targeted and whole population approaches to suicide prevention awareness continue across the SHSCT locality including: • Working in partnership with the Community and Voluntary sector mental health / suicide prevention training providers to ensure co-ordinated delivery of suicide prevention gatekeeper training (Applied Suicide Intervention Skills Training (ASIST)	Green

	and delivery of SafeTALK in both SHSCT and community settings; and • Suicide prevention awareness sessions to be offered as part of the Promoting Wellbeing (PWB) training programme from September 2018.	
8.13 Dysphagia Awareness Training By March 2020, Dysphagia awareness training designed by speech and language therapy to be available to Trust staff in all Trusts. **Lead Director - EDN**	A Dysphagia Team has been established since January 2019, comprising a Dysphagia Coordinator, 1 x Band 7 SLT, 1 x Band 7 Dietician, and 2 x Band 4 SLT Assistants. This team have identified the training needs, designed the dysphagia training resource and have/continue to deliver training programmes (level 2) adopting a phased approach targeted to areas of priority: o Domiciliary care staff; o Health care assistants; o Nursing/AHP staff; o Pharmacy; o Social Work staff; and o Medical staff. The next stage will target the Private Nursing Home sector. More specialist training (Level 3) will be delivered to facilitate clinical involvement of heath care staff to assist the qualified SLT in completing the tele-assessment of swallowing difficulties (Dysphagia) initially in Private Nursing Homes. This concept when proven will greatly impact on capacity to complete more timely swallow assessments offering an efficient, cost efficient model for the future. All Trust staff working with people with dysphagia have been trained in the past year on IDDSI and the Trust has established a Dysphagia Steering group to oversee all issues and service developments relating to Dysphagia. This group is across all Directorates.	Green

3.2 Trust Response to Regional and Local Commissioning Priorities

Regional Priorities

CANCER SERVICES (10)

R	A	G	Not applicable
0	4	5	1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to deliver cancer access targets. (CPD 4.10)	The Trust will strive to deliver cancer access standards across all relevant services. However, due to an ongoing increase in red flag referrals across all tumour sites it remains difficult for the Trust to achieve cancer access targets. Teams are continuing to explore ways of improving cancer access.	AMBER
2.	Effective arrangements should be in place to work as part of a network to ensure timely access to breast assessment across Northern Ireland.	The Trust will work with the commissioner and other Trusts to progress the recommendations from the Review of Breast Assessment Services.	GREEN
3.	Effective arrangements should be in place to support peer review of the SACT service and review of the sarcoma and thyroid MDTs.	Work is in progress to prepare for the forthcoming Peer Review visit on 15th November, 2019 for SACT services. Operational policy, Annual Report and work plan for next year will be completed by the end of September. The Head Of Cancer Services is working closely with colleagues in Belfast Trust to submit information for the sarcoma and Thyroid MDTs.	AMBER
4.	Effective arrangements should be in place to ensure implementation of the Regional Information System for Oncology and Haematology (RISOH) within haematology	Electronic Prescribing and Administration sign off is now fully embedded within Oncology. The Haematology EPR has been delayed across the region and there are ongoing regional discussions regarding this.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	services.		
5.	Effective arrangements should be in place to further develop radiotherapy services across Northern Ireland.	Not Applicable	
6.	Effective arrangements should be in place to support the delivery of a sentinel lymph node biopsy (SLNB) service for malignant melanoma.	Effective arrangements are in place within the Southern Trust to provide sentinel lymph node biopsy (SLNB) for melanoma cases. Cases requiring SNLB are discussed both at our local MDT and then with patients before taking discussion to the Specialist MDT in the Belfast City Hospital. Our Plastic surgery colleagues then arrange to see the patients and arrange assessments in centres across the UK including Bristol and Leeds. This will be the process until the service is up and running in the South Eastern Trust. It is expected that this service will be established in 2020 as a regionally commissioned service. All discussion via the regional service has been via a regional task force group attended by dermatologists and plastic surgeons regionally (at a subgroup for the regional provision of SLNB Melanoma service).	**GREEN**
7.	Effective arrangements should be in place to improve the patient experience of people using cancer services.	Results have been received following the roll out of the regional Cancer Patient Experience Survey (2018) and feedback has been delivered to all teams within the Southern Trust. Patient surveys have been sent out from the Trust to tumour groups (Gynaecology and Upper Gastrointestinal) that were not represented in the results due to the low number of responses. Recommendations are being put in place following feedback	**AMBER**
8.	Effective arrangements should be in place to ensure the provision of	This has now been fully embedded within the SACT colorectal service and patients are being seen and their treatment prescribed by Non –Medical Prescribers. Some	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	appropriate non-surgical oncology services.	patients are offered a two stop model where they are seen, assessed and prescribed on one day and treatment is delivered the next day. This has improved waiting times for patients and efficiency within the unit. Work is ongoing to explore other areas for improvement.	
9.	Effective arrangements should be in place to ensure the provision of SACT.	The Trust participated in the regional Non-medical Prescribing Implementation Group which was set up to implement the non-medical prescribing model of care. Non- medical prescribing has been implemented across both Haematology and Oncology services. Currently there are 5 non-medical prescribers in the Trust across 10 Systemic Anti-Cancer Therapies (SACT) clinics (3 Pharmacists & 2 Nurses). Southern Trust has proposed one additional person per year to be trained subject to availability of funding, and have included this one person per year in the Pharmacy expansion plan	**GREEN**
10	Effective arrangements should be in place to expand the clinical nurse specialist (CNS) workforce in Northern Ireland in line with national benchmarks and the agreed regional CNS development plan.	In line with the agreed regional CNS development plan: • 1 WTE Urology CNS was appointed late 2018 • 1 WTE Upper GI CNS was appointed June 2019 • 1 WTE Gynae CNS was appointed June 2019. Minimum datasets have been agreed across the region and this has been set up within the Trust in order to collate CNS activity.	**GREEN**

CARE OF THE ELDERLY (17)

R	A	G
	8	9

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure the implementation of requirements contained in Adult Safeguarding and Protection in Partnership (2015).	The Trust continues to operate an Adult Protection Gateway Service and as part of the work of the SHSCT Corporate Adult Safeguarding Blueprint is reviewing the roles and functions of the Gateway service and those holding specialist protection functions within the Trust. This review is in line with the new definitions and thresholds of the 2015 Policy and aims to focus specialist responses to those at greatest risk. The review of practice includes cognisance of associated governance arrangements to promote a continuous improvement approach. The Blueprint also focuses on the critical aspect of prevention and early intervention in adult safeguarding and therefore work is being undertaken to embed a culture of empowerment and keeping me safe within all areas of adult service delivery.	GREEN
2.	Effective arrangements should be in place to support people living with frailty. The Frailty Network was launched in March 2019 and a structure has been established with wide reaching stakeholder input to develop services which support those identified as living with frailty as well has having a focus on prevention and early intervention to secure the best outcomes for older people.	Southern Trust is participating in the Frailty Network. A frailty pilot is operational across Bannview and Riverside GP practices to screen patients over 75 for frailty and advise on support networks available or refer on to appropriate services. As of end of August 2019, 102 patients have been screened. The pilot findings will contribute to discussions around future models of care. Rockwood Clinical Frailty Scale has been introduced across Acute Care at Home, Day Hospitals, Older People's Assessment Unit (OPAU) and Integrated Care Service (ICS) to screen all new referrals and provide with a frailty score. As of August 2019 Patients in non acute hospitals are being screened for frailty as a preventative strategy.	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
3.	Effective arrangements should be in place to provide a standardised model for the delivery of services to older people and individuals with dementia.	A Trust representative is currently working with the HSCB to develop a regional standardised operating model for people with dementia. When the regional New Stepped Care Model for people with dementia has been agreed the Trust would intend to work with ICPs to implement the model subject to availability of funding. The Trust will also work to identify the needs of individuals with dementia and their carers and the resources required to meet demands. These demands present across a range of teams.	**GREEN**
4.	Effective arrangements (local and regional) should be in place to ensure continuity of care in the event of any business failure / closure within the Care Home Sector.	The Trust has been working with Regional colleagues the HSCB and DOH to develop a Regional Continuity / escalation plan in the event a chain of care homes closing. This plan is in its final stages. SHSCT have a cross directorate workshop planned to review and update the current Trust continuity / escalation / SOP on the management of a home closure in the SHSCT to include sourcing alternative environments in which residents could be safely transferred in the event of a care home closure. Continuity Plans have been recently updated for a range of services including, AC@H, ICS and Day Hospital services.	**AMBER**
5.	Effective arrangements should be in place to implement the recommendations of the National Audit of Intermediate Care (NAIC) in 2018, particularly in relation to bed based Intermediate Care.	SHSCT is a member of the regional Intermediate Care Group and reports on progress being made to implement the recommendations from NAIC. SHSCT Intermediate Care services are multi-disciplinary and embrace a “Home First” ethos. To implement the recommendations of NAIC, focus has been on promoting and developing Discharge to Assess and Step Up referrals. From January to July 2019 the service has received 406 referrals for Step Up intervention -equates to 33% of total activity.	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		This compares to 30% in 2018/2019 and to 19% in 2017/2018. Discharge to Assess referrals also indicate an increase in activity: • August 2018 to January 2019: Average of 42 discharges per month via Discharge to Assess; • February 2019 to July 2019: Average of 68 discharges per month via Discharge to Assess. An increase of 39%.	
6.	Effective arrangements should be in place to provide shared lives approaches of care to older people who may require short breaks or long term placements (CPD 6.2).	In keeping with Regional expectations, the SHSCT has appointed a Shared Lives Project Manager who is working closely with the Regional Shared Lives Project Steering Group and focussing on the development of a suite of supporting information and documentation to support project implementation.	**GREEN**
7.	Effective arrangements should be in place to optimise capacity to meet the needs of people with dementia.	A Trust representative is currently working with the HSCB to develop a regional standardised operating model for people with dementia. When the regional New Stepped Care Model for people with dementia has been agreed the Trust would intend to work with ICPs to implement the model subject to availability of funding. The Trust will also work to identify the needs of individuals with dementia and their carers and the resources required to meet demands. These demands present across a range of teams.	**GREEN**
8.	Effective arrangements should be in place to address the issue of delayed discharges from the acute sector and other institutional settings due to the non-availability	Since April 2019 Care Packages for all clients who require domiciliary care are offered on a daily basis to Trust Home Care first and then all providers via a central administrative hub (Care bureau). A dedicated broker has now been identified in Care Bureau to manage the outstanding list. Acute/Community communication is ongoing to facilitate timely discharge. Cases are prioritised by key workers such as palliative care	**AMBER**

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	of independent sector community based services especially domiciliary care.	/ hospital discharges / discharges from Statutory Homes / hand backs from IS providers to expedite service responses. Capacity issues remain within the independent sector providers. This has been addressed by procuring four new supplementary providers. In addition the statutory domiciliary care service has a rolling monthly recruitment exercise in place and has organised 4 large recruitment events Trust wide to grow the workforce to meet demand. An OT outcomes focused model of domiciliary care continues to be rolled out Trust wide. This new service model will influence the new Regional Care and support at home model and procurement specification. The Trust is working with the HSCB, Social Care Procurement Unit and Directorate of Legal Services to agree an interim procurement arrangement while the Region finalises the new Domiciliary care model. The Trust continues to engage with independent sector providers and commissioning teams.	
9.	Effective arrangements should be in place to provide services for carers that can be developed to maintain individuals to live as independently as possible in their own home (CPD 6.1 & 6.2).	The Trust actively participates in the Regional Carers Strategy Implementation Group and mirrors the action plan at local level through the Carers Reference Group. The Trust continues to implement the 2018 - 2020 carers' action plan which was finalised at a co-production workshop with carers, carer support organisations and Trust staff in May 2018. The targets contained within the action plan include increased carers needs and support planning in line with V4 Northern Ireland Single Assessment Tool (NISAT) which can mobilise a range of support options to meet identified need including the availability of short breaks. Directorate champions focus on these to maximise support for carers across all teams. The Trust has also contracted with a voluntary sector organisation for additional support service for adult carers. A directory of carer support services and resources has been updated May 2019 and	**AMBER**

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		circulated widely. There continues to be a high demand from staff and carers for this resource which the Trust is meeting. The Trust has developed a carers' assessment support booklet for staff outlining responsibility with regard to offering carers' assessments and providing information on the range of support services and resources available locally to support the development of carers' needs and support plans. The 'Useful Contacts' list has been up-dated and circulated widely. A booklet outlining the range of peer carer and other relevant support groups available across the SHSCT area has been developed. The Trust continues to offer cash grants to carers to facilitate the purchase of items or services to relieve carer stress and/or provide a short break from the caring role. Review and the availability of weekly reports via Qlikview enables managers to monitor the activity with regard to carers assessments, and the Carers Coordinator and Carers Trust can now target teams that require additional support and provide tailored carers awareness training.	
10	Effective arrangements should be in place to review existing day opportunities for older people to ensure that they meet current needs and expectations.	The Trust is currently developing an Outcomes Based Framework for Older Persons Day Care Services. This framework seeks to ensure that day services are responsive to the individual needs of service users, which will support them to maximise their independence. The Trust has evaluated the service user experience, using 10,000 Voices methodology and as a result will further develop Reablement ethos to day care services, the introduction of the Outcomes Based Assessment Tools and new programmes. Review and variation of existing independent sector contracts has been completed and streamlined existing ISP in line with capacity, need and available funding. This has	**GREEN**

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		made better use of resources.	
11	Effective arrangements should be in place to support the full implementation of the regional model of reablement.	The Trust has fully implemented the regional model and the Reablement service is available in all areas of the Trust and targets are consistently achieved. The Trust has identified the level of resource required to allow the Reablement service to offer a full 7 day service across weekends and the out of hour periods, however, at this point no additional resources are available to facilitate this enhancement.	**GREEN**
12	Effective arrangements should be in place to optimise recent demography funding to meet domiciliary care demand and wider demographic demand.	The Trust continues to deliver domiciliary care, residential and nursing home placements in line with assessed need and available funding. The Trust has identified an emerging risk aligned to securing placements at regional tariff in Residential and Nursing Homes as Independent sector providers introduce third party payments. This includes a difficulty with the placement of individuals with more complex needs. The Trust has also identified an emerging in year pressure on the domiciliary care budget allocation, as well as demographic related increases in demand across a wide range of existing core services including ICTs, ICS, Reablement and Specialist Community, Dental and Allied Health Profession Services. Recruitment within this sector remains challenging. The Trust has a rolling monthly recruitment process in place and a number of recruitment days have been held and are planned 19/20.	**AMBER**
13	Effective arrangements should be in place to optimise capacity to support the numbers of people aged over 65 and over 85.	The Trust is working collectively to strengthen and enhance current services, which are supporting healthy ageing across the end to end patient/ client journey. The Trust provides a range of opportunities to support healthy ageing in the community, including health improvement interventions such as those referenced below: Health Improvement:	**GREEN**

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		• Ongoing dissemination and promotion of physical activity guidelines; • Co-ordination of Southern locality based 'Walking for Health' scheme and 'Cycle for Health' scheme; • 2 'Move More Often' Programmes were delivered in 17/18 to staff in residential/daycare settings to support physical activity with frail/elderly older people. A further 3 programmes were held in 18/19 and more are planned for 2019/20; • A rolling programme of 'Strength and Balance' programmes is provided to those at risk of fall through the physio service, Falls Prevention Co-ordinator and joint working with Council leisure centres. There is a falls prevention and early intervention service across community, statutory and voluntary partners across the Southern area; A new dementia page has been published on the SHSCT Falls Directory. 4 x Safe & Steady sessions have been delivered to Reablement Support Workers and community workers to enable them to promote falls prevention and provide equipment and resources to older people. Further community facilitators were trained and supported to deliver community-based nutrition and cooking skills programmes to support people to learn the practical skills for cooking healthy meals on a low budget. Home safety equipment was purchased and distributed to Trust staff teams including Health visiting, family nurse partnership, Reablement, Dementia Navigators, Parenting Partnership and Learning Disability. Oral health care programmes are facilitated with a range of older people's groups by the Community Dental service. Community Planning	

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		• The Trust has established a cross-Directorate and cross-sectoral structure to support the implementation and outworking of the regional Public Health Framework, Making Life Better and the ongoing development of local council community plans. 19/20 will see a greater focus on the implementation of these community plans in collaboration with local councils and other statutory, community and voluntary sector partners. Support for Community & Voluntary (CV) Sector • Support for sustainable approaches to community development for health and social wellbeing including delivery of Community Sector Training programme (that now provides adult safeguarding modules in addition to the range of child safeguarding modules), further development of the role of and support for Community Health Champions and Trainers across the community, and implementation of Neighbourhood Renewal Health Improvement Plans in Newry, Craigavon, Lurgan, Portadown, Dungannon and Coalisland. • Work with others as above to develop a strategic approach to the improvement of social support and health and wellbeing for older people in the community. The Trust works in partnership with and provides funding to a range of community and voluntary sector organisations. The Trust plans to complete its review of current contracts to ensure services are delivered in line with the Trust strategic direction and offer value for money. Multi- agency initiatives working with PHA and local councils include for example: • Newry and Mourne Age Friendly Strategic Alliance and • Good Neighbourhoods for Ageing Well The Trust provides support for the development and implementation of Multi-Disciplinary Teams aligned to Primary Care – particular reference to support for social prescribing models including focus on frailty and development and implementation of	

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		an Older People's Support Hub. mPower The Trust, as a partner of CAWT, commenced the implementation of the mPower project in Newry/South Armagh in Autumn 2018. The primary purpose of this project is to enable older people to live well, safely and independently in their own homes by empowering them to self-manage their health and care issues in the community. The Trusts Community Promoting Good Nutrition (PGN) group is supporting the implementation of the Regional PGN strategy raising the awareness of malnutrition and the importance of nutrition screening/nutrition care planning across community teams and day care settings. A nutrition event is being planned for early 2020.	
14	Effective arrangements should be in place to support an appropriate balance of services between the statutory and independent sectors in relation to domiciliary and residential care. (CPD 2.8)	The Trust is actively engaged in the Regional Domiciliary Care reform project. Currently statutory domiciliary care delivers 41% market share and capacity/demand issues influence this ratio as well as financial parameters. The future procurement plans will consider the hours to be commissioned and provided by both sectors to ensure a sustainable outcome focused service model. Change Plans have been submitted for Statutory Residential Homes to HSCB in November 2015 and we await a decision from HSCB/Department of Health. All new permanent residential placements are currently directed to independent providers. Capacity within statutory homes has been mobilised to support resilience plans in response to winter/ seasonal pressures. Intermediate Care scheme is now provided across all 4 Statutory homes.	**AMBER** (Trust contribution)
15	Effective arrangements should be in place to support the development of intermediate/step down care to relieve pressures on acute care and promote rehabilitation.	The Trust has established an 'Unscheduled Care Operational Improvement Group' to work across Acute and Community to further improve the urgent care pathway. A number of workstreams have been established to progress specific actions aimed at further exploring opportunities to promote rehabilitation and improve discharge processes to relieve pressures on acute care.	**AMBER**

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		Capacity within statutory homes has been mobilised to support resilience plans in response to pressures. Both Cloughreagh House and Roxborough House have enhanced staffing levels to support step down from acute and non-acute beds. Intermediate Care has enhanced staffing levels to support both Discharge to Assess and Step Up referrals. Currently, Discharge to Assess patients are identified in Acute and Non-Acute hospitals and reviewed rapidly in the community by Intermediate Care. There are constraints with this service operating Monday to Friday 9am-5pm. Further investment would be required to allow these pathways to be fully implemented at scale. A quality improvement project is underway to engage with GPs and promote the use of Step up to Intermediate Care, thereby preventing hospital admission.	
16	Effective arrangements should be in place to promote self-directed support to increase individual choice and facilitate responsive remodelling of service models. (CPD 5.2)	The Trust is represented on the regional implementation group for Self-Directed Support and will continue to implement local actions in line with regional implementation arrangements. Additional resources will be required to support the associated activity in the completion and follow-up of SDS requirements.	**AMBER**
17	Effective arrangements should be in place to ensure there is appropriate skill mix within the domiciliary care workforce to facilitate the implementation of the new domiciliary care model (CPD 8.3).	The SHSCT is piloting the use of Domiciliary Care Occupational Therapists within the Trust Home Care staffing to deliver efficiencies and quality improvements within the service offered. The Trust is also looking to implement a new approach to delivering “Home Sits” within the current staffing allocation.	**AMBER**

ELECTIVE CARE (7)

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ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to establish and implement a regional programme of pathology transformation.	The Laboratory in the SHSCT remains committed to pathology transformation as evidenced by: • All disciplines continue to support regional speciality fora in standardisation. The SHSCT continue to contribute significantly to the standardisation projects with the Head of Service on the Board for this particular initiative; • A number of SHSCT staff recently facilitated the very successful regional recruitment process for Biomedical Scientists; • The SHSCT Labs continue to maintain UKAS accreditation in all disciplines and is exploring collaborative models for increasing regional quality services; • Through the Laboratory Managers Forum – effective clinical services proposals are being considered and supported as appropriate; • The SHSCT continues to be an integral part of the LIMS and digital pathology projects.	GREEN
2.	Effective arrangements should be in place in primary and community care settings to minimise the need for patients to be referred by GPs and wider primary care to hospital consultants for specialist assessment.	**ENT** is proposing to draw up referral guidelines for GPs to use / help with their decision on ENT conditions Guidelines are in place to provide advice for GPs on **urological** conditions. **Dermatology** Photo Triage - discussions are ongoing at a regional level regarding funding for a service model to enable photographs to be taken in primary care and assessed by specialists in secondary care. **Cardiology -** Discussions are ongoing with primary care colleagues regarding blood pressure monitoring and ECG being undertaken in primary care and analysed by	GREEN

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		specialists in secondary care. **Neurology** - Transformation funding has been allocated enabling Non Contact Specialist Assessment (NCSA) to be introduced in neurology, improving GP access to neurology specialist opinion. Primary care education sessions are also ongoing. **Cardiac Investigations** – direct access to cardiac investigations is in place at Craigavon Area and Daisy Hill Hospitals. Funding for an additional technician would enable the Trust to reduce the lengthy waiting times for cardiac echo.	
3.	Effective arrangements should be in place to establish Regional Assessment and Surgical Centre's across Northern Ireland.	Trust Heads of Service and Lead Nurses are members of the Regional Assessment and Surgical Centre (RASC) specialty groups. South Tyrone Hospital has been selected as a RASC unit for cataract surgery. The service commenced in January 2019. Full capacity will be achieved by Sept ember 2019 when the number of weekly sessions will be increased to 9. Varicose veins – the daycase waiting list has transferred to a pooled regional waiting list. Two of the Trust's consultants are undertaking varicose vein sessions in Omagh. The Trust will continue to support the development of further RASCs and awaits confirmation from the DoH of the next steps.	**AMBER**
4.	Effective arrangements should be in place at the interface between primary and secondary care, organised around the needs of patients with effective communication between GPs and wider primary care and hospital consultants.	The Trust will continue to engage with and support the regional scheduled care reform process. E-referral /e-triage is progressing well and is live across multiple specialties: • Gynaecology • Urology • Paediatric medicine • General Surgery in Daisy Hill • Pain Management • Cardiology • Gastroenterology/General Medicine	**AMBER**

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		• Dermatology • Orthopaedic ICATS • Cardiology • Rapid Access Chest Pain • Rheumatology • Dermatology • Neurology (via CCG system) ENT preparing to go live in mid-September 2019. The Trust Pharmacy team is providing patients with a copy of their discharge medicines to give to their chosen community pharmacist, with the aim of reducing medication incidents at the interface.	
5.	Effective arrangements should be in place to improve further the efficiency and effectiveness of elective care services (outpatients, diagnostics and inpatients/day case treatment) delivered by Trusts.	The urology service has through funding from Macmillan appointed a 3rd Urology Cancer Nurse Specialist (CNS). A proposal has been completed and is awaiting confirmation of final funding for an additional 2 x CNS in urology. One of these will be for cancer follow up and the other will be for benign disease. There is also an IPT being drafted for a 7th Urologist. The Trust will continue to engage with and support the regional scheduled care reform process. E-referral /e-triage is progressing well and is live across multiple specialties. Please refer to Elective Care response number 4 for a full list. Five Radiographers are trained in Breast Ultrasound and undertake examinations within Breast Assessment Services. It is anticipated this will be extended to cyst aspirations in the next 6 months. Three Radiographers are training in mammography film reading, one of which has been signed off. One Radiographer has been trained in vacuum assisted core biopsies.	**AMBER**

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		A consultant radiographer in training will commence in the breast clinic in the Autumn.	
6.	Effective arrangements should be in place to support the monitoring of clinical outcomes to further improve the quality and effectiveness of interventions.	The Orthopaedic practitioner team undertakes PROMs (Patient Reported Outcome Measures) in conjunction with the T&O consultants. This information is available in report form on a yearly basis from the National Joint Register.	**GREEN**
7.	Effective arrangements should be in place to ensure the appropriate volume and case mix of staff are in place to deliver the agreed strategic priorities.	The Trust continues to make every effort to fill vacant posts but this remains challenging across a range of specialties and disciplines. Filling medical vacancies is particularly challenging, as other Trusts are in a position to offer job plans with dedicated specialty rotas which preclude the need to provide out of hours cover for general medicine. The Trust is in the process of appointing additional Medical Assistant Practitioners (previously known as Physician Associates) along with filling existing vacancies. Six prescribing pharmacists have also been recruited to assist with patient discharge process in Craigavon Area Hospital. Four more and to be recruited for Daisy Hill Hospital in the coming months.	**AMBER**

FAMILY AND CHILDCARE SERVICES (16)

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1.	Effective arrangements should be in place to implement the Managed Care Network for Children and Young People with Acute and High Intensity Care Needs as recommended by the independent review into CAMHS Inpatient Services (CPD 4.14)	CAMHS continues to participate in the regional planning group to deliver the Acute Managed Care network model. The Trust remains concerned however that it is the HSCB expectation that the delivery of the service can be sourced from our existing CAMHS funding. This development is not anticipated to be cost neutral and the operational adjustments to deliver the service model will require changes to current practitioner job plans and working practices. With regard to the 2018 /19 position regarding the recruitment of a Clinical Lead and Operational lead through "Confidence and Supply," unfortunately funding was withdrawn and appointments were unable to be made.	AMBER
2.	Effective arrangements should be in place to prevent the increasing threat of Child Sexual Exploitation (CSE) as identified by the Marshall Inquiry.	The Trust in collaboration with the DOH, HSCB, and Safeguarding Board Northern Ireland (SBNI) has fully implemented Trust actions to achieve the recommendations of the Marshall Review report. The Assistant Director of Safeguarding participated in regional groups convened by both the Department of Health and HSCB to progress and review implementation of actions. The Trust is currently participating in a SBNI Child Sexual Exploitation Update Review based on the Marshall Review recommendations which will be completed by September 2019. The Trust has a dedicated Senior Social Work practitioner for Child Sexual Exploitation (CSE) co-located in the Police Service of NI Public Protection Unit. The CSE risk assessment tool has been implemented. Missing Children from Home and Care Protocol has been fully implemented. CSE is on the agenda of the Southern Safeguarding Panel; Southern Children's Safeguarding Interface Group; Regional Health & Social Care/PSNI Strategic Group;	GREEN

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		Regional Children's Services Improvement Board.	
3.	Effective arrangements should be in place to safeguard children and promote their welfare in line with Co-operating to Safeguard Children (2017).	The Trust has arrangements in place to respond to referrals, investigate, assess and intervene when children and young people require protection: Gateway and Family Intervention Service. Child protection interventions and activity are monitored monthly to ensure performance standards are being met (Priority 5 returns). The Trust together with the Safeguarding Board for Northern Ireland (SBNI) and the Children's Services Improvement Board (CSIB) agree audit activity to keep under review the effectiveness of safeguarding services. The Directorate of Children and Young People's Services also sets audit priorities for family support and safeguarding using the GAIN audit process. The Trust adheres to the SBNI Child Protection Procedures issued in December 2017. Children's Services are currently implementing the Signs of Safety Practice Approach alongside introducing a Trauma Informed Practice approach (ACE) in partnership with the SBNI EITP initiative and CAWT. A Trust wide rolling training programme is in place. Children's Services have service level agreements in place with the NSPCC and Barnardo's to provide therapeutic support to children who have been abused.	**GREEN**
4.	Effective arrangements should be in place to meet the requirements of the Children's Co-operation Act (2015) and the Special Educational Needs and Disability Act (2016).	The Trust is participating in the regional SEN transformational project and have a Special Educational Needs (SEN) Coordinator and Data Manager in post to streamline processes for community paediatric and Allied Health Professional departments in order to meet the 6 week target for Statement advice. A training programme is also being rolled out to improve staff understanding and compliance with the new legislation. An ICT pilot was completed in Children and Young People's Directorate in June 2019 to inform the development of integrated services to support children in special schools in partnership with school staff and parents / carers. The Trust is a member of SBNI, Southern Area Safeguarding Panel, Children and Young	**AMBER**

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		People's Strategic Partnership and Southern Area Outcomes group alongside a range of other statutory and voluntary agencies including education which put in place action plans to co-operate and work together to meet identified needs of children.	
5.	Effective arrangements should be in place to improve data collection in CAMHS services to capture need, demand activity, outcomes and service user experience.	CAMHS continue to comply with the regionally agreed HSCB data set. The service had introduced the Child Outcomes Research Consortium (CORC) measurement framework across all services however this has been disrupted due to recruitment issues. CAMHS continues to comply with the principles of the CAPA model. Internal data collection has been improved with the introduction of PARIS across all CAMH Services. Professional Leads and Clinical managers have conducted a workforce training audit of the range of therapeutic skills interventions within the service. In addition a CAMHS Psychological Therapies Group has been established and has identified gaps in some evidenced therapies. Training in these areas is being prioritised.	**AMBER**
6.	Effective arrangements should be in place to support the CYPSP multiagency children's services planning process	The Trust has an established Multi Agency Southern Area Outcomes Group chaired by the Director of Children's Services and fully supported by locality planning groups. Family Support Hubs are established in the Southern Area with multi -agency input. Funding provided by HSCB is fully utilised to support the work of the Hubs based on needs analysis of the population in the Southern area which is kept under review by the Outcomes group and informs the action plan of same.	**GREEN**
7.	Effective arrangements should be in place to appropriately manage the increasing number of children with complex health care needs and challenging behaviour.	The SHSCT has a Rapid Response Team in place aligned to Community Paediatrics. This team supports timely assessment and diagnosis enabling intervention to commence sooner, improving outcomes for this group of children and young people in the longer term. The team provides physiotherapy, occupational therapy and speech and language therapy for children with complex physical healthcare needs and challenging behaviour. The team will help facilitate early discharge, provide advice and training to staff and parents/carers, facilitate the provision of complex equipment and adaptations to meet child and carers	**AMBER**

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		complex physical and medical needs including the respite carer, provide assessment and advice as part of the statementing process for children to ensure their special educational needs are identified and met. The Trust continues to work to fill vacant children's nursing posts (via the regional recruitment process) as these arise, in order to provide nursing care to children with complex health care needs. The Trust has offered posts to all of the children's nursing pre-registration nursing students on the current waiting list. The Trust has expanded the Scaffold Service (Psychology Service for Looked after children) and thus increased capacity to provide therapeutic intervention and support to Looked After Children. The Trust is developing integrated models of care to improve multiagency approaches to meet the needs of complex children with challenging behaviour using ACE and evidence based trauma informed approaches.	
8.	Effective arrangements should be in place to appropriately manage the increasing number of Looked After Children (LAC) entering the system. (CPD 1.12)	The vast majority of Looked After Children are cared for within various types of foster care provision including kinship care, Trust Foster Care including Specialist Foster Care Placements with Independent Fostering Agencies. This has created immense challenges in relation to recruiting, assessing and supporting sufficient numbers of Foster Carers to meet demand. These challenges have also been reflected in a significant increase in staff associated costs as a consequence of having to ensure minimum staffing levels are maintained at all times, whilst being able to deploy additional staff to meet the needs of individual young people at any particular juncture. A small number of children with disabilities and complex mental health /emotional /behavioural difficulties have required full-time care placements, creating significant challenges for the Trust in ensuring appropriate options are available. Children's Disability Services have done extensive work over the last 5 years to extend the Trust's range of	**AMBER**

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		support services for children with disabilities and their families, including a new residential care unit, Bluebell House, but the 3 beds within this new service are already full. Recent experience has evidenced that need/demand exceeds capacity, and so work continues to try to address this. Whilst foster-care will always be considered for every child/young person, the specialist knowledge and skills needed to understand and manage the needs and behaviours of some of these children is unlikely to be found in 'mainstream' foster-care. Children's Disability and Family Placement Services have been working collaboratively to further develop a specialist salaried scheme, with additional training, planned breaks, and high levels of support from Children's Disability Services built in, in addition to support from Family Placement. It is hoped that a small number of specialist placements can be developed to provide emergency care and/or ongoing care placements for children whose assessed needs can be met in a family-type setting with extensive and intensive support, customised to the carers' needs. Nevertheless, experience has shown that children and young people with learning disabilities and complex emotional /behavioural difficulties can engage in a range of very difficult to manage behaviours not suited to family-based care, especially when first having to live away from home. The Trust has had to provide residential placements for a small number of children in such circumstances, and has had to place them in the residential short breaks units on an emergency basis as Bluebell House is already full and no other suitable placement could be identified. This has resulted in breaches of Children's Home Regulations and Arrangements for the Placement of Children Regulations, and ongoing liaison with RQIA. It has also meant children who should be having short breaks in these units have had no service or a reduced service, creating significant upset and anxiety for many. The Trust is continuing to work on resolving this and in building options and capacity in both residential and foster care provision. However, this is also a regional issue and regional work needs to be undertaken to	

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		address this growing area of need and ensure adequate provision for these children and young people. Improved options should reduce the need for young people having to be placed outside N.Ireland, leaving everyone and everything they know, usually at very high financial cost through ECR funding. SHSCT will participate in the forthcoming development of a regional strategy for children with disabilities, which needs to include this issue. The Trust has a robust recruitment and assessment process for new foster carers with the objective of increasing availability, capacity and choice. The Trust has invested in additional staffing for the post adoption support team, given the increasing awareness of the challenges faced by adopted children and their families and the need to avoid the potential for placement breakdown in adoption. The post adoption support team provides a continuum of multiple levels of support that varies in levels of intensity (information, resources, and financial allowances where appropriate) to ensure long term stability and true permanence for children who have been adopted. The Trust recruited additional fee paid foster carers to enhance the service's capacity to manage more complex children and young people. The Trust has 2 dedicated youth Homeless social workers based within the Young Persons Project (a preventative service working with Adolescents) with a remit of working with young people, their families and other professionals to support placements at home, and or facilitating short term time out via the STAY scheme. The Trust seeks to avoid the use of bed and breakfast for young people if at all possible. (If in the future we have to use B&B HSCB guidance would be applied). The Trust has developed a supported lodgings service, STAY (16 placements) for 16/17 year olds including short and long term placements. The Trust is committed to increasing the number of intensive support carers to meet need. The Gateway, Family Intervention and Children's Disability Services develop family support and child protection multi-disciplinary/agency plans to support children to remain	

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		with their families in collaboration with other services eg, Barnardos, NSPCC and a range of other voluntary and community services. Service development and improvement is overseen by the Children Services Improvement Board including the implementation of Early Intervention Transformation Programme initiatives. The Trust is committed to work with Commissioners to bring forward robust SBA levels. Historic levels of activity will inform this position. Commissioned levels of activity for Social Work input into Foster Care and other placements will be agreed subject to the finalisation of the Social Work Community Indicator project including data definitions.	
9.	Effective arrangements should be in place to ensure the stability of mainstream care placement arrangements for children in care	The Trust is committed to expanding the use of the Resource Panel with the objective of better matching children's needs with specific placements, thus avoiding further placement changes. The Trust continues to invest in support services for children in care. Additional posts have been created in the Family Placement service to support foster carers. These include Family Support workers to provide a range of supports to Looked After Children and their foster carers with the aim of maintaining young people within their placement with an emphasis on personal development, social integration and education. These also include additional staffing resources for the Parent and Baby scheme within the service to ensure a placement is available to meet the need for placements for babies and young parents who need a placement to provide a period of assessment. Additional posts have been recruited to further develop the Fostering Intensive Support Scheme to support challenging and complex foster care placements with the objective of avoiding breakdown. The FPS continues to prioritise the promotion and recruitment of all types of foster carers and providers of supported lodgings for young people aged 16 and 17 years of age. The Trust works with the Regional Team to review initiatives to ensure that market research	**AMBER**

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		informs practice and alongside this the Trust uses a range of strategies, including consistent high quality local profiling events and articles and campaigns to achieve ongoing publicity about the need for foster carers and the benefit of the task. The two assessment and support teams within Family Placement carry out comprehensive assessments and ensure each foster carer is allocated a supervising social worker to monitor and support the placement in order to raise the quality of support services to foster carers and children in foster care and to promote placement stability. Further work has been carried out in respect of respite provision within foster care and key principles have been developed within the service to ensure that respite is child focused and that the Trust service is responsive in relation to respite provision. Additional training has been made available to foster carers and the Trust's comprehensive training programme provides a range of relevant and specialist training. Training and supports provided include additional Psychology support input via the Trust expanded Scaffold Psychology Service to ensure relevant supports are in place for parents and children Intensive work continues in respect of the Trust's residential child care provision to support staff and young people who have high levels of complexity. Under Transformation funding the Trust has established a residential support service to improve community engagement and make alternative experiences available to young people in residential care with the objective of supporting and stabilizing mainstream placements. This team is now fully operational and works closely with the residential teams to ensure each young person is matched with a community engagement worker. The Trust is committed to developing effective inter professional collaboration in implementing care plans for young people based on their assessed therapeutic needs.	
10.	Effective arrangements should be in place to appropriately manage the increasing number of unplanned/emergency	The Trust has fully established the Resource Panel which has resulted in increasing numbers of presentations to the panel with the objective of a planned LAC admission where deemed appropriate. The Trust has been promoting the use of the Resource panel	**AMBER**

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	placements where children are known to a Trust.	which meets at least weekly to consider presenting cases. The Trust has delivered a significant training programme in respect of Signs of safety to staff across frontline services as well as LAC - 14 plus Social work staff. A key element of this training has been to work closely with families at an earlier stage to identify and develop networks which can inform contingency arrangements should children and young people need to enter the care system. The implementation of family network meetings as part of Signs of Safety should have a positive impact in reducing unplanned/emergency admissions to care. FGC and Pre Proceeding are also fully utilised in practice.	
11.	Effective arrangements should be in place to ensure a seamless care pathway for LAC which promotes stability and permanency for children. (CPD 3.2)	The Trust implemented the Looked After Child Pathway in November 2014 with the objective of ensuring smooth/seamless transfer of relevant cases across teams. This pathway was reviewed and updated in Autumn 2017 and remains the relevant Case Transfer Pathway across the service. The Permanence Panel continues to review the circumstances of LAC who have been in care for 3 months and more. The objective of the panel is to ensure that LAC has a permanence plan in place within the appropriate timescales and to ensure stability. The panel will also review the legal status of LAC and potential pathway moves in the best interest of the child or young person. The Trust is committed to reducing the number of unplanned placement moves for LAC and is striving to increase the number and choice of foster care placements available to facilitate better matches between LAC and Carer. The Family Placement Service has recently appointed LAC support workers with the objective of working with social workers, foster carers, schools and community based groups to improve participation of Looked After Children in various activities and in turn support placement stability. The permanence panel considers the permanence needs of children following the first 3 month LAC review with an emphasis on avoiding drift. The Trust is working within the	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		context of the LAC commissioning paper. The LAC service has moved to 14 plus (from 16 plus) to facilitate earlier intervention with LAC in assisting better planning in terms of education, training and employment and in preparation for leaving care and better meeting young people's assessed needs for when they formally leave the looked after child system.	
12.	Effective arrangements should be in place to ensure that children's care plans explicitly state what is to be achieved by the admission to care, the child and young person's views about their care plan, what is expected from parents in order for the child to return home and the anticipated duration of the placement. (CPD 3.2)	The Trust adheres to and implements the regionally agreed permanence policy for LAC. There are independent Chairpersons appointed to preside over the LAC review process and associated decision making regarding care plans. LAC cases are regularly audited as part of the GAIN Audit requirements. .All LAC reviews and assessments are reviewed by the Head of Service who acts as reviewing officer with a governance role. The same process is applied to these cases, i.e. Independent Chair person, reviewing officer and detailed discussions between Head of Service and team manager re: agreed care plan. Care orders are only maintained on children at home where there are ongoing issues and there is a need to share parental responsibility. A guardian is appointed by the Court and interface is as per every care proceedings case. There are increasing numbers of cases being presented to the Resource Panel where objectives and goals are discussed and appropriate suggestions made for further consideration before LAC admission or as part of the subsequent agreed care plan.	**AMBER**
13.	Effective arrangements should be in place to meet the increasing demand for Autism Services to include the creation of an integrated care system for Children, Young People with Developmental, Emotional	Autism Spectrum Disorder (ASD) and CAMH services currently provide assessment, diagnosis and post diagnostic intervention to the 0-18 population. Within the 18-30 population ASD services provide post diagnostic interventions to support adults to better understand and manage their diagnosis. Currently the 0-12 population is managed through the ASD service and post primary young people are assessed and diagnosed through Child and Adolescent Mental Health Service (CAMHS). Service re-design to incorporate both services into a single 0-18 service has been completed and will be	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	and Mental Health services.	delivered when additional core funding is sourced. There is the potential to deliver in 19 /20 with additional HSCB funding. On-going and increasing referral demand continues to present significant pressures across the Assessment / diagnostic and intervention processes. There are currently significant waits for diagnosis in the Adult Services. Support for Adults 18-30 is solely in terms of advice and information. No services in terms of Safe Guarding or bespoke care packages for the 18 + population are available where ASD is the sole presentation. The urgency of this ongoing risk has been directed to the HSCB and DoH.	
14.	Effective arrangements should be in place to manage the increasing demand in CAMHS and the continued implementation of the stepped care model focusing on: improvement of the interfaces between acute and CAMHS community care including secure care and Youth Justice; integration of CAMHS and children's neurodevelopmental (autism and ADHD) provision.	The Trust cannot fully implement the CAMHS Integrated Care Pathway until additional recurrent resource is available for core CAMHS. (HSCB and DoH acknowledge the current position and have requested an additional £4.8 million to be invested recurrently in Regional CAMHS). The CAMHS service continues to struggle to meet the Integrated Elective Access Protocols (IEAP) expectation. An 80% increase in accepted referrals since 2013 and an acknowledgement that 20% of the current workforce will now meet the retirement threshold within the next four years is concerning. The process of integrating CAMHS with ASD / ADHD and Youth Justice services continues. ADHD service is now fully integrated. ASD will follow once proposed new investment from the HSCB has been realised (19/20). CAMHS have been successful in 2019 delivering a CAMHS / JYA pilot which will report back in September 2020.	**AMBER**
15.	Effective arrangements should be in place to strengthen and improve placement services for children	Under transformation funding the residential support team has now been established and operational from April 2019. The team aims to support young people and staff in residential care with an objective of stabilising residential placements.	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
16.	Effective arrangements are in place to ensure transitions/exit from care, are timely and well planned and co-ordinated.	The majority of young people involved with Children's Disability Services need ongoing support and services into young adulthood and beyond, including those in care. The Transition Co-ordinators in Children's Disability Teams work with all those involved with young people with complexities of need from age 16, with particular regard being given to those who are in residential or foster care placements. They liaise directly with the various professionals in the Transition Team in Adult Disability Services to ensure all appropriate referrals are made and relevant assessments completed so that the young person can transfer smoothly from Children's Disability to Adult Disability Services. Relevant professionals in Adult Services are invited to all planning meetings and LAC reviews from age 16 years onwards so that they can contribute to care planning, including if the young person is likely to require accommodation post 18 years. A period of co-working is usually established to progress the plan, with Adult Services assuming responsibility for the young person on their 18th birthday.	**GREEN**

FAMILY PRACTITIONER SERVICES (8)

Dental Services (1)

R	A	G	Not applicable
			1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to reduce the number of patients referred to Trust Oral Surgery/OMFS services.	The Oral Surgery/OMFS service is provided on an outreach basis by the South Eastern Trust. The Southern Trust will endeavour to facilitate any changes to the patient pathway etc proposed by the South Eastern Trust.	N/A

General Medical Services (2)

R	A	G	Not applicable
	1		1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure multi-disciplinary teams are embedded within Primary Care.	The Trust has completed an IPT setting out the basis for the development of the Mental Health Practitioner role in the Multi-disciplinary Team in Primary Care. The Director of MH&D is one of a number of Directors who sit on the joint Trust/GP Federation oversight Board. The Trust has identified key outcome measures specifically related to the development of these roles required in order to demonstrate the effectiveness of this new service including swifter access to assessment, signposting and a marked reduction in the numbers of Service Users being referred into secondary Mental Health care.	**AMBER**
2.	Effective arrangements should be in place to ensure the implementation of Phase 7 Delivering Care (Practice Nursing Workforce).	**Not Applicable**	**N/A**

General Ophthalmic Services (2)

R	A	G	Not applicable
	1		1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Prototype modelling around day case Elective Care Centres for cataracts offer the potential to better manage demand, increasing capacity in primary care optometry to facilitate community review of post-operative cataract procedures. Integrated Care will ensure that arrangements are in place to facilitate transfer of a proportion of cataract post-operative reviews to community optometry.	Post op Cataract patients are currently being reviewed within the Trust either by an Optometrist who provides a weekly review clinic in South Tyrone Hospital or by a consultant. The Trust is working towards all cataract patients being reviewed in secondary care by an Optometrist. This will be following introduction Medisoft electronic reporting tool (Medisoft is currently used in the community setting). Confirmation of a rollout plan for Medisoft is awaited.	**AMBER**
2.	Effective arrangements should be in place to facilitate the planning and delivery of optometry-led enhanced services aligned to identified eyecare pathways (glaucoma, acute eye). These services will assist in managing demand within the primary care setting. Integrated Care will develop plans to • roll out a primary care service for the monitoring and review of patients with Ocular Hypertension (OHT) • performance manage the regional enhanced service for the management of acute non-sight threatening eye conditions (NI PEARS) across all LCG areas.	The service sits with Belfast Trust.	**N/A**

Pharmaceutical Services & Medicines Management (3)

R	A	G
1	1	1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure the skill mix of the Pharmacy workforce is appropriate.	Work is underway to improve the Pharmacy team skill mix. The Trust is training 6 additional pharmacy technicians as part of the Transformation funding projects and is also training a number of band 3 Assistant Technical Officer dispensers, to free technicians' time to take over suitable tasks from pharmacists in the dispensary, at ward level and in the aseptic unit. The shortage of qualified pharmacy technicians remains a challenge to this work.	AMBER
2.	Effective arrangements should be in place to ensure that Trusts achieve 70% compliance with the Medicines Optimisation Quality Framework (MOQF) consistent with CPD 2.7 requirements.	The compliance assessment completed in May 2019 showed an increase in compliance to 46%. The Trust continues to work on improving compliance however the outstanding issues are reliant on additional funding being secured – for example 7 day and extended day working for clinical pharmacists to achieve the medicines reconciliation targets, post discharge follow-up, etc.	RED
3.	Effective plans should be in place to deliver £20m efficiencies with £8m from secondary care and £12m from primary care (CPD 7.6).	Plans are in place to deliver the Southern Trust share of the £8m target for secondary care. The outcomes of this plan is being scrutinised by the regional MORE program Board, led by the Department of Health.	GREEN

Primary Care Infrastructure Development (1)

R	A	G
	1	

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Ensure appropriate infrastructure is in place to support the delivery of Multi-disciplinary working arrangements and an increase in capacity with GMS.	The Trust is committed to maintaining and improving Trust owned primary care premises and has undertaken a number of schemes using general capital funding. As part of the Newry and District Federation of Family Practices MDT project, the Trust will work with the Business Services Organisation to identify capacity constraints and opportunities for improvement.	**AMBER**

HEALTH CARE IN THE CRIMINAL JUSTICE SYSTEM (11)

R	A	G	Not applicable
		1	10

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to implement *Improving Health within Criminal Justice*.	The Southern Trust will work with the South Eastern Trust and the Belfast Trust in respect of criminal justice/forensic services to deliver on the agreed action plan.	**GREEN (SHSCT contribution)**

LEARNING DISABILITY (9)

R	A	G
	2	7

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to address deficits in assessment and treatment in LD inpatient units as highlighted by the Independent Review of Muckamore Abbey Hospital (and other incidents affecting NI patients in private Learning Disability (LD) hospitals) (CPD 2.8)	Robust additional community treatment services have been developed in the SHSCT over the past 5 years. These will be further developed in this year. In addition an IPT for a community based assessment and rehabilitation service is in development and will be submitted in October 19. If funded this service will be operational in 20-21.	AMBER
2.	Effective arrangements should be in place to complete the resettlement and address the discharge of people with complex needs from learning disability hospitals to appropriate places in the community (CPD 5.7)	The Southern Trust completed the resettlement agenda in October 2013 for all long stay patients in Longstone Hospital including delayed discharges. One person remains in an out of Trust Long Stay Hospital placement and engagement continues to progress this resettlement. The individual involved refuses to leave the long stay hospital. SHSCT have had a placement available for over 6 months now and have engaged with the host Trust (BHSCT) and DLS in an attempt to expedite the resettlement. The host Trust is currently undertaking a capacity assessment and SHSCT await the outcome of this.	AMBER
3.	Effective arrangements should be in place to support families providing care and deliver on the “ordinary lives” objectives. (CPD 6.2 & 6.3).	All contracts with the Community Voluntary Sector pertaining to day services are being reviewed with the goal of increasing day opportunities for adults with a disability. The Trust will be going to public consultation on a redesign of day care and day opportunities services during this financial year. This redesign has been coproduced with carers and service users during the past 2 years.	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
4.	Effective arrangements should be in place to develop a regionally consistent service model for people with a learning disability.	The SHSCT is engaged regionally with all other HSC organisations in the development of this service model. The SHSCT Project Lead is coordinating engagement and service review across the SHSCT.	**GREEN**
5.	Effective arrangements should be in place to develop "Shared Lives" models of care to increase the availability of alternative family based living opportunities for people with a learning disability.	A Senior Lead officer has been appointed to deliver the objectives of this project and the key milestones identified to date are complete.	**GREEN**
6.	Effective arrangements should be in place to appropriately manage people with LD developing dementia and other conditions associated with old age including short breaks/respite which are varied and flexible in nature (CPD 6.1 & 6.2)	Carers with assessed need are currently offered a menu of options re short breaks which include: • Promotion of Self -directed support (SDS) • Direct Payments • Cash grant • Residential/nursing break • Rotational respite Flexible short breaks are offered to all carers including those caring for people with dementia. The frequency of breaks is based on assessed need and offered via direct payment, SDS or via traditional means. They are developed with the carer and service user and are responsive and person specific. The adult service is also developing a protocol for Senior Management Team approval for delivery of flexible breaks	**GREEN**
7.	Effective arrangements should be in place to increase the number of individuals availing of community	The development of community based day opportunities is a key focus of the SHSCT current Review of Disability Day Services. A desktop scoping exercise has taken place as part of this review, in identifying service users who could potentially avail of day opportunities within their local	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	based day opportunities.	community. The findings of the Day Services Review will likely be subject to public consultation with a range of stakeholders including service users, carers, statutory and independent sector organisations which will inform final recommendations of the review. This may involve the development of an implementation plan to support the progression of day opportunities within local communities with the necessary supports and infrastructure put in place to meet the needs of service users availing of community options. There will also need to be continued strong partnership working with independent sector organisations to ensure that investments made in community based day opportunities appropriately meets the needs of service users referred to these services. Within the Southern Trust, there is continuous planning and discussion between Transition and Adult Services to ensure that service users requiring day opportunities also have their needs appropriately met, within a range of person centred community options.	
8.	Effective arrangements should be in place to improve health care for people with a learning disability.	The Trust has increased the size of the Health Facilitation team to three WTE Health Facilitators, 1 part time Admin Support and 1 WTE Health Facilitator Manager. This will enable the Trust to become involved in the promotion and delivery of a greater number of annual health checks; however 2018/19 has already seen an increase in the uptake of annual health checks. Health Facilitators are actively involved in the development of health and wellbeing plans in partnership with service users, carers and Trust staff. The Health Facilitators along with members of the Adult Learning Disability Carers Forum have been delivering awareness raising training to a range of staff across Acute Services. This has increased the knowledge of key acute services managers in	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		respect of the value of the Hospital Passport. The Trust has recently launched a digital version of the Hospital Passport which is now being used as an information tool for all Trust staff and carers. This new digital version has been developed for region wide use. All carers have received a copy of the Hospital Passport and have been given clear advice as to the value of its use. This is being reinforced through newsletters which are regularly shared with carers. Health Facilitators are actively promoting the uptake of annual health checks through GP practices. The SHSCT Team of health facilitators have already developed a DVD promoting the need for health checks throughout the Learning Disability population and have developed easy read documents for men and women including information on prostate cancer, menopause and Abdominal Aortic Aneurysm Screening. The PARIS system has been recently implemented within the Dorsy Unit, and the Health Passport assessment forms are included within this. The Registered Nursing staff assess and track this information which forms part of the individual's care plan.	
9.	Effective arrangements should be in place to develop Multi-Disciplinary services in community settings to address the actions required within the Independent Review of Muckamore Abbey Hospital.	The Learning Disability (LD) Forensic Service and LD Crisis Response Service are true multi-disciplinary teams and their statement of purpose clearly reflects this objective. LD Specialist Services across the spectrum also work in a partnership model with the independent sector in that they have commissioned services from relevant providers in line with procurement guidelines. They have offered bespoke training to staff and meet regularly to address care needs of clients. Regular contract meetings are also held and there is an open door for providers to contact the Head of Service as Contract Owner. Information is current via a database and vacancies are identified and flagged to the Accommodation Panel so that extended voids are prevented. The contract owner regularly sends out relevant information to the independent sector to keep them updated on current events and issues as well as learning points. LD Services have a range of very complex people placed with the independent sector and they regularly	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		meet as a core group to review careplans which can include the independent advocate to ensure a person centred approach to care. The SHSCT continues to submit business cases to enhance our community infrastructure across core services and specialist services. The SHSCT continues to work with independent sector providers to attract investment into LD services and to create additional community placements to meet the needs of individuals with complex presentations.	

R	A	G
	3	1

MANAGING LONG TERM CONDITIONS (34)

Coronary Heart Disease (4)

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure that referrals to Rapid Access Chest Pain Clinics (RACPC) comply with NICE CG95 - Chest pain of recent onset: assessment and diagnosis.	The Trust is participating in a regional task and finish group which is developing referral criteria, technical guidance and feedback to GPs to enable the 2 week target to be achieved.	**AMBER**
2.	Effective arrangements should be in place to ensure that there is an appropriate clinical physiology workforce in place to deliver cardiac investigations.	Trusts should work with the HSCB/PHA to develop a regional clinical physiology workforce plan.	**AMBER**
3.	Effective arrangements should be put in place to ensure that patients receive timely access to TAVI implantation	The Southern Trust complies with all requirements for patients awaiting TAVI.	**GREEN** (SHSCT contribution)
4.	Effective arrangements should be put in place to develop models for cardiac rehabilitation services.	The Trust's workforce plan has been submitted to the HSCB and feedback is awaited.	**AMBER**

Diabetes Care (13)

R	A	G
1	5	7

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be put in place to develop services for women with diabetes in pregnancy in Northern Ireland.	Transformation and some recurrent funding has been allocated to enable improvement of the service provided to diabetic mothers. The following have been established: • Virtual clinics to enable mothers to be streamlined to either virtual or face-to-face clinics as appropriate; • Staff Grade cover at diabetic/ante-natal outpatient clinics facilitating post-natal patients to be reviewed; • Daily inpatient ward rounds (Monday to Friday) for diabetic expectant mothers.	GREEN
2.	Effective arrangements should be put in place to implement the funding for piloting of in-patient diabetes teams and new models of care in the community.	Transformation funding was allocated to enable a pilot of the inpatient diabetes team to be undertaken. However the funding was insufficient to enable full implementation of the model on both acute hospital sites. Securing the additional necessary consultant capacity also proved to be challenging. A band 6 specialist nurse was appointed. Currently there is a consultant led ward round 2 days of the week on each site and a diabetic nurse specialist ward round on 3 days. A Diabetes project with Bannview medical practice is to commence September 2019 to explore new ways of working.	AMBER
3.	Effective arrangements should be in place to expand the number of structured Diabetes Education programmes in the 5 Trusts for people with Type 1 and Type 2 diabetes.	The Trust runs the regionally agreed structured patient education programmes: • DESMOND for people with Type 2 Diabetes (replacing Xpert). There are 70 programmes planned to March 2010; • Practice nurses have been recruited to support additional DESMOND sessions within the Trust; • Refresher training for patients with Type 2 Diabetes are now provided: 19 programmes planned;	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		• DAFNE for people with Type 1 Diabetes (1 team has been trained for the Newry and Mourne locality, pending further DAFNE training available SHAIRE continues to run in Armagh and Dungannon and Craigavon and Banbridge). Further DAFNE training is scheduled for 2 teams in December 2019. There are 4 DAFNE programmes planned.	
4.	Effective arrangements should be in put in place to implement the NI Diabetic Foot Care Pathway.	All staff have been recruited and are in post. Progress has been made across each tier of the pathway to standardise podiatry care in line with NICE Guidance and the regional Integrated Diabetes Foot Pathway. A Foot Protection Team and Enhanced Foot Protection Team are in place and local pathways are being enhanced to ensure smooth and timely patient flow in the Trust and to the Multidisciplinary Diabetic Foot Team. Training of Podiatry assistants has commenced to provide additional resource to maintain the tier 1 screening model.	**GREEN**
5.	Effective arrangements should be put in place to provide education and support for people recently diagnosed with diabetes.	The Trust is phasing in the regionally agreed structured patient education programmes, currently: • DESMOND for people with Type 2 Diabetes (replacing Xpert); • DAFNE for people with Type 1 Diabetes (1 team has been trained for the Newry and Mourne locality, pending further DAFNE training available SHAIRE will continue to run in Armagh and Dungannon and Craigavon and Banbridge); • The Trust is awaiting new funding to support additional training and refresher programmes.	**AMBER**
6.	Effective arrangements should be put in place to develop patient pathways for insulin pumps and Continuous Glucose Monitoring (CGM).	The Trust has purchased sufficient insulin pumps to enable new patients to access, as deemed appropriate, following full assessment by the MDT.	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
7.	Effective arrangements should be put in place to ensure appropriate usage of Freestyle Libre.	Consultants continue to prescribe Freestyle Libre. Consultants/Diabetic Nurse Specialists undertake group sessions with patients prior to commencement. The Trust suggests that further discussion at a regional level is required regarding a methodology for this audit. There are a number of issues including the fact that not all patients have signed up to using libreview and NIECR does not have an auditable field for recording HbA1c.	**RED**
8.	Effective arrangements should be put in place to improve transition arrangements for transfer of care from paediatric to adult diabetes services.	Transition clinics were established in the Southern Trust to support the transfer of patients from paediatric to adult diabetes services. However the consultant with special interest in transition planning accepted a post in another Trust. The Southern trust is currently negotiating with the South Eastern trust to secure a weekly consultant session to enable the clinic to be re-instated. MDT protocols are being developed. The Trust also ran a Young Adult event in June 2019 to provide additional support and resources. The Trust is testing a new model of the Paediatric Diabetic Clinic, moving to community setting which will offer the opportunity to provide alternative activities for children and young people. This is commencing in September 2019 - March 2020 in the Newry leisure centre.	**GREEN**
9.	Effective arrangements should be put in place to provide education and support for children with diabetes.	The Trust has a system in place to review annual health plans for all children and young people with diabetes (currently ~280). A range of booklets and electronic processes are in place to facilitate communication for those on insulin injections and pumps. These include the use of diasend, carelink, communication booklets and 'Ready Steady Go'. Structured Education – the CHOICE programme is provided to children and young people within 6 months of diagnosis. All patients are also are offered refresher training every 2 years. A general presentation on diabetes is included in all CHAT training sessions for school	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		staff. In keeping with best practice guidance patient specific training on children and young people with diabetes who require support in school alongside comprehensive assessment of competencies is also provided by the Trust. The diabetes nurse specialist team provide phone support for parents in and out of office hours (out of hours is unfunded) to support parents to manage their children and young people at home and prevent hospital admission. The Trust has recruited 1.3 wte Band 6 Diabetic Nurses who will undertake specialist training to support and sustain the service. Service leads are currently working with the ICP and network lead to secure additional funding to support this service.	
10.	Effective arrangements should be put in place to ensure children with diabetes are treated in age appropriate settings.	Children and young people up to the age of 16 years who require admission are admitted to children's inpatient wards within the SHSCT. Comprehensive guidance is available to support staff in managing these patients and update training is provided regularly to acute nursing and medical staff. The SHSCT Paediatric Diabetes service is managed within the Children and Young People's Directorate. There is an identified medical lead for this service. CYP representatives are part of the Trust's Internal Diabetes Implementation Group and Diabetes Strategic Group. MDT and management representatives sit on the Regional Paediatric MCM Group which is part of the Regional Diabetes Network and meets quarterly. The SHSCT paediatric diabetes service is a multidisciplinary service supported by doctors, nurse specialists, dieticians, psychology and administrative staff. There is a need for additional resources for psychology support within this service. Acute and community services work closely to support CYP with IDDM. Diabetes outpatient clinics are now divided into age groups and are provided at	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		locations across the Trust. A transition clinic is being piloted between acute, OPPC and CYP directorates and feedback is positive. The Trust is testing a new model of the clinic and moving the Paediatric Diabetic Clinic to a community setting which will offer the opportunity to provide alternative activities for children and young people. This is commencing in September 2019 - March 2020 in the Newry leisure centre.	
11.	Effective arrangements should be put in place to optimise new and existing care pathways for mothers and babies with complex needs.	There are clear pathways in place for the diagnosis and management of women with Type 1, Type 2 and Gestational Diabetes during pregnancy and delivery. An additional weekly clinic has been put in place.	**GREEN**
12.	Effective arrangements should be put in place to develop new models of care for people with diabetes.	A Diabetes project with Bannview medical practice is to commence September 2019 to explore new ways of working.	**AMBER**
13.	Effective arrangements should be put in place to provide appropriate workforce and education programmes for staff working in specialist and generalist areas across primary, secondary and tertiary care in the care and treatment of people living with diabetes.	The community diabetes service is providing a range of training to staff in the care of people living with diabetes - targeting Practice based staff including GPs, practice nurses and pharmacists, district nursing teams and care home staff.	**AMBER**

Pain Management (6)

R	A	G	Not applicable
	5		1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to enhance the skills and capacity of secondary care pain management teams and their scope for integrated working in line with *Core Standards for Pain Management Services in the UK* published by the Faculty of Pain Medicine at the Royal College of Anaesthetists in 2015. This should include capacity for a leadership role in educating and training practitioner colleagues in other secondary, primary and community care services.	A multi-disciplinary approach is central to the delivery of the pain management service. Staff education and training plays an important role. A GP with special interest in pain management undertakes outpatient sessions. In addition to providing essential capacity within secondary care, this arrangement also enhances the expertise available within primary care. A key component in the provision of pain services is the ongoing education of other healthcare staff who deal with patients with chronic pain. Ad hoc talks to GP's, nurses and physiotherapists are currently provided and will continue. The Trust participates in the Regional Pain Forum and is willing to contribute to regional awareness campaigns. The Acute Pain Sister provides education and training for nursing staff on the all Trustwide acute wards. The clinical lead for acute pain provides education and learning on current practice updates for medical and nursing staff.	**AMBER**
2.	Effective arrangements should be in place to ensure patients have timely access to supported self-management options as part of a stepped care model, including those provided with the help of expert patients, peer and lay	Patients referred to the Pain Management service have an initial appointment with either a consultant or GP with special interest in pain management. An appropriate treatment plan is developed at this appointment. Patient education and self-management strategies are an essential component and patients may be referred on to the Psychology Team. They may also be enrolled on a Pain Management Programme where individual or group psychological techniques are employed. Psychological therapies are critical to the treatment of this cohort of patients. However capacity is a	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	trainers in community settings.	major constraint and there is no potential to direct additional capacity towards Pain Management without further investment in the Psychological Therapies service. Non recurrent funding allocated for chronic pain outpatient referrals whilst welcome will increase the number of patients needing a place on a Pain Management Programme. Chronic pain is extremely debilitating and can be life changing. Patients need to be assessed quickly and a treatment plan put in place. Patients currently wait 46 weeks for a routine first appointment at the Trust. Capacity to deliver treatment is also limited and patients are now waiting 135 weeks for daycase treatment. A proposal for the necessary additional funding to address the current capacity gap, both in terms of initial assessment and also treatment and support for self-management had been drafted in the past and will be kept under review.	
3.	Effective arrangements should be in place to ensure patients are managed along regionally agreed integrated pathways to improve outcomes and patient experience.	The Trust will be happy to work with the local ICP/MDTs to develop integrated patient pathways for painful conditions.	**AMBER**
4.	Effective arrangements should be in place to ensure patients with persistent pain have equitable access to evidence based services.	The Trust has in place mechanisms for referrals to all pain and musculoskeletal specialities as appropriate. Those patients requiring regional expertise are also referred on for treatment. The Trust provides a number of interventional treatments locally including neuromodulation interventions and provides treatment for some patients from outside the Southern area. Outpatient clinics are provided in each of the 3 Trust localities. Pain Management Programmes have now been established in the Newry and Mourne area. As previously noted, a proposal for the necessary additional funding to address the	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		current capacity gap, both in terms of initial assessment and also treatment and support for self-management had been drafted in the past. It is proposed to keep this updated to reflect the current position and service pressures.	
5.	Effective arrangements should be put in place to deliver a sustainable regional multidisciplinary persistent pain management service for children and young people with complex needs.	Not Applicable	**N/A**
6.	Effective arrangements should be in place for multidisciplinary and interagency working across the wide ranging spectrum of patient need to meet the challenges of prescription drug misuse.	The pain consultant reviews the current analgesia requirement for individual patients and adjusts accordingly. Dr J Sobocinski is the Pain change lead for the NICE clinical guidelines CG173 - Neuropathic pain in adults. The Trust pharmacy team has developed a number of patient leaflets to be used when an opiate needs to be introduced to a patient's treatment plan for a short time following surgery. The leaflet will be given to the patient during their stay and shared with the patient's GP and Community Pharmacist on discharge, so that all members of the team are aware of the plan to stop opiates on or post discharge. The leaflets are being piloted in Orthopaedics and if successful they will be rolled out to other surgical areas. The aim of this project is to combat the high number of patients that remain on opiates long term after surgery.	**AMBER**

Respiratory (4)

R	A	G
	3	1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to continue to implement the recommendations of relevant review and evidence based guidance including: • 2015 RQIA review of respiratory teams • NCEPOD reports • NICE Guidance	The HOSAR service is fully operational. The elements of the COPD discharge bundle are incorporated into discharge planning processes delivered by the acute respiratory team All appropriate pulmonary rehabilitation referrals are being directed to community based pulmonary rehabilitation programmes. An ambulatory respiratory service has been established, currently running 2 days per week. The Trust is currently developing plans to extend the service to a third day.	AMBER
2.	Effective arrangements should be in place to ensure appropriate integrated pathways for adults and children across community, primary, secondary and tertiary care.	The HOSAR service is fully operational across all three locality areas. Within the Paediatric service the Trust is using the British Thoracic Society/SIGN 2014 asthma guidelines and pathway for asthma along with the Respiratory Framework. A regional GAIN audit (Guidelines and Audit Implementation Network) will commence in September. For Allergy the Trust is also using the British Society for Allergy and Clinical Immunology (BSACI) pathways and documentation for paediatrics which is accredited by NICE guidelines. The Trust is participating in piloting a safe asthma discharge pathway follow up for children and young people who attend ED. This will reduce hospital admission, frequency of ED attendances, reduce asthma attacks and reduce use of steroids. There has been an appointment of 0.74 wte respiratory nurse specialist with transformation funding to provide support/assessment education and training as specified within the respiratory	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		framework. The audit of adult asthma services will be repeated in October 2019. An additional clinic is required to reduce the waiting time from the current 4-6 weeks. Further funding may be required to facilitate this. The Trust has submitted its requirements to establish an Interstitial Lung Disease service for which additional funding will be required. The Trust awaits feedback.	
3.	Effective arrangements should be in place to promote self-management, self-directed care and other suitable training programmes for patients.	All patients referred to the community COPD team have an individualised self-management plan. Pulmonary Rehabilitation clinics are available and have been developed and agreed in collaboration with the patient. The Trust collaborates with Chest Heart and Stroke, Arthritis Care and local leisure centres for the provision of living with long term conditions training and ongoing exercise programmes. The Trust has reviewed its PPI Strategic Action Plan and has co-produced its PPI Framework which together with the PCE Framework feeds into its Quality Strategy. The Trust has also co-produced a PPI Cycle fact sheet outlining the relationship between PCE, PPI, Co-production and Quality Improvement and is finalising the up-date of its PPI Toolkit for staff which includes guidance on co-design and co-production in improving and developing services in line with the Delivering Together agenda.	**GREEN**
4.	Effective arrangements should be in place to support the development of networked services across Northern Ireland for the following: • Long term ventilation (LTV)) • Ambulatory Care Pathways in	The Trust has representatives involved in the regional procurement exercise for NIV and will continue to participate in this exercise. The bronchiectasis audit has been completed and submitted. The actions for SHSCT are minimal. Transformation funding was secured for both acute and community staff to enable an ambulatory respiratory service to be established. It currently runs 2 days per week. The Trust is currently developing plans to extend the service to a third day. The Trust has a procedure in place to deliver difficult asthma services for children, young	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	the Unscheduled Care Reform Programme including Home IV antibiotics services. • Implementation of COPD, bronchiectasis, paediatric and adult asthma audit recommendations.	people and adults. COPD, bronchiectasis and asthma audit audits continue to be carried out. The Trust will continue to participate in the initiative to standardise the Home Intravenous Anti biotic and Anti-Viral service for respiratory patients. An OPAT service has been established using Transformation funding. Additional pharmacy staff have been appointed. They have developed the prescribing and supply aspects of the service, in conjunction with consultant microbiologist support. This is facilitating the transfer of work from acute to community settings. Early results show a 17% increase in patients switched to oral therapy, which has saved District Nursing time, average length of treatment has reduced by 4 days, 21 hours per month of Consultant time has been saved and the longest duration of treatment has reduced from 51 days to 35 days. However it should be noted that delivery and effectiveness is still reliant on core district nursing teams which are under significant pressure.	

Stroke Services (7)

R	A	G	Not applicable
	5	1	1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to provide appropriate stroke services for younger people as 20% of all stroke occurs in people aged under 65.	The Stroke service is currently available to all over 18 year olds in SHSCT. The Trust is continuing to work in partnership with Northern Ireland Chest Heart and Stroke and Stroke Association (NICHS) to increase support networks e.g. Young Women Stroke Survivors Group, (SHSCT and Stroke Association) The Trust fully participates in the regional stroke work and is awaiting further information from the Regional Stroke Strategy Group. Return to work issues are identified as soon as possible after the person's stroke, reviewed regularly and managed actively by the community stroke team. Stroke survivors who have work issues are referred to Disabled Employment Agency-jobs and benefits and also links with Cedar foundation. Community stroke services address the specific psychological needs of younger stroke survivors – these include hidden cognitive deficits, identity & adjustment, as well as return to work. Employment is a key psychological outcome and indicator of successful rehabilitation (NICE, 2013). Individuals receive a neuropsychological (cognitive) assessment to facilitate a return to work. The regional stroke consultation has closed and the outcome is awaited.	GREEN
2.	Effective arrangements should be in place to ensure that all stroke patients are admitted in line with NICE guidance.	A bed is protected for lysis/stoke assessment in the stroke ward at Craigavon Area Hospital improving the potential for stroke patients to be admitted directly to the stroke ward The ability to protect this bed is challenging due to ongoing unscheduled care pressures however it is prioritised for this purpose. On the DHH site, stroke patients are admitted to the High Dependency Unit.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		The Trust continues to experience blockages in ED due to the volume of demand which can potentially impact on delay in the identification of stroke patients, particularly 'walk-in' patients. Additional training has been provided to reception and triage staff which has improved early identification of stroke patients. Whilst the extension of hours for thrombectomy at the regional stroke centre is beneficial for patients, it has exacerbated the nursing staff pressures at the Trust. A nurse must be allocated to accompany the patient to Belfast. This pressure has not been funded for the service. All stroke patients presenting to the Trust have their patient journey mapped post admission to assess any areas for learning and improvement in the patient pathway.	
3.	Effective arrangements should be in place to provide appropriate specialist spasticity services for stroke survivors.	Stroke patients at the Southern Trust do not have access to a botox service. The in-reach service that had been provided by the Belfast Trust has been stood down.	**AMBER**
4.	Effective arrangements should be in place to provide thrombolysis as a treatment for acute ischaemic stroke (CPD 4.8).	Between May 2018 and April 2019 15.7% of patients received thrombolysis. Clinical decision ultimately determines when the thrombolysis drug can be delivered to individual patients. Performance is therefore, impacted by the variable presentation of strokes and clinical decisions considering clinical risks and benefits. Whilst the presentation of individual cases will affect the ability to achieve this objective, the Trust continues to seek improvement in this and across a broader range of indicators, via participation in the Sentinel Stroke National Audit Programme (SSNAP) that creates and monitors quality outcomes for the management of stroke.	**AMBER**
5.	Effective arrangements should be in place to provide mechanical thrombectomy for large vessel stroke as an effective intervention for	Not Applicable	N/A

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	selected stroke patients (CPD 4.8).		
6.	Effective arrangements should be in place to provide assessment within 24 hours of all suspected TIAs on a 7 day basis.	The ability to extend the existing 5 day TIA service in Craigavon Area Hospital to provide a 7 day service will be dependent on allocation of additional funding and the ability to attract and secure skilled staff. The Trust would welcome engagement with the Commissioner to discuss opportunities for investment in this service development.	**AMBER**
7.	Effective arrangements should be in place to facilitate, where appropriate, early supported discharge (ESD) of acute stroke patients from hospital.	Recruitment to ESD posts progressed with the exception of 3 posts which required re advertisement and are in the recruitment process. SHSCT has commenced phased implementation of ESD:- • From 1st May, ESD was introduced Monday to Friday – this has allowed testing of pathway, procedures and development of a data collection spreadsheet; • From 1st July, Saturday and public holiday working commenced; • Full monitoring of response times has been implemented.	**AMBER**

R	A	G
	5	6

MATERNITY & CHILDHEALTH (19)

Maternity & Neonatal Services (11)

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure that appropriate pre-conceptual advice and care is available so that women are supported to be as healthy as possible at the time of conception to improve outcomes for mother and baby (CPD1.8).	The Trust will continue to actively participate in the Maternity Strategy Implementation Group. This work is being led by the Public Health Authority. The Strategy Document is currently being compiled by the Implementation Group and will shape the work to be taken forward.	GREEN
2.	Effective arrangements should be in place to ensure that required data is captured to monitor service activity, compliance with standards and to underpin quality improvement work.	A Paediatric Advice Line is in place on both the CAH and DHH sites for GP's Health Visitors and Midwives to ensure access to senior decision makers facilitating same day and next day assessment. The Trust also offers urgent outpatient general paediatric slots for patients that need to be seen in less than 9 weeks which are accessible by GP's via the designated Consultant of the Week. In the new Blossom and Daisy Paediatric Units there are dedicated short stay beds facilitating care close to home and actively preventing admission to acute children's inpatient beds. Consultant led training sessions and simulation exercises are provided twice yearly for Primary Care colleagues to enhance their paediatric assessment and intervention skills. Simulation training sessions are also provided to Maternity staff and ED staff to ensure maintenance of skills. The Trust works closely with the Neonatal Network to ensure outcomes from information and data inputted to Badgernet are interrogated at the network meetings and comparisons to other services regionally challenged for service improvement and	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		improved outcomes for babies. The Trust is contributing to regional pathway work to ensure patients are cared for in the most appropriate setting. Data from NIMATS is collated for the Regional and Trust Dashboard which will form the basis of quality indicators to be developed within the Trust.	
3.	Effective arrangements are in place to support multidisciplinary learning and service improvement through regular multi-disciplinary morbidity and mortality review.	There are monthly Governance and Morbidity & Mortality meetings across both acute sites and then quarterly meetings with maternity services to review all deaths. Learning is discussed and shared. Death notification processes for all child deaths have been reviewed. A generic email address has been set up to assist with improved notification into the CHS. The Trust reports into Each Baby Counts National Trial by RCOG to identify themes across the country which relate to events in intrapartum care and share lessons learned to improve future care.	**GREEN**
4.	Effective arrangements should be in place to ensure that the agreed regional antenatal care pathway is delivered. This pathway, developed by the Maternity Strategy Implementation Group, is designed to promote a healthy pregnancy and improve outcomes for mothers and babies – including a reduction in low birth weight – through a range of	The Trust has moved all low risk pregnancies to midwifery led clinics (MLC) in the hospital & community. There is now a self-referral letter on the Trust's website and Facebook page so women can self-refer directly to a midwife for antenatal booking. The Trust is fully baby friendly accredited and has had reassessments undertaken this year in 1 hospital and 3 community localities. The Trust will progress to the Gold award for Baby Friendly which is the next stage. The Trust has implemented Group based antenatal care and education through the Early intervention Transformation Programme (EITP). The Getting Ready for Baby (GRFB) initiative is currently being rolled out across the Trust. It has been fully implemented in the Banbridge, Newry and Craigavon areas. This has proven to be a very beneficial and successful programme for first time mothers and their partners. For sustainability into 19/20 the Trust require to secure appropriate accommodation and this is currently being explored. The Trust has been able to sustain the 'Getting Ready for Baby Programme' of	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	actions including reducing smoking and high quality antenatal care.	Group based antenatal care and is exploring options to further develop this service into other localities but accommodation constraints are limiting the ability to implement this.	
5.	Effective arrangements should be in place to ensure that women with complex pregnancies are offered the best possible care in line with national evidence based guidelines.	The Trust is complying with the NICE guidelines and is working towards the early contact visit. Current resources do not facilitate this additional appointment. However to cope with the increasing demand the Trust had run at risk with an additional diabetic clinic on a Thursday morning in Craigavon Area Hospital. This clinic has now been sustained through Transformational funding to enable improvement of the service provided to diabetic mothers. The following has been implemented: • Virtual clinics to enable mothers to be streamlined to either virtual or face-to-face clinics as appropriate • Staff Grade cover at diabetic/ante-natal outpatient clinics facilitating post-natal patients to be reviewed Weigh to a Healthy Pregnancy is a regional programme which has been running in the Southern Trust since June 2013. It is aimed at pregnant women with a Body Mass Index greater than 38 at their antenatal booking appointment to help limit gestational weight gain through healthy lifestyle changes. The key performance indicator is that 100% of eligible women are offered the programme with a 65% uptake. This target is met within the Southern Trust, and current figures would suggest that 90% of women do gain within or below the 5-9kgs recommendation from the American Institute of Medicine. Dedicated twins clinics have been established at Craigavon Area and Daisy Hill Hospitals. Twins are seen only by a number of lead consultants. There are two lead consultants on each site who look after ladies with epilepsy. The Trust will continue to participate in the regional initiative to implement an agreed care pathway for women with epilepsy.	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
6.	Effective arrangements should be in place to offer early pregnancy assessment pathways for women.	There are early pregnancy assessment clinics at Craigavon Area Hospital, (5 day service, Monday – Friday) and at Daisy Hill Hospital (3 day service - Monday, Wednesday and Friday). The Trust will work with the Public Health Agency and the Health and Social Care Board to explore opportunities to extend the service to 7 days. However additional resources will required for a 7 day service at CAH and DHH.	AMBER
7.	Effective arrangements should be in place to ensure that there is appropriate monitoring of transfers to the RoI that take place because of capacity constraints.	There is a regional protocol to capture all transfers within Northern Ireland. However the pathway is currently being updated. Moving forward for transfers to and from the ROI - these will be captured on the Datix system. The Trust continues to be part of the Maternity Collaborative where work undertaken is reviewed as part of the Neonatal Collaborative.	AMBER
8.	Effective arrangements should be in place to ensure that opportunities to offer early intervention and prevention of long term disability by enhanced therapy services in neonatal units are realised.	The Neonatal Unit provides an enhanced therapy service from a Dietician, Occupational Therapist, Speech and Language Therapist and Physiotherapist. These post holders are now embedded in the neonatal MDT ensuring holistic care based on assessed needs are provided to this patient group. The Trust has a long established integrated neonatology /Child Development Service for high risk infants with developmental needs.	GREEN
9.	Effective arrangements should be in place to care for women who have recurrent miscarriages.	The Trust will continue to work with PHA/HSCB to standardise the referral and clinical pathways for women who have recurrent miscarriages. On the Craigavon Area Hospital site there is a bi-monthly recurrent miscarriage clinic.	GREEN
10.	Effective arrangements should be in place to ensure that mothers and babies are not separated unless there is a clinical reason to do so.	Where clinically possible mothers and babies are not separated. Babies are only admitted to the neonatal units where this is clinically indicated. The Trust will endeavour to progress in this direction however there are limitations in relation to existing accommodation and Midwifery staffing levels.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
11.	There would be an opportunity to enhance skill mix further with the appointment of additional maternity support workers to work alongside midwives to support mothers.	The Trust is fully committed to working with the PHA to scope out the additional requirement for maternity support workers. There has been a first meeting with the PHA to progress this work. The Trust continues to utilise all available places for the maternity support worker courses.	**GREEN**

Paediatric Services (8)

R	A	G	Not applicable
	2	3	3

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure that care is provided as close to home as possible with children only being transferred to the regional children's hospital for a service which is not provided locally.	The new Blossom and Daisy Paediatric Units have dedicated short stay beds facilitating care close to home accommodating parents and carers and actively preventing admission to acute children's inpatient beds. The children with complex comorbidities have direct access to each short stay and inpatient facility. A paediatric advice line is in place also available on both CAH and DHH sites for GPs, health visitors and midwives to ensure access to senior decision makers facilitating same day and next day assessment. The Trust also offers urgent general paediatric slots for patients that need to be seen in less than 9 weeks which are accessible by GPs, via the designated Consultant of the Week. With increased age limit up to 16th Birthday some service users 14-16 years require to be accommodated in an agreed cohorted area outside the paediatric units; as a result of this and in keeping with the current regional position work is ongoing to ensure the supports to these areas are provided by paediatric staff when required. Simulation training sessions are also made available to staff to ensure maintenance of skills. Processes and Pathways for those requiring transfer out to the regional centre are being reviewed with Paediatric Collaborative/network. Consultant led training sessions and simulation exercises are provided twice yearly for Primary Care colleagues to enhance their paediatric assessment and intervention skills. The Trust is contributing to regional pathway work to ensure patients are cared for in the most appropriate settings.	GREEN

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
2.	Effective arrangements are in place to support multi-disciplinary learning and service improvement through regular multi-disciplinary morbidity and mortality review.	The Trust is part of the Saving Babies Lives review where every child death is reviewed and discussed with learning disseminated to staff. There are monthly Mortality and Morbidity meetings with discussion of cases with Maternity and Neo Natal Unit staff. There is also a Trust annual perinatal audit meeting.	**GREEN**
3.	Effective arrangements should be in place for the provision of Paediatric Cardiac Services in line with the Ministerial decision on the establishment of an All-Island Network. An increasing number and range of elective cardiac procedures, as well as emergency and urgent cases are now being accommodated in the ROI. The paediatrician with a specialist interest role in cardiology is being established in both Southern and Western Trusts.	The Trust has worked with the Commissioner to agree a service model for a paediatrician with expertise in cardiology. The service model includes a consultant paediatrician with expertise in cardiology, a part-time paediatric cardiac liaison nurse and a full-time cardiac clinical physiologist. An Investment Proposal Template has been completed and has been forwarded to the Commissioner for approval. If funding is released to implement the model in a timely way it is anticipated that new service model will be implemented from January 2020.	**AMBER**
4.	Effective arrangements should be in place to improve the resilience, sustainability and	Not Applicable	N/A

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	access to specialist paediatric services		
5.	Effective arrangements should be in place to implement the Paediatric Red Blood Screening Strategy by January 2020 and ensure that patients admitted have dietetic support when required.	Not Applicable	N/A
6.	Effective arrangements should be in place to offer short stay assessment and ambulatory models of care in all paediatric units. These should be available during times of peak demand.	In the new Blossom and Daisy Paediatric Units there are dedicated short stay beds The short stay beds are currently open 5 days a week (Mon to Fri 09:00 to 22:00hrs). In Blossom the opening hours of the short stay unit has been extended on Saturday and Sunday 14:00-20:00hrs which coincides with the increased presentations of children and young people into the ED department. Extended opening hours both in time and across both acute sites are dependent on appropriately skilled staff and staff availability; these will be reviewed in the future. Extended roles continue to be developed including Advanced Paediatric Nurse Practitioners with the support of senior medical staff. A paediatric advice line is in place also available on both CAH and DHH sites for GPs, health visitors and midwives to ensure access to senior decision makers facilitating same day and next day assessment. The Trust also offers urgent general paediatric slots for patients that need to be seen in less than 9 weeks which are accessible by GPs, via the designated Consultant of the Week. The Short Stay Paediatric Assessment beds are for children and young people up to their 16th birthday and referrals are received from the Emergency Department, GPs, Health Visitors and Community Midwives for short stay assessment, observation, treatment and	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		admission/discharge.	
7.	Effective arrangements should be in place to deliver a sustainable scoliosis service.	Not Applicable	N/A
8.	Effective arrangements should be in place to ensure children and young people receive age appropriate care up to their 16th birthday.	The new Blossom and Daisy paediatric units admit children and young people up to their 16th birthday. These are purpose built wards with single rooms and ensuite facilities which effectively meet the needs of this age group. A protocol is in place to guide staff on the clinical management of 14-16 year olds requiring inpatient admission. This protocol is being reviewed by the Director of Children and Young People's Services, the Director of Acute Services, the Medical Director; service managers, Associate Medical Directors and Clinical Directors from the interfacing services. There are good working relationships between specialities internally and externally thereby ensuring appropriate care. Paediatricians provide training and simulation experiences to colleagues in acute services enhancing safe high quality care provision. Clinical pathways are in place to provide high quality and safe care ensuring transfer to the regional centre only if appropriate.	**AMBER**

R	A	G
1	8	

MENTAL HEALTH (9)

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangement should be in place to deliver Phase 1 of the Regional Trauma Network which will provide treatment for people with complex Post Traumatic Stress Disorder (PTSD) (as identified in the Stormont House Agreement).	The Trust is an active participant in the Regional Trauma Network and has recruited additional staff to meet the needs of those identified as requiring specialist Trauma support. Not all posts were filled from an initial recruitment drive and further recruitment is ongoing. Temporary accommodation has been identified but permanent therapy accommodation is required. Options for the provision of suitable permanent accommodation for this expanding patient facing service are currently being explored. There is an excellent working relationship with the Victims and Survivors Service and good relationships with their enhanced services which work closely with the Trust. The Trust awaits the outcome of the current consultation on the Trauma Service.	**AMBER**
2.	Effective arrangements should be in place to develop enhanced mental health liaison services in acute general hospitals.	The Trust bid for the enhanced Liaison Model in the first round of the Transformation Projects was unsuccessful in achieving the required investment. The Trust has submitted and been successful in a second bid for fewer resources. The Trust will continue to develop the enhanced liaison model and seek funding for the full liaison service as in operation elsewhere.	**AMBER**
3.	New legal requirements for HSC Trusts to provide systems and processes to implement and administer the Deprivation of Liberty requirements from the Mental Capacity Act (Northern Ireland 2016) will be enacted from 1 October 2019.	The Trust has established a Task and Finish Group to oversee the implementation of the Deprivation of Liberty (DoLs) element of the Mental Capacity Act. This is focussed on developing arrangements to meet the requirements of the Short Term Detention Orders (STDOs) and for the operation of the Deprivation of Liberty Panels as part of a 5 Trust arrangement to ensure consistency of development. Staff have been released for the Training for Trainers process and arrangements are also being put in place to bolster the centrally provided training processes for in particular medical staff. A rolling programme of training for priority staff will be undertaken in September and October with a view to completion of all remaining staff	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		who require DoLs training by the end of the year. To date there has been no agreement reached regionally with regard to the rate to be paid to medical practitioners for MCA DoLs work.	
4.	Effective arrangements should be in place to implement the recommendations from the review of acute mental health services	The Trust has commenced implementation of a number of recommendations specified in the Regional Acute Review. The availability of suitably qualified and experienced staff remains the single biggest challenge in providing consistent, safe and effective care.	**AMBER**
5.	Effective arrangements should be in place to implement the recommendations from the review of acute mental health services. The review also identified deficits in the regionally consistent quality and performance information to support robust strategic planning.	The Trust has commenced implementation of a number of recommendations specified in the Regional Acute Review and specifically the engagement in the NHS Benchmarking Scheme, the adoption of the Royal College Accreditation Schemes in LD In-patients, General Working Age Wards and the regional collective on Psychiatric Intensive Care Unit (PICU) development.	**AMBER**
6.	Effective arrangements should be in place to implement the recommendations from the review of the Addictions Care Pathway including substitute prescribing (CPD 1.14).	The Trust will undertake this review as specified in 2019-20 subject to the availability of Resources.	**AMBER**
7.	Develop a stepped care pathway for the enhancement and further development of dedicated perinatal mental health services.	The Trust will undertake this review as specified in 2019-20 subject to the availability of Resources. A 0.6WTE Substance Misuse Liaison Midwife has been appointed (Band 7). The Integrated Liaison Team offers a response to maternity services. Currently, all	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		referrals in perinatal phase received in triage are processed as an urgent referral. Triage will consult with a PMHC Consultant where advice on medication or diagnosis is required. Support and Recovery teams have ongoing input throughout the perinatal period..	
8.	Effective arrangements should be in place to ensure the continued recruitment and retention of Approved Social workers (CPD 8.10).	The Trust will undertake this review as specified in 2019-20 subject to the availability of Resources. Consideration is being given to plans which relate to meeting the statutory functions under the Mental Capacity Act whilst sustaining our responsibilities under the Mental Health Order. Social Work staff will be identified for a specific role and prioritised for Approved Social Worker (ASW) training within a reasonable timescale. Available spaces on the ASW programme have been increased and we have 5 ASW candidates going for training this year. Focus for ASW candidates in moving towards Older People and Primary care (OPPC) and Acute hospital services as much of the MCA work will be generated from these areas. With this in mind, we have 3 OPPC social workers and one Acute Hospital social worker going for training, as well as one perinatal mental healthcare social worker. Significant re-organisation of the current ASW workforce is being planned to meet these functions and sustain our responsibilities under the MHO.	**AMBER**
9.	Effective arrangements should be in place to ensure an appropriate skill mix in community mental health teams with reference to best practice evidence and recommendation with Delivering care Phase 5b (Nursing).	The Trust will undertake on-going work to deliver a more balanced MD workforce in 2019-20 subject to the availability of staffing. The Trust notes a continued mismatch between the numbers of disciplines in Training and requirements to meet capacity. The Trust will also revise its current model of peer-support employment given recent developments elsewhere in the UK and the outworkings of the Royal College of Psychiatrists' Invited Review June 2019.	**RED**

PALLIATIVE & END OF LIFE CARE (5)

R	A	G
	3	2

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to embed Advance Care Planning within operational systems.	The Trust is committed to supporting people living with a progressive condition to have the opportunity to engage in an Advance Care Planning conversation (if that is their choice) and record their wishes. Work continues to raise awareness of Advance Care Planning with health and social care staff and with the wider general public. The Trust is engaging with the local councils in order to identify and utilise opportunities to raise awareness with the general public. The "Your Life, Your Choices" booklet is now available across all Trust Macmillan information stands and GP surgeries. The Trust continues to roll out the Heart of Living and Dying initiative which provides the opportunity for members of the public to start a conversation about their future plans. The Trust facilitated several events during Dying Matters week in May. These events were targeted at members of the public and focused on raising awareness of Advance Care Planning. The Trust is committed to delivering ongoing sessions on Advance Care Planning throughout the 2019/2020 year.	GREEN
2.	Effective arrangements should be in place to improve the identification of palliative care patients in primary care – identification prototype. (CPD 3.4)	Within Southern Trust locality there were originally four GP Practices that commenced in the Regional identification prototype pilot. Two GP Practices had to discontinue and at present the Trust has two GP Practices involved in this project. The PHA is looking at developing this project to include software systems that will allow additional GP Practices to be included in the pilot in the future. District Nursing staff are committed to prioritising attendance at the GP Palliative Care meetings for these practices. The Trust has also committed to members of the Specialist Palliative Care teams and District Nursing attending GP Palliative Care meetings across the Trust. The Trust has utilised the allocation of a 0.50 whole time equivalent District Nursing resource to support District Nursing involvement in the identification pilot.	AMBER
3.	Effective arrangements should be in place to increase the capacity	Generalist palliative care is available 24 hours per day, 7 days per week. During the Out of hours period palliative care is provided by the GP Out of Hours service, District	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	of the out of hours rapid response nursing service across the region to provide full regional coverage of the Marie Curie led service.	Nursing Services and the Marie Curie Nursing Service. The Trust has also been successful in securing Transformation funding to extend the operating hours of the Marie Curie Rapid Response Service.	
4.	Effective arrangements should be in place to implement a specialist palliative care out of hours advisory rota across the region.	The Trust is committed to being fully involved in the scoping exercise by the HSCB/PHA Palliative Care Service Team in relation to out of hours Specialist Palliative Care advice. The Trust is committed to working with HSCB/PHA Palliative Care Service Team to implement any proposals that arise from the scoping exercise.	**AMBER**
5.	Effective arrangements should be in place to improve the education and training of the professional workforce in palliative care.	The Trust continues to provide a Palliative Care education and training programme suitable for all staff, with a focus on raising awareness of palliative care and enhancing staff skills and confidence to engage in difficult conversations. The Trust has been successful in securing Transformational funding for the delivery of Palliative Care education and training. The Trust is planning delivery of an all-day conference on Palliative and End of Life Care. This is planned to be delivered on a 6 monthly basis. The Trust has also developed links with Social Work Training, Medical Training, Nursing Training, Allied Health Professionals, and Domiciliary Care Workers to deliver education programs to each and every professional group within the Trust. This education and training is of a rolling nature and being embedded in education programs within the Trust.	**GREEN**

PHYSICAL DISABILITY (4)

R	A	G
	2	2

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure the seamless transition of people with Physical and/ or Sensory Disability from children's services to adult services and from adult services to Older People's services.	The Southern Health and Social Care Trust established a Transition Team in September 2015 for those with a learning disability/physical disability aged 18 – 21 years. There is an agreed protocol in place and ongoing communication between children and adult services to ensure early identification of young people in transition particularly those with complex needs. In addition there is an agreed protocol in place to govern the transition of individuals with physical disability transferring to Older People's services.	GREEN
2.	Sensory Loss pathways to ensure people with sight loss and/or hearing loss are implemented to deliver better outcomes for service users	Specialist Services Manager leads on Regional Task and Finish Groups as part of the Physical and Sensory Disability Strategy to develop pathways for people with sight and/or hearing difficulties. These have now been completed and are currently with the Health and Social Care Board to be formally launched across the region. Sara Templar from HSCB has now been tasked to deliver on this launch. The pathways very clearly identify steps service users need to navigate through primary and secondary care sectors and identify the standards of care including communication and access which service users should be afforded.	AMBER
3.	Effective arrangements should be in place to develop a Physical and Sensory Disability structure/ network which facilitates regional, multi-agency strategic planning for the needs of people with Physical	The SHSCT is actively involved in awareness raising across primary and secondary care sectors. The Trust in partnership with the Board are currently examining how this awareness raising can be extended throughout the Trust. The Trust is a member of a Board led Steering Group to develop a new communication strategy for people who are profoundly Deaf. This strategy will encompass a range of mediums for engaging with Deaf people including interpreting.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	and/ or Sensory Disability.	Trust Sensory staff are often involved in providing advice on facility improvement including signage, lighting and numerous forms of communication including room loops. This involvement is limited to a small number of Trust facilities and it is hoped that the wider awareness raising being led by the Board will ensure that the Trust will audit all of its facilities with a view to improving access for people with a physical and/or sensory disability. Trust staff will provide equipment where appropriate following assessments with both service users and carers.	
4.	Trusts and their independent sector suppliers should have effective arrangements in place to ensure staff are trained to understand the disparate needs of people with Physical and/or Sensory Disability.	In addition to ongoing professional training and development staff receive induction training and disability awareness training as well as specialist training for example sensory integration which keeps staff abreast of new developments	**GREEN**

POPULATION HEALTH (12)

R	A	G
	7	5

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to reduce the levels of obesity within the NI population, particularly in those aged 0-5 years. (CPD 1.2)	Public Health Nursing SHSCT have been working with colleagues from the PHA and the other Trusts with a view to implementing a new regional strategy which aims to promote healthy eating and lifestyle choices in the first years of life. This will include evidence based programmes delivered in the family's home by members of the health visiting teams, as both a preventative and early intervention approach.	AMBER
2.	Trust responses should demonstrate plans to implement the "Tobacco Control Strategy", including smoking cessation services. (CPD 1.1)	All first time ante-natal mothers are offered an ante-natal contact with the health visitor, smoking cessation services will be promoted if appropriate. The Family Nurse Partnership team supports young mothers to use nicotine replacement products. Some of the nurses have been trained in smoking cessation and the use of carbon monoxide monitors. The school nursing service offers all secondary school aged Looked After Children a health appraisal and offer support to young people who report smoking.	GREEN
3.	Effective arrangements should be in place to reduce Healthcare Associated Infections (HCAIs) including Surgical Site Infections (SSIs). (CPD 2.3)	The Trust will be happy to work with the Public Health Authority to develop and deliver improvement plans to reduce infection rates for all Healthcare Associated Infections (HCAIs). A series of audits are being undertaken to identify evidence base to develop a robust action plan. Preliminary results from a prospective audit looking at gram negative bacteraemias occurring 48-hours after admission have indicated that a proportion are preventable. The Trust continues to work towards low incidence of C. Difficile against a background of increasingly complex clinical needs and an ageing population. A clostridium difficile infection (CDI) trigger system to alert staff is in place. It triggers enhanced IPC and antibiotic stewardship monitoring to provide assurance of sustained good clinical	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		practice to prevent further transmission. Antimicrobial Stewardship Ward Rounds are carried out to identify inappropriate antibiotic use. The Trusts continues with its systems and processed to minimise MRSA bloodstream infections and has a range of actions ongoing linked to it infection control strategy.	
4.	Effective arrangements should be in place to support women during pregnancy. (CPD 1.10)	The SHSCT currently has capacity to offer the Family Nurse Partnership Programme to approximately 60 – 70% of teenage mothers in the Trust. However this is the result of transformation funding; the available recurrent funding will only support delivery to 50% of teenage mothers at the most. Health visitors aim to offer a home based antental contact to all first time mothers, to identify any additional health and social care needs to support new parents. All health visitors are trained in the Solihull Approach which supports practitioners to work in partnership with families and to help parents understand the impact of infant mental health and what they can do to support their children's health and development. The health visitor will aim to offer additional support to those families who require it, based on an individual family health assessment that is completed in partnership with the parents.	**AMBER**
5.	Effective arrangements should be in place to promote and maintain Baby Friendly Initiative standards. (CPD 1.3)	All community areas in the SHSCT have achieved and maintained Baby Friendly Standards, re-accreditation is carried out every two years and the health visiting service has maintained these standards at every re-assessment. Public Health Nursing and Midwifery services work closely together to ensure standards are maintained and that all Trust areas meet BFI standards. The BFI standards include standards for the training of all practitioners. Breast feeding Support groups in the Trust area are supported by both services; currently we are carrying out a review of the supports available. We are also engaging with PHA in relation to increasing the number of breast feeding co-ordinator hours in the community in line with BFI recommendations.	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
6.	Effective arrangements should be in place to support the Frailty Agenda including falls, physical activity, mild cognitive impairment (MCI)/dementia, nutrition Isolation and loneliness.	The Trust is currently running a Frailty pilot across 2 GP practices to screen for frailty and identify onward referral pathways for action and support for over 75s. The Trusts Community Promoting Good Nutrition (PGN) group is supporting the implementation of the Regional PGN strategy raising the awareness of malnutrition and the importance of nutrition screening/nutrition care planning across community teams and day care settings. A nutrition event is being planned for early 2020.	**GREEN**
7.	Effective arrangements should be in place to provide services to people who are homeless as these individuals often experience very challenging health inequalities, including a much lower life expectancy.	The Trust has a range of services in place for service users who present to services for treatment with no place to return to. In those instances our social work teams will work to secure a safe place of discharge. There are no dedicated services presently for the homeless population within the Trust but the Trust will work with the regional group and the commissioner to agree the way forward in providing such services. Access to services for homeless patients with mental health / substance abuse issues is dependent on whether or not the person has a GP. In the case of those who have a GP then a referral would be accepted directly from the GP as is the case for the homed population. For those without a GP presenting at ED, referrals would be accepted from ED via Psychiatric Liaison. The Trust doesn't have a homeless nursing team so no referral pathway operates. We would seek to mimic the pathways for the homeless in Belfast if the necessary level of resource was to be allocated.	**AMBER**
8.	Effective arrangements should be in place to increase the number of childhood immunisations.	Generally the rates for all childhood immunisations in SHSCT are above target levels. Quarterly returns are produced to help monitor the rates across the Trust, these returns are shared with all members of the public health nursing teams to help them monitor at an individual practitioner and team level. Arrangements are in place to follow up individual children who have an incomplete immunisation record.	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		In addition the school nursing service targets schools that have a low uptake of individual immunisations,. School principals are updated when their school is below the local targets and staff offer to meet with parents to provide information about the immunisations that will be offered to their children, providing the opportunity to present additional information to parents who may be reluctant to consent to immunisations for their children.	
9.	Effective arrangements should be in place to ensure de-escalation of patients presenting to trusts and emergency services with emotional and social crisis. (CPD 1.13)	The Trust continues to provide an out-of-hours service to support de-escalation, between 01:00 and 09:00, based in Craigavon Area Hospital, and providing cover to Daisy Hill Hospital in line with initial investment made for this provision. However, the delivery of this service is challenging due to the geographical spread of the two Emergency Departments. A number of Trust actions are in place and ongoing to seek improvement including: • A proposal for development of an enhanced community health infrastructure was made via transformation funding, however this has currently not been prioritised; • Ongoing review and revision of protocols to further inform on-going safe and effective provision for this challenging service; • A Zero-Suicide Co-Ordinator has been appointed and the Trust is part of the Towards Zero Suicide Network. In terms of children and young people's services: • The CAMHS Assessment Crisis Team provides a hospital liaison service 365 days a year from 09.00 – 17.00 hours; • Young people when referred are seen the same day or next by CAMHS; • After 17.00 hours a staff grade or above in the hospital can determine if a young person can be discharged and followed up the following day by CAMHS; • It can also be agreed to admit to hospital overnight for assessment the next day; • In extreme circumstances adult psychiatry can be contacted overnight for	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		consultation; • Regional Emergency Social Work Services are also contactable should there be concerns around safeguarding.	
10	Effective arrangement should be in place for HSC facilities to lead by example in preventing obesity by adopting minimum nutritional standards developed in partnership by PHA, Food Standards Agency and Safe Food.	Catering Services have been working alongside the Trust's Nutrition in the Workplace Group to make realistic changes in the dining rooms and coffee bars to provide healthier options. As part of the work of this group audits have been conducted in the Dining Rooms and Coffee Bars to measure compliance against the Minimal Nutritional Standards and 26 recommendations were identified during these audits to improve compliance against the Standards. An action plan has been developed. Work is ongoing to implement the recommendations but Catering Services will need support in order to progress some of the recommendations. This will require training, marketing and promotion and increased customer education with regards to nutritional information. Investment in Catering Services will therefore be required to deliver many of the recommendations. Some recommendations will also require support from the Business Services Organisation to ensure a greater range of products or alternative products are available on contract. It may not be possible to address these issues until contracts come up for renewal.	**AMBER**
11	Effective arrangements should be in place to ensure consistency in provision of and availability of workplace health to employees in all HSC settings. (CPD 8.9)	The Trust is represented on the Regional Healthier Workplace Network and plays an active role in a number of workstreams. The Trust is committed to maintaining and improving the health and well-being of all staff from induction through to retirement. Please refer to section 6.1 'Workplace Health and Wellbeing' for further detail.	**GREEN**
12	Effective arrangements should be in place to Implement Infant and Perinatal Mental Health workforce and service development. (CPD 1.11)	Children's Services is taking the Trust lead to develop a Multi -Agency Southern Area Infant Mental Health (IMH) Strategy and associated action plan to be launched in November 2019. The Southern Trust has established an IMH Strategy Group; completed an in- Trust and external stakeholder scoping exercise and held a Strategy Development Engagement Workshop.	**AMBER**

SEXUAL HEALTH (10)

R	A	G
1	5	4

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure provision of clinical sexual health services in higher education settings, including services such as condom distribution, pregnancy testing, contraception advice and STI testing.	The Trust has supported the delivery of C Card scheme pilot to increase provision of condoms to young people attending youth settings including the One Stop Shops for young people in Newry and Banbridge. The regional evaluation of this scheme is awaited to inform future roll out. The Trust provides a Health clinic service for young people aged 16-25 years in 8 Further Education College campuses across Southern Regional College and South West College. In 17/18 471 young people accessed the Health Clinic service .This service includes access to condoms, pregnancy testing, STI tests oral emergency contraception and now provides access to progestogen only contraceptive pill.	GREEN
2.	Effective arrangements should be in place for safe and clinically governable SRH and GUM services to respond to patient need within 48 hours.	There is currently 0.2 WTE Visiting Consultant from BHSCT. New funding has been secured for 1.0WTE Consultant; this has been appointed and a commencement date is currently being agreed. This will provide sufficient Clinical Governance for the GUM Service. There are vacant posts outstanding within the service. When filled these will help to support current service provision. Due to capacity of service within SHSCT we are unable to meet 48 hour access with our current Trust population and demographic locations. To date there is no mechanism within GUM services to capture unmet demand.	RED
3.	Effective arrangements should be in place for patients to access telephone and online advice for clinical sexual health matters	A telephone appointment line and Triage system operates on a part time basis (16hrs per week). Additional resources would be required to enable full time 5 days a week access to appointments and triage.	AMBER

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	including family planning and sexually transmitted infections.	Once the NHSCT pilot on-line testing service is available any patients who contact the STI service and fit the pilot criteria will be advised of the new service should they wish to avail of it. It is hoped that this will free up capacity for our symptomatic level 2-3 patients. Any positive patients from the online testing service who require treatment at their local service will be referred directly into the Health Advisor Team to arrange follow-up.	
4.	Effective arrangements should be in place for evidence-based promotion of sexual health and wellbeing for young people and adults, including HIV awareness, STI prevention, with a particular focus on those most at risk.	The Trust promotes sexual health awareness through workshops and events in 8 Further Education colleges as part of the Health clinic service for young people aged 16-25 years. Workshops and activity has included a focus on consent, HIV awareness and sexual health.	**GREEN**
5.	Effective arrangements should be in place for Trust Health promotion staff to support the whole schools model of Relationships and Sex Education (RSE) provided by the BHSCT Sexual Health team.	The BHSCT Sexual Health team is commissioned by the PHA to provide Relationships & Sex Education (RSE) teacher training to schools in the Southern area. The SHSCT is in communication with the BHSCT about schools participating and supports this by offering follow on RSE support to the schools.	**GREEN**
6.	Effective arrangements should be in place to provide integrated sexual health services to vulnerable parts of the population	Genitourinary medicine (GUM) and Contraception and Sexual Health (CASH) services are co-located in Newry and Portadown. GUM sexual health services are provided to vulnerable parts of the population at a weekly clinic in Craigavon Area Hospital. Nurse SV is provided by the CASH service lead nurse for the sexual health nurses within the Promoting Wellbeing Division. However there is no formal integration of the services	**AMBER**
7.	Effective arrangements should be in place to ensure that HIV prevention clinics are	A pathway is in place for referral into the regional HIV risk reduction clinic in Belfast Trust.	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	established for high risk groups.	Until such times as a permanent consultant for SHSCT is in place, we do not have capacity to provide a HIV Risk Reduction Clinic. However, the Trust is committed to establishing these clinics in the future. Funding would be required to support the introduction of a HIV Risk Reduction Clinic in line with other transformation pilots.	
8.	Effective arrangements should be in place between local and regional GUM services to support a prototype HIV high risk reduction clinic within the defined agreed eligibility criteria for the administration of PrEP as part of a regional and clinically agreed risk reduction package for the assessed patient.	An established system is in place for patients to be assessed for PrEP at the local GUM service. A pathway for referral to the PrEP clinic at the Royal Victoria Hospital is in place. All patients who are eligible for PrEP are coded on Lilie System as per the Regional Direction.	**GREEN**
9.	Effective arrangements need to be put in place to ensure sustainability of clinical sexual health services	The Trust will continue to liaise with HSCB/PHA colleagues regarding workforce planning and training requirements. Recurrent funding allocated in 2019/20 will enable the existing local GUM service which is currently provided on an outreach basis by Belfast Trust to be expanded with the appointment of a full time consultant and some nursing and admin support. This will facilitate Clinical Governance and training of staff in the future. An appointment has been made to the consultant post and a commencement date is currently being agreed. Recruitment is also ongoing for vacant posts within the service. These will contribute to future proofing the GUM Service.	**AMBER**
10	Effective arrangements should be in place to ensure all relevant staff are trained in sexual health issues, including core skills such as awareness, attitudes, information, communication skills, sexuality and	The Trust promotes Sex e-learning and lesbian, gay, bisexual and trans-sexual (LGBT) e-learning training to staff as part of the PWB training calendar. British Association for Sexual Health and HIV (BASHH)/Sexually Transmitted Infection Foundation (STIF) training is available for GUM staff to attend. The Trust Website has been updated with links to Sexual Health	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	relationships.	and the applicable training.	

SPECIALIST SERVICES (10)

R	A	G	NOT Applicable
	2		8

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to ensure: • New patients continue to access previously approved specialist drug therapies. • Access to new NICE TAs, HSTs and other NICE recommended therapies during 2019/20.	The Trust will continue to engage with the HSCB regarding projected demand and funding requirements and will continue to participate in regional fora including the Regional Biologics Forum and the Regional MS Group. The Trust continues to review the capacity for treatment of patients with biological therapies and will address any deficits with the commissioner. The Trust opened its new pharmacy aseptic unit in July 2019, so can now move to commence administration of Tysabri and other specialist Multiple Sclerosis treatments at the Southern Trust in line with NICE guidance. The Trust will deliver on the requirements to ensure access to new NICE TA's and other therapies in line with the available investments to facilitate this.	**AMBER**
2.	Effective arrangements should be in place to continue to progress the implementation of the Northern Ireland Rare Disease Plan working in partnership with the NI Rare Disease Partnership Board/Agency membership of the national Rare Disease Advisory Group	**Not Applicable**	**N/A**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	ensures that Northern Ireland is fully engaged in the planning and evaluation of highly specialist services		
3.	Effective arrangements should be in place to deliver a future model for consultant staffing to ensure delivery of a robust and sustainable Infectious Diseases service for the future.	**Not Applicable**	**N/A**
4.	Effective arrangements should be in place to progress the work of the Plastics and Burns Project Board which will provide strategic direction for the service and respond to the RQIA recommendations (2017) In particular, the Project Board will agree a service specification and develop options for the future configuration of plastics and burns services, including consideration of a single service/site model.	**Not Applicable**	**N/A**
5.	Effective arrangements should be in place to improve the resilience, sustainability and access to Cochlear Implant Service.	**Not Applicable**	**N/A**
6.	Effective arrangements should be in place to improve the resilience, sustainability and access to nephrology and transplant surgery services.	Recurrent funding has been allocated by the commissioner to enable the appointment of a 4th consultant nephrologist. The available funding will not fully cover the necessary support staff. The Trust will continue to liaise with the commissioner regarding the funding gap. Two middle tier doctors (Medical Training Initiative) have been appointed working between the Belfast and Southern Trusts. One of the doctors will commence in Southern trust in October.	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
7.	Effective arrangements should be in place to meet the demand for supporting services given the increase in bone marrow transplants.	**Not Applicable**	**N/A**
8.	Effective arrangements should be in place to deliver a sustainable scoliosis service.	**Not Applicable**	**N/A**
9.	Effective arrangements should be in place to ensure the opening of the Phase 2B Critical Care Unit to accommodate the transfer of ICU/HDU capacity with the service to be fully operational in 2019/20. Work will continue to progress during 2019/20 on the current role, scope of responsibility and accountability arrangements offered by the Northern Ireland Critical Care Network and how it might best develop consistent with the vision set out in *Delivering Together*.	**Not Applicable**	**N/A**
10	Effective arrangements should be in place to deliver a sustainable neuromuscular service for Northern Ireland.	**Not Applicable**	**N/A**

UNSCHEDULED CARE (9)

R	A	G
	8	1

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
1.	Effective arrangements should be in place to enhance a therapeutic frontline home based intermediate care team, responding rapidly and with a focus on recovery, independence and patient experience.	Discharge to assess has been introduced over the last 18 months across both Daisy Hill and Craigavon Area Hospital sites. This model provides a quicker process for the discharge of patients (same day) who require ongoing therapeutic intervention post discharge. Enhanced staffing levels in Integrated care Services allow for same day assessment of need post discharge as required to meet the needs of the patient.	**AMBER**
2.	Effective arrangements should be in place to ensure availability of a regional Outpatient Parenteral Antibiotic Therapy service.	Additional pharmacy staff have been appointed using Transformation funding. They have developed the prescribing and supply aspects of the service, in conjunction with consultant microbiologist support. This is facilitating the transfer of work from acute to community settings. Early results show a 17% increase in patients switched to oral therapy, which has saved District Nursing time, average length of treatment has reduced by 4 days, 21 hours per month of Consultant time has been saved and the longest duration of treatment has reduced from 51 days to 35 days. However it should be noted that delivery and effectiveness is still reliant on core district nursing teams which are under significant pressure.	**AMBER**
3.	Effective arrangements should be in place to build on the 7 day working for Physiotherapists, Occupational Therapists, Pharmacists and Social Workers in base wards building on the 2014 paper “Improving Patient Flow in HSC Services”.	7 day working is in place for hospital social work. Work is ongoing with acute Occupational Therapy and Physiotherapy on the implementation of 7 day working across base wards CAH and DHH. We plan to implement a phased approach by October 2019. Once implemented we will assess the impact on the reduction in time from referral, the reduction in patients declared as a complex delay over 48 hours, and the total number of AHP contacts at weekends and over holiday periods.	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
4.	Effective arrangements should be in place to ensure Trusts have in place local arrangements for site co-ordination/ control room to manage patient flow.	Transformation funding was secured to enhance the Control Room function. The control room presently operates 5 days per week 8am – 5pm and is managed through existing management structures. The Trust will undertake further review of the control room arrangements and operational escalation plans informed by the experience and learning from other Trusts.	**AMBER**
5.	Effective arrangements should be in place to provide Acute / Enhanced Care at Home that provides active treatment by health care professionals in the persons own home for a condition that would otherwise require acute hospital in-patient care.	The Acute Care at Home service is now available for suitable patients over 65 years who are acutely unwell and at the point of admission. There are plans in place for the service to extend to provide full Trustwide coverage from mid Sept 2019. Nursing cover is provided from 8am to 11pm, 7 days a week and there is medical cover from 9am to 8pm Monday to Friday and 4 hours cover on Saturday, Sunday and Bank Holidays. A challenge to this further roll out is the availability of appropriately skilled staff. The Trust is actively developing a workforce plan that will seek to address the difficulties in recruiting staff, particularly Consultant Geriatricians, Middle Grade Doctors and Advanced Nurse Practitioners. The service has well-established referral pathways with GPs, the Northern Ireland Ambulance Service (NIAS) and Specialist Community teams e.g. Heart Failure and COPD. There will be significant issues with moving to 24 hour provision due to workforce pressures across the region and major investment would be required. To date there is little evidence to suggest that there is a demand for an overnight service. Enhanced care at home is currently provided by Chronic Obstructive Pulmonary Disease (COPD), Heart Failure and Specialist Palliative Care services Monday – Friday 9am – 5pm. This care and support for patients with complex symptoms, exacerbation of their condition, or at end of life will prevent hospital admission. Both COPD and Heart Failure services have agreed treat, leave and referral pathways which have been implemented by NIAS.	**AMBER**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		The SHSCT is currently working with the commissioners to agree Transformation funding to re-establish the respiratory ambulatory service (first phase). This investment will also support an enhancement of the community COPD service to increase the capacity to accept referrals for patients with a range of respiratory symptoms and conditions beyond COPD and to provide care at home for people assessed by the ambulatory clinic. If this investment is realised this will increase capacity for the team to prevent hospital admission and facilitate early discharge.	
6.	Effective arrangements should be in place to provide care to seriously injured patients at a regional Major Trauma Centre with the aim of increasing survival following major trauma and reducing the incidence of long-term disability from injuries.	The Trust continues to engage in regional discussions to facilitate development of protocols for the network. The Southern Trust has identified a Major Trauma Team that would respond in the event of a major trauma alert. The team is led by ED consultants with active participation from Anaesthetics and all surgical specialties as patients' injuries dictate.	**AMBER**
7.	Effective arrangements should be in place to ensure patients receive access to rehabilitation services to maximise their recovery following major trauma.	The Trust will continue to engage with regional network developments. The Trust is working to progress a range of service reforms to improve effectiveness and efficiency of response times. This includes exploring new service models and skill mix proposals. Work is ongoing with acute Occupational Therapy and Physiotherapy on the implementation of 7 day working across base wards CAH and DHH. We plan to implement a phased approach by October 2019. Once implemented we will assess the impact on the reduction in time from referral, the reduction in patients declared as a complex delay over 48 hours, and the total number of AHP contacts at weekends and over holiday periods.	**AMBER**
8.	Effective arrangements should be in place to support the prompt diagnosis and effective management of patients who have	The SHSCT is now in its second year providing rapid response Flu testing. The SHSCT was the first to adopt this process and currently meets and exceeds the targets set down in this initiative.	**GREEN**

ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	symptoms suggestive of flu.		
9.	Effective arrangements should be in place to increase the number of unscheduled care patients managed on ambulatory pathways avoiding the need to be admitted to hospital.	The Trust has an established Ambulatory Project Group with defined objectives. This is now a formal workstream of the unscheduled care improvement 'SPEED' project. Whilst development of ambulatory models remains a priority challenges in securing skilled staff to enable development remains the biggest challenge. • A Direct Assessment Unit has been established at DHH under the auspices of the Daisy Hill Pathfinder project, providing 'same day' emergency/urgent care services. It aims to assess and treat patients who might otherwise have attended ED. • Capital funding was also identified for an ambulatory care unit at Craigavon Area Hospital in 2018/19. The first phase of the works at Craigavon Hospital is completed and this ambulatory respiratory service has been established funded from the transformation programme, and is currently running 2 days per week. • The Older Persons Assessment Unit will also move into this facility in 2019/2020; These two units will provide the much needed accommodation to support the further development of unscheduled care ambulatory services at the Trust; • The Older Persons Assessment Unit has been operational since December 2017 on the CAH site and from April 2018 on the DHH site and provides a Comprehensive Geriatric Assessment for the selected frail patients over the age of 65 who have presented to the Emergency Department (ED) or have been identified by their GP for urgent assessment. The unit has an environment that is more suited to the older person, calmer than ED with a layout more suited to the needs of elderly patients. Staff in the unit complete a Comprehensive Geriatric Assessment on all patients and will initiate diagnostics and treatment. A plan of care is prescribed that may involve referring to community teams that can manage the patient appropriately outside of the acute environment. There is also	**AMBER**

ISSUE/OPPORTUNITY	PROVIDER RESPONSE	RAG
	the option of referring to the admitting teams within the hospital both in Acute and Non-Acute sites for admission; The Trust is developing plans to extend the service to a third day as part of the 19/20 USC Resilience Plan. Further work is also underway in a number of key specialities: • Neurology – Non Contact Specialist Assessment (NCSA) to be introduced in neurology, improving GP access to neurology specialist opinion supported by C&S transformation funding. Primary care education sessions are also ongoing. • Paediatrics – A paediatric advice line is in place on both CAH and DHH sites for GPs, health visitors and midwives to ensure access to senior decision makers facilitating same day and next day assessment. The Trust also offers urgent general paediatric slots for patients that need to be seen in less than 9 weeks which are accessible by GPs, via the designated Consultant of the Week. • Urology and ENT - Guidelines are in place to provide advice for GPs on urological conditions. ENT is proposing to draw up referral guidelines for GPs to use / help with their decision on ENT conditions • Dermatology Photo Triage - discussions are ongoing at a regional level regarding funding for a service model to enable photographs to be taken in primary care and assessed by specialists in secondary care. • Cardiology - direct access to cardiac investigations is in place at Craigavon Area and Daisy Hill Hospitals. Discussions are ongoing with primary care colleagues regarding blood pressure monitoring and ECG being undertaken in primary care and analysed by specialists in secondary care. A surgical ambulatory model (ACCESS) is in place for ED referrals and has been evaluated. Expansion of this model is dependent on ability to attract staffing and subject to funding.	

SOUTHERN TRUST RESPONSE TO LOCAL COMMISSIONING PLAN PRIORITIES (11)

R	A	G
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Common Local Commissioning Priorities (8)

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
L1	Effective arrangements should be in place to ensure that the volumes of activity to be delivered reflect commissioned services and investment.	Appendix 2 identifies the investments committed to in 2019/2020 via demography funding and the estimated full year effect volumes where these apply. All volumes will be formalised in the service and budget agreement document for 2019/2020 and previous volumes in the service and budget agreement document for 2018/2019. The Full year effect of previous investments is included in the Post Project Evaluation for each scheme.	RED
L2	Effective arrangements should be in place to ensure patients who can be discharged to their own home are supported to do so as soon as appropriate.	Intermediate Care is operational Monday to Friday 9am-5pm. If a patient is assessed as requiring review within 4 hours, this can be facilitated within these working hours. Patients are all seen within 1 working day. Discharge coordinators work Saturdays and Bank Holidays to facilitate discharge. The service is a short term intervention and aims to avoid unnecessary hospital admission, promote independence and prevent a move to care. The service is patient focussed with joint goal setting between patient and therapists. This service is delivered under the home first ethos. Project work is ongoing to improve step up referrals to maximise patients remaining at home. Acute Care at Home service - Plans are in place for the service to roll out Trust wide as detailed at S3 below.	AMBER
L3	Effective arrangements should be in place to ensure people at risk of Type 2 Diabetes should be offered self -management	Patients newly diagnosed with Type 2 Diabetes are now offered the DESMOND programme, which supports self-management. Waiting lists are currently undergoing validation to ascertain the number of programmes required. The Trust will implement locally a new regional prevention of Type 2 diabetes initiative, whereby patients who are pre-diabetic will be offered a place on a local lifestyle modification	GREEN

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	support.	programme. The Trust has been actively engaged in planning for this initiative.	
L4	Effective arrangements and infrastructure should be in place to support an integrated model of care across the LCG/Trust area.	The Trust is considering 'Diabetes Non-Contact Specialist Assessment' as part of a proposed new model of care for community diabetes.	**AMBER**
L5	Effective arrangements should be in place to ensure patients referred by GPs for Talking Therapies are able to access the service to meet their needs as soon as possible.	The Southern Trust will work with its ICP partners and the new Primary Care Multi-disciplinary Teams to further develop the timely availability of Talking Therapies through the "Well Mind" hub. This will be dependent upon availability of additional resources and the ability/willingness of third party community partners to provide a range of accredited services staffed by appropriately registered and trained therapists.	**AMBER**
L6	Effective arrangements should be in place to ensure that diagnostics /imaging services are appropriate.	The Division monitors actual activity against expected SBA/contract levels. Where there is deviation, plans are put in place to ensure activity is in line with expected levels. The Division has been working with Planning to prepare a 10 year investment plan for diagnostic equipment. This plan will be review each year in line with new operational requirements and advances in technology. The Trust will require additional capital funding to support effective replacement programmes for imaging services. Reporting Radiographers continue to provide a plain film reporting service 7 days per week, and it is planned to extend further into reporting of GP examinations in the next year. 3 Ultrasonographers have been trained in musculo-skeletal scanning and this service has been extended. 1 Ultrasonographer has completed mentorship and is now undertaking an	**AMBER**

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
		independent session. A 2nd ultrasonographer is commencing on the same pathway. 1 CT Radiographer currently reports on CT brains on the Daisy Hill site.	
L7	Effective arrangements should be in place to appropriately manage the increasing number of older people over 75 years.	Acute Care at Home - Nursing cover is provided from 8am to 11pm 7 days a week and there is medical cover from 9am to 8pm Monday to Friday and 4 hours cover on a Saturday, Sunday and Bank Holidays. This service aims to treat frail elderly clients at home or facilitate earlier discharge of acutely ill patients from hospital to home. The Older Persons Assessment Unit has been operational since early December 2017 on the Craigavon Area Hospital site and from April 2018 on the Daisy Hill Hospital site and provides a Comprehensive Geriatric Assessment for the selected frail patients over the age of 65 who have presented to the Emergency Department (ED) or have been identified by their GP for urgent assessment. The unit has an environment that is more suited to the older person, calmer than ED with a layout more suited to the needs of elderly patients. Staff in the unit complete a Comprehensive Geriatric Assessment on all patients and will initiate diagnostics and treatment. A plan of care is prescribed that may involve referring to community teams that can manage the patient appropriately outside of the acute environment. There is also the option of referring to the admitting teams within the hospital both in Acute and Non-Acute sites for admission.	**AMBER**
L8	Effective arrangements should be in place to ensure that services provided are safe, effective and delivered in accordance with national guidance.	The ward/departments have access to all RQIA documents. Lead Nurse and ward sisters carry out inspections and spot checks on an ad-hoc basis to ensure compliance with RQIA recommendations. The ward environments are a significant issue due to the age of the hospital. In the Children and Young Person's (CYP) Directorate a senior change lead is identified to lead the implementation of new guidance in order ensure safe and effective care e.g. the CYP lead for Occupational Therapy is leading on a service improvement on the upper limb pathway in line with NICE Spasticity in under 19s.	**AMBER**

Specific Local Commissioning Priorities (3)

R	A	G
	3	

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
S1	Effective arrangements should be in place to ensure unscheduled care services in the Southern LCG/Trust area are safe, sustainable and accessible.	The SLCG is fully engaged with the operational proposals and Seasonal Resilience Planning through the Southern Area USC Locality Network Group.	**AMBER**
S2	Effective arrangements should be in place to enhance the Trauma and Orthopaedic Team, recognising the significant growth in fracture demand.	The Trust has plans to provide additional bed and theatre capacity to support the development of the Trauma and Orthopaedic service. However, the provision of additional beds will require some internal service moves along with general capital investment to upgrade existing wards. An IPT has been submitted for consultant 11, along with the necessary support staff. The required level of funding is currently being discussed by the Health and Social Care Board and the Trust. Transformation funding was made available for a musculoskeletal (MSK) Hub. This has been in progress for 2-months and is showing an average reduction in referrals to fracture clinics as envisaged.	**AMBER**
S3	Effective arrangements should be in place to	The Acute Care at Home service is now available for suitable patients over 65 years who are acutely unwell and at the point of admission. There are plans in place for the service to extend to	**AMBER**

LOCAL ISSUE/OPPORTUNITY		PROVIDER RESPONSE	RAG
	meet the acute care needs of older people.	provide full Trustwide coverage from mid Sept 2019 as detailed above under regional priorities Unscheduled Care (5) Capacity within statutory homes has been mobilised to support resilience plans in response to pressures. Both Cloughreagh House and Roxborough House have enhanced staffing levels to support step down from acute and non-acute beds. Intermediate Care has enhanced staffing levels to support both Discharge to Assess and Step Up referrals. Currently, Discharge to Assess patients are identified in Acute and Non-Acute hospitals and reviewed rapidly in the community by Intermediate Care. There are constraints with this service operating Monday to Friday 9am-5pm. Further investment would be required to allow these pathways to be fully implemented at scale. A quality improvement project is underway to engage with GPs and promote the use of Step up to Intermediate Care, thereby preventing hospital admission.	

4 Resource Utilisation

4.1 Finance Strategy

The Financial Strategy for the Trust moving into 2019/20 is aimed at identifying all available opportunities that could be deployed in seeking to manage a challenging financial position, whilst also securing delivery of reform and transformation.

The approach identified a number of key principles that apply to the current financial year:-

- An understanding of the current and prevailing financial position, of both the Trust and the HSCB at a regional level, and current use of resources;
- Resources are prioritised to deliver the Trust's strategic objectives, with the aim of improving the health and social well-being of, and reducing the health inequalities between, those for whom we provide, or may provide health and social care;
- Continue to develop collaborative working across the organisation which will facilitate ownership of the use of resources and the financial challenge;
- Under-pinning financial processes need to be robust, timely and provide complete financial information to assist in the delivery of the strategy;
- We need to continue with robust internal monitoring arrangements as the final financial plan is developed and in doing so the Trust needs to allocate a budget up to the maximum of the indicative income available to it.

Financial Position 2019/20

The Trust is responsible for developing a financial plan which demonstrates the ability to live within the overall allocation and the savings which are planned to be achieved.

The Health and Social Care system has been working collaboratively to address the significant financial pressures facing the service in 2019/20. It has been well publicised that the cost of providing services is increasing, with estimates suggesting 5-6% annually. This is due to an increasing ageing population with greater and more complex needs, increasing costs for goods and services, growing expertise and innovation which mean a more extensive range of continually developing services are available, supporting improvement in the health of our population. All of these factors combine to impose an upward pressure on the funding required just to stand still.

The scale of the gap between funding and costs is reflected in the amount to be released by Trusts through opportunities for savings\income generation of some £52.5m, summarised as follows:-

Regional savings\income generation opportunities

		Regional £m	Trusts £m
1	Regional cash releasing efficiency target	42.85	42.85
2	Regional cash releasing medicines optimisation target	20.00	8.00
3	Other – Car Parking Charges Target	1.70	1.70
	Total Gap	**64.55**	**52.55**

This is against a background of increasing demand in both acute and community services at Trust level, waiting list pressures and an already stretched resource base.

The Trust has received confirmation of its indicative allocations and contribution requirements towards the savings\income generation targets, these are summarized below:-

Trust requirements against regional savings\income generation opportunities

		Regional £m	SHSCT £m
1	Regional cash releasing efficiency target	42.85	0.00
2	Regional cash releasing medicines optimisation target	20.00	1.04
3	Other Cash Releasing	1.70	0.11
	Total Target	**64.55**	**1.15**

The most significant observation from the above is that the Trust has not been tasked to contribute to the overall regional gap of £42.85m. The Trust's fair share of this funding gap is £7m. For the third consecutive financial year ongoing negotiations between the Trust, the HSCB and DoH specifically around the capitation inequity gap have secured this positive result for 2019/20, which means the Trust is not required to make this level of savings. Cumulatively the Trust has avoided the need to make recurrent savings of some £21m.

It is important to remember, that before account is taken of the new savings\income generation targets above, the Trust entered the new financial year with an opening recurrent gap of some £14.78m. Carried forward cost pressures, (some of which were funded non-recurrently in 2018/19), increased the deficit to £17.6m. £650k of this opening deficit is directly associated with underachievement of the pharmacy

prescribing targets for 2017/18 and 2018/19. However, a detailed review has confirmed that the Trust has achieved more than originally anticipated and in fact the complete target has now been delivered.

A detailed review of the indicative allocations for 2019/20 and the recurrent positive impact of savings in excess of planned now confirms that this gap is reduced to £1.4m, before new inescapable pressures for 2019/20. After taking into account the Trust's share of regional savings\income generation target the gap increases to £2.6m as summarised below.

Total Gap to be Addressed before additional pressures

	£m	**£m**	**£m**
Opening Recurrent Gap 2019/20	**17.6**		
Less decrease in underachievement of Medicines Optimisation	(0.6)	**17.0**	
Less indicative HSCB Allocation		(15.6)	
Residual Opening Gap to be addressed by Trust		**1.4**	
Trust Share of regional savings\income generation target – as per table 2 above		1.2	
TOTAL TRUST GAP			**2.6**

Anticipated Income 2019/20

The Trust has received confirmation from HSCB and PHA of a level of indicative funding available for 2019/20 totalling £679.1m. The Trust is assuming that commissioned courses will be funded by the DoH to the level of £900k and that £1.9m funding will be released to support Undergraduate Medical and Dental Education.

In addition the Trust is also anticipating non-RRL income from a range of different sources as indicated below. These figures have been established by using the 2018/19 actual audited position reduced for one-off elements of income and by increasing other income streams to represent the full year effect of recurrent income received part way through 2018/19.

	£m	£m
Income from Activities		
Private patients	0.4	
Client Contributions	29.3	
Other Income from Activities	1.7	
Total Income from Activities		**31.4**
Other Operating Income		
Boarding and Lodgings	0.8	
Restaurant Receipts	2.2	
Miscellaneous Income	6.2	
Total Other Operating Income		**9.2**
NIMDTA	5.8	
Supporting People	1.8	7.6
TOTAL ESTIMATED NON-RRL INCOME 2019/20		**48.2**

Total Income Available 2019/20

	£m	£m
Total anticipated RRL Income	679.1	
Plus commissioned courses	0.9	
Plus SUMDE	1.9	**681.9**
Total anticipated Non RRL Income	48.2	
Total Anticipated Income 2019/20		**730.1**

Anticipated Expenditure 2019/20

In estimating the expenditure projections for 2019/20 there are a number of factors to take into account:-

- The Trust has been provided with inflationary funds of £9.2m, it is assumed that this full amount will be required to cover the increase in underlying expenditure inflation. This includes an increase in tariffs for nursing and residential homes of 5.5% and 5% respectively and 5% for independent domiciliary care providers. Fixed costs inflation, e.g. on rates and other utility costs as well as maintenance contracts and pharmacy are also covered;

- The Trust has consistently applied the recommended inflationary uplift to independent sector domiciliary care providers, however, over recent financial years a gap has emerged between what other neighbouring Trusts are paying per hour and that agreed by the SHSCT, even though as a Trust we applied an uplift of 7.17% in 2018/19 compared to the recommended and funded level of 5%. In an effort to maintain current service provision for the most vulnerable of our service users the Trust has increased its percentage uplift by a further 3.47% above the funded rate of 5%. This uplift now brings the SHSCT hourly rate up to £14.61 and in line with that of three other Trusts and secures current service. This is an inescapable cost pressure of £800k;
- The Trust, as previously agreed with HSCB and DoH, will continue to redirect £1.9m of 2015/16 demographic funding to support the ongoing pressure at Daisy Hill Hospital ED;
- During 2018/19 the Trust benefited from natural slippage of some £2.3m, the expenditure forecast below assumes that this slippage will be spent in full during 2019/20;
- The additional costs directly associated with superannuation auto-enrolment are £569k;
- The assessment below excludes all Confidence & Supply transformational expenditure and associated income streams.

An assessment of expenditure requirements confirms that the Trust expects to spend some £734m during 2019/20.

As summarized in the table below, the total gap between committed expenditure and indicative income is **£3.9m** .

Opening Position	**£m**	**£m**
Total Anticipated Income	730.1	
Total Estimated Expenditure	734.0	
Total Remaining Gap 2019/20		**(3.9)**

Addressing the Forecasted Gap 2019/20

This section will deal with each component of the gap in turn:-

- **£1.1m** of the remaining gap is directly related to the Trust's share of the medicines optimisation savings target. The Trust is confident that it can secure the full level of savings in year;
- All Trusts were tasked in 2018/19 with generating recurrent savings from the community and voluntary sector. Regionally this totalled £1.9m and the Trust's share of this was **£310k**. Trusts were advised that to the degree that savings were not achievable in this sector, that alternative savings proposals are sought to address any shortfall. This remains part of our gap;
- As part of the Department of Health's car parking policy all Trusts have been tasked with ensuring that where the facility has 100 or more car parking spaces that the full cost of providing these car parks is covered through charging. The regional target for 2019/20 is £1.7m, as identified in table 2 the Trust's share of this is **£112k**;
- It is compulsory for the Trust to automatically enrol all eligible staff into a pension scheme. In 2018/19 this cost the Trust £1m and for 2019/20 a further £0.6m. Total **£1.6m**;
- **£800k** directly associated with the additional price inflation uplift applies to the independent domiciliary care sector.

A range of no\low impact proposals, totalling £3.9m, have been identified to address the remaining gap, they are:-

- Slippage on Dungannon Supported Living Facility - £140k. The Trust has the recurrent funding to support this facility; however, it has not yet available for use;
- The Trust's experience has shown that due to a shortage of healthcare professionals it can take many months for vacancies to be filled on a permanent basis, the result is an unplanned non-recurrent expenditure benefit. It is not unreasonable to expect this to reach c £500k during 2019/20, which represents a marginal 0.1% of the overall forecasted payroll expenditure;
- In recent financial years, the Trust has ensured that discretionary non-direct patient and client goods and services are kept to an absolute minimum. This has the potential to achieve a reduction in expenditure of £533k;
- The Trust has carefully considered the level of demography funding available for investment during 2019/20 and again based on prior year trends and the

time required to recruit it is not unreasonable to expect an unplanned non-recurrent expenditure benefit of £1053k;

- The Trust is comfortable that is can achieve £1.2m of pharmaceutical prescribing savings in year;
- After concluding an assessment of other non-specific allocations it is not unreasonable to expect further unplanned non-recurrent expenditure benefit of c £475k.

The table below summarises the overall gap to be addressed and the measures being proposed at this stage to go some way to addressing this gap.

	£m	**£m**
Summary of Gap to be Addressed		
Medicines Optimisation remaining target	1.1	
Community & Voluntary Sector	0.3	
Inescapable superannuation pressure	1.6	
Increase in Independent Domiciliary Sector Rates	0.8	
Car Parking charging target	0.1	**3.9**
Measures to Address the Gap		
Dungannon Supported Living	0.1	
Unplanned expenditure benefit directly related to the time taken to recruit scarce resources – to be used to reduce the flexible workforce pressure	0.5	
Non-direct patient\client goods and services	0.5	
Other non-specific non-recurrent expenditure benefit	0.5	
Pharmacy Prescribing savings	1.2	
Demography non-recurrent expenditure benefit	1.1	**3.9**
Remaining Unresolved Gap		**0**

The Trust, through the above measures, has addressed in full the in-year savings requirement and will present break-even.

As explained at the outset of this report, the Trust has submitted its view of the indicative allocations as set out above and made it explicitly clear that our financial plan 2019/20 was set in the context of the Southern Trust's overall position in relation to relative efficiency, capitation and demographic pressures compared to the rest of the region.

4.2 Human Resources and Organisational Development

The Human Resources and Organisational Development (HROD) Directorate has a central role to play in supporting the Trust to achieve its strategic objectives during 2019/20 in what continues to be another challenging and changing time in the delivery of services to patients and clients in the provision of health and social care. The Directorate, through the established Business Partner arrangements and through our specialist Human Resources (HR) service teams continues to work closely with other Trust Directorates and Trade Unions to develop and deliver services, in order to meet the needs of our patients, clients and carers as well as their families.

During 2019/20, the HR Directorate will complete its restructuring exercise with a result that there will be greater strategic capacity for organisational development and development of our core HR services, to provide a more focused and integrated approach to strategic workforce, organisational development and people management issues.

4.2.1 Workforce Strategy

The Department's Workforce Strategy 'Delivering for our People' was been launched in early 2019/20, and provides the overarching framework for resolving fundamental problems with the supply, recruitment and retention of the highly trained and talented health and social care workforce in NI. The Trust will be actively involved in the implementation structures at regional level associated with the HSC Workforce Strategy.

The Trust's People Strategy will be developed during 2019/2020 through engagement with staff across all directorates. It will be aligned with the wider needs of the organisation and will support the delivery of the Trust's strategic objectives. It will outline the strategic imperatives for the next 3 years (2020 – 2023) and will be developed in line with the overarching HSC Workforce Strategy, HSC Collective Leadership Strategy and key themes arising from the regional 2019 HSC Staff Survey. It will aim to recognise the value brought to the Trust by its people and the link that exists between an engaged, happy workforce who feel valued and the quality and efficiency of the care and support they are able to deliver.

4.2.2 Organisational and Workforce Development

A key strand of the Trust's People Strategy will be on Workforce and Organisation Development. The Trust is committed to building the capacity of the organisation and its workforce to achieve a collective leadership culture that delivers safe, high quality, continually improving compassionate care and support. The HROD Action Plan 2019/20 will provide the focus for activities.

4.2.3 Attracting and Recruiting Talent (Priority 1)

The Trust remains committed to ensuring effective Recruitment and Selection as a means to ensure the right people, with the right skills are deployed in sufficient numbers in the right place, at the right time, to allow the Trust to effectively deliver all essential services. However, given the ongoing recruitment and retention difficulties particularly in the medical and nursing workforces, but not exclusively, there are significant challenges to this.

In the above context, key areas for 2019/20 in terms of improving how we attract and recruit staff, the HROD Directorate will:

- Launch and implement a Trust-wide strategy 'Inspire, Attract, Recruit' along with an associated action plan to address a number of challenges in the attraction and recruitment of staff across a range of staff groups. With oversight provided by a Corporate Steering group, this will be themed around 6 key objectives as follows:
    - Increasing the Supply of People: by continuing to raise the profile and build the 'brand' of the Trust as a leading Employer of Choice and a great place to work and by engaging with education providers to enhance awareness of HSC careers inspiring future HSC applicants. We also aim to create better linkages with our volunteers and those individuals seeking job placements with the Trust;
    - Improving Our Attraction: by utilising a wide range of communication channels to maximise our reach and attract a broad and diverse audience. Part of our strategy will be development of how we best utilise social media in promoting the Trust and the HSC brand;
    - Enhancing Applicant Engagement: by improving our recruitment systems and processes to ensure these are as streamlined as possible and that applicants are at the heart of the recruitment process.

      We will review existing recruitment documentation to ensure the initial experience of the Trust as an employer is positive, continue to influence change through regional forums to reduce the timescales for recruitment of staff and ensure our pre-employment checks are robust but timely;

- Developing our Workforce Business Intelligence: to ensure that we have a robust understanding of our current workforce issues, supply and vacancy rate in order to best meet service needs.

  We will continue to work with our regional colleagues to enhance the quality of data available and to make this visible to our recruiting managers;

- Supporting Recruiting Managers: by ensuring they have easy access to the necessary training, tools and resources to enable and empower them to recruit staff efficiently and effectively, reducing administrative burdens and addressing any bottlenecks in the process.

  We will create and deliver a recruitment and selection skills programme for Trust managers to ensure recruiting managers are properly equipped to secure high calibre staff;

- Developing Creative and Innovative Approaches: underpinning all the above, to ensure that there is a drive to seek and implement new innovations wherever possible, including benchmarking with other sectors.

  We will also continue to develop and enhance our approach to international recruitment.

Along with the launch of our strategy, HROD staff will continue in 2019/20:

- To proactively contribute to Strategic Resourcing Innovation Forum (SRIF), which will incorporate 4 key workstreams:
  - Attraction and Retention of Staff,
  - Selection,
  - Performance Improvement,
  - Systems.

  The Recruitment & Selection Shared Service Centre (RSSC) will be fully engaged in this work, alongside a range of other key stakeholders;
- To monitor service delivery from the RSSC on an ongoing basis and to work collaboratively with them to ensure that they provide an efficient, effective and responsive recruitment and selection service for non-medical posts in the Trust. A key focus this year will be improving the functioning of the various customer forums, and further development/monitoring of robust performance management information;
- To take account of, and plan for the workforce implications arising from the UK's exit from the EU and the subsequent implications for the EU/EEA and non-EU/EEA workforce, and our ability to sustain services.

4.2.4 Supporting & Retaining Our People (Priority 2)

Key areas of focus for 2019/20 include:

- Review and identify actions resulting from the staff survey through engagement with staff;
- Review of managers' development programmes and training pathways;
- Continued focus on increasing Corporate Mandatory Training rates;
- Supporting implementation of Trust Nursing and Midwifery action plan;
- Develop medical staffing action plan based on Trust Nursing and Midwifery action plan;
- Continue to implement the Trust's RQF Strategy ensuring vocational training opportunities for support staff related to their job role;
- Three Health and Wellbeing work streams established: Physical, Psychological & Employee experience supporting Trust Health and Wellbeing Strategy;
- Implementation of the Trust Occupational Health review with an emphasis on occupational health and staff wellbeing.

4.2.5 Embedding a Culture of Collective Leadership (Priority 3)

Key areas of focus for 2019/20 include:

- Communicate new HSC Core Values and develop an action plan to start to embed values and behaviours, in line with 5 Fundamentals of Civility Model;
- Implementation of Regional Culture Assessment Survey;
- Host a Trust Leadership Conference for leaders at all levels.

4.2.6 Supporting Organisational Transformation (Priority 4)

HROD continues to assist managers with the challenge of workforce modernisation and reconfiguration of services in line with service reform priorities. This will nurture quality improvement and innovative approaches to the way services are delivered to ensure safety and quality of care for our patient and clients.

In 2019/20 key activities will include:-

- Draft a People Strategy (2020-2024);
- Develop a model for team based working;
- Support and implement actions to support single employer for junior doctors;

- Support the transformational agenda in directorates. This will mean:
    - Continuing to lead effective change management in support of a number of reform programmes,
    - Continuing to engage and consult with our staff, Trade Unions and the community in support of service improvement reform and modernisation,
    - Supporting the use and capacity of Trust managers to use continuous improvement techniques, methodologies and practices to review and improve service delivery,
    - Continuing to explore and develop new roles, redesigning existing roles to improve productivity and including, as required, new ways of working, in light of significant workforce challenges,
    - Continuing to develop 7 day working;
- Implement nurse agency reduction programme;
- Review 'raising concerns' work 1 year on and determine next steps.

4.2.7 Internal HROD Transformation Programme (Priority 5)

Key areas of focus for 2019/20 include:

- Implement new HROD structure;
- Create and support opportunities for development of HROD staff and teams;
- Start to embed a culture of shared leadership within and across teams including introduction of HROD Engagement events;
- Develop and embed new HROD governance arrangements and processes;
- On-going service improvements through digitalisation and use of HR Technology; to include e-filing and HROD SharePoint developed for all teams.

4.2.8 Workforce management information & workforce planning

The Trust will continue to use workforce management information and analysis to support its decision making for service delivery, including workforce planning which is critical in helping the Trust ensure it has the right people in the right place at the right time to deliver, and modernise, health and social care services. The Trust will also continue to support Directorates and work in partnership with DOH, HSC Board, Trade Union representatives and staff on various workforce planning initiatives.

4.2.9 Equality & Human Rights Considerations

Section 75 of the Northern Ireland Act 1998 (the Act) requires public authorities, in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity and regard to the desirability of promoting good relations across a range of categories outlined in the Act. In our Equality Scheme we set out how the Southern Health and Social Care Trust (the Trust) proposes to fulfil the Section 75 statutory duties. In so doing, we realise the important role that the community and voluntary sector, the general public, staff and Trade Union colleagues have to play in the discharge of the Section 75 statutory duties.

Our Equality Scheme demonstrates how determined we are to ensure there are opportunities, for people affected by our work, to positively influence how we carry out our functions in line with our Section 75 statutory duties.

The Trust is also mindful of the Human Rights Act, which was enacted in October 2000, and will seek to ensure that it carries out its functions in a way that is compatible with the European Convention on Human Rights.

Further, the Trust is mindful of its duties under Section 49A of the Disability Discrimination Act 1995 (DDA 1995) (as amended by Article 5 of the Disability Discrimination (NI) Order 2006) when carrying out its functions to promote positive attitudes toward persons with a disability and to encourage their participation in public life.

Through the application of our Equality Scheme, specifically through the methodologies of Equality Screening and Equality Impact Assessments (EQIA) the Trust will seek to promote and further its equality duties.

The Trust's 5 year Equality Scheme and Disability Action Plans (2018-2023) also set out actions the Trust will take to further ensure:

- The effective discharge of the Section 75 Equality and Disability duties;
- The promotion of equality in our services;
- Support for our staff in adhering to these duties.

The principles of fairness, respect, dignity, equality and autonomy will inform our work.

4.3 Capital Investment Plan

The Trust has received notification of its Capital Resource Limit (CRL) for 2019-20. Capital allocations are confirmed for the following projects:

Project	CRL 2019/20	Comments and Status
General Capital Allocation	**4,732,088**	General Capital Allocation to progress Estates, IT, Medical Equipment and Transport priorities of the Trust. This allocation also covers backlog maintenance for Trust estate.
CAH Aseptic Suite	52,111	This funding will enable completion of the new build Pharmacy Aseptic Unit attached to the Mandeville Unit at Craigavon Area Hospital.
Invest to Save	1,423,700	This funding will enable a wide range of schemes to reduce running costs. These include loft insulation, pipework insulation, LED lighting schemes, double glazing and oil to gas conversions.
Transformation projects	1,052,000	This funding will enable 3 schemes to be progressed: • Purchase of equipment for phase 1 of the Ambulatory Unit at CAH and progression of phase 2 works; • Works to South Tyrone Hospital to facilitate a regional Assessment and Treatment Centre for cataract surgery; • Relocation of paediatric outpatient services at Daisy Hill.
Regional Car Parking Policy	170,000	This funding will enable the upgrade and expansion of existing care parks to facilitate the introduction of charging.
ICT Tranche 1 & 2 Funding	1,206,984	Funding from the regional HSC eHealth programme for commissioned

Project	CRL 2019/20	Comments and Status
		ICT projects and work.
GP Improvement Scheme	138,875	Upgrade to Gilford Health Centre which is Trust owned.
Paediatric Cardiology Equipment	35,550	Funding for the purchase of an echo machine for paediatrics.
TOTAL CRL	**£8,811,308**	

Primary and Community Care

Newry Community Treatment and Care Centre (CTCC)

The new Community Treatment and Care Centre (CTCC) in Newry is one of two pathfinder projects in Northern Ireland, to test the affordability and viability of a revenue based solution to funding primary and community care infrastructure, as an alternative to the traditional capital procurement route, given constraints on available capital funding.

In April 2013, Ministerial Direction confirmed that the project should proceed to third party development (3PD) procurement and in February 2016 the Trust received an instruction from the then Department of Health Social Security and Public Safety to proceed to appoint the Preferred Bidder for the Newry CCTC project.

In 2017/18 the preferred bidder was appointed and works concluded on the detailed design of the building. The project is awaiting issue of full planning approval to enable finalisation of the project programme and costs so that the Full Business Case (FBC) can be developed and submitted to the Department of Health and the Health and Social Care Board for approval. Approval of the FBC will permit award of the contract to deliver the Newry Health Hub building.

Dungannon Community Treatment and Care Centre

The Primary Care Infrastructure Programme Strategic Implementation Plan (SIP) sets out the regional plan for investment in primary care infrastructure and is based on a hub and spoke model. The Department of Health (DoH) recognises that further Primary and Community Care Centre developments (hubs) will be required to deliver the Minister's vision, *Health and Wellbeing 2026: Delivering Together*. The DoH has reaffirmed this position and has requested the HSCB and the Health and Social Care Trusts (the Trusts) to commence work on Business Cases for a further four hub projects. It is envisaged that these projects will form Tranche 2 of the Primary Care Infrastructure Development (PCID) Programme. The Dungannon Community Treatment and Care Centre Project has been selected as one of the four priority hub projects to be progressed to Business Case stage.

The Trust is currently progressing the service model, needs assessment and feasibility studies with a view to having an outline business case completed during this financial year.

4.3.1 Asset Management Strategy

The Trust continues to be committed to the delivery of the NI Executive Asset Management Strategy which requires the optimum use of property assets and rationalisation of surplus assets and vacant assets for which there is no deliverable foreseeable need, ensuring property costs demonstrate value for money. The Trust has planned its disposals for 2019/20 and progress against targets will continue to

be reviewed with the Department of Health Asset Management Unit through the current established processes.

4.3.2 Proposed Projects

General Capital / MES UPDATE

The Trust has received a General Capital Allocation for 2019/20 of £4,732,088

General Capital will be allocated to the following areas:

1. Carry forward schemes (i.e. schemes started during 2018/19 which will be completed during 2019/20);

2. Requirements identified during 2018/19 which were not funded due to insufficient funding;

3. Estate-led schemes – this includes Maintaining Existing Services, CERI, DDA, Health and Safety, Firecode and backlog maintenance;

4. Service-led schemes – this includes the development of new services which may require estates work to be undertaken;

5. Transport – this allocation supports the fleet replacement programme;

6. Information Technology – this includes systems management, infrastructure replacement and development;

7. Medical Equipment – this is to fund new and replacement for both hospital and community.

Trust Capital Priorities Review

In 2018/19 the Trust was asked by the Department of Health (DoH) to re-assess its capital priorities and submit a revised 10 year plan for investment, within funding limits specified by the Department. Given the age and condition of the Trust infrastructure and particularly the challenges presented in the current acute hospital estate, this prioritisation proved extremely difficult as a number of schemes would be seen by the Trust as being a priority 1.

The Trust's top 5 ranked schemes were: -

- Low voltage works for Craigavon and Daisy Hill Hospitals. There is a severe low voltage capacity constraint at both hospital sites which will restrict future development. Craigavon Area Hospital is the more critical of the two. An

outline business case has been drafted and will be submitted to the Department of Health in the current financial year;

- Daisy Hill Hospital Evacuation Strategy – an outline business case has been submitted to improve the evacuation strategy including the provision of fire evacuation lifts;
- Oakridge Day Care Centre for Adults with a Learning Disability;
- Dungannon Community Treatment and Care Centre;
- Craigavon Area Hospital Site Redevelopment (Phase 1A & 1B).

The Trust was subsequently asked by the DoH to provide further detailed information on its plans for redevelopment of its two acute hospital sites. The requested information was provided early in 2019/20.

4.4 Measures to Break Even

The Trust has identified a range of measures to address in full the gap during 2019/20. These measures, which include payroll reductions and non-recurrent slippage on financial investments, will continue to ensure that the Trust delivers on all savings targets allocated to it. This is an approach consistently applied by the Southern Health and Social Care Trust.

The details of the proposals at this stage are included in the Financial Templates attached as Appendix 1.

4.5 HSC Transformation Programme

“Health & Wellbeing 2026: Delivering Together” set the blueprint for how the health and social care system is to be transformed. In response, the Department of Health and HSCB set out plans for investment in 2018/19 and 2019/20.

The Trust will continue to work in partnership with the DOH and HSCB to implement local transformation projects, in line with funding allocated. The Trust has continued to embed transformation initiatives which were established during 2018/19. Additional investment of c£13m to sustain transformation initiatives until March 2020 has been welcomed. A range of positive outcomes have been noted as a result of investment in local services including the following:

- Increase in the numbers of Specialist Foster Carers across the Southern Trust area;
- Introduction of Signs of Safety – introduction of strengths based approach to Social Work across the Trust, with staff and partner agencies trained.

Alignment of case management processes and systems with Signs of Safety framework and language;

- Introduction of a Residential Care Support Service and also a Post Adoption Support Service for children and young people;
- Establishment of a Direct Assessment Unit at Daisy Hill Hospital and extended ambulatory provision at Craigavon Area Hospital;
- Establishment of a Respiratory Ambulatory Care Service at Craigavon Area Hospital, delivered in a new Ambulatory Unit;
- Extension of the Acute Care at Home Service to cover a wider geographical area to reduce the need for hospital admissions and ensure where possible patients are treated in the comfort of their own homes;
- Enhancement in Diabetes Services across both Acute & Community Services to transform patient pathways eg. Diabetes Foot Care Pathway, Diabetes In-Patient service and also Diabetes in Pregnancy;
- Implementation of an Enhanced Mental Health Liaison Service within Craigavon Area Hospital.

The Trust welcomes the opportunities presented through the Transformation Programme however moving forward the Trust will continue to work closely with Department of Health and Health & Social Care Board to determine sustainability options into 2020/21 and/or the need for agreed exit strategies beyond the transformation period.

5 Governance

5.1 Overview of Governance Arrangements

The Trust has an Integrated Governance Framework in place which brings overall coherence to the various component parts of governance. This sets out the arrangements by which the Trust Board, which has primary responsibility for effective governance, will be assured that there is a comprehensive system for all aspects of governance including financial, organisational, clinical and social care; that objectives are being met and services are safe and of a high quality. Committee structures are in place to reflect this approach and to support the Board.

The Governance Committee is the overarching strategic Committee responsible for providing assurance to the Board on all aspects of governance (except financial control which is the remit of the Audit Committee). The Trust continues to strengthen its governance arrangements and their effectiveness will continue to be regularly considered by this Committee.

5.2 Assurance

A systematic approach is taken to ensure that the systems upon which the Trust relies are challenged and tested. The Board Assurance Framework is an integral part of the Trust's governance arrangements and is compiled in conjunction with all Directorates. The Assurance Framework for 2019/20 defines the organisation's objectives, identifying risks to their achievement, highlighting the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It sets out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

The framework will provide the Board with the necessary information to enable them to:

- Assess the assurances given;
- Identify where there are gaps in control and/or assurances;
- Take corrective action where gaps have been identified.

The Corporate Risk Register is complementary to and works in conjunction with the Assurance framework. A high level summary of the Corporate Risk Register is included with the Board Assurance Framework and this provides the Board with information on other significant risks that are under active management and

review. The Corporate Risk Register is reviewed by the Governance Committee on a quarterly basis and by SMT monthly.

5.3 Risk Management

The key components of Risk Management within the Trust are underpinned by the Controls Assurance Standard for Risk Management and the Trust's Risk Management Strategy and procedures for the identification and management of risk within the organisation.

Each service Directorate has a Governance team who facilitate the senior management of the Directorate (the Director, Assistant Directors and Associate Medical Directors) to identify, assess and manage risk within their area of responsibility.

The key objectives for 2019/20 are to promote further the risk identification and management process within all Directorates across all divisions and within each team of staff working within the Trust. The Senior Management Team and Trust Board via the Governance Committee will keep under regular review the identified risks ensuring they are managed, monitored and escalated externally where appropriate. Directorate Risk Registers are in place at team, division and directorate levels within the Trust and inform the Corporate Risk Register.

5.4 Emergency Planning and Business Continuity

The new Emergency Planning Controls Assurance Standards requires that the Trust:

"*Has an annual work programme to mitigate identified risks and incorporate the lessons identified relating to emergency planning (including details of training and exercises and past incidents) and improve response*."

1. Given the nature of Trust services, it is critical that it is able to continue the delivery of essential services in the event of a major incident (mass casualty) or emergency situation (pandemic influenza, severe weather, civil unrest);

2. To ensure that the Trust conducts its emergency management activities in line with the requirements of the NI Civil Contingencies Framework (2005). The Trust's strategic aim is to ensure preparedness to provide a proportionate, effective response to any major incident or emergency situation impacting on achievement of its corporate objectives.

This is achieved through:

- Implementation of an appropriate risk assessment process to identify the threats to the organisation;
- Provision and dissemination of information and advice on emergency planning and business continuity to all appropriate Trust Directorates;
- Ensuring emergency preparedness and business continuity management are part of every-day decision making through education, training, exercises, job descriptions, policies and procedures;
- Execution of exercise events (including cross border and multi-agency) to regularly test the effectiveness of Emergency Response and Business Continuity Plans and review outcomes of tests/drills;
- Compliance with the new Emergency Planning Controls Assurance Standards and regional, local and ministerial Emergency Planning targets;
- Close working relationship with relevant external agencies (DoH, HSCB, PHA, PSNI, NIFRS, NIAS, Local Councils) to ensure an integrated multi-agency emergency response capability.

5.5 Clinical and Social Care Governance

The Medical Director supported by the Assistant Director of Clinical and Social Care Governance has the responsibility for providing assurance regarding Clinical and Social Care Governance systems and processes within the Trust. The Clinical and Social Care Governance structures are embedded within the organisation and cut across all professions and Directorates.

In 2019/20 the Trust's Clinical and Social Care Governance agenda will continue to be shaped by professional standards and learning lessons from key internal and external reports. This process includes the reporting of incidents, scrutiny of risk associated with the provision of clinical and social care, safe systems of care delivery, the reporting of serious adverse incidents and the lessons learned.

During 2019/20 the Trust will strive to continuously develop and improve its clinical and social care governance arrangements by undertaking to:

- Continuously review its present mechanisms for the identification investigation and learning from incidents and SAI's (Serous Adverse Incidents);
- Improve on existing systems in place to support easy reporting, trend analysis, visibility of lessons learned and action planning following incidents and complaints by developing the use of 'real time' electronic incident/complaints dash boards across the Trust;

- Put in place a CSCG audit programme which links to key areas of patient safety and risk;
- Strengthen the range of CSCG Quality Indicators in place to provide the type and depth of organisational intelligence/information required to adequately inform the organisation's CSCG, Risk, Safety and Quality Improvement priorities;
- To foster links with experts in the area of developing and improving on organisational 'safety cultures'.

6 Promoting Wellbeing, PPI and Patient Client Experience

Promoting health and wellbeing and reducing health inequalities remains a key priority for the Trust. The Trust continues to work closely with partners from across the statutory, community and voluntary sectors to ensure effective collaborative approaches to address the needs of local communities:

- The Trust has established a cross-Directorate and cross-sectoral structure to support the implementation and outworking of the regional *Public Health Framework*, *Making Life Better* and the ongoing development of local council community plans. 19/20 will see a continued focus on and leadership in the implementation of these community plans in collaboration with local councils and other statutory, community and voluntary sector partners; this will include Trust investment into enhancing Ageing Well, Mental and Emotional Health and Wellbeing, and Physical Activity opportunities;
- Local implementation of the regional Tobacco Control Strategy through the provision of stop smoking support services and by leading the ongoing implementation of Smoke Free sites for the Trust;
- Leading on development and delivery of health improvement action plans to progress physical activity opportunities, nutrition and cooking skills, sexual health, home accident prevention, mental health, suicide prevention, stop smoking support and health improvement for children and young people;
- Implementation of the Trust Staff Health and Wellbeing strategic action plan – including ongoing promotion and updating of the *UMatter Hub*, planning and delivery of an annual action plan of activity including physical activity classes, and support of Workplace Health Champions;
- Development and implementation of a Trust *Arts for Health and Wellbeing Strategic Action Plan;*
- Health Improvement/Community Development action plans for 2019/20 have been tailored to meet the needs of vulnerable and harder to reach groups as indicated by the commissioner and in keeping with collaborative working arrangements linked to local council community planning processes and structures;
- Specific plans will be developed to target the health and wellbeing needs of Looked After Children and Adults with a Learning Disability. Promoting wellbeing will continue to work with Learning disability services and support the health and wellbeing support worker for adults with a learning disability;
- The MacMillan Cancer Health and Wellbeing programme will continue to increase access to cancer information and support, and health and wellbeing events across the Trust. A bid for funds to develop a navigator service for people

affected by cancer will be progressed and a delivery model developed informed by those affected by cancer and wider stakeholders;

- Work with Macmillan and Newry, Mourne and Down Council to promote uptake of the Move More Physical Activity programme for people affected by cancer;
- Co-ordination and delivery of Early Interventions programmes including "*Roots of Empathy*" in primary schools and a portfolio of parenting support programmes being commissioned by the Public Health Agency and related primarily to the Delivering Social Change (DSC) Early Intervention Transformation Programme;
- Participation in the PHA's Implementation and Innovation Board and sub-groups to further develop the framework for the expansion of community development approaches;
- Support for sustainable approaches to community development for health and social wellbeing including delivery of Community Sector Training programme (that now provides adult safeguarding modules in addition to the range of child safeguarding modules), further development of the role of and support for Community Health Champions and Trainers across the community, and implementation of Neighbourhood Renewal Health Improvement Plans in Newry, Craigavon, Lurgan, Portadown, Dungannon and Coalisland;
- Continue to implement Traveller health and wellbeing training and support programme and co-produce Traveller friendly information and guidance to meet identified need;
- Work with others as above to develop a strategic approach to the improvement of social support and health and wellbeing for older people in the community;
- The Trust's Access and Information Service will continue to be developed to provide a single, centralised point of access and a single access strategy for referral for a range of social and health care services within the Older People and Primary Care (OPPC) Directorate as well as reaching out into the community, voluntary sectors and other statutory providers;
- Continued implementation of EU-funded *CoH-Sync* (Population Health) and *mPower* (Older People) projects under the auspices of the Co-operation and Working Together (CAWT) partnership;
- Continue to deliver the transformation funded Pre-Diabetes prevention programme increasing referrals from primary care and delivery of programmes at Trust level as agreed by the regional Transformation Implementation Group;
- Support for social prescribing models of health and social wellbeing, including continued implementation of a frailty pilot with a GP practice and support for the development of a social prescribing network across the Southern Area;
- Support for the development and implementation of a Trust Infant Mental Health strategic action plan.

6.1 Workplace Health and Wellbeing

The Trust is committed to maintaining and improving the health and well-being of all staff from induction through to retirement. The Trust Health and Wellbeing Strategy 2018-2021 is based on 6 key objectives to help the Trust achieve this over the 3 years. The Health and Wellbeing (H&WB) Steering Group will ensure the strategic leadership and direction in the development and implementation of the Strategy and Action Plan. A range of health campaigns and workshops will continue to be shared with staff throughout the year focusing on physical, psychological and emotional issues via a range of communication mediums including desktop messages, U-matter website and fortnightly email, desktop messages and organised events. The health calendar is promoted among the Trust's Health Champions enabling it to be used as a planning tool.

During 2019-2020 two additional H&WB workstreams will be established to support the Trust's aim of achieving and maintaining a healthy workforce providing a safe, supportive, and health promoting workplace. In addition to the Better Physical Health and Wellbeing work stream these will also include the Better Psychological Health and Wellbeing and Employee Experience workstreams.

A broad range of policies are in place in support of health and wellbeing. During 2019/20 the Trust will develop Guidance for staff and managers affected by cancer to ensure they access the support they need and a Menopause at Work Policy to increase the guidance and support available to managers and staff.

A review of the Trust's Occupational Health Service has been completed. Key recommendations from the review focused on a number of issues including: more focus on broader health and wellbeing activities, potential relocation of the service to achieve greater visibility for staff, development of a communication strategy to change the perception of the work of Occupational Health. These will be a key focus of work for 2019-2020.

With the appointment of a new Clinical Psychologist, a referral pathway will now be established for the Clinical Psychology Service in Occupational Health. Referrals will be for individual or team groups who need psychological assessment and intervention for difficulties related to their work. Future service development plans include the provision of group-based psychological interventions which will be co-delivered with a member of the Occupational Health team. The Clinical Psychologist will also begin to offer psychological assessment, consultation, training and therapeutic intervention for teams within the Trust and support the work of the Organisational Development team.

6.2 Personal and Public Involvement and Patient Client Experience

The Trust is committed to ensuring the active and meaningful involvement of individuals, communities and stakeholders in improving the design, delivery and efficiency of services.

In promoting Personal and Public Involvement the Trust will:

- Provide effective leadership and support across all areas to create and implement appropriate mechanisms and opportunities for involvement for all those who wish to engage with the Trust, including service users and carers, in identifying needs and priorities and in the design, planning and delivery of services as per the regional standards for Personal and Public Involvement (PPI) and Patient Client Experience (PCE);
- Review and up-date PPI support resources for staff and service users/carers and develop new resources to meet identified need;
- Evaluate the process and the impact of the **Confidence and Supply Transformation** non-recurrent funding allocated to the Southern Trust to progress **Partnership Working Infrastructure** and determine to what extent this small injection of non-recurrent funding supported service teams in the meaningful involvement of their service users and carers in the planning, management, delivery and evaluation of their services and to test models for the potential development of Trust based Citizens Hubs. The report will assess the impact of these projects for service users and carers and Trust services, identify the positive outcomes for all involved and identify any barriers or challenges which will inform local and regional learning;
- Induct, place and evaluate the impact of the bank of service user/carer consultants recruited under **Confidence and Supply Transformation** non-recurrent funding;
- Evaluate the impact of the Senior PPI Officer resourced through **Confidence and Supply Transformation** non-recurrent funding;
- Identify and support carers to access a wider range of services, improve their health and wellbeing and access financial support through the implementation of the carers support action plan which was co-produced with carers in 18/19;
- Review and up-date carer support resources for staff and carers and develop new resources to meet identified need;
- Influence regional approach to the auditing and analysis of PCE and PPI processes and outcomes across health and social care – to streamline and improve reporting processes and build capacity for wider involvement across Trust services;

- Build on the work of the Trust Volunteer Service through the targeted recruitment of volunteers and the development of new volunteer roles as needed to address a range of needs in the community and enhance patient experience through befriending and social support;
- Complete the assessment process for achieving the Investing in Volunteers quality standard award;
- Continue to work in partnership with Volunteer Now to develop an OBA framework for volunteering;
- Embed community development approaches to support local involvement and innovation in the future delivery of services including working in partnership with other key stakeholders to encourage support for a mixed economy approach to the provision of health and social care across all sectors;
- Involve and engage patients, service users, carers and representative groups in establishing priorities and plans and supporting the evaluation of health and social care delivery to provide learning and continuous improvement, e.g. PPI Panel, Carers Reference Group, Mental Health Service User Groups, Maternity Services Liaison Committee, Traveller Action Group, etc.;
- To play a leading role in the development of regional and local implementation structures for *Making Life Better* including participation in the newly established MLB network ;
- Continue to participate in the *10,000 Voices Project* in line with the agreed regional action plan for 2019/20.

APPENDIX 1 FINANCIAL TEMPLATES
INFORMATION FOR TRUST DELIVERY PLANS 2019/20

Trust	Southern Health and Social Care Trust
Table No.	

FP1 **Forecast Financial Position**

This should reflect both the planned 2019/20 in -year and full year projected financial position.
In respect of a pay award for 2019/20 neither assumed income for pay nor estimated pay expenditure should be factored into the financial position at this point.
Income to offset the additional 6.2% Employers Superannuation costs should be assumed, including income for the 6.2% impact on superannuation costs of C&S Transformation projects.
Expenditure for the 6.2% superannuation costs of C&S Transformation Fund projects should be included in the financial plan but all other Transformation project costs should be excluded from the plan.

FP2 **Reconciliation of RRL Income**

This table should be used to indicate income assumptions by reconciling current RRL to planned income anticipated from HSCB and PHA. Once agreed as part of the TDP, additional Trust income is not to be assumed without the approval of HSCB / DoH.

FP3 **Trust Savings Target 2019/20 (excluding Regional Pharmacy - see Table 3a)**

In regard to the advised Trust Savings Target for 2019/20, this table should reflect the savings plan proposals included within the calculation of the financial position. Where a range of savings / expenditure control measures are required to be put in place to ensure in year financial balance, these should also be included on this template. As appropriate, a commentary should be included against planned measures together with a RAG status. Additional rows can be inserted as required. Each proposal should be identified by Programme of Care.

FP3a **Regional Pharmacy Prescribing Savings 2019/20**

This table is to indicate the proposals to address the Trust's Pharmacy Prescribing Savings target for 2019/20, which it is expected will be delivered to the target level set. All Medicines efficiency savings are to be reported against this target.

FP4 **Workforce Planning - Indicative Impact on WTE**

Trusts should provide estimate of staffing impact of the cash releasing plans detailed on FP3 and indicative allocations/investments on paid WTE.

FP5 **Workforce Planning - Total Staff**

This should indicate the projected paid WTE for the Trust analysed between Trust's staff and Agency/Locum staff and across all staff groups

FP6 **Detail of Income**

This table should analyse all income in 2019/20 by Programme of Care

FP7 **Detail of Expenditure**

This table should analyse all expenditure in 2019/20 by Programme of Care **before** impact of any savings delivery

FP8 **Demography**

Gross pressure by Scheme by Programme of Care should be recorded with slippage identified separately in the proforma and the Trust identifying:

- The level of modelled demand that will be avoided in year by the reform and transformation investments made by LCGs in prior years
- The level of demand that is realised in year that can be addressed through productivity and other cash avoidance means

FP9 **Reconciliation Check**

This table provides high level reconciliation between FP1 in year position and the tables on Income (FP2), Expenditure (FP7) and Savings (FP3 & FP3a).

INFORMATION FOR TRUST DELIVERY PLANS 2019/20 **FP1**

TRUST: SHSCT

Contact Name:	Carol Cassells
Position:	ADOFFM
Phone No:	02837565001

Note: This table excludes all Provisions, Depreciation, Impairment Expenditure.

Date Completed:	04.10.19

TABLE 1 **FINANCIAL POSITION**	**2019/20** In Year Effect	 Full Year Effect
	£'000	£'000
1.0 Expenditure:		
1.1 Staff costs	459,963	457,998
1.2 Other expenditure	270,137	268,891
1.3 Total expenditure	730,100	726,889
2.0 Income:		
2.1 Income from activities	31,378	31,157
2.2 Other income	9,229	6,823
2.3 Total income	40,607	37,980
3.0 Net expenditure	689,493	688,909
add: RRLs agreed for services provided by other HSC bodies		
4.1 BSO		
4.2 Other (specify)		
4.3 Other (specify)		
4.4 Total RRLs agreed	-	-
5.0 Net resource outturn	689,493	688,909
6.0 Calculation of Revenue Resource Limit (RRL)		
6.1 Allocation from HSCB (as per FP2)	676,838	665,830
6.2 Allocation from PHA (as per FP2)	5,077	4,865
6.3 Total Allocation from HSCB/PHA	**681,915**	**670,695**
6.4 NIMDTA	5,813	5,813
6.5 RRL agreed with other HSC bodies (specify)		
6.6 RRL agreed with other gov't departments - NIHE Supporting People	1,765	1,765
6.7 **Revenue Resource Limit**	689,493	678,273
7.0 **Surplus / (Deficit) against RRL**	**0**	**(10,636)**
7.1 % Surplus / (Deficit) against RRL	0.00%	-1.57%

Notes:

Please note FYE Deficit excludes the following:-
DECC/MDTs, Mental Capacity Act, Superannuation increase to 22.5%, Impact of 19/20 Pay Awards, 2nd CT Scanner Funding, New Pressures that may emerge over the remainder of 19/20, C&S Transformation Projects, Elective, Allocations recevied on a non-recurrent basis every year e.g. Grant in Aid, Legacy Transformation.

INFORMATION FOR TRUST DELIVERY PLANS 2019/20 **FP2**

Name of Trust:
SHSCT

RECONCILIATION OF RRL TO PLANNED INCOME

Date Completed: 19.09.19

INCOME FROM COMMISSIONERS	**2019/20**	
	In-Year Effect	**Full Year Effect**
1. HSCB	**£'000**	**£'000**
RRL as at 1st April 2019	590,838	590,838
Indicative Allocations:		
Ring Fenced (if applicable)		
Mental Health	2,488	2,488
Legacy Transformation	155	0
Other		
Learning Disability	1,342	1,342
Renal Services additional consultant	15	0
Renal Services NR 18/19 FYE	120	0
Paediatrics - 0.5 theatre session		
gastro	25	0
External Support for unscheduled care	50	0
RCCE	61	61
Childrens	1,218	512
Drugs	50	50
Elective	4,601	0
Cancer	50	0
18/19 Pay Awards - Recurrent	10,402	10,402
18/19 Pay Awards - Non Recurrent	1,711	0
18/19 Control Total	102	102
Prior year pressures	6,166	6,166
Demography 18/19 FYE	3,163	3,163
Childrens - implementation of SEN act	173	0
Implementing Adult safeguarding		
prevention and protection policy	45	45
Domiciliary Care regrading	2,300	2,300
Energy Costs	1,053	1,053
Independent Sector Fostering / LAC	1,626	1,626
Renal services and transplant	30	0
Demography 19/20	4,508	4,508
Non Pay (including National Living		
Wage)	9,180	9,180
Apprenticeship Levy	80	80
Drugs and Therapies	1,201	1,201
MORE Savings Target	-1,040	-1,040
Car parking charges target	-112	-112
Total Indicative Allocations	50,762	43,127
Other Assumed Allocations		
SUMDE	1,944	1,944
Surestart	4,512	4,512

SAUCS	4,621	4,621
GIA commissioned courses	900	0
Superannuation Rate Increase 19/20	18,736	18,736
Additional Spec Drugs funding	1,552	1,552
General Pressures	500	500
Additional Income In Year	1,500	0
Mobile Cath Lab	705	0
DECC Phase 1 Cataract Non ringfenced	268	0
Total Other Allocations	35,238	31,865
HSCB Income as per FP1	676,838	665,830
2. PHA	**£'000**	**£'000**
RRL as at 1st April 2019	4,744	4,744
Indicative Allocations:		
Ring Fenced		
Other		
18/19 Pay Awards - Recurrent	74	74
18/19 Pay Awards - Non Recurrent	12	0
Non Pay	47	47
Total Indicative Allocations	133	121
Other Assumed Allocations		
Roll over of non-recurrent	200	0
Total Other Allocations	200	0
PHA Income as per FP1	5,077	4,865
Total Allocation from HSCB/PHA	681,915	670,695

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

Name of Trust: SHSCT

FP3

Date Completed: 19.09.19

Trust Savings Target 2019/20

	Recurrent/Non recurrent	RAG Status	POC	POC	POC	POC	POC	POC	POC	POC	POC	Total	Commentary
Project Title			1	2	3	4	5	6	7	8	9		
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
1 Slippage on Dungannon Supported Living	NRR	Green	0	0	0	0	140	0	0	0	0	140	
2 Vacancy factor	NRR	Green	176	27	34	124	40	53	17	10	20	500	
3 Non-direct Clinical Goods & Services	R	Green	209	27	34	124	40	53	17	10	20	533	
4 Demography Slippage	NRR	Green	285	0	78	468	166	0	56	0	0	1,053	
5 Slippage on allocations	NRR	Green	167	25	32	118	38	50	16	10	19	475	
6 Car Parking Income	NRR	Green	19	0	0	0	0	0	0	0	0	19	
etc												0	
Total			**856**	**79**	**178**	**834**	**423**	**156**	**106**	**30**	**58**	**2,720**	

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

Name of Trust: SHSCT

FP3a

Date Completed: 19.09.19

Regional Pharmacy Prescribing Savings 2019/20

	Recurrent/Non recurrent	RAG Status	POC	POC	POC	POC	POC	POC	POC	POC	POC	Total	Commentary
Project Title			1	2	3	4	5	6	7	8	9		
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	
1 Switching c/f 18/19	R	Green	138	0	0	0	0	0	0	0	0	138	
2 Price Reduction (inc Discounts)	R	Green	257	0	0	0	0	0	0	0	0	257	
3 Procurement	R	Green	216	0	0	0	0	0	0	0	0	216	
4 Rebates	NRR	Green	214	0	0	0	0	0	0	0	0	214	
5 Switching 19/20	R	Green	272	0	0	0	0	0	0	0	0	272	
6 Benchmarking	R	Green	25	0	0	0	0	0	0	0	0	25	
etc												0	
Total			**1122**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1122**	

INFORMATION FOR TRUST DELIVERY PLANS 2019/20 **FP4**

Trust SHSCT Date Completed: 19.09.19

2019/20 Gross Planned Workforce Reductions (Savings Plans on FP3) ***(Show Reductions as Negatives)***

	Admin	AHP	Support Services	Nursing / Midwifery	Social Work	Professional / Technical	Medical / Dental	Ambulance	Totals
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Permanent Staff	0.0								**0.0**
Temporary Staff									**0.0**
Decreases in Overtime & ADH Payments									**0.0**
Agency/Bank Staff (Equivalent)									**0.0**
Independent Sector Staff									**0.0**
Totals	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

This table is expected to capture the WTE (or WTE Equivalents) of all Reductions incorporated in the Trust Savings Plan.

2019/20 Planned Increases due to Backfill (Increases due to Re-Provision to facilitate Savings Plans on FP3)

	Admin	AHP	Support Services	Nursing / Midwifery	Social Work	Professional / Technical	Medical / Dental	Ambulance	Totals
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Permanent Staff	0.0								**0.0**
Temporary Staff									**0.0**
Increases in Overtime & ADH Payments									**0.0**
Agency/Bank Staff (Equivalent)									**0.0**
Independent Sector Staff\foster carers									**0.0**
Totals	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

This table is expected to capture the WTE (or WTE Equivalents) of increases due to re-provision to facilitate savings (e.g. Skill mix adjustments) in the Trust Savings Plan.

2019/20 Planned Workforce Increases (New Investments)

	Admin	AHPs	Support Services	Nursing / Midwifery	Social Work	Professional / Technical	Medical / Dental	Ambulance	Totals
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Permanent Staff	0.0								**0.0**
Temporary Staff									**0.0**
Increases in Overtime & ADH Payments									**0.0**
Agency/Bank Staff (Equivalent)									**0.0**
Independent Sector Staff								0.0	**0.0**
Totals	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

This table is expected to capture the WTE (or WTE Equivalents) of increases due to indicative HSCB Investment (e.g. Demography and other Service Development)

2019/20 Net Planned Workforce Increases (Decreases)

	Admin	Estates	Support Services	Nursing / Midwifery	Social Work	Professional / Technical	Medical / Dental	Ambulance	Totals
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Permanent Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Temporary Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Increases in Overtime & ADH Payments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Agency/Bank Staff (Equivalent)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Independent Sector Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	**0.0**
Totals	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

INFORMATION FOR TRUST DELIVERY PLANS 2019/20 **FP5**

Name of Trust:
SHSCT

Workforce Planning

Date Completed: 19.09.19

Staff Group	Actual WTE as at 31 March 2019			Staff on Payroll	Agency/Locum Staff		Total
	On Payroll	Agency/locum	Total	Projected WTE 31-Mar-20	Projected WTE 31-Mar-20		Projected WTE 31-Mar-20
Admin & Clerical	1637	75	1712	1670	86		1756
Estate Services	0	0	0	0	0		0
Support Services	1028	88	1116	1049	101		1150
Nursing & Midwifery	3373	551	3924	3440	634		4074
Social Services	2265	51	2316	2310	59		2369
Professional & Technical	1086	8	1094	1108	9		1117
Medical & Dental	629	127	756	642	146		788
Ambulance Service	0	0	0	0	0		0
Total	**10018**	**900**	**10918**	**10218**	**1035**		**11253**

FP6

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

TRUST: SHSCT

Date Completed: 19.09.19

Detail of Income 2019/20

Description	POC 1	POC 2	POC 3	POC 4	POC 5	POC 6	POC 7	POC 8	POC 9	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening HSCB RRL 2019/20	207,830	31,503	40,011	146,667	46,713	62,640	20,096	12,115	23,262	**590,838**
Opening PHA RRL 2019/20	0	0	0	0	0	0	0	4,744	0	**4,744**
Indicative Allocations:										
Ring Fenced										
£10m Mental Health inescapables CYE (exc Psychological Therapies)	0	0	0	0	876	0	0	0	0	**876**
£10m Mental Health inescapables FYE	0	0	0	0	428	0	0	0	0	**428**
£10m Mental Health - Psychological Therapies	0	0	0	0	1,069	0	0	0	0	**1,069**
19/20 Mental Health	0	0	0	0	103	0	0	0	0	**103**
Regional Mental Health Trauma	0	0	0	0	12	0	0	0	0	**12**
Legacy Transformation - ICT Reform	35	5	7	25	8	11	3	2	4	**100**
Legacy Transformation - Direct Access Physio	0	0	0	55	0	0	0	0	0	**55**
Other										
2018/19 Learning Disability FYE	0	0	0	0	0	1,041	0	0	0	**1,041**
2019/20 Learning Disability	0	0	0	0	0	301	0	0	0	**301**
Renal Services additional consultant	15	0	0	0	0	0	0	0	0	**15**
Renal Services NR 18/19 FYE	120	0	0	0	0	0	0	0	0	**120**
Paediatrics - 0.5 theatre session gastro	25	0	0	0	0	0	0	0	0	**25**
External Support for unscheduled care	50	0	0	0	0	0	0	0	0	**50**
RCCE	61	0	0	0	0	0	0	0	0	**61**
17/18 Recurrent Funding for Prior year Pressures- Autism	0	0	79	0	0	0	0	0	0	**79**
Childrens Services - Autism - Framework	0	0	232	0	0	0	0	0	0	**232**
Children's Services - Autism - Framework - NR	0	0	9	0	0	0	0	0	0	**9**
19/20 Childrens Services - Autism framework	0	0	250	0	0	0	0	0	0	**250**
Implementation of SEN Act (DOH advised expenditure dependent on Legislation)	0	0	201	0	0	0	0	0	0	**201**
Intensive Outreach for Young People in Accommodation in the Community	0	0	120	0	0	0	0	0	0	**120**
Social Services PSS Training Support	0	0	115	0	0	0	0	0	0	**115**
GEM 16/17 - scheme expansion	0	0	202	0	0	0	0	0	0	**202**

GEM (17/18 funding) existing scheme pressure	0	0	10	0	0	0	0	0	0	**10**
Drugs	50	0	0	0	0	0	0	0	0	**50**
Elective	4,601	0	0	0	0	0	0	0	0	**4,601**
Cancer	50	0	0	0	0	0	0	0	0	**50**
2018/19 AfC Recurrent	3,158	479	608	2,228	710	952	305	184	353	**8,976**
2018/19 Increase in BSO charges recurrent	26	4	5	18	6	8	2	1	3	**73**
2018/19 Adjustment for National Living Wage recurrent	-141	-21	-27	-99	-32	-42	-14	-8	-16	**-400**
2018/19 DDRB 2018 -issued 2018/19 recurrent	467	71	90	330	105	141	45	27	52	**1,329**
2018/19 Locum/Agency Pay Uplift recurrent	175	27	34	124	39	53	17	10	20	**498**
2018/19 AfC Non Recurrent	606	92	117	428	136	183	59	35	68	**1,723**
18/19 Control Total	102	0	0	0	0	0	0	0	0	**102**
18/19 prior year pressures - recurrent	4,520	119	351	554	176	237	76	46	88	**6,166**
Demography 18/19 FYE	2,113	65	83	344	97	345	42	25	48	**3,163**
Childrens - implementation of SEN act	0	0	173	0	0	0	0	0	0	**173**
Implementing Adult safeguarding prevention and protection policy	0	0	0	45	0	0	0	0	0	**45**
Domiciliary Care regrading	0	0	0	2,300	0	0	0	0	0	**2,300**
Energy Costs	370	56	71	261	83	112	36	22	41	**1,053**
Independent Sector Fostering / LAC	0	0	1,626	0	0	0	0	0	0	**1,626**
Renal services and transplant	30	0	0	0	0	0	0	0	0	**30**
Demography 19/20	1,243	4	207	2,325	303	231	104	0	91	**4,508**
Non Pay (including National Living Wage)	3,246	492	625	2,290	730	978	314	189	363	**9,227**
Apprenticeship Levy	28	4	5	20	6	8	3	2	3	**80**
Drugs and Therapies	1,201	0	0	0	0	0	0	0	0	**1,201**
MORE Savings Target	-1,040	0	0	0	0	0	0	0	0	**-1,040**
Car parking charges target	-112	0	0	0	0	0	0	0	0	**-112**
										0
Other Assumed Allocations:										
SAUCS	0	0	0	0	0	0	0	0	4,621	**4,621**
Surestart	0	0	4,512	0	0	0	0	0	0	**4,512**
SUMDE	1,944	0	0	0	0	0	0	0	0	**1,944**
GIA commissioned courses	900	0	0	0	0	0	0	0	0	**900**
Roll over of NRR PHA	0	0	0	0	0	0	0	200	0	**200**
Superannuation Rate Increase 19/20	6,590	999	1,269	4,651	1,481	1,986	637	384	738	**18,736**
Additional Specialist Drugs funding	1,552									**1,552**
General Pressures	176	27	34	124	40	53	17	10	20	**500**
Additional Income In Year	528	80	102	372	119	159	51	31	59	**1,500**
Mobile Cath Lab	705									**705**
DECC Phase 1 Cataract Non ringfenced	268									**268**
Total Income	**241,491**	**34,006**	**51,120**	**163,062**	**53,209**	**69,395**	**21,794**	**18,020**	**29,819**	**681,915**

Should agree to FP2

FP7

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

TRUST: SHSCT

Date Completed: 04.10.19

Detail of Expenditure 2019/20

Description	POC 1	POC 2	POC 3	POC 4	POC 5	POC 6	POC 7	POC 8	POC 9	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Deficit	7,353	194	509	3,306	2,348	663	186	75	143	**14,777**
Less: MH Psychological Therapies, Inescapables & Demography - ringfenced	0	0	0	0	-1,998	0	0	0	0	**-1,998**
Opening HSCB RRL 2019/20	207,830	31,503	40,011	146,667	46,713	62,640	20,096	12,115	23,262	**590,838**
Opening PHA RRL 2019/20	0	0	0	0	0	0	0	4,744	0	**4,744**
Prior Year Pressures :										
Opening Prior Year Pressures	2,200	0	600	0	0	0	0	0	0	**2,800**
2018/19 AfC Recurrent	3,158	479	608	2,228	710	952	305	184	353	**8,976**
2018/19 Adjustment for National Living Wage recurrent	-141	-21	-27	-99	-32	-42	-14	-8	-16	**-400**
2018/19 DDRB 2018 -issued 2018/19 recurrent	467	71	90	330	105	141	45	27	52	**1,329**
2018/19 Locum/Agency Pay Uplift recurrent	175	27	34	124	39	53	17	10	20	**498**
2018/19 AfC Non Recurrent	606	92	117	428	136	183	59	35	68	**1,723**
Apprenticeship Levy	28	4	5	20	6	8	3	2	3	**80**
2019/20 Inescapable Pressures:										
Auto-enrolment	200	30	39	141	45	60	19	12	22	**569**
RCCE	61	0	0	0	0	0	0	0	0	**61**
IS Price Lift Dom Care Sector	0	0	0	800	0	0	0	0	0	**800**
Ringfenced Pressures:-										
£10m Mental Health inescapables CYE (exc Psychological The	0	0	0	0	876	0	0	0	0	**876**
£10m Mental Health inescapables FYE	0	0	0	0	428	0	0	0	0	**428**
£10m Mental Health - Psychological Therapies	0	0	0	0	1,069	0	0	0	0	**1,069**
19/20 Mental Health	0	0	0	0	103	0	0	0	0	**103**
Regional Mental Health Trauma	0	0	0	0	12	0	0	0	0	**12**
Legacy Transformation - ICT Reform	35	5	7	25	8	11	3	2	4	**100**

Legacy Transformation - Direct Access Physio	0	0	0	55	0	0	0	0	0	**55**
Other Pressures (list):										
2018/19 Learning Disability FYE	0	0	0	0	0	1,041	0	0	0	1,041
2019/20 Learning Disability	0	0	0	0	0	301	0	0	0	301
Renal Services additional consultant	15	0	0	0	0	0	0	0	0	15
Renal Services NR 18/19 FYE	120	0	0	0	0	0	0	0	0	120
Paediatrics - 0.5 theatre session gastro	25	0	0	0	0	0	0	0	0	25
External Support for unscheduled care	50	0	0	0	0	0	0	0	0	50
17/18 Recurrent Funding for Prior year Pressures- Autism	0	0	79	0	0	0	0	0	0	79
Childrens Services - Autism - Framework	0	0	232	0	0	0	0	0	0	232
Children's Services - Autism - Framework - NR	0	0	9	0	0	0	0	0	0	9
19/20 Childrens Services - Autism framework	0	0	250	0	0	0	0	0	0	250
Implementation of SEN Act (DOH advised expenditure dependent on Legislation)	0	0	201	0	0	0	0	0	0	201
Intensive Outreach for Young People in Accommodation in the Community	0	0	120	0	0	0	0	0	0	120
Social Services PSS Training Support	0	0	115	0	0	0	0	0	0	115
GEM 16/17 - scheme expansion	0	0	202	0	0	0	0	0	0	202
GEM (17/18 funding) existing scheme pressure	0	0	10	0	0	0	0	0	0	10
Elective	4,601	0	0	0	0	0	0	0	0	4,601
Cancer	50	0	0	0	0	0	0	0	0	50
Demography 18/19 Additional FYE	427	65	83	305	97	130	42	25	48	1,223
Childrens - implementation of SEN act	0	0	173	0	0	0	0	0	0	173
Implementing Adult safeguarding prevention and protection policy	0	0	0	45	0	0	0	0	0	45
Energy Costs (Less £400k in prior year pressures)	230	35	44	162	52	69	22	13	26	653
Independent Sector Fostering / LAC (less £600k in prior yr pressures)	0	0	1,026	0	0	0	0	0	0	1,026
Renal services and transplant	30	0	0	0	0	0	0	0	0	30
Demography 19/20	1,243	4	207	2,325	303	231	104	0	91	4,508
Non Pay (including National Living Wage)	3,246	492	625	2,290	730	978	314	189	363	9,227
Drugs and Therapies	2,153	0	0	0	0	0	0	0	0	2,153
2018/19 Increase in BSO charges recurrent	26	4	5	18	6	8	2	1	3	73
SAUCS	0	0	0	0	0	0	0	0	4,621	4,621
Surestart	0	0	4,512	0	0	0	0	0	0	4,512
SUMDE (Less £100k in Prior Year Pressures)	1,844	0	0	0	0	0	0	0	0	1,844
GIA commissioned courses	900	0	0	0	0	0	0	0	0	900
Roll over of NRR PHA	0	0	0	0	0	0	0	200	0	200
Superannuation Rate Increase 19/20	6,590	999	1,269	4,651	1,481	1,986	637	384	738	18,736
Mobile Cath Lab	705									705
DECC Phase 1 Cataract Non ringfenced	268									268
Total Expenditure	**244,495**	**33,984**	**51,153**	**163,821**	**53,238**	**69,413**	**21,841**	**18,011**	**29,803**	**685,757**

FP8

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

TRUST:
SHSCT

Date Completed: 19.09.19

Demography 2019/20

Description	POC 1	POC 2	POC 3	POC 4	POC 5	POC 6	POC 7	POC 8	POC 9	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Gross Demography -Programme/Scheme list:										
Demography 2019/20	1,243	4	207	2,325	303	231	104	0	91	4,508
Total Gross Demography	1,243	4	207	2,325	303	231	104	0	91	4,508
Demand avoided through reform investment in prior year(s)										0
Demand avoided through reform investment in 2018/19										0
Other productivity measures										0
Managed Slippage										0
Natural Slippage	285	0	78	468	166	0	56	0	0	1,053
Total Net Demography 2019/20	**958**	**4**	**129**	**1,857**	**137**	**231**	**48**	**0**	**91**	**3,455**

INFORMATION FOR TRUST DELIVERY PLANS 2019/20

RECONCILIATION CHECK

		2019/20 In Year Effect
		£'000
1.0	Surplus / (Deficit) against RRL (FP1)	0
2.0	Income (FP2)	681,915
3.0	Expenditure as per (FP7)	685,757
4.0	Trust Savings Target 2019/20 Delivery (FP3)	2,720
5.0	Regional Medicines Optimisation Efficiency Savings 2019/20 (FP3a)	1,122
6.0	Surplus / (Deficit) against RRL (should agree to 1.0 above)	(0)

Southern Health and Social Care Trust 2019/20
TDP – Indicative volumes (demography allocations) pending Investment Proposal Templates

Appendix 2 Activity Volumes

POC 1 Service Description – Acute Services	Currency	Confirmed SBA Positon for 2018/2019	Additional Demography Volumes 2019/20 FYE	Associated Additional Costs
			FYE when posts in place	FYE
4.0 wte Physician Associates To enhance and support the medical staffing resources on acute hospital wards to meet demand and improve flow and patient care 2 x DHH (ED/Acute Medicine) 2 x CAH (Geriatric Acute & Haematology) No impact on SBA activity	N/A	N/A	**0**	**251**
4th Microbiologist 0.68 wte To support antimicrobial stewardship, infection control and Oral Parenteral Antibiotic Therapy (Note part funded 0.34 wte @ 53k from OPPC, see below) No impact on SBA activity	N/A	N/A	**0**	**53**
Patient Flow posts Additional posts to support inpatient flow and control room functions as part of management of unscheduled care pressures Posts in place but previously unfunded No impact on SBA activity	N/A	N/A	**0**	**170**
Cardiac Telemetry – 5.6 wte nurses To enable cardiac telemetry 24/7 monitoring at DHH hospital Part of ward function. No impact on SBA activity	N/A	N/A	**0**	**244**
Pharmacist Essential 8a pharmacist position to provide enhanced support to ICU Ward to ensure effective and safe provision of care No impact on SBA	NA	N/A	**0**	**62**
Point of Care Testing 3 WTE Band 3 posts to facilitate point of care testing/assurance processes for kit for provision of safe and effective care Regrading of band 6 post No impact on SBA	NA	N/A	**0**	**114**
Social Work Band 7 social worker to facilitate earlier and effective discharge planning from Acute hospital beds (DHH & CAH) with a particular focus on patients <65 year with challenging mental health and disability issues Improving patient care and inpatient flow No SBA impact	N/A	N/A	**0**	**55**

Southern Health and Social Care Trust 2019/20
TDP – Indicative volumes (demography allocations) pending Investment Proposal Templates

Pharmacy 4 wte Band 7 prescribing pharmacists (Surgery and Medicine) Provide support to DHH wards including discharge prescriptions supporting safe and effective care and inpatient flow No SBA impact	N/A	0	**0**	**210**
POC 4 **Service Description – Older People Services**				
Statutory Residential Home Provision of capacity to enable management of more complex cohort (Assistance of 2 people) to enable hospital discharges This investment represents a level of capacity to enable the current service provision to deal with high level of complexity Increased utilisation of the current resources with greater throughput 5.6 WTE Band 3 4 WTE Band 4 No impact on SBA /No increase in physical beds	Stat Homes Beddays	N/A	**0**	**300**
Access & Information staff 4 wte Band 4 staff to provide increased capacity for Access & Information centre No SBA impact	N/A	0	**0**	**110**
Care Bureau 3 WTE Band 3 Staff to facilitate domiciliary care placements and processing of invoices etc No impact on SBA	N/A	0	**0**	**76**
Domiciliary Care Increase service provision to meet demand and incremental grade drift This investment will see additional hours provided to service users increasing independent sector and in house capacity Note: SBA reflected includes memory/dementia hours which are now within the Mental health Programme. SBA adjustment required in 2019/20 to reflect this and potential rebasing of DP/SDS hours (inclusive of proxy figures of 176,836 for SDS/DP)	Domiciliary Care Hours	Opening position for 17/18 (baseline 2,325,546 + uplift 85,326 = 2410,872) Opening position 2018/19: Baseline 2410 872 + uplift 65,190 Hours = 2410,872) Opening position 2019/2020: Baseline 2410,872 + 18/19 uplift of Hours TBC	**0**	**583**

Southern Health and Social Care Trust 2019/20
TDP – Indicative volumes (demography allocations) pending Investment Proposal Templates

Domiciliary Care Enhanced administration staff to support governance and quality management No SBA Impact	N/A	0	**0**	**51**
Non Acute Wards 4.67 wte x Band 5 nurses to works across non acute hospitals (Lurgan and STH) To increase complement to ensure nursing workforce at safe working levels and ensure continuity of care No SBA impact ; post already in place	N/A	0	**0**	**159**
Primary Care Integrated Care Team Additional MD staff for ICT to support reduced caseload management initiative Recruitment in process 7 WTE Band 4 Social Work Assistant 11.2 WTE Band 6 Social Workers 0.5 WTE Band 7 Physiotherapy 4 WTE Band 6 Physiotherapists 1 WTE Band 3 Physiotherapist Assistant No SBA Impact	N/A	0		**915**
Microbiology *(0.34 wte of 4th Microbiologists identified above funded from Older People and Primary Care Directorate (53k))* 1 x Band 7 quality assurance nurse 1 x Band 8a microbial pharmacist To support antimicrobial stewardship, infection control and Oral Parenteral Antibiotic Therapy project to provide safer and effective care No impact on SBA activity	N/A	0		**102**
POC 3 **Service Description – Children and Young Peoples Services**				
Family Support & Safeguarding 3 wte x Band 4 New Contact Workers for Family Support Division to enhance the existing team capacity	Social Care Contacts	No agreed SBA baselines	**TBC**	**93**
Children with Disabilities 2 wte x Band 6 Social Workers Investment to supporting increased complexity and current demand; reduce timescale for unallocated referrals 1 Short breaks team and	Social work Caseload	No agreed SBA baselines	**TBC**	**92**

Southern Health and Social Care Trust 2019/20
TDP – Indicative volumes (demography allocations) pending Investment Proposal Templates

3 children with disability teams with focus on children autism				
CYPs Pressures 1wte x B3 Admin support to health psychology service No SBA impact	N/A	N/A	**0**	**26**
POC 5 **Service Description – Mental Health**				
Rehabilitation Enhanced MD staff to support 7-day working for mental health rehabilitation team support community support and discharge management	TBC	TBC	**TBC**	**400**
POC 6 **Service Description – Disability Services**				
Supported Living To support increase costs in Supported Living (IS facility) Accommodation associated with greater needs of aging profile of individual residents Work ongoing to renew contractual arrangements with Provider and move to block contract No SBA impact	N/A	N/A	**0**	**40**
Physical Disability Placement of complex clients into community to facilitate discharge Packages of care will be dependent on individual need and may include a flexible range of provision including residential/nursing home bedday capacity, independent sector contracted provision, additional domiciliary care provision which may be in the form of Direct Payments, traditional provision or via SDS. Whilst no impact on SBA each placement will have a contracted provision with agreed outcomes	Flexible	N/A	**0**	**135**
Domiciliary Care Provision of enhanced domiciliary care provision to meet unfunded demand and increased complexity, particularly in Armagh & Dungannon area Packages of care will be dependent on individual need and may include a flexible range of provision including domiciliary care provision which may be in the form of Direct Payments, traditional provision or via SDS.	Domiciliary Care (Hours) Direct Payments (individuals) SDS (individuals)	Flexible in line with spend	**TBC**	**61**

Health and Social Care Board

FOR APPROVAL Paper No: **HSCB/105/19**

TRUST DELIVERY PLANS 2019/20

1. Overview

This paper provides an assessment of the Trust Delivery Plans for 2019/20 and seeks HSC Board approval of these plans as an adequate response to the Draft Commissioning Plan 2019/20.

2. Background

Trusts are required to develop TDPs to respond to both the commissioner priorities contained within the draft HSCB/PHA Commissioning Plan and the Ministerial Objectives set out within the Department of Health (DoH) draft Commissioning Plan Direction. The draft Commissioning Plan 2019/20 was formally submitted to DoH on 28 August 2019 following approval by HSCB Board on 8 August 2019 and approval by PHA Board on 15 August 2019.

The role of the HSCB, as set out in the HSC Framework Document (September 2011), is to provide the Department with assurance regarding the quality, safety and financial viability of services. The HSCB discharges this responsibility in-part through the consideration and approval of TDPs.

In order to ensure consistency of approach, Trusts were issued with guidance outlining the format and structure of TDPs for 2019/20. Trusts were asked to prepare TDPs that adequately responded to the Ministerial Targets and the Commissioning Priorities outlined in the draft Commissioning Plan 2019/20.

3. Assessment of Trust Delivery Plans 2019/20

On receipt of draft TDPs, the documents were circulated to a wide range of regional and local commissioning leads across the HSCB and PHA. Feedback was co-ordinated by Local Commissioning Leads and included an assessment of:

- The financial elements of the plan; in particular the forecast financial position at end-of-year, associated financial assumptions and components of savings plans etc.

- The service elements of the plan; in particular details of key deliverables in response to Ministerial Targets and Commissioning Priorities.

All Trusts have indicated that a number of targets cannot be delivered but will work to achieve them as far as possible. All TDPs are considered to provide a generally acceptable response in relation to the commissioning priorities and demographic pressures identified in 2019/20. However, further clarity is required from all Trusts on the volume of activity expected against investments made in 2019/20 which will be determined as part of the routine commissioning process.

At this stage, only Southern Trust and NIAS have forecasted a breakeven position in-year for 2019/20. Further work is required by the remaining Trusts to provide a balanced TDP. As a result, these plans cannot yet be formally considered by the HSCB Board. Revised TDPs will be brought forward for consideration by Board members at a later date.

4. Recommendation

On the basis of this assessment, Southern Trust and NIAS TDPs are being brought forward for consideration by the HSCB Board at this stage.

It is proposed that HSC Board approve the two TDPs as an acceptable response to the draft Commissioning Plan 2019/20.

DR MIRIAM MCCARTHY
DIRECTOR OF COMMISSIONING

Enc

I. Southern Trust Delivery Plan 2019/20
II. NIAS Trust Delivery Plan 2019/20

Southern Health and Social Care Trust

Service and Budget Agreement

2019-2020

HSC Health and Social Care Board

HSC Southern Health and Social Care Trust

HSC Public Health Agency

INDEX

SCHEDULE 1: TERMS OF AGREEMENT

1. TERMS AND CONDITIONS

1.1 The Service and Budget Agreement for 2019/20 sets out the service activity and outcomes to be delivered within the Revenue Resource Limit, to meet the health and social care needs of the population. It provides a signed record of agreement between the parties; the Health and Social Care Board (HSCB) the Public Health Agency ("the Agency"); and the **Southern Health and Social Care Trust** ("the Trust") that the specified level of service is appropriate, affordable and deliverable, and will be delivered efficiently and effectively on an equitable and responsive basis.

1.2 Signatories to the agreement will pursue these aims in a spirit of co-operation and through partnership working, building in continuous improvement goals, agreed performance measures and related efficiency targets.

1.3 The agreement defines the services the Trust undertakes to provide, both directly and by arrangement with third parties, the agreed budget and the context within which the Board and Trust will operate the agreement.

1.4 The agreement is in line with Ministerial priorities, targets and objectives and is framed in the context of the Public Service Agreement, the Department's Commissioning Direction, the Health and Social Care Board and Public Health Agency Commissioning Plan and the Trust Delivery Plan (TDP).

2. TERMS OF THE AGREEMENT

2.1 The **2019/20** baseline revenue resource limit under this agreement for **Southern Health and Social Care Trust** comprises a total of **£595,582,000.** The analysis of this sum (including analysis by LCG and Board) and the arrangements in respect of financial monitoring are as outlined in **Schedule 3**. The baseline value represents funding for services to be provided to residents of Northern Ireland throughout the year from 1st April 2019 to 31st March 2020. The total funding available under the agreement may be subject to variation during the year to reflect agreed revenue resource limit additions or reductions.

2.2 The Trust should adhere to the instructions in Circular HSS(F) 29/2000 "Promoting Financial Stability within HPSS Organisations" (see **Schedule 3** for further details) and should not make recurrent commitments without a source of funding confirmed by the HSCB. Any recurrent variations approved during the financial year will have their full year effect of funding and activity applied in the subsequent years' Service and Budget Agreement.

3. SERVICES COMMISSIONED

3.1 Within the total funds available to the Trust under the agreement, all statutory requirements will be addressed as a first priority. Any plans to introduce new services or treatments must be reviewed with the Board in advance. Only services which have the prior agreement of the Board, based on a clear assessment of priorities will be commissioned.

3.2 Signatories to the agreement will develop services in line with the processes, priorities, objectives and targets outlined in the Department of Health and Social Services and Public Safety's Commissioning Plan Directions and reflected in the Board and Agency Commissioning Plan and the Trust Delivery Plan (TDP).

3.3 **Schedule 5** to the agreement records the most recent estimate of **baseline activity** associated with the range of services provided by the Trust at 1 April 2019. Significant in-year changes in the level, range and nature of services outlined in **Schedule 5** and in any associated figures relating to the distribution of costs between

programmes of care should only be by prior agreement between the Board and the Trust.

3.4 The Board will fund baseline activity in keeping with the levels identified in **Schedule 5**, which includes provision to meet changing patient flows. Actual **over and underperformance** in relation to this agreement will be addressed in line with a balancing of risk between the provider and the commissioner.

3.5 The Board and the Trust agree that the strategic direction in relation to **non-elective activity** is to see a reduction in hospital admissions facilitated by investments and service reforms directed at preventing inappropriate admissions. It would, therefore, be counter strategic to arrange to pay for increases in hospital based non-elective activity not clearly linked with changes in patient flows. However, where non-elective over performance does occur in a given specialty, this should be set, in the first instance, against any non-elective underperformance in other specialties. Where total non-elective performance across specialties is below the total baseline levels for non-elective activity identified in **Schedule 5**, such underperformance should generally be offset against elective over-performance in the same or related services where similar resources are being applied.

3.6 In relation to **elective activity**, systems are in place to facilitate activity monitoring in respect of both baseline agreements and the additional activity in 'Delivery Plans' that address Elective Access targets. The Board will expect, as a minimum, that core activity will be delivered, and may take into account Trust core performance in considering any financial assistance the Trust may require to meet Ministerial access targets.

3.7 Services commissioned under this agreement will be provided throughout the year in line with management initiatives aimed at responding optimally to **seasonal changes in the pattern of need**.

3.8 Notwithstanding 3.4 and 3.5 above, the Trust may be required to adjust the pattern of service provision recorded in **Schedule 5** during the year to address **priority pressures** associated with major epidemics or disasters, significant industrial action, or significant changes in statutory requirements or revenue allocation to the Board.

3.9 Subject to the approval of the DoH, the record of services and volumes outlined in **Schedule 5** will be amended in line with any relevant **service developments** outlined in the Commissioning Plan.

3.10 Where the Trust **sub-contracts** for services it will ensure that the arrangements meet the requirements of this agreement and relevant standards set by the Regulation and Quality Improvement Agency. The Trust also agrees to ensure that all services provided under sub-contract are in line with relevant departmentally approved governance and quality assurance guidance on commissioning from the independent sector. Where required, the Trust will supply a copy of sub-contracts to the Board.

3.11 Circular **HSS(F) 07/2007** and Guidance (Gateway Reference 7057) outline the arrangements for the funding of treatment provided by N.I. Trusts to G.B. residents. The Trust should ensure it is familiar with the specific invoicing arrangements for both **Non-Contract Activity and Specialised Services** in order to recover treatment costs directly from the patient's responsible Clinical Commissioning Group (CCG) or other NHS commissioner of service.

4. MONITORING AND PERFORMANCE

4.1 It is anticipated that **monitoring and performance review processes** under this Agreement will be supported by information reporting described in **Schedule 4**. Monitoring processes will involve on-going dialogue and communication between Board, Trust and Agency officers and regular formal monitoring reviews based on structured agendas supported by appropriate records and action notes.

4.2 In addition to information requirements outlined in **Schedule 4**, the Board and Agency reserve the right to undertake **supplementary monitoring** should this be required. In practice, this means that signatories to the agreement hereby agree that the arrangements in **Schedule 4** may be supplemented where significant concern arises regarding the level or quality of service being delivered under the Agreement or where the Department or an appropriate regulatory body requires or requests such intervention.

5. SIGNATURES

_____ Date: _____

On behalf of the **Health and Social Care Board** and **Public Health Agency**

_____ Date: _____

On behalf of the **Southern Health and Social Care Trust**

SCHEDULE 2: SERVICES TO BE COMMISSIONED

Arrangements are in place to review on a rolling basis key currencies within the SBAs to ensure these remain appropriate.

The transformation agenda has a focus on developing appropriate currencies in primary care service delivery to discrete populations in particular those with long-term conditions. LCGs will continue to work within Integrated Care Partnership Projects to develop measures of service value and outcome.

Except where amendments are agreed using this process the volumes contained in the SBA schedules represent the minimum levels of service which the Trust is expected to deliver.

Whilst agreement has been reached regarding some SBA uplifts associated with demographic funding investments, this SBA is not reflective of all investments. The HSCB and Trust will work together to reach agreement on the outstanding SBA uplifts in-year. The SBA excludes uplifts for transformational investments as this is regarded as non-recurrent.

2.1 Non Elective Acute Hospital Activity

The Trust will provide non-elective acute and community services on the basis of assessed need and appropriate provision. Volumes of demand-led activity within the SBA have been set to reflect the anticipated demand in 2019/20, based on 2018/19 outturn, including statutory requirements.

The Trust should plan to accommodate or avoid the anticipated increase in ED attendances through the deployment of demography funding, ICP initiatives aimed at reducing ED attendances and winter resilience funding.

The Trust and Commissioner will pro-actively seek opportunities, in line with the Commissioning Plan Direction and Transforming Your Care, to 'shift' activity and resources from hospital to community settings with the patient's or client's home as the Hub of Care, particularly working through ICPs.

The Trust will continue to be funded for in-patient care on the basis of finished Consultant Episodes, except where otherwise stated for example, where Procedures or Occupied Bed Days have been agreed.

2.2 Elective Acute Hospital Activity

The Commissioning Plan Direction requires that the Trust will deliver core levels of activity based on its capacity as far as possible. The Trust will configure its resources to ensure the agreed planned activity is delivered. For specialties where this is not possible, the Trust will continue to implement a trajectory plan which gives assurance of progress towards agreed levels. The Trust will also undertake action, where feasible, to secure the agreed levels if it is anticipated delivery will fall short.

If unscheduled or demand-led services exceed predicted activity in the SBA, the Trust will ensure the potential for disruption to elective services is minimised and patients' and clients' needs are addressed appropriately. The Trust will take proportionate action to sustain planned elective activity as far as possible, and minimise cancellations, in consultation with the HSCB and PHA.

The elective schedule sets out the indicative volumes for planned activity and represents the magnitude of service expected for the resources provided through this SBA.

The HSCB and Trust also recognise that in addition to operational challenges (e.g. recruitment and retention of specialist skills or restricted numbers of available training grades) new clinical standards and unscheduled care demand may require a different model of delivery. In such circumstances the elective and unscheduled care aspects of a service will be reviewed by the Trust and HSCB. Adjustments to volumes may therefore be agreed in 2019/20 to reflect changes in working practice, reform, investment and updated contract currencies.

In the current financial context the HSCB is unable to commit significant additional resources to meet elective demand in full. The Trust, having more financial autonomy during 2018/19 will continue to maximise the impact of its current resources through its service reform programme.

2.3 Maternity Activity

The indicator used for Maternity services is currently the number of Births. The Trust currently has capacity to deliver at least 5,995 births. A decrease in the number of births in the Southern Trust over the past number of years has been noted; 5,976 births in 2015/16, 5,901 births in 2016/17, 5,820 in 2017/18 and 5,689 in 2018/19.

2.4 Family and Child Care

The Southern Trust continues to experience a high growth rate in its child population - an increase of 9.8% between 2014 and 2024 is anticipated. The Trust has a caseload of 560 Looked after Children in a variety of settings at 31 March 2019, as per the Trust Delivery Plan 2019/20. The Trust should aim to have as many of these children as possible appropriately placed in family settings.

2.5 Acute Mental Health In-patients

SBA volumes for Acute Mental Health are based on a current capacity of 84 beds and an occupancy rate of 80%.

2.6 Child and Adolescent Mental Health

SBA volumes have not been included; these will be agreed with the Trust in-year and will be based on the regional review of CAMHS activity levels. All Trusts are expected to aim to achieve the productivity levels set out by CAPA.

2.7 Domiciliary Care

The SBA volumes for Programmes of Care 5, 6 and 7 have been based on 2018/19 outturn. In terms of Programme of Care 4, the SBA volumes are a roll forward of the revised 18/19 SBA volumes which were uplifted to reflect Demography Investment. Further uplifts will be agreed to reflect 2019/20 Demography investment.

2.8 Direct Payments

The 2019/20 SBA volumes have been based on "Hours Delivered" in line with Domiciliary Care baselines. The 2016/17 outturn from the Trust's Financial Return has been used as a proxy figure or otherwise stated in the note column.

2.9 Nursing Home Care

The growing and ageing population of the Southern Area has been reflected in the increasing number of bed-days commissioned by the Trust from nursing homes over recent years. The SBA volumes for Programmes of Care 4 to 7 have been rolled forward based on 2015/16 SBA.

2.10 Residential Home Care

The SBA volumes for Programmes of Care 4 to 7 have been rolled forward based on 2015/16 SBA.

2.11 Nursing Services

The SBA volumes are based on 14/15 Trust Financial Returns (TFR).

2.12 Health Visiting

The SBA volumes are based on 14/15 Trust Financial Returns (TFR).

2.13 Allied Health Professions

The SBA volumes are generally a roll forward of the 16/17 SBA. These were based on the Trust's funded capacity post investment of the additional 14.2 WTE posts as per HSCB/PHA Demand & Capacity analysis. AHP activity has been removed from the POC sections and shown in a separate table.

2.14 Social Work

The SBA volumes are based on 14/15 Trust Financial Returns (TFR).

2.15 Unscheduled Care

The Unscheduled Care volumes describe the outturn achieved by the Trust at the end of March 2019. This reflects the totality of the investments made by the Trust through the recurrent allocation of 2018/19 demography funds and the allocation of Winter Resilience funding in 2018/19 which was allocated recurrently.

SCHEDULE 3: FUNDING ARRANGEMENTS - 2019/20

Revenue Resource Limit (RRL) 2019/20

The Service and Budget Agreement provides the opening Revenue Resource Limit (RRL) for the Trust.

The financial schedules show the recurrent baseline resources available from the HSCB/PHA for the Trust. These have incorporated 2018/19 pressures and savings amended where advised by Trusts.

Analysis of Opening RRL

The attached spreadsheet reflects a range of Service and Budget Agreement allocations (RRL) appropriate to your Trust.

Schedule 1 provides a high level analysis by HSCB/PHA.

Schedule 2 provides a programme of care analysis by HSCB/PHA.

Schedule 3 provides a SBA grouping within PoC by HSCB/PHA.

Financial Context

The Commissioning Plan 2019/20 currently sets out a challenging financial plan with additional funding for inescapable pressures only. The plan provides for Non Pay, national living wage and demography pressures and the pressures arising from 2018/19 investments. Given the scale of investments required to be commissioned to address these, it is crucial that the SBA accurately reflect these investments along with the impact of the recurrent efficiency savings at service and Programme of Care level.
These figures exclude any funding from the Confidence and Supply source.

Financial Monitoring Arrangements

The Trust is required to forward electronically to the Board, monthly financial monitoring returns in line with the format and timescales specified by the HSCB. Reporting formats/requirements in respect of both cash releasing and productivity plans will be advised.

Test Drilling

To satisfy the requirements of the DoH/DoF test drilling process and ensure that Green Book Guidance on investment appraisal is followed, the Board will require that all bids from the Trust for additional funding are submitted on the appropriate Investment Appraisal documentation.

Note for Users:

These finance schedules have been collated by the Finance staff in the HSCB informed by submissions from Trusts. The financial tables are collected separately from the activity data and therefore any matching of activity and costs should be treated as indicative only.

Southern HSC Trust

Schedule 1

2019/20

	Stream		
Funding Source	**HSCB £'000**	**PHA £'000**	**Total £'000**
Recurrent Baseline 2019/20	590,838	4,744	595,582
SubTotal	**590,838**	**4,744**	**595,582**

Southern HSC Trust

Schedule 2: Recurrent Funding by Stream, Source & PoC

2019/20

Stream	POC	£'000
HSCB	PoC 1	206,112
	PoC 2	36,535
	PoC 3	36,247
	PoC 4	150,546
	PoC 5	41,577
	PoC 6	62,017
	PoC 7	17,204
	PoC 8	9,028
	PoC 9	31,571
HSCB Total		**590,838**
PHA	PoC 1	1,694
	PoC 2	161
	PoC 3	89
	PoC 4	38
	PoC 5	199
	PoC 8	2,426
	PoC 9	137
PHA Total		**4,744**
Grand Total		**595,582**

Southern HSC Trust

Schedule 3: Recurrent baseline by funding Stream, PoC & SBA grouping

2019/20

Stream	POC	SBA Grouping	£'000
HSCB	POC 1 - Acute Services	Accident and Emergency	28,025
		Cardiology	11,162
		General Medicine	35,246
		General Surgery	28,872
		Intensive/High Dependency	12,242
		Medical & Clinical Oncology	3,191
		Other Acute	71,969
		Trauma and Orthopaedics	15,405
	POC 1 - Acute Services Total		**206,112**
	POC 2 - Maternity & Child Health	AHPS	5,584
		Grants, Goods & Services	332
		Non Acute Hospital	21,316
		Nursing	6,864
		Other Comm / PSS	2,439
	POC 2 - Maternity & Child Health Total		**36,535**
	POC 3 - Family & Child Care	AHPS	96
		Grants, Goods & Services	8,759
		Nursing	802
		Other Comm / PSS	4,705
		Residential Home Care	4,888
		Social Work	16,997
	POC 3 - Family & Child Care Total		**36,247**
	POC 4 - Older People	AHPS	7,661
		Domiciliary Care	42,392
		Grants, Goods & Services	2,514
		Non Acute Hospital	28,456
		Nursing	11,567
		Nursing Home Care	32,501
		Other Comm / PSS	14,384
		Residential Home Care	6,581
		Social Work	4,490
	POC 4 - Older People Total		**150,546**
	POC 5 - Mental Health	AHPS	1,011
		Domiciliary Care	2,655
		Grants, Goods & Services	664
		Non Acute Hospital	11,217
		Nursing	3,705
		Nursing Home Care	4,011
		Other Comm / PSS	15,407
		Residential Home Care	1,423
		Social Work	1,485
	POC 5 - Mental Health Total		**41,577**

Stream	POC	SBA Grouping	£'000
	POC 6 - Learning Disability	AHPS	2,348
		Domiciliary Care	5,227
		Grants, Goods & Services	1,588
		Non Acute Hospital	2,368
		Nursing	1,901
		Nursing Home Care	9,503
		Other Comm / PSS	26,158
		Residential Home Care	7,950
		Social Work	4,973
	POC 6 - Learning Disability Total		**62,017**
	POC 7 - Physical & Sensory Disability	AHPS	1,724
		Domiciliary Care	6,251
		Grants, Goods & Services	1,548
		Nursing	635
		Nursing Home Care	1,893
		Other Comm / PSS	2,049
		Residential Home Care	97
		Social Work	3,006
	POC 7 - Physical & Sensory Disability Total		**17,204**
	POC 8 - Health Promotion	AHPS	121
		Grants, Goods & Services	1,630
		Nursing	6,359
		Other Comm / PSS	315
		Screening Services	603
	POC 8 - Health Promotion Total		**9,028**
	POC 9 - Primary Health & Adult Community	AHPS	4,018
		GP Direct Access Services	20,464
		Grants, Goods & Services	1,284
		Nursing	5,251
		Other Comm / PSS	554
	POC 9 - Primary Health & Adult Community Total		**31,571**
HSCB Total			**590,838**

Stream	POC	SBA Grouping	£'000
PHA	POC 1 - Acute Services	Accident and Emergency	101
		Cardiology	21
		General Medicine	78
		General Surgery	328
		Intensive/High Dependency	34
		Medical & Clinical Oncology	919
		Other Acute	186
		Trauma and Orthopaedics	27
	POC 1 - Acute Services Total		**1,694**
	POC 2 - Maternity & Child Health	Non Acute Hospital	20
		Nursing	141
	POC 2 - Maternity & Child Health Total		**161**
	POC 3 - Family & Child Care	Nursing	46
		Social Work	43
	POC 3 - Family & Child Care Total		**89**
	POC 4 - Older People	AHPS	31
		Grants, Goods & Services	6
		Non Acute Hospital	1
	POC 4 - Older People Total		**38**
	POC 5 - Mental Health	Grants, Goods & Services	89
		Non Acute Hospital	99
		Nursing	11
	POC 5 - Mental Health Total		**199**
	POC 8 - Health Promotion	Grants, Goods & Services	160
		Nursing	1,924
		Screening Services	341
	POC 8 - Health Promotion Total		**2,426**
	POC 9 - Primary Health & Adult Community	GP Direct Access Services	125
		Grants, Goods & Services	12
	POC 9 - Primary Health & Adult Community Total		**137**
PHA Total			**4,744**
Grand Total			**595,582**

Summary of Investments from Public Health Agency

Trust Area:	Southern Trust	2019/20

Jul-19

REVENUE

Directorate	Business /Strategy area		Investment	Agreed Funding (£)		Planned Funding	TOTAL	Monitoring Requirements	Outcomes
				TOTAL RECURRENT	TOTAL NON-RECURRENT	IPT To Be Finalised			
Health Improvement									
Health Improvement	Breastfeeding		Breastfeeding Coordinator - Support for Baby Friendly Initiative	£0	£0	£26,320	£26,320	As indicated on IPT	As indicated on IPT
Health Improvement	Breastfeeding		Breastfeeding Facilitator	£0	£0	£16,965	£16,965		
Health Improvement	Breastfeeding		Breastfeeding Peer Support Link Worker	£0	£0	£17,885	£17,885	As indicated on IPT - Regional budget	As indicated on IPT - Regional budget
Health Improvement	Breastfeeding Regional	BF/R/05	Neo-natal Infant Feeding Lead	£17,372	£0		£17,372	Quarterly monitoring and end of year reports to Regional Breastfeeding Lead	1. Support to lead quality improvements to breastfeeding and parental involvement within the Neonatal Unit. 2. Development of a Neonatal Infant Feeding and Relationship building policy. 3. Professional development of the Neonatal Infant Feeding Lead Role. 4. Development and delivery of a staff skills training programme. 5. Development of an ongoing audit plan to examine implementation of the policy. 6. Collation and reporting of breastfeeding outcomes of infants in the Neonatal Unit. 7. Establish a Neonatal BFI steering Group.
Health Improvement	Drugs & Alcohol		CAT Step 2	£0	£0	£198,829	£198,829	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Drugs & Alcohol		SMLS CAT	£0	£0	£88,832	£88,832	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Drugs & Alcohol		CAT Services Interface	£0	£0	£44,722	£44,722	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Drugs & Alcohol		CAMHS	£0	£0	£91,948	£91,948	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Drugs & Alcohol		Dry Blood Spot Testing	£0	£0	£1,090	£1,090	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Fit Futures / Obesity		BMI Measurement	£28,984	£0	£10,500	£39,484	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Food & Nutrition		Cook-It Programme/Weigh to Health	£0	£0	£113,505	£113,505	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Food & Nutrition		Oral Health	£0	£0	£5,800	£5,800	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Home Accident Strategy		Home Accident Action Plan	£0	£0	£27,130	£27,130	Quarterly reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Home Accident Strategy		SHSCT - Falls Coordination	£0	£0	£32,548	£32,548	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan

PC Appendix 8

Directorate	Business /Strategy area		Investment	Agreed Funding (£)		Planned Funding	TOTAL	Monitoring Requirements	Outcomes
				TOTAL RECURRENT	TOTAL NON-RECURRENT	IPT To Be Finalised			
Health Improvement	Mental Health		Mental Health Action Plan	£0	£0	£40,000	£40,000	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As indicated on IPT
Health Improvement	Mental Health		SHSCT - Looked After Children (LAC)	£0	£0	£15,000	£15,000	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Physical Activity		Fit 4 U Co-ordinator & Programme funding	£53,465	£0		£53,465	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Physical Activity		Physical Activity Co-Ordinator	£52,219	£0		£52,219	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Physical Activity		Physical Activity Plan:	£21,427	£0	£8,650	£30,077	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Suicide Prevention		Protect Life Co-Ordinator & Plan	£0	£0	£162,203	£162,203	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As indicated on IPT
Health Improvement	Suicide Prevention		Stress Control	£0	£0	£12,000	£12,000	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As indicated on IPT
Health Improvement	Sexual Health		Sexual Health Action Plan	£0	£0	£101,304	£101,304	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Tobacco		SHSCT Chronic Care	£0	£0	£43,497	£43,497	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Tobacco		SHSCT Specialist cessation/training/prevention programmes	£0	£0	£54,370	£54,370	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Tobacco		Mental Health smoking cessation services	£0	£0	£44,531	£44,531	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Tobacco		Maternity Services	£0	£0	£25,000	£25,000	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Tobacco		Smoke Free HSC Trusts	£0	£0	£10,000	£10,000	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Travellers		Traveller Health Trainer	£0	£0	£58,515	£58,515	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Travellers		Support to Traveller Groups	£0	£0	£38,300	£38,300	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Child Development Early Years		Child Development Interventions Post	£53,284	£0	£9,250	£62,534	Quarterly Reports to be submitted to Health & Social Wellbeing Senior Officer	As detailed in the programme plan
Health Improvement	Roots of Empathy (Regional)		0.5 band 3 to support Roots of Empathy Initiative	£14,065	£0		£14,065	As indicated on IPT - Regional budget	As indicated on IPT - Regional budget
Health Improvement	Regional Obesity	HI/R/15	Weigh to Healthy Pregnancy Programme	£85,930	£0		£85,930		To offer and deliver a weight management intervention programme to all pregnant women identified with a BMI of 40 or above at booking, in line with a regional programme
Health Improvement	EITP (Regional)		Incredible Years	£0	£0	£6,600	£6,600	A Progress Monitoring Report is completed at the end of the programme, there is an excel database to collect and collate the information from the programme which is then formatted into an OBA Report card which contains the outcomes of the programme.	As indicated on the OBA Report card - Regional Budget

PC Appendix 8

Directorate	Business /Strategy area		Investment	Agreed Funding (£) TOTAL RECURRENT	Agreed Funding (£) TOTAL NON-RECURRENT	Planned Funding IPT To Be Finalised	TOTAL	Monitoring Requirements	Outcomes
HEALTH IMPROVEMENT TOTALS				£326,746	£0	£1,305,294	£1,632,040		
Nursing / AHP									
Nursing / AHP	Public Health Nursing		Public Health Nurse Travellers	£43,420	£0		£43,420	[illegible] contacts per post. The Trust will complete an Annual Report on the impact of the new posts	Additional nursing resource will help to improve the health outcomes of Vulnerable populations within Southern trust. These posts will enhance the exiting teams within the
Nursing / AHP	Public Health nursing		Public Health Nurse BME	£51,307	£0		£51,307	[illegible] contacts per post. The Trust will complete an Annual Report on the impact of the new posts	Additional nursing resource will help to improve the health outcomes of Vulnerable populations within Southern trust. These posts will enhance the exiting teams within the
Nursing / AHP	Ward Sister Initiative		Ward Sister Assistants	£388,850	£0		£388,850	Monitored through Assistant Director of Nursing Monitoring Group	Appointment of staff to improve quality of care and reduce administrative burden on ward sisters.
Nursing / AHP	Family Nurse Partnership		Family Nurse Partnership	£329,642	£0		£329,642	Monitored through Project Board	Reduced smoking in pregnancy; improved pregnancy outcomes and child health development
Nursing / AHP	Delivering Care		Delivering care	£144,714	£0		£144,714		
NURSING & AHP TOTALS				£957,932	£0	£0	£957,932		
CCHSC									
CCHSC	CCHSC		RTNI Contract – Standing Charge Element	£0	£31,753		£31,753	None. Legal contractual obligation.	RTNI Contract
CCHSC	CCHSC		RTNI - Trust Management	£68,395	£0		£68,395	None. Legal contractual obligation.	RTNI Contract
CCHSC	CCHSC		Telecare	£0	£59,111		£59,111		
CCHSC TOTALS				£68,395	£90,864	£0	£159,259		
Health Protection									
Health Protection	Flu Vaccination		Seasonal Flu Vaccine additional baseline funding from DHSSPS (Transfers to Boards/Trusts for GP Payments)	£89,996	£0		£89,996	Monthly monitoring forms completed by GPs.	Ensuring maximum vaccination uptake throughout Northern Ireland
Health Protection	Flu Vaccination		Child Flu Vaccination	£367,656	£0		£367,656	monthly returns provided during the programme	Ensuring maximum vaccination uptake throughout Northern Ireland at least 75%
Health Protection	Flu Vaccination		Seasonal Flu Vaccination of Staff	£2,851	£0		£2,851	Monthly returns provided from Trusts and Occupational Health on uptake rates.	Management of risks via Occupational Health Dept.
Health Protection	Immunisation		HPV Immunisation Programme	£83,860	£0		£83,860	biannual returns providing uptake rates. Final annual return by July	Ensuring maximum vaccination uptake throughout Northern Ireland
Health Protection	Immunisation		HPV recurrent Pharmacy costs (BASELINE to TRUSTS)	£10,260	£0		£10,260	Quarterly returns provided on storage and disrtibution of vaccination.	Ensuring supplies of vaccine to School nursing.
Health Protection	Immunisation		HPV Vaccine costs	£89,137	£0		£89,137	Annual returns provided.	To cover cost of vaccines.
Health Protection	Immunisation		HPV Vaccination Programme for Boys (New funding for 2019/20 to support nursing & CHS costs)	£68,001	£0		£68,001	Quarterly returns.	Ensure high uptake of vaccine.
Health Protection	Immunisation		MMR Immunity testing for HSC Workers	£3,536	£0		£3,536	Annual returns provided.	Management of risks via Occupational Health Dept.
Health Protection	Immunisation		Provision of Men ACWY Vaccination	£28,404	£0		£28,404	Returns provided by SHSCT	Provision of Men ACWY vaccine to Year 11 and 12 pupils
Health Protection	Immunisation		Men-ACWY Vaccination	£0	£0	£78,610	£78,610	Annual returns provided.	Ensuring maximum vaccination uptake throughout Northern Ireland

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Directorate	Business /Strategy area		Investment	Agreed Funding (£)		Planned Funding	TOTAL	Monitoring Requirements	Outcomes
				TOTAL RECURRENT	TOTAL NON-RECURRENT	IPT To Be Finalised			
Health Protection	Immunisation		Men B Vaccination	£218,052	£0		£218,052	Annual returns provided.	Ensuring maximum vaccination uptake throughout Northern Ireland
Health Protection	Immunisation		Men B Vaccination Programme - Pharmacy Costs	£125,047	£0		£125,047	Annual returns provided.	To cover cost of vaccines.
Health Protection	Immunisation		Men B Vaccination - Input Costs to Child Health System	£2,311	£0		£2,311	Annual returns provided.	To cover the input costs and administration
Health Protection	Immunisation		Pertussis Vaccination	£0	£0	£44,640	£44,640	Annual returns provided.	Ensuring maximum vaccination uptake throughout Northern Ireland
Health Protection	Immunisation		Rotavirus Trust Pharmacy vaccine	£132,573	£0		£132,573	Quarterly returns.	Ensure high uptake of vaccine.
Health Protection	Immunisation		Hexavalent Programme	£32,026	£0		£32,026		
Health Protection	Hepatitis		Healthcare Worker (HCW) Clearance	£7,295	£0		£7,295	Annual returns provided.	Management of risks via Occupational Health Dept.
HEALTH PROTECTION TOTAL				£1,261,004	£0	£123,250	£1,384,254		
Screening & Service Development									
Service Development & Screening	Breast Screening Programme		Provision of Local Breast Screening Service	£1,138,366	£0		£1,138,366	Monitored by Young Person and Adult Screening Team	One third of the eligible population of women aged 50-70 invited for screening, with at least a 70% uptake. NHSBSP outcome standards met. £39,540 retracted as FYE savings resulting from the implementation of digital mammography.
Service Development & Screening	Breast Screening Programme		Additional imaging staff 2017/18	£41,365	£0		£41,365	Monitored by Young Person and Adult Screening Team	This funding will cover the additional administration and radiography support necessary to have an adequate complement of funded staffing that meets national guidance for staffing and to maintain the QA standards for the breast screening programme, in accordance with the investment proposal template submitted by the Trust
Service Development & Screening	Breast Screening Programme		Medical Physics support to the NI Breast Screening Programme	£15,232	£0		£15,232	Monitoring Requirements	Annual Report from Medical Physics Agency
Service Development & Screening	Bowel Cancer Screening Programme		Colonoscopy	£502,144	£0		£502,144	Monitored by Young Person and Adult Screening Team via performance and quality reports	Delivery of programme in line with regional standards and targets - 519 screening colonoscopies in 2019/20 with associated preassessment, histopathology and CTC.
Service Development & Screening	Cervical Screening Programme		Cervical Screening Programme	funding embedded in HSCB allocation				Monitored by Young Person and Adult Screening Team via performance and quality reports	Delivery of cytology, colposcopy and histopathology services in line with national standards and regional policy
Service Development & Screening	Newborn Screening		New born hearing Screening	funding embedded in HSCB allocation	£0			Annual Report	Delivery of programme in line with regional standards
Service Development & Screening	Antenatal Screening		Antenatal Infection Screening	Funding in Trust baseline from HSCB	£0			Annual Report	Delivery of programme in line with national programme standards revised 2010.

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Directorate	Business /Strategy area		Investment	Agreed Funding (£)		Planned Funding	TOTAL	Monitoring Requirements	Outcomes
				TOTAL RECURRENT	TOTAL NON-RECURRENT	IPT To Be Finalised			
Service Development & Screening	Newborn Screening		Newborn Bloodspot	funding embedded in HSCB allocation	£0			Annual Report	Delivery of programme in line with national standards including MCADD and revised CF.
SCREENING & SERVICE DEVELOPMENT TOTAL				£1,697,106	£0	£0	£1,697,106		
Other Funding									
	Baseline		Apprenticeship Levy	£12,051	£0		£12,051		
OTHER				£12,051	£0	£0	£12,051		
Revenue Totals				£4,323,235	£90,864	£1,428,544	£5,842,643		
				£5,842,643					

CAPITAL

Research and Development									
Research and Development	Research and Development		Implementation of the R&D programme plan	£0	£545,000		£545,000		
RESEARCH & DEVELOPMENT TOTAL				£0	£545,000	£0	£545,000		
Capital Total				£545,000					

Signed :

Chief Executive , PHA

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SCHEDULE 4 - Information Requirements 2019/20

1. For the 2019/20 year acute demand and activity data pertaining to this agreement will be accessed by the HSCB on a regular basis in line with established arrangements which will be updated and communicated to Trusts accordingly.

2. To facilitate this access to data, the Trust should ensure that timely and accurate clinically and administratively coded acute activity is available to the Board, in line with the following standards and requirements:-

   - all elective Inpatient, Day Case and Outpatient activity must be recorded on PAS within 3 days of admission/attendance

   - all non-elective inpatient activity must be recorded on PAS within 1 day of admission

   - all acute Inpatient and Day Case activity must be OPCS and ICD-10 clinically coded in line with the timeliness and depth standards required.

   - all PAS activity must be administratively coded in line with the series of Technical Guidance issued by the HSCB, in particular those associated with recording IS activity, additional in-house activity, Review Waiting lists and OP referrals.

3. The Trust should continue to provide activity and financial information relating to acute services procured from the Independent Sector in line with established arrangements.

4. For non-acute services, work continues to review and standardise the indicators, definitions and currencies used in the activity and cost schedules. In the interim, Trusts should ensure that non-acute activity returns will made in line with arrangements which will be updated and communicated to Trusts accordingly.

5. Information required to monitor the targets, standards and indicators outlined in the Board's Commissioning Plan and the Department's Commissioning Plan Direction document must be returned to the HSCB in line with the schedule and requirements notified by the Performance Management and Service Improvement directorate of the Board.

6. Data quality, in particular Clinical Coding, will continue to be monitored and audited under this SBA in line with regular performance management arrangements.

7. In addition to the information outlined above, the Trust should anticipate that further returns may be required in-year once these items have been specified.

8. Board staff will continue to have access to Trust data from various provider information systems via the Regional Data Warehouse (managed by BSO staff). This data will be used for the purposes of analysing needs and trends, demand and supply issues and providing other appropriate information to support the commissioning functions of the HSCB. The Trust will be expected to participate fully in processes established by the Board to automate electronic flows of other data required during the year.

   In accessing this data, for viewing or transferring purposes, the HSCB will conform to individual Honest Broker and Data Access Agreements between Trusts, the HSCB and the BSO, the Data Protection Act, 2018 and the guidelines on "The Protection and Use of Patient and Client Information".

Schedule 5: Activity Schedules

Schedule 5a: Acute Activity

HSCB Service and Budget Agreement 2019/20

POC	Korner Code	Korner Specialty	SubSpecialty	Activity Description (Currencies)								
				Non-Elective IP	Admissions	Elective Inpatient	Day Cases	New OP	Review OP	New Outpatients with procedure	Review Outpatients with procedure	Other
Acute	100	General Surgery	Adult General Surgery or General Surgery (This includes Paediatric)	10,452		1,529	4,301	9,839	12,774			
Acute	100	General Surgery	Breast Surgery	0		299	101	4,205	1,763			
Acute	100	General Surgery	Family History	0		0	0	218	796			
Acute	101	Urology	Urology	1,197		1,056	3,142	3,591	4,489	432		
Acute	110	Trauma and Orthopaedics	Orthopaedics (Excludes ICATS for NOP)			1,107	861	2,872	4,104			
Acute	110	Trauma and Orthopaedics	Trauma/Fractures	1,691	1,125			5,866	11,904			
Acute	120	ENT(Ear, Nose and Throat)	ENT (This includes paediatrics and Staff Grade & 6th Consultant)	815		1,460	1,390	9,463	9,463			
Acute	143	Orthodontics	Orthodontics			0	0	542	3,932			
Acute	180	Accident and Emergency	A&E Attendances (excl. fracture clinics done by Orthopaedic Cons. (incl under T&O)	0		0	0	177,854	8,665			
Acute	180	Accident and Emergency	Clinical Decision Area (CDA)	3,157		0	0	0	0			
Acute	190	Anaesthetics	Adult ICU - CAH	583								1862 OBDs
			Adult HDU - CAH									1241 OBDs
Acute	190	Anaesthetics	Adult HDU - DHH									2191 OBDs
Acute	191	Pain Management	Pain Management	1		0	550	1,190	769			
Acute	300	General Medicine	General Medicine	38,950		117	1,738	487	837			
Acute	301	Gastroenterology (Non-Scope)	Gastroenterology	34		17	188	2,256	4,540			
Acute		Endoscopy	Endoscopy Symptomatic			71	10,419	0	0			
		Endoscopy	Bowel Screening				471					
		Diabetology	Diabetology					543	3,171			
Acute	302	Endocrinology	Endocrinology					662	1,726			
Acute	314	Rehabilitation/Stroke (where not mapped to spec. 430)	Rehabilitation/Stroke (where not mapped to spec. 430)									5687 OBS
Acute	315	Palliative Medicine	Palliative Medicine	0		0	0	113	321			
Acute	320	Cardiology including Coronary Care	Adult Cardiology	0		0	0	2,415	2,592			Procedures
	320	Cardiology including Coronary Care	Cath Lab - Currently under review SBA TBA	5,422		0	0	0	0			675 PCIs 100 Pacemakers 1148Cath
Acute	330	Dermatology	Adult Dermatology	3		0	1,066	7,322	9,348			
Acute	340	Thoracic Medicine	Thoracic Medicine	2		10	490	1,724	3,576			
Acute	361	Nephrology	Adult Nephrology	824		34	70	161	1,391			
Acute	361	Nephrology	Renal Dialysis	0		0	0	17	112			
Acute	400	Neurology	Neurology	1		0	390	2,948	3,982			
Acute	410	Rheumatology	Rheumatology (incl Anti-TNF)	0		10	2,899	1,692	4,333			
Acute	420	Paediatrics	Neonatal beddays (levels undefined)									581 OBDs
Acute	420	Paediatrics	Neonatal Level 1 (beddays)	0		0	0	0	0	0	0	664 OBDs
Acute	420	Paediatrics	Neonatal Level 2 (beddays)	0		0	0	0	0	0	0	1055 OBDs
Acute	420	Paediatrics	Neonatal Level 3 (beddays)	0		0	0	0	0	0	0	4436 OBDs
Acute	420	Paediatrics	Neonatology	0		0	0	0	308	0	0	0
Acute	420	Paediatrics	Paediatrics	3,004		80	40	2,600	7,869			
Acute	420	Paediatrics	Paediatric Ambulatory (currency as applicable)	2,114		130						
Acute	502	Obs & Gyn (Gynaecology)	Fertility	0		0	0	137	2,109			242 Scans
Acute	502	Obs & Gyn (Gynaecology)	Family Planning					143	199			
Acute	502	Obs & Gyn (Gynaecology)	Urodynamics					400				
Acute	502	Obs & Gyn (Gynaecology)	Colposcopy (Cons Led only)					1,354	661			
Acute	502	Obs & Gyn (Gynaecology)	Obs & Gyn (Gynaecology Excluding Fertility)	859		1,030	1,563	6,853	6,853	1,265		
Acute	620	General Practice (Non-Maternity)	Community Dentistry	0		0	1,746	0	0	0	0	0
Acute	810	Radiology	Mammography Screening/Scans									9029 Scans

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HSCB Service and Budget Agreement 2019/20

POC	Korner Code	Korner Specialty	SubSpecialty	Activity Description (Currencies)								
				Non-Elective IP	Admissions	Elective Inpatient	Day Cases	New OP	Review OP	New Outpatients with procedure	Review Outpatients with procedure	Other
Acute	810	Radiology	DEXA Scans									2500 Scans
Acute	810	Radiology	MRI Scans									15,550
		Radiology	Plain Film									213,009
		Radiology	CT									23,141
		Radiology	Non Obs Ultrasound									47,035
		Radiology	Neurophysiology									1,499
		Radiology	Transthoracic Echocradiogram (TTE)									10,332
		Radiology	Endobronchial Ultrasound (EBUS)									0
Acute	822	Chemical Pathology	Chemical Pathology (if not included under General Medicine)	0		0	0	140	206			
Acute	303 & 823	Medical & Clinical Haematology	Adult Medical & Clinical Haematology	299		100	1,050	408	3,952			
Acute	303 & 823	Medical & Clinical Haematology	Anti-Coagulant	0		0	0	322	6,371			
			Geriatric Medicine	4,499		10	0	1,912	2,786			
				73,907		7,060	32,475	250,249	125,902			

Visiting Services

POC	Korner Code	Korner Specialty	SubSpecialty	Activity Description (Currencies)								
				Non-Elective IP		Elective Inpatient	Day Cases	New OP	Review OP	New Outpatients with procedure	Review Outpatients with procedure	Other
Acute	130	Ophthalmology	Ophthalmology (Outreach Clinic)	0		0	699	2,378	5,371			
Acute	141	Restorative Dentistry	Restorative Dentistry	0		0	0	65	86			
Acute	311	Clinical Genetics	Clinical Genetics and Molecular Genetics	0		0	0	165	28			
Acute	320	Cardiology incl Coronary Care	Paediatric Cardiology			0	0	174	150			
Acute	400	Neurology	Paediatric Neurology			0	0	0	90			
Acute	420	Paediatrics	Paediatric Dentistry				83	243	870			
Acute	370 & 800	Clinical Oncology combined	Clinical Oncology combined	4		5	195	550	4,824			
Acute	360	Genito-Urinary Medicine	Genito-Urinary Medicine Outreach Clinic					1,726	428			

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HSCB Service and Budget Agreement 2019/20
Acute POC - Non-Consultant Led

22-Jan-20

POC	Korner Code	Korner Specialty	SubSpecialty	Activity Description (Currencies)										
				Non-Elective IP	Elective Inpatient	Day Cases	New OP	Review OP	New Outpatients with procedure	Review Outpatients with procedure	Other	Att	New Att	Review Att
Acute	110	Trauma and Orthopaedics	Orthopaedics (ICATS)				5469	7437						
Acute	110	Trauma and Orthopaedics	Review Ortho OPs (Outcomes Practitioner)					3292						
Acute	120	ENT(Ear, Nose and Throat)	Audiology								32340			
Acute	180	Accident and Emergency	Minor Injuries Units										10472	2094
Acute	320	Cardiology including Coronary Care	Chest Pain Clinic - OP				1440							
Acute	320	Cardiology including Coronary Care	Dignostic Clinics								1071			
Acute	320	Cardiology including Coronary Care	Nurse Led					276						
Acute	330	Dermatology	Nurse Led			328	2503	12006						
Acute	330	Dermatology	Teledermatology								2050			
Acute	330	Dermatology	Photo Dynamic Service										0	0
Acute	360	Genito-Urinary Medicine	Genito-Urinary Medicine Outreach Clinic											252
Acute	361	Nephrology	Renal Dialysis									18239		
Acute	400	Neurology	Neurology											162
Acute	303 & 823	Medical & Clinical Haematology	Chemo Fractions/Regular Attenders									1170		
Acute	502	Obs & Gyn (Gynaecology)	Cervical Cytology					785						
Acute	810	Radiology	Mammography Screening											260
						328	9412	23796			35461	19409	10472	2768

Non-Consultant Led - Visiting Services

POC	Korner Code	Korner Specialty	SubSpecialty	Activity Description (Currencies)										
				Non-Elective IP	Elective Inpatient	Day Cases	New OP	Review OP	New Outpatients with procedure	Review Outpatients with procedure	Other	Att	New Att	Review Att
Acute	370 & 800	Clinical Oncology	Chemo Fractions/Regular Attenders									2001		
Acute	370 & 800	Clinical Oncology	Radiotherapy Attenders										580	5127
Acute														

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Schedule 5b: Non -Acute Activity

PROGRAMME OF CARE: MATERNITY & CHILD HEALTH

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column
MCH	AHPs	Audiology			Face to Face contacts	
MCH	AHPs	Clinical Psychology			Face to Face contacts	
MCH	AHPs	Ophthalmics			Face to Face contacts	
MCH	AHPs	AHP - Orthoptics			Face to Face contacts	7,613
MCH	Other Comm / PSS	Child & Adolescent Psychiatry			Face to Face contacts	
MCH	Other Comm / PSS	Community Paediatricians			Face to Face contacts	
MCH	Other Comm / PSS	Community / Clinical Medical Officer			Face to Face contacts	
MCH	Other Comm / PSS	Health Care Assistants			Face to Face Contacts	
MCH	Other Comm / PSS	Community Dental			Face to Face Contacts	8,129
MCH	Nursing	Nursing- Behavioural Nurse Therapist			Face to Face Contacts	
MCH	Nursing	Nursing - Community Midwifery			Face to Face contacts	103,017
MCH	Nursing	Nursing - District			Face to Face contacts	70
MCH	Nursing	Nursing - Health Visiting			Face to Face contacts	83,181
MCH	Nursing	Nursing - Marie Curie			Face to Face contacts	
MCH	Nursing	Nursing - Community Paediatric			Face to Face contacts	
MCH	Nursing	Nursing - School			Face to Face contacts	
MCH	Nursing	Nursing - Treatment Rooms			Face to Face contacts	
MCH	Nursing	Nurisng- Other Specialist Nursing			Face to Face contacts	12,317
MCH	Nursing	Nursing - Macmillan			Face to Face contacts	
MCH	Other Comm / PSS	Social Workers			Caseload	
MCH	Other Comm / PSS	Technical Instructor			Face to Face Contacts	
MCH	Other Comm / PSS	Community Development Teams				

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SCHEDULE 5b - Non-Acute Activity

PROGRAMME OF CARE: MATERNITY & CHILD HEALTH

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column
		Non Acute Services on Hospital Sites:				
MCH	Hospital	Obstetrics			ATT	
MCH	Hospital	Obstetrics			Births	5,995
MCH	Hospital	Obstetrics			Day Cases	
MCH	Hospital	Obstetrics			New Outpatients	TBC
MCH	Hospital	Obstetrics			Review Outpatients	TBC
MCH	Hospital	Obstetrics			Elective Inpatients	
MCH	Hospital	Obstetrics			Non-Elective Inpatients	
		TOTAL				

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column
F&CC	Other Comm / PSS	Adolescent Community Placement Scheme			Places	
F&CC	Other Comm / PSS	Adolescent Unit	Day care		Places	
F&CC	Other Comm / PSS	Adoption Services			Block	
F&CC	Other Comm / PSS	Aftercare (Personal Advisors)			Caseload	
F&CC	Other Comm / PSS	Leaving Care / Aftercare - Former foster carers			Caseload	
F&CC	Other Comm / PSS	CAHMS Therapeutic Team Looked After Children			Caseload	
F&CC	Other Comm / PSS	Child Care Centre			Child referrals	
F&CC	Other Comm / PSS	Child Health Assistants				
F&CC	Other Comm / PSS	Community Dental				
F&CC	Other Comm / PSS	Community Paediatricians			Face to Face contacts	
F&CC	Other Comm / PSS	Community / Clinical Medical Officer			Face to Face contacts	
F&CC	Other Comm / PSS	Family Centres	Statutory		Attendances	
F&CC	Other Comm / PSS	Family Centres	Voluntary		Attendances	
F&CC	Other Comm / PSS	Family Support Intervention Teams			Caseload	
F&CC	Other Comm / PSS	Family Support Scheme				
F&CC	Other Comm / PSS	Gateway Team			Face to Face contacts	
F&CC	Other Comm / PSS	Home Helps	Statutory		Total hours delivered	
F&CC	Other Comm / PSS	Living with Former Foster Carers			Places of residence	
F&CC	AHPs	Audiology			Face to Face contacts	
F&CC	AHPs	AHP - Orthoptics			Face to Face contacts	185
F&CC	Nursing	Nursing - Health Visiting			Face to Face contacts	7,376
F&CC	Nursing	Nursing - District Nursing			Face to Face contacts	147
		Nursing - Other Specialist Nursing			Face to Face contacts	3,202
F&CC	Social Work	Out Of Hours Emergency Duty Social Work Service				
F&CC	Other Comm / PSS	Clinical Psychology			Face to Face contacts	3,213
F&CC	Other Comm / PSS	Playgroups & Day Nurseries	Statutory		Places	
F&CC	Other Comm / PSS	Playgroups & Day Nurseries	Voluntary		Places	
F&CC	Other Comm / PSS	Preparation for Adulthood - Career Coordinator			Caseload	
F&CC	Other Comm / PSS	Playgroups & Day Nurseries	Private		Places	
		Residential Care Home	Statutory		Purchased Beddays	9,125

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column
		Residential Care Home	Voluntary		Purchased Beddays	1,460
F&CC	Residential Home Care	Residential Care Home			Children	27
F&CC	Social Work	Social Workers - Children Looked After	Foster Care		Active caseload	442
F&CC	Social Work	Social Workers - Children Looked After	Other(Places at home, specialist facility etc)		Active caseload	TBC
F&CC	Social Work	Social Workers - Children Looked After	Residential		Active caseload	
F&CC	Social Work	Social Workers - Family Support & Assistance	Protection		Active caseload	
F&CC	Social Work	Social Workers - Family Support & Assistance	Adoption		Active caseload	
F&CC	Social Work	Social Workers - Family Support & Assistance	General Family Support		Active caseload	6,193
F&CC	Social Work	Social Workers - Aftercare			Active caseload	265
F&CC	Social Work	Social Workers - Day Care				
F&CC	Social Work	Social Workers - Permanency Planning				
F&CC	Social Work	Social Services Training (PSS)				
F&CC	Social Work	Social Workers On Call Duty Roster				
F&CC	Social Work	Social Workers - Early Years			Places	11,476
F&CC	Social Work	Social Workers - Early Years			Facilities	771
F&CC	Other Comm / PSS	Specialist Care Scheme			Places	
F&CC	Other Comm / PSS	Transport				
F&CC	Other Comm / PSS	Voluntary organisations supported (detail on separate schedule)			Block	
F&CC	Other Comm / PSS	Assessment Centres - Independent				

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	Proposal Based on Notes column
F&CC	Other Comm / PSS	Assessment Centres - Statutory				
F&CC	Domiciliary Care	Domiciliary Care - Statutory				
F&CC	Domiciliary Care	Domiciliary Care - Independent				
F&CC	Other Comm / PSS	Community Development Teams				
F&CC	Other Comm / PSS	Surestart Programme				
CwD	Domiciliary Care	Domiciliary Care - Total			Total hours delivered	
CwD	Domiciliary Care	Domiciliary Care - Independent	Private		Total hours delivered	
CwD	Domiciliary Care	Domiciliary Care - Independent	Voluntary		Total hours delivered	14,813
CwD	Domiciliary Care	Domiciliary Care - Statutory	Statutory		Total hours delivered	5,565
CwD	Domiciliary Care	Domiciliary Care - Dual			Total hours delivered	969
CwD	Domiciliary Care	Domiciliary Care - SDS/DP Hours			Total hours delivered	TBC

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column	Notes 19/20
ELD	Other Comm / PSS	Aftercare					
ELD	Other Comm / PSS	Community Care					
ELD	Other Comm / PSS	Day care services	Private		Attendances	15,592	Source: Based on 16/17 TFR Independent = 15,592 as 17/18 TFR = 12,587 & is lower
ELD	Other Comm / PSS	Day care services	Statutory		Attendances	32,884	Source: Roll forward 15/16 SBA based on 14/15 TFR as 17/18 TFR = 31,185
ELD	Other Comm / PSS	Day care services	Private		Adults in Receipt	56	Source: DSF 31.3.19 = 56 (Page 73 1.6 - use >65 total figs)
ELD	Other Comm / PSS	Day care services	Statutory		Adults in Receipt	519	Source: DSF 31.3.19 = 519 (Page 73 1.6 - use >65 total figs)
ELD	Other Comm / PSS	Day Opportunities			Adults in Receipt	77	Source: DSF 31.3.19 = 77 (Page 73 1.6a - use >65 total figs)
ELD	Other Comm / PSS	Community Dental			Face to Face Contacts	4,256	Source: Roll forward 4,256 based on 14/15 TFR as 17/18 TFR=2,257
ELD	Other Comm / PSS	Memory Service	Statutory		Face to Face Contacts	865	Source: Roll forward 865 based on 14/15 TFR as 17/18 TFR N/A
ELD	Other Comm / PSS	Memory Service	Statutory	Nurse-led Screening	Face to Face Contacts	1,676	Source: Roll forward 16/17 SBA based on A Magwood letter to D Sullivan dated 14.08.2015 (718 new and 958 review 2012/13 IPT)
ELD	Other Comm / PSS	Memory Service	Statutory	Nurse Prescribing/ Treatment Clinic	Face to Face Review Contacts	319	Source: Roll forward 16/17 SBA based on A Magwood letter to D Sullivan dated 14.08.2015 (2012/13 IPT)
ELD	Other Comm / PSS	Memory Service	Statutory	Memory Service OT	Face to Face Contacts	239	Source: Roll forward 16/17 SBA based on A Magwood letter to D Sullivan dated 14.08.2015 (2012/13 IPT)
ELD	Other Comm / PSS	Memory Service	Statutory	Psychology Support	To be confirmed	To be confirmed	
ELD	Other Comm / PSS	Memory Service	Statutory	Dementia Support Workers	Contacts	540	Source: Roll forward 16/17SBA 540 based on 2013/14 PPE dated May 2016

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column	Notes 19/20
ELD	Other Comm / PSS	Memory Service	Statutory	Community Navigator	Face to Face Contacts	500	Source: Roll forward 16/17 SBA based on D Sullivan letter to A Magwood dated 18.12.2015 re 2015/16 IPT.
ELD	Other Comm / PSS	**Domicliary Care - TOTAL**			Total hours delivered	2,539,254	
ELD	Domiciliary Care	Domiciliary Care - Independent	Private		Total hours delivered	1,381,763	
ELD	Domiciliary Care	Domiciliary Care - Independent	Voluntary		Total hours delivered		2019/20 SBA volumes are a roll forward of revised 18/19 SBA vols submitted by SHSCT as an amendment to 18/19 signed SBA. These reflect uplifts for 2018/19 Demography Investment. Further uplifts to be agreed to reflect 19/20 Demography investment.
ELD	Domiciliary Care	Domiciliary Care - Statutory	Statutory		Total hours delivered	980,655	
ELD	Domiciliary Care	Domiciliary Care - SDS/Direct			Total hours delivered	176,836	Source: Roll forward 15/16 outturn as 17/18 TFR = 137,155
ELD	Other Comm / PSS	Acute Care At Home			No of Referrals	2,177	Source: E-mail 21/1/20 MMcG information from A Patterson/C Sheeran, SHSCT
ELD	Other Comm / PSS	Acute Care At Home			No Of New Assessments	1,371	
ELD	Nursing	Home Helps	Statutory		Total hours delivered		
ELD	Other Comm / PSS	Consultant Psychiatry			Attendances		
ELD	Nursing	Nursing - Incontinance Advisor			Face to Face contacts		
ELD	Domiciliary Care	Meals on wheels			Number of Meals		
ELD	Nursing	Nursing - Community Psychiatric			Face to Face contacts	5,995	Source: Roll forward 5,995 based on 14/15 TFR as 17/18 TFR=4,696
ELD	Nursing	Nursing - District			Face to Face contacts	207,073	Source: Roll forward 16/17 SBA based on 14/15 TFR as 17/18 TFR=146,524 *As per 16/17 notes column 2015/16 IPT to be quantified.

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column	Notes 19/20
ELD	Nursing	Nursing - Health Visiting			Face to Face contacts		
ELD	Nursing	Nursing - Other Specialist			Face to Face contacts	17,973	Source: Roll forward 17,973 based on 14/15 TFR as 17/18 TFR=14,490
ELD	Residential Home Care	Independent Free Nursing Care			Purchased Bed Days		
ELD	AHPs	Audiology			Face to Face contacts		
	AHPs	Orthoptics			Face to Face contacts	1,016	Source - Roll forwrad 1,016 based on 16/17 TFR as 17/18 TFR = 736
ELD	AHPs	Clinical Psychology			Face to Face contacts		
ELD	Nursing Home Care	Nursing Home Care - Total	IS & Stat		Purchased Bed Days	534,243	Source: Roll forward 534,243 as 17/18 TFR = 73,542 occupied weeks (= 514,794 beddays)
ELD	Residential Home Care	Residential Care Home - Total	IS & Stat		Purchased Bed Days	145,441	Source: Roll forward 145,441 as 17/18 TFR =17,190 occupied weeks (= 120,330 beddays)
ELD	Social Work	Social Workers			Active caseload	6,214	Source = 17/18 TFR 6,214
ELD	Social Work	Social Work - Palliative Care			Active caseload		
ELD	Residential Home Care	Supported Living			Packages of Care	108	Source DSF Report 181/9 Page 73 (All POCs >65yrs) = 108. POC4 (Elderly) = 23
ELD	Other Comm / PSS	Daycare Facilities (EMI) -Independent			Day Attendances		
ELD	Other Comm / PSS	Daycare Facilities (EMI) - Statutory			Day Attendances		
ELD	Other Comm / PSS	Luncheon Clubs					

PC Appendix 8

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column	Notes 19/20
ELD		Non Acute Services on Hospital Sites:					
ELD	Hospital	Geriatric Medicine	CAH	Geri Med	Inpatients FCE	2,509	Source 17/18 TFR = 2509
ELD	Hospital	Geriatric Medicine	DHH	Geri Med	Inpatients FCE	429	Source 17/18 TFR = 429. Note incorrect fig used in 18/19 SBA should have read 412 for DHH
ELD	Hospital	Geriatric Medicine	Lurgan	Geri Med	Inpatients FCE	953	Source: Roll forward 953 based on 13/14 TFR as 17/18 TFR=946
ELD	Hospital	Geriatric Medicine	STH	Geri Med	Inpatients FCE	620	Source: Roll forward 620 based on 13/14 TFR as 17/18 TFR= 559
ELD	Hospital	Geriatric Medicine	CAH	Geri Med	Patient Beddays	13,537	Source: Roll forward 13,537 as 17/18 TFR = 12,655
ELD	Hospital	Geriatric Medicine	DHH	Geri Med	Patient Beddays	5,840	Source: Roll Forward 16/17 SBA based on 20 beds x 80% x 366
ELD	Hospital	Geriatric Medicine	Lurgan	Geri Med	Patient Beddays	14,892	Source: Roll forward 16/17 SBA based on 51 beds x 80% x 365
ELD	Hospital	Geriatric Medicine	STH	Geri Med	Patient Beddays	13,140	Source: Roll forward 16/17 SBA based on 45 beds x 80% x 365
ELD	Hospital	Geriatric Medicine	CAH	Geri Med	Total Cons Led Atts	2,187	Source: Roll forward 2,187 based on 13/14 TFR as 17/18 TFR = 1,880
ELD	Hospital	Geriatric Medicine	CAH	Geri Med	New OP Atts	786	Source: Roll forward 786 based on 13/14 TFR as New OP Atts not recorded in 17/18 TFR
ELD	Hospital	Geriatric Medicine	CAH	Geri Med	Review OP Atts	1,443	Source: Roll forward 1443 based on 13/14 TFR as Review OP Atts not recorded in 17/18 TFR
ELD	Hospital	Geriatric Medicine	Lurgan	Geri Med	Total Cons Led Atts	2,359	Source: Roll forward 2,359 based on 13/14 TFR as 17/18 TFR = 1,843
ELD	Hospital	Geriatric Medicine	Lurgan	Geri Med	New OP Atts	686	Source: Roll forward 16/17 TFR= 686 as New OP Atts not recorded in 17/18 TFR (May include some Nurse led OPs)
ELD	Hospital	Geriatric Medicine	Lurgan	Geri Med	Review OP Atts	1,319	Source: Roll forward 16/17 TFR = 1,319 as ROP Atts not recorded in 17/18 TFR (May include some Nurse led OPs)

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column	Notes 19/20
ELD	Hospital	Geriatric Medicine	Mullinure	Geri Med	Total Cons Led Atts	747	Source: Roll forward 747 based on 13/14 TFR as 17/18 TFR= 514
ELD	Hospital	Geriatric Medicine	Mullinure	Geri Med	New OP Atts	344	Source: Roll forward 344 based on 13/14 TFR as NOP Atts not recorded in 17/18 TFR
ELD	Hospital	Geriatric Medicine	Mullinure	Geri Med	Review OP Atts	403	Source: Roll forward 403 based on 13/14 TFR as ROP Atts not recorded in 17/18 TFR
ELD	Hospital	Geriatric Medicine	STH	Geri Med	Total Cons Led Atts	765	Source: Roll forward 765 based on 13/14 TFR as 17/18 TFR = 650
ELD	Hospital	Geriatric Medicine	STH	Geri Med	New OP Atts	314	Source: Roll forward 314 based on 13/14 TFR as NOP Atts not recorded in 17/18 TFR
ELD	Hospital	Geriatric Medicine	STH	Geri Med	Review OP Atts	451	Source: Roll forward 451 based on 13/14 TFR as ROP Atts not recorded in 17/18 TFR
ELD	Hospital	Geriatric Medicine		Geri Med	Day Hosp Atts		
ELD	Hospital	Geriatric Medicine		Osteoporosis	New OP Atts		
ELD	Hospital	Geriatric Medicine		Osteoporosis	Review OP Atts		
ELD	Hospital	Geriatric Medicine	DHH	Geri Med	Total Cons Led Atts	211	Roll forward 18/19 SBA as 17/18 TFR = 182
ELD	Hospital	Geriatric Medicine	DHH	Geri Med	New OP Atts		
ELD	Hospital	Geriatric Medicine	DHH	Geri Med	Review OP Atts		
ELD	Hospital	Geriatric Medicine	Lurgan	Geri Med	Cons Led Day Atts	1,162	Roll forward 1,162 based on 16/17 TFR as 17/18 TFR = 1,101
ELD	Hospital	Geriatric Medicine	Mullinure	Geri Med	Cons Led Day Atts	1,112	Source 16/17 TFR = 1,112 as 17/18 TFR = 1,035. *Note incorrect SBA vol used for 18/19 SBA (used STH fig)
ELD	Hospital	Geriatric Medicine	STH	Geri Med	Cons Led Day Atts	1,377	Source: Roll forward 1377 based on 14/15 as 17/18 TFR= 1,119
ELD	Hospital	Inpatient - Dementia	St Luke's Hospital (Gillis)		Occupied Bed Days	7,008	Source: Roll forward 16/17 SBA based on 24 beds x 365 x 80% occupancy level = 7,008.
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	Bluestone (Willows)		FCEs	302	Roll forward 16/17 TFR total of 302 (Bluestone 159 + St Luke's 143) as 17/18 TFR = 253 (Bluestone 151 + St Luke's 102)
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	Bluestone (Willows - POA FMI only)		Occupied Beddays	13,624	Source: 16/17 TFR Bluestone = 5,496 & St Luke's Hospital 7128 =13,624 Total. 17/18 TFR = 12,345 (Bluestone 5,346 + St Luke's 6,999)
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	Bluestone		Total Cons Led Atts	1,690	Source: Roll forward 16/17 SBA based on 13/14 TFR as 17/18 TFR = 1,[illegible]

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column	Notes 19/20
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	Bluestone		New OP Atts	546	Source: Roll forward 16/17 SBA based on 13/14 TFR as NOP Atts not recorded in 17/18 TFR
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	Bluestone		Review OP Atts	1,144	Source: Roll forward 16/17 SBA based on 13/14 TFR = 1,144, as ROP Atts not recorded in 17/18 TFR
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	DHH		Total Cons Led Atts	1,144	Source: Roll forward 16/17 SBA based on 13/14 TFR as 17/18 TFR = 893
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	DHH		New OP Atts	343	Source: Roll forward 16/17 SBA based on 13/14 TFR as NOP Atts not recorded in 17/18 TFR
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	DHH		Review OP Atts	801	Source: Roll forward 16/17 SBA based on 13/14 TFR as ROP Atts not recorded in 17/18 TFR
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	St Luke's Hospital		Total Cons Led Atts	1,386	Source: Roll forward 16/17 SBA based on 13/14 TFR as 17/18 TFR = 997
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	St Luke's Hospital		New OP Atts	441	Roll forward 16/17 SBA based on 13/14 TFR as NOP Atts not recorded in 17/18 TFR
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	St Luke's Hospital		Review OP Atts	934	Roll forward 16/17 SBA based on 13/14 TFR as ROP Atts not included in 17/18 TFR
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	Lurgan		Daycare	1,553	Source: Roll forward 16/17 SBA based on 14/15 TFR as 17/18 TFR= 1,101
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	Mullinure		Daycare	1,551	Source: Roll forward 16/17 SBA based on 14/15 TFR as 17/18 TFR= 1,095
ELD	Hospital	Hospital (PoC4) Old Age Psychiatry	STH		Daycare	1,601	Source: Roll forward 16/17 SBA based on 14/15 TFR as 17/18 FR= 1,195
ELD	Hospital	Hospital (POC4) Intermediate Care	Lurgan		Commissioned Beds		
ELD	Hospital	Hospital (POC4) Intermediate Care	Lurgan		Admissions		
ELD	Hospital	Hospital (POC4) Intermediate Care	STH - Loane House		Commissioned Beds		
ELD	Hospital	Hospital (POC4) Intermediate Care	STH - Loane House		Admissions		

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column	Notes 19/20
ELD	Hospital	Hospital (POC4) Intermediate Care	Other - Spot Purchase		Admissions		
ELD	Other Comm/PSS	Domiciliary Based - Intermediate Care			No Of Referrals		
ELD	Other Comm/PSS	Domiciliary Based - Intermediate Care			No of Service Users Accepted		
		TOTAL					

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POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column
MH	Nursing	Addiction team CPNS			Face to Face contacts	
MH	Social Work	Addiction team Social workers			Active Caseload	
MH	Other Comm / PSS	Cognitive Behavioural Therapist			Face to Face contacts	
MH	Other Comm / PSS	Non Inpatient Psychological Therapy Services	Statutory	O/P	Consultations	998
MH	Other Comm / PSS	Support and Recovery Practitioners	Statutory	O/P	Face to Face contacts	
MH	Other Comm / PSS	Community Mental Health Team	Statutory	O/P	Face to Face contacts	34,323
MH	Other Comm / PSS	Community Infrastructure - Community Support Workers			Face to Face contacts	
MH	Other Comm / PSS	Primary Mental Health Care	Statutory	O/P	Face to Face contacts	12,940
MH	Other Comm / PSS	Home Treatment/Crisis Response Team	Statutory	O/P	Face to Face contacts	TBC
MH	Other Comm / PSS	Talking Therapies Hub	Mixed	O/P	Face to Face contacts	2,400
MH	Other Comm / PSS	Personality Disorder Services		O/P	Face to Face contacts	456
MH	Other Comm / PSS	Forensic Services		O/P	Face to Face contacts	88
MH	Other Comm / PSS	Day care services	Private		Attendances	20,47[illegible]
MH	Other Comm / PSS	Day care services	Statutory		Attendances	4,764

PSC Appendix 8

SCHEDULE 5b - ACTIVITY PROGRAMME OF CARE: MENTAL HEALTH

POC	2012 SRF Grouping	Service Line Descriptor	Sector	Type	Currency	19/20 Draft Proposal Based on Notes column
MH	Other Comm / PSS	Day care services	Private		Adults in Receipt	137
MH	Other Comm / PSS	Day care services	Statutory		Adults in Receipt	8
MH	Other Comm / PSS	Day Opportunities			Adults in Receipt	26
MH	Other Comm / PSS	Community Dental			Face to Face Contacts	3,080
MH	Other Comm / PSS	**Domiciliary Care - TOTAL**			**Total hours delivered**	**165,721**
MH	Domiciliary Care	Domiciliary Care - Independent	Private		Total hours delivered	72,066
MH	Domiciliary Care	Domiciliary Care - Voluntary	Voluntary		Total hours delivered	
MH	Domiciliary Care	Domiciliary Care - Statutory	Statutory		Total hours delivered	48,552
MH	Domiciliary Care	Domiciliary Care - Dual	Dual		Total hours delivered	-
MH	Domiciliary Care	Domiciliary Care - SDS/Direct Payments			Total hours delivered	45,11
MH	Other Comm / PSS	Drop in centres				

PC Appendix 8